



# How is a large-scale reform perceived by citizens in Finnish primary health care?

Laura Kihlström<sup>a,b,\*</sup>, Ilmo Keskimäki<sup>a,c</sup>, Henna Paananen<sup>d</sup>, Satu Paatela<sup>a</sup>,  
Markku Satokangas<sup>a</sup>, Liina-Kaisa Tynkkynen<sup>a</sup>

<sup>a</sup> Welfare State Research, Finnish Institute for Health and Welfare, Mannerheimintie 166, 00300, Helsinki, Finland

<sup>b</sup> Department of Anthropology, University of South Florida, 4202 E Fowler Avenue, Tampa, FL, 33620, United States

<sup>c</sup> Faculty of Social Sciences, Tampere University, FI-33014 Tampere, Finland

<sup>d</sup> Faculty of Management and Business, Tampere University, Finland

## ARTICLE INFO

### Keywords:

Health systems  
Anthropology of policy  
Reform  
Ethnography  
Citizens  
Nordic countries

## ABSTRACT

We build on the anthropology of health systems and policy to study how Finland's 2023 health and social services reform has been perceived and experienced by citizens, and how these perceptions reflect broader societal shifts. We draw on interviews ( $n = 65$ ) and 11 months of ethnographic fieldwork completed from January to November 2024 in Finnish primary health care in three regions. Citizen reactions towards the reform were mixed, ranging from fear to distrust and from indifference to cautious acceptance. Older citizens, in particular, view the reform as a turning point which alters the relationship between them and public healthcare services, and more broadly between citizens and the state. This perception has been amplified by austerity politics and measures taken during reform implementation, mainly closing of local health care centers, swift transition to remote care, and lack of citizen engagement during the implementation process. We introduce the concept of exceptionalism complacency to critique the assumption that universal health care in Nordic countries is inherently stable. In Finland, this complacency manifests itself as the tendency of politicians, policymakers, administrators, and sometimes researchers to take citizens' trust for granted, as system-focused analyses of the reform, and as a disregard of local needs in policy implementation. There is a risk that this might fuel resentment towards public institutions and the reform by leaving more vulnerable citizens behind. Citizens' experiences regarding changes in health care should therefore be carefully monitored.

## 1. Introduction

Around the world, countries with welfare systems that have historically provided free, publicly funded healthcare are experiencing major changes (Kehr et al., 2023). These are part of a longer-term change and have been well documented by anthropologists since the 1990s, a period of rapid social change and neo-Keynesian economics being replaced by neoliberal thinking (Shore and Wright, 1997). During the past decade and a half, anthropological scholarship and ethnographic work on health systems has increased significantly (Closser et al., 2022). This work has highlighted how studying health policy continues to be a powerful lens for "examining large-scale transformations in systems of governance and in the operations of power" (Shore & Wright, 2023). It has demonstrated the relevance of ethnographic work in studying the impact of policy among those targeted by it, offering counter-evidence

to policy knowledge production (Qureshi and Tichenor, 2024). Anthropological work has also highlighted the conditions under which the idea of "health for all" has continued to persist despite external pressures such as austerity politics (Kehr et al., 2023).

This article builds and expands upon anthropological studies on health systems, including medical anthropological studies conducted in the context of Nordic countries. Despite documented inequities within Nordic health systems, Nordic countries still often rank high in international comparisons on health care affordability and have been described as equity-focused (Autto et al., 2022; Keskimäki, 2010; Mackenbach et al., 2008). Furthermore, Nordic countries are also often characterized as societies with egalitarian principles, high trust between citizens and institutions and as global leaders in civil liberties and political rights and gender parity (Freedom House, n.d.; Greve et al., 2021; OECD, 2021; World Economic Forum, 2024). A critical stance towards

\* Corresponding author. Welfare State Research, Finnish Institute for Health and Welfare, Mannerheimintie 166, 00300, Helsinki, Finland.

E-mail address: [laura.kihlstrom@thl.fi](mailto:laura.kihlstrom@thl.fi) (L. Kihlström).

<https://doi.org/10.1016/j.socscimed.2025.118688>

Received 25 April 2025; Received in revised form 3 October 2025; Accepted 12 October 2025

Available online 14 October 2025

0277-9536/© 2025 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

these notions entails that they may amplify the trope of Nordic exceptionalism and in the context of health care, it may lead to associating struggles related to achieving universal health coverage to low-income countries, leading to an unwillingness or inability of Nordic countries to study exclusions and inequities in their “own backyard” critically (Fredriksson, 2024; Kehr et al., 2023; McKee et al., 2013). Medical anthropological studies conducted in Nordic countries have documented shifting attitudes towards the welfare state and its role in healthcare provision (Alava et al., 2025; Ingstad and Talle, 2009; Mikkelsen, 2019; Spalletta, 2025; Svendsen et al., 2018). In the context of Finland, for example, Alava and colleagues (2025) use the case of a new children’s hospital to demonstrate how previously taken-for-granted aspects of Nordic health systems are being challenged by the emergence of charity as a key player in funding public health services within a “post-welfare state”.

Indeed, Nordic health systems are not immune to challenges described in health systems in other contexts, such as the growing influence of financialization and commercial determinants on health systems, politics of resentment, rising authoritarianism, and the social impacts of rapid technological changes (Al Dahdah and Mishra, 2023; Cordilha, 2023; Mulligan and Brunson, 2020; Shore & Wright, 2023; Unruh and Rice, 2025). There are indications of ongoing, long-term paradigmatic changes in Nordic countries’ health systems, including declining trust towards public health systems, rise in voluntarily purchased private insurance, a context of growing economic inequality as well as questioning of the welfare state model among society’s wealthiest (Kantola and Kuusela, 2024; Kuusela, 2022; Sointu et al., 2021). Recent work has also brought forward how Nordic welfare states create different citizen-based bordering mechanisms, such as excluding undocumented migrants from their health care services (Bendixsen and Näre, 2024; Tervonen et al., 2018).

Against this background, our aim in this paper is to bring into conversation the anthropologies of policy and health systems with current changes taking place in one Nordic country, Finland. Among the Nordic countries, Finland makes a particularly compelling case as the country has recently gone through a major restructuring of its health system through an administrative reform implemented in early 2023. Much like health systems themselves, reforms are not merely administrative or technical events but inflection points and system shocks during which the values and rationales of health systems are brought to light and can be studied.

Prior anthropological and social scientific work on reforms has brought forward that while reforms and reformist language often bring about a narrative of progress, reforms often also promise too much and continue to reinforce inequities that were present in the past (Castañeda, 2020; Dao and Mulligan, 2016; Horton et al., 2014; Lashaw, 2010; Muinde and Prince, 2023; Razon and Sideman, 2022). Indeed, reforms provide a fruitful entry into one of the core domains of analyses in the anthropology of policy, namely what policy is and what policy does (Shore & Wright, 2023). This question can be explored by anthropologists through robust ethnography which helps to uncover “quiet cues” among those targeted by health policy (Closser et al., 2022; Qureshi and Tichenor, 2024). How, we ask, is the Finnish health system reform experienced by its users? How are those experiences at odds with the reform’s national objectives, and what does this reveal about the broader operations of power and societal change?

We contextualize our findings by introducing the concept of exceptionalism complacency. Exceptionalism complacency offers a critical lens through which to examine the narrative of Nordic exceptionalism, particularly in Finland. While high levels of trust and social mobility have long been characterized as hallmarks of Nordic societies, this narrative can also obscure inequalities and foster a false sense of stability (Conolly et al., 2025; Delhey and Newton, 2005; Fochesato and Bowles, 2015). In Finland, this complacency is evident in the so-called “Finnish paradox”, where citizens express strong trust in institutions yet report low-political self-efficacy, potentially undermining democratic

engagement (OECD, 2021). Extending this critique to the health care sector, we argue that exceptionalist assumptions risk masking the challenges facing universal health care in Finland. By focusing predominantly on administrative and organizational aspects, politicians, policymakers, administrators and sometimes researchers may neglect the lived experiences and socio-cultural dimensions of health system changes, thereby potentially alienating citizens and weakening public trust. To date, in Finland, scant attention has been paid on how citizens are responding to ongoing changes in the health care system. Our study responds to this gap by foregrounding local perspectives and emphasizing the need for more citizen-engaged methods to study health care reform.

## 1.1. Study context

### 1.1.1. Health system in Finland

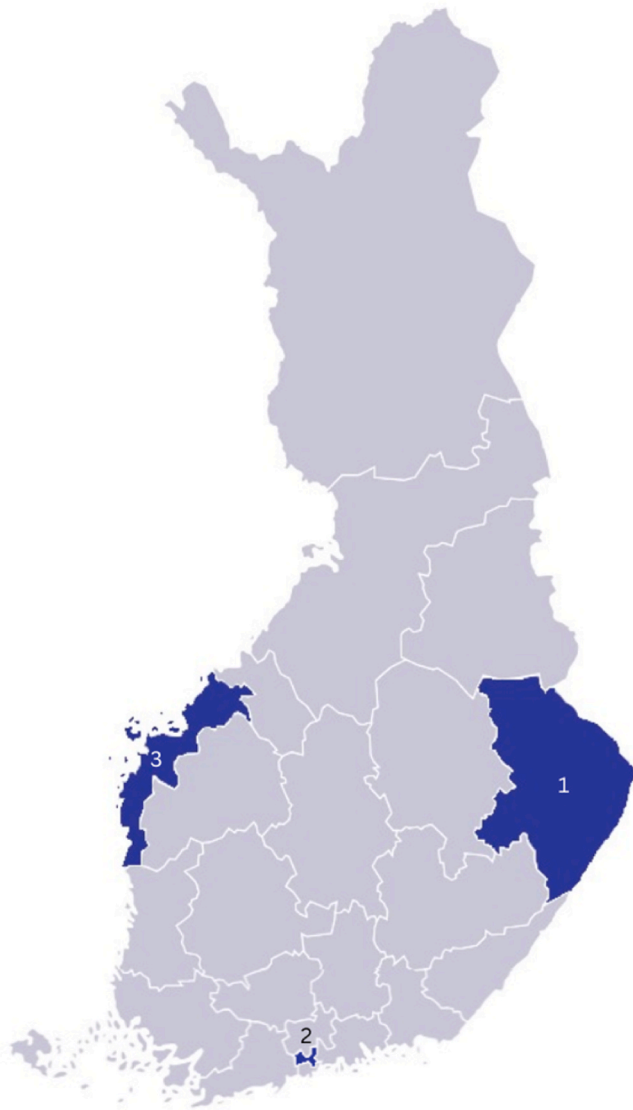
The context for our study is the Finnish public health care system, a tax-funded health system which traditionally has relied on strong public stewardship and provision in public health care services. This system ensures that all permanent residents of Finland have the right to receive necessary healthcare. All permanent residents are covered by the public health care system, but there are also parallel channels for accessing ambulatory care services. Individuals can choose to use private health services which are funded with out-of-pocket payments, private health insurances and with small reimbursement from national health insurance funds. Employers also organize primary health care services as part of occupational health care contracts and a large share of the population accesses primary care through this channel. This makes the Finnish public primary health care system fragmented and in that way the system differs from those in other Nordic countries (Tynkkynen et al., 2021).

In the public health care system, access to primary care is possible by directly arriving to a health care center (HCC) or via telephone (including callback), and more recently also via telemedicine solutions (e.g., symptom questionnaires and online messages). Public health care in Finland does not yet allow direct online appointment booking for GP consultations. The initial contact is to registered nurses who assess the need for care and then either give basic level medical advice, consult a GP or book an appointment. Usage of tax-funded public primary health care requires some out-of-pocket payments with National Health Insurance covering main portion of medication fees (Tynkkynen et al., 2021). Access to specialist care requires a GP referral (Tynkkynen et al., 2024).

### 1.1.2. History of health system reform

The reform in focus centralized power from the local level to the state, with financing now being steered from the national level and organizing of services centralized into larger regional administrative structures called well-being services counties (WSCs) which are governed by democratically elected councils (Fig. 1) (Tynkkynen et al., 2024). The reform marked not only an administrative but cultural shift, as prior to the reform, over 300 municipalities were responsible for organizing health care and social services, and after the implementation of the reform, this responsibility was now on the 21 newly established WSCs, the city of Helsinki, and the HUS group (former hospital district of Helsinki and Uusimaa).

The need for the reform was acknowledged already in the early 2000s after which successive governments have made varying proposals to reform the system. The key drivers for the reform were population ageing, population concentration in larger cities, widening regional disparities, poor access especially to public primary health care services, shortage of personnel and later also the need to curb increasing costs of health and social services. The proposals were different in terms of the structural solutions but the aims and acknowledged drivers were widely shared across the political spectrum. It was indeed the structural issues (e.g. centralization vs. decentralization, the number of entities



**Fig. 1.** The WSCs involved in this study are marked with blue: North Karelia (1), Vantaa and Kerava (2), and Ostrobothnia (3). (For interpretation of the references to colour in this figure legend, the reader is referred to the Web version of this article.)

responsible for the services, the funding model) which were at the core of the political debate - not so much the reform aims or justifications. The different structural reforms that were proposed over the years shaped the idea of the reform and what was possible to do in the context of the Finnish system both politically and in terms of the legislative framework, eventually the Finnish constitution. Thus, the long process created also path dependencies through which the final form of the reform eventually came about (Tynkkynen et al., 2024).

The history of the current reform can also be placed in a continuum of long-term changes to the Finnish welfare state, particularly in the context of financial crises during the past three decades. Kantola and Kananen (2013) argue that the financial crisis and deep recession which occurred in Finland in the early 1990s opened a window of opportunity for the Ministry of Finance for becoming a major power broker and starting an ideological shift towards dismantling the Nordic welfare state paradigm, one which was in contrast with party and popular support but popularized the political strategy of national competitiveness for subsequent governments, often resulting in cuts to the public sector. Regarding health care, economic adjustments made during this

era in the 1990s prioritized hospital care over primary health care, a trend which continues to date and which may have deepened inequities given the multiple channels of access to primary health care in the Finnish system (Keskimäki, 2003). In the aftermath of the 2008 financial, economic, and euro crises, Finland voluntarily adopted austerity policies, albeit later than other European countries. Austerity policies were justified in parliamentary discussions in the mid-2010s as necessary for maintaining Finland's autonomy in decision-making as a member state in the European Union, and for saving the welfare state (Autto et al., 2022).

Yet, according to Lehto et al. (2015), responses to the financial crisis in the mid-2010s were not able to create paradigmatic changes to the Nordic public and equity-oriented health systems. This may be because austerity policies then mainly focused on weakening unemployment and basic benefits as well as adjustments in pensions, although they also led to a decrease in public spending on health and increases in co-payments for public health care services (Saari and Tynkkynen, 2019; Tervola et al., 2021). Since then, growing concerns have emerged about deepening structural inequalities in Finnish health care and regarding ideological shifts towards individual responsibility over welfare state systems (Ahola-Launonen, 2016). These shifts have been documented for example in evolving state-market relations in eldercare (Hoppania et al., 2024). During the time of the reform implementation in 2023, Finland was in a similar position with many other high-income countries which have traditionally provided access to universal health care; after increases in health spending during the COVID-19 pandemic, other government priorities, such as defense and energy, now increasingly compete with health for public spending, with potential and likely repercussions for the welfare state "service promise" (OECD, 2024). It is likely that the post-reform years will continue to reveal shifts in Finland's welfare state, including changes in the balance between public, private, and third sector service provision, growing tensions around eligibility for universal services, and debates over centralization versus local autonomy.

### 1.1.3. Implementation of the reform

It is against these long-term developments that the current reform to the Finnish health system was signed into law 2021 by a left-center government and finally implemented in 2023 with a right-wing government in power. The first two years of reform implementation were characterized by political polarization and critique towards the reform by political parties which were in opposition during the time of the reform being passed into law. Implementation also took place in the context of poly-crises; during a pandemic which had already put a strain on the health system and its workforce as well as during an inflation and energy crisis caused by Russia's unprovoked invasion of Ukraine. The five national objectives set for the reform were: 1) strengthening prevention, 2) improving integration, availability and continuity of services, 3) clarification of the service system, 4) improving effectiveness and cost-effectiveness, and 5) improving preparedness and treatment during disruptions (Ministry of Social Affairs and Health, 2024). However, none of these broad and potentially conflicting objectives were given priority, nor were indicators set for achieving them. The first two years of the reform's implementation have been characterized by cost containment measures due to large deficits reported by the new administrative structures (Tynkkynen et al., 2024). While no officially compiled reports are yet available, national news sources have reported that over 100 local HCCs will be closed during the coming years, and many HCCs will have less comprehensive services in the future (Rautavuori and Kammonen, 2024). It must also be noted that a major parallel shift with the reform has been that of shift to transition towards telemedicine. As in many countries, the COVID-19 pandemic accelerated the transition towards telemedicine also in providing GP appointments (e.g., via chats and video consultations), a development which was further emphasized by the reform's cost containment measures.

## 2. Materials and methods

This research was completed as a multi-sited ethnography as part of a larger research study focusing on the political determinants of health and health equity in the context of a health care reform. All data presented in this article were collected by the lead author, while other authors contributed to the conceptualization of the research study, preparations of fieldwork and obtaining of ethical permits, data analysis, as well as write-up of the article. Throughout the article, we deliberately use the word citizen rather than patient to conceptualize health care systems as part of society's critical infrastructure and a site for democratic encounters and engagement (Menon et al., 2025). The word citizen also better encapsulates citizens' diverse experiences at health care facilities not simply as patients caring for their own needs but also as caregivers of others, such as their children or elderly parents. Here, we understand the term citizen broadly, meaning anyone who participates in society, not as a term with linkages to any legal status in the country. Therefore, in this study the term also covers people who do not have Finnish citizenship.

### 2.1. Data collection

Our multi-sited ethnography was conducted in three primary health care centers (HCC) in newly established WSCs: North Karelia, Vantaa and Kerava, and Ostrobothnia in Finland (Fig. 1). Given this focus on HCCs, it should be noted that our study produced specific type of data as it primarily, but not exclusively, brings forward the perspectives of citizens who do not have access to the previously mentioned parallel channels to primary care, i.e. occupational health care or private health care. The regions were selected to represent differences in terms of geography, health outcomes, and the ways in which the reform and the allocation of funds impacted the funding base of the region. The representation of different regions in the article also accounts for Finland's demographic and linguistic diversity, for example, the Swedish-speaking minority as well as the presence of other home languages in Finland, such as Russian, Somali, and Arabic. The locations of the HCCs beyond the region are not revealed to protect the anonymity of the participants.

The data for this study were collected between January and November 2024 which marks the second year of reform implementation. The article draws upon semi-structured, in-depth interviews ( $n = 65$ ) as well as observations and informal discussions conducted with patients in the HCCs. We used a semi-structured interview guide, recorded all interviews with participants' consent and transcribed them verbatim using an external transcription service. The recorded interviews and transcripts form the majority of data utilized in this article and are complemented by field observations or highlights from informal discussions when relevant. Study participants were recruited using purposive and snowball sampling. The lead researcher promoted the study through flyers posted on the walls of the health care center (HCC) and staffed an information desk with additional details. HCC staff also distributed flyers during patient appointments. Interested participants either approached the researcher directly at the HCC or contacted them by phone to schedule a meeting. Recruitment flyers were available in multiple languages (Finnish, Swedish, and English in all places, and additionally in Vantaa and Kerava in Arabic, Somali, and Russian). Eligibility criteria included being over 18 years old and a user of HCC services. While participants were not financially compensated, small giveaways—such as pens, candies, and reflectors from the researcher's institute—were available at the information desk.

The total number of interviews was distributed across three regions: North Karelia ( $n = 31$ ), Vantaa and Kerava ( $n = 18$ ), and Ostrobothnia ( $n = 16$ ). Interviews were completed by the lead researcher in Finnish, Swedish, and English. Additionally, two interviews were completed with the help of a translator in Russian and Somali. The majority of interview participants were over 66 years old, had multiple chronic health

conditions and were retired. While this means that the sample is biased towards older adults, the study participants' profile aligns quite accurately with the population that are frequent users and thus "key clients" public primary health care (Satokangas et al., 2025). The research was completed in accordance with ethical guidelines of the Finnish National Board on Research Integrity of research completed with human participants. Ethical permits for data collection were first obtained from the Finnish Institute for Health and Welfare and then from each participating well-being service county.

### 2.2. Data analysis

The data analysis began already during fieldwork and included the lead researcher's own observations, questions, and interpretations of the collected data (Small and Calarco, 2022). Systematic coding of the data was completed by the lead researcher after the fieldwork ended and was done on AtlasTi version 9.1. The data analysis on Atlas.Ti followed an iterative process and included both inductive and deductive coding as outlined by Bingham (2023). The data were first categorized into broad codes which were pertinent to the research questions in the project and included titles such as "reform" and "access" and "availability". Data for this article include data which was coded under the broad code of "reform", totaling circa 120 segments of data as well as 70 field note entries. These segments were coded with a more inductive approach to identify themes from each participating region. Throughout the process, the lead researcher utilized memos to link early findings back to relevant literature, particularly on prior work related to anthropology of reform, as well as health systems and policy research. Any quotations in Finnish and Swedish were translated by the lead author into English.

We did not calculate inter-coder reliability statistics. Instead, rigor was ensured through established practices, including collaborative discussions, maintaining an audit trail of theme development and field reflections, and regular debriefings with a multidisciplinary research team (Lincoln and Guba, 1985; Small and Calarco, 2022). In addition to anthropology, the team's expertise includes health and social policy, medicine, and political science, with some members having clinical experience in Finnish primary health care. Regular team debriefings were essential for interpreting the findings, particularly discrepancies regarding whether citizen experiences were directly linked to the current reform or shaped by broader factors. To address this complexity, we provide contextual information to highlight regional differences. By the time of writing, initial findings have also been presented at two of the participating HCCs for community validation of the data. Additionally, as part of the wider research project, we are also conducting mixed methods analyses to triangulate the qualitative findings with quantitative data on post-reform health care access across the three regions.

## 3. Findings

In what follows, we first present key findings from each participating region. The findings are presented per participating region as to not flatten local variability as part of the qualitative approach and local focus (Chowkwanyun, 2022). After this, we draw together some of the similarities and differences in the three regions, followed by a discussion section on how the findings could be interpreted. Demographic information of each region as well as how they compare to the rest of Finland can be found in Table 1. The themes are presented in a narrative format with key quotations and each quote including an identifier for the interviewee. Some quotes may have been shortened for the purposes of clarity, but the original meaning of the quotes has never been modified.

### 3.1. Region 1: North Karelia

The studied HCC in North Karelia is located in a rural town with a circa 50-min distance to the capital of the region via public transportation. North Karelia as a region has been prioritized in national

**Table 1**  
Demographic information of the three regions in the study.

2024	North Karelia	Vantaa and Kerava	Ostrobotnia	Finland in total
Population at year end	162 091	289 730	178 749	5 635 971
Land area, square kilometers	22 903	271	17 834	390 905
Population density, population/km <sup>2</sup>	8,6	1077	24,1	18,4
Population aged 0–18 as % of total population	16,8	20,8	20,9	19,1
Population aged 18–64 as % of total population	55	63,9	56,6	58,4
Population aged 65 and over as % of total population	29,2	16,5	23,7	23,6
Demographic dependency ratio <sup>a</sup>	72,3	48,5	65,8	61,6
Unemployed people, as % of labour force	13,8	12,4	6,5	10,8
Native language other than Finnish, Swedish or Sami per 1000 inhabitants	65,8	272	106,9	108,3
Number of municipalities in area <sup>b</sup>	13	2	16	308

<sup>a</sup> The number of people aged under 15 and over 64 per hundred working-age people aged 15–64. The greater the number of children and/or retirement-age people, the higher the dependency ratio is.

<sup>b</sup> Ministry of Social Affairs and Health (2025). <https://stm.fi/en/wellbeing-services-counties-on-the-map1>.

The National Institute for Health and Welfare (2025). Statistical information on welfare and health. <https://sotkanet.fi/sotkanet/en/index?>

public health interventions and in the development of primary care facilities (HCCs) particularly in the 1960–1980s due to high incidence of coronary disease and disparities in access to health care (Harjula, 2016; Honkasalo, 2008; Jauho, 2021). Rapid structural transformations in the Finnish economy from an agrarian-based economy to an industry and service-based economy as well as the 1990s recession have left their marks on regions like North Karelia which has experienced loss of jobs and outmigration (Kantola, 2022; Kiander and Vartia, 1994). At the studied HCC, the majority of study participants who participated in interviews were over 66 years old (75 %), women (65 %), retired (84 %), and had one or more chronic health conditions (84 %). Compared to the rest of the country, North Karelia has established a regional model for organizing health care services already early on in 2017, making it a pioneer for implementing such an administrative structure prior to the nationwide reform.

We found three major themes related to citizen perceptions regarding the current reform: growing state retrenchment, widening digital inequalities, and distrust towards “distant elites”. These perceptions closely linked to the history of earlier reforms in the region, experiences of welfare state retrenchment over time, as well as experiences during the covid-19 pandemic. First, citizens at the HCC were skeptical about how the new reform could solve existing problems, as they already associated reform with less accessible services. Many feared that the new reform would mean further state retrenchment through closing of local health care centers and through centralizing services to bigger cities and towns:

There were these promises that when they have larger organizing structures, they could take better care of us. But this is only becoming worse. They keep complaining that there is no money. That hasn't changed one bit. (North Karelia\_P28)

Indeed, centralization of services has often been deemed necessary to maintain accessible and universal health care services in an aging country such as Finland, yet this notion was challenged by citizens in

North Karelia who posed that the promise of more accessible health care through larger organizing structures had not materialized. Such disappointment was often channeled in the interviews and informal discussions through measuring the current as well as the 2017 reform against the past. The past, many felt, was characterized by not only better access but a more humane approach to healthcare:

I felt that I received more personal services. I was not just a figure being pulled on a conveyor belt ... Physical access is the most crucial thing. If they take that away from you, then they don't take care of you. It's neglect. I think it's neglect towards people that they take these services somewhere ... I have a car, so I can access those services too. But the elders, they can't. (North Karelia\_P27)

The history of reform in the region was also associated with a healthcare that had become more complicated for the patient through the administrative and bureaucratic hoops that one had to get through in order to receive care. This related particularly to general practitioner's (GP) appointments. The difficulty in accessing GP appointments at the local level had led to many seeking services at the hospital in the region's capital, which included additional costs particularly for older adults and those with restricted mobility due to reliance upon state-supported taxi services.

Second, citizens' perceptions of a retrenching welfare state were intensified by a transition to remote care in the region – i.e., emphasizing telemedicine solutions in booking GP appointments as well as meeting GP via chat or video consultation. For many older adults, this transition had happened too quickly with a top-down manner that disregarded local realities and patient needs. The development towards more remote care had begun already prior to the implementation of the current reform, and now citizens were expressed worry towards remote care becoming the norm for public health care. One participant recalled how the push towards remote care in North Karelia had happened during prior years without much consultation from citizens:

The most troublesome situation was when they decided, when they had these consultants with them. They introduced this sort of family nurse that you called. I don't remember what they called this system, but it had quantitative targets. I read in the local paper that they aimed at treating 70 % of patients without seeing them. I found that to be strange, to have a quantitative target regardless of what type of patients you are treating. (North Karelia\_P18)

It is important to note that for many citizens remote services per se were not always the issue. For example, many saw the developments as positive, such as being able to book laboratory times remotely and not having to queue at the HCC. Similarly, had the patients already established trust with a health care professional, remote care as part of healthcare was considered a positive development. The problem according to citizens, however, was that the transition to remote care was now often considered a blanket solution despite people's individual experiences and illness histories. As a result, how citizens were able to navigate remote systems of care seemed to be contributing to inequalities in accessing care.

I hope they keep some kind of physical services even in smaller places. You know, the types of services that grandmas and grandpas can visit even if they don't own a car. It could be just a nurse's consultation, but they could speak to that person about their situation, because not all of them know even how to use a computer. There's a lot of people who don't use a computer. For example my partner refuses to use one. (North Karelia\_P10)

Indeed, throughout the fieldwork, the lead researcher encountered individuals who were either unable or unwilling to navigate digital systems or booking care remotely, which led them to continuing the “old ways” of navigating healthcare: walking to the local health center and seeking personal guidance from an information desk or patient office. Due to strained resources, however, the person at the info desk was not

able to spend all their working hours there but had to complete paperwork in separate area at the HCC. Having no one present at the info desk baffled some of the patients and left them feeling neglected or lost in navigating the system or going to their appointments angry. According to our observations, this lack of personal contact affected not only older adults who were unable to navigate remote care but also persons who were new to the region, had multiple care needs (such as having older parents or a disabled child to care for), or spoke other language as Finnish as their home language.

Third, alongside citizen experiences related to perceptions of welfare state retrenchment over time and less accessible healthcare through a transition to remote care, the current reform was viewed as mostly benefiting “distant elites”. For citizens, such elites represented either those in administrative or leadership roles in the newly established WSCs or those in the national government. In many conversations, citizens juxtaposed the deterioration of primary health care services and lack of resources with money spent on “well-paid positions” in the WSCs, suggesting that the reform had only benefited elites, despite the fact that the WSCs councils had been democratically elected. Particularly older adults experienced that the changes they affiliated with the reform – or prior reforms – were insulting and had breached the social contract of the Finnish welfare state:

When you think about it, all these systems have been built with society’s (public) money. You know, all the foundations: roads, electricity, boats and all. No one else has paid for them. No private actor has invested in them. Now they would like to take it all away, and I don’t think that’s fair at all. (North Karelia\_P6)

This citizen’s perception was an emotional response to ongoing changes in the welfare state: having a functioning society was considered a public good and the sole result of taxpayers’ money, yet there was a sense of unfairness and of fear that “they would like to take it all away”. Here, the “they” remains unspecified, but as described above, it was not uncommon for citizens to place the blame on the new administrative structures in the WSCs, the government or the abstract “system”, whereas their sympathies aligned with the health workforce at the local HCC.

### 3.2. Region 2: Vantaa and Kerava

The studied HCC in Vantaa and Kerava is located in an urban area accessible via commuter train and bus from other parts of the region as well as the city of Helsinki. Compared to the rest of the country, the population in Vantaa and Kerava is fairly young and ethnically diverse. Citizens in this region had not yet experienced large administrative reforms such as the one in North Karelia in 2017. At this HCC, participants had a broader age range than in North Karelia: 33 % were aged 35–54, 22 % were 55–65, and 44 % were over 66. The majority of participants were women (83 %), half were retired, and the majority had one or more chronic health conditions (84 %). Some distinct themes were present in the data: indifference towards the reform, fear of worsening access to services as well as growing social comparisons and divides.

First, indifference towards the reform was characterized by citizens’ sense that the reform was irrelevant from their perspective. Citizens discussed, for example, that the reform was still in its early stages of implementation, and the “worst” (mostly referring to closing of local HCCs) was viewed as happening elsewhere in Finland rather than in Vantaa and Kerava which represented a growing metropolitan area:

I haven’t experienced changes. Maybe it’s happening somewhere else in the rural areas. (Vantaa and Kerava\_P5)

Many study participants had followed the news regarding closures of local HCCs and were grateful that the same developments were not taking place in their region. The reform was also viewed as irrelevant for individuals who did not need health care services that often, and prior positive experiences from healthcare seemed to lead to more positive

citizen accounts of the reform.

I have always received care. Prior to and after the reform. Maybe I have just lucked out. Or I don’t know, maybe it is good luck to have one of those chronic illnesses that are so serious, that I am never denied care. (Vantaa and Kerava\_P16)

The fieldwork also demonstrated that in this region, the HCC had better resources for helping citizens navigate the facilities. For example, there was a patient office staffed by four practical nurses in the main area which was constantly attended by patients asking about their appointments, about how to navigate the building, and consulting questions related to care. In addition to this, there was an additional info desk at the ground floor of the HCC. Therefore, compared to the HCC in North Karelia, citizens in Vantaa and Kerava would likely always be able to find a human to seek guidance from upon their arrival to the HCC. The HCC was also surrounded by metropolitan “buzz”: a public transportation center, a mall, and a library.

Second, citizen perspectives in Vantaa and Kerava also revealed growing fears regarding how the reform might worsen services in the future. Following the news regarding reform implementation in more rural regions had its impact on how citizens in the metropolitan area viewed the future of healthcare. This related to, for example, how the centralization of services into larger structures was perceived skeptically by citizens regards to how it would affect quality of care:

Vantaa, I think, has had good services. Does the fact that we now organize services jointly with Kerava mean that these services will worsen? Having equal services has typically not meant elevating the level of services, but lowering standards for everyone. These are the type of worries I have about the well-being services counties. (Vantaa and Kerava\_P8)

The fear of worsening services was particularly salient among those citizens who had multiple health care needs and/or were older.

Us older people have all kinds of ailments. Each and everyone of us. I only realize it now that I am seventy years old. How will this end? Probably so that we will no longer be able to see the doctor ... I am scared. What will happen when they tighten the budget even more? (Vantaa and Kerava\_P7)

In Vantaa and Kerava, these fears seemed to be partly assuaged by the fact that similar cuts to services had not yet occurred in the metropolitan areas, but the future nevertheless seemed uncertain. The future seemed particularly uncertain for those who had multiple health care needs. One respondent who was on disability pension described themselves as needing “lots of services” due to chronic illnesses. They described being worried about the direction towards which health care was headed. This direction, they described, had been detectable for years, with a lot more administrative and bureaucratic hurdles for individuals to pass through before receiving help. While these changes had been years in the making, they described the reform and the way it had been implemented as a turning point for healthcare:

I am not a leftist. But these cuts are too hard and ideological ... we are heading in the wrong direction. This is also a matter of security. When people trust public services and when they are healthy, they can also trust society. That maintains cohesion, and we can defend our country. Now all of this is heading downwards. It’s becoming more unequal, and trust in the welfare state is crumbling. We have already seen our education (system) crumble. I see this through my own grandchildren. Now we are about to see the same happen in healthcare. This is a really bad thing. (Vantaa and Kerava\_P13)

This citizen brings forward the notion that overall public support for welfare state services in Finland has traditionally remained strong. While balancing the government budget was deemed necessary by many study participants, current budget cuts were considered too harsh, focusing dominantly on primary health care, and thus having the most

impact on those who were least advantaged in society. This, as in North Karelia, challenged citizens' sense of fairness and solidarity in Vantaa and Kerava.

Third, citizen perspectives in Vantaa and Kerava revealed potential for growing social comparisons and divides between population groups. On the one hand, social comparison could mean solidarity for those in more marginalized positions. Many expressed being aware of stark social inequalities in the region and that there were differences in how different groups of people received and accessed care. There seemed to be a shared understanding that some individuals received care (such as GP appointments) faster than others, and that there were people who fell through the cracks in the system. On the other hand, there were also signs that social comparisons meant pitting population groups against each other. For example, one citizen found it that some sought health care services too frequently and strained the system:

I seek help when I need it and I have gotten it every time. And I also don't think we should seek out to use society's resources to take care of every little thing. I criticize the fact that we have gotten used to being treated too well.

Discussions also revealed racialized social comparisons. The HCC in Vantaa and Kerava served diverse populations, with many patients not speaking Finnish as their home language. This led to some older, Finnish-speaking patients to state that "nobody cares about us older people who were born in Finland" echoing the type of divisive political rhetoric sometimes employed by politicians to weaken the cultural legitimacy of universal health care systems (McKee et al., 2013)

### 3.3. Region 3: Ostrobothnia

The studied HCC in Ostrobothnia is located in a semi-rural town approximately 15 min from the region's capital via public transportation. The majority of residents in the area of the HCC speak Swedish as their home language. Amongst regions in Finland, Ostrobothnia ranks high in terms of health outcomes, employment and social cohesion, and its population has continued to grow particularly through immigration. In this region, the studied HCC had been part of a joint municipal authority prior to the implementation of a national reform to get a head start in moving towards larger administrative structures. At this HCC, 57 % of participants were over 66, 57 % were women, 63 % were retired, and 75 % had at least one chronic condition. We found three predominant themes regarding the reform in the region: a sense of declining proximity between healthcare and citizens mostly through changes in how healthcare could be contacted, reform as a necessity, and reform as challenging the ideal of a fair society and welfare state.

First, while citizens in the region had some experience of administrative reforms (such as through the joint municipal authority), the one implemented in 2023 seemed to be mostly associated with decreasing local agency. Discussions in the field revealed that citizens viewed the newly established WSCs as distant, and many joked about them calling them "ill-being services counties". Distance of the new structures was measured against the closeness and proximity that was perceived as the local HCC. Citizens described that prior to the reform it had been straightforward to contact the local HCC by phone and that they had always received excellent service. After the reform, citizens had to call a centralized phone number for the entire region. This led to a sense of decreased proximity through having to interact with health workforce that did not know them personally.

We had our own phone number. We had this A4 sheet with all the numbers to our local health care center. Now we don't have that anymore, instead they all go to the same Ostrobothnia wellbeing services county. There is only one number, which is the number to Vaasa Central hospital. And through that number they wonder where they would put us. We've had trouble in accessing the services. I am a

little impatient, so I just get in the car and drive here. (Ostrobothnia P11\_P12)

One respondent remarked that politicians were too afraid to admit that the old system had actually been better and as a result citizens now "just have to adapt to the catastrophe."

Second, however, many in the region also viewed the reform as a necessity. Discussions in the HCC revealed some sort of shared understanding that Ostrobothnia was and had been doing a lot better compared to other regions, both financially and in terms of health outcomes. Compared to other HCCs participating in this study, the studied HCC in Ostrobothnia seemed to invest the most in making the HCC appear visually pleasant, also with ample signs to navigate the building, an active info center, as well as a coffee shop which patients frequently visited. Therefore, as one respondent put it, "we have gotten used to having it too good, we are spoiled, and now the changes feel painful." From this perspective, the current changes were also seen as necessary. One respondent also said that challenges had preceded the current reform.

There is a lot of crisis talk about how they are going to close health centers. but I have always had 17 km distance to this health care center. We haven't ever had a health care center closer to us ... it is not like this is only happening now. (Ostrobothnia P8)

For some, the changes brought on by the reform were also making services more accessible. For example, those who could easily navigate digital services, described that it had become easier to access non-urgent services through the chat feature at WBSC's website.

Third, while such positive experiences existed, many associated the reform as challenging the ideal of a fair society and welfare state. This related particularity to older adults, with one respondent stating: "All that our parents built will be destroyed now", referring to the welfare state and services that had been built to Finland in the decades following World War II. The ideal of a fair society had meant that those who had contributed to the welfare state construction during their lives and careers could rely upon the state during their older years. This, many perceived, was now being challenged, and many spoke about their fears of getting older: "Where will we live? Who is going to take care of us when we are older?"

Discussions in the field in Ostrobothnia also revealed that many were skeptical that critical information from citizens would not reach those in positions in power. While critical voices regarding the reform might be ample at the HCC, one participant noted: "when this message reaches those in power, they are just told that all is well". In other words, citizen knowledge was considered to be sidelined. This led to some being skeptical about participating in citizen engagement measures available at the HCC, such as surveys distributed by the WSCs to gauge citizen opinions on health care changes. Another citizen described that the reform made it visible that "society does what is easiest", meaning that it is easiest to "fight with those who fight back the least". In other words, they described that changes to HCCs would not cause problems for decision-makers because those changes affected citizens in marginalized positions. This led to cynicism against the new administrative structures and the reform.

### 3.4. Summary of findings from the three regions

Overall, our findings show that citizen responses to the Finnish health care reform varied across regions—from fear and distrust to indifference and cautious acceptance—highlighting tensions between the reform's stated objectives and its local reception. A striking similarity between the regions was a sentiment of fear and pessimism about the future of public health care: in North Karelia, concerns about further service cuts or state retrenchment; in Vantaa and Kerava, fears over worsening care; and in Ostrobothnia, a sense of a broken social contract. These reactions likely reflect the reform's strong emphasis on cost

containment during its early implementation, despite its many other goals, including equal access. In all regions, older adults expressed concern about the rapid shift to remote care, which many felt introduced new inequities and was implemented without sufficient local input. While some individuals adapted well to remote services, many viewed the transition as abrupt and undemocratic. Notably, despite challenges in accessing care, citizens consistently expressed strong attachment to their local health care centers.

Differences in citizen responses reveal that distrust towards the reform was more pronounced in some areas. In North Karelia more so than in other regions, experiences regarding health care reform seemed to be absorbed with a broader sense of welfare state retrenchment over time, resulting in a strong sense of being left behind by the reform and the state (Fiorentino et al., 2024; Menon et al., 2025; Mulligan and Brunson, 2020). Access to in-person services appeared to influence citizen perceptions: in regions like North Karelia, where the shift to remote care was perceived as rapid, citizen responses were more negative. In contrast, Vantaa and Kerava, as well as Ostrobothnia, offered better access to in-person services—including appointments and support through patient offices—which seemed to mitigate distrust and foster less negative responses to the reform. Continued access to local health care centers or at least some in-person services may, in other words, emerge as a key factor in maintaining public support and reducing resentment towards the reform. These centers were widely valued, and cuts to them were unpopular (Fredriksson et al., 2019). The similarities and differences in citizen responses as well as in regional dynamics should be followed up in the post-reform years.

#### 4. Discussion

We have drawn on the anthropology of health systems and anthropology of policy in order to critically assess and contextualize ongoing changes in Finland's health system. Our work builds upon one of the core interventions of anthropology of health policy, that is the examining the effects of policy implementation upon the intended subjects of policies and the offering of “counter-stories and counter-evidences that dismantle narrow systems of policy knowledge production” (Qureshi and Tichenor, 2024). Through its focus on lived experience, previous anthropological work has brought forward – almost presciently – how the politics of resentment around healthcare or exclusions in healthcare can forebode broader political shifts, as has been the case in the United States (Kline, 2019, 2022; Mulligan and Brunson, 2020). In other words, health policy matters and close engagement with those affected by policy continues to be a powerful method. The anthropological lens is particularly important in the current political moment of rapidly shifting policy landscapes, crises of democracy and rising authoritarianism (Shore & Wright, 2023).

Our fieldwork shows that citizens did not perceive the reform merely as an administrative or organizational change. Many viewed the reform as a cultural and social shift which alters the relationship between them and healthcare, and more broadly between citizens and the state. These findings confirm in the context of a Nordic country what anthropologists in other settings have found; that for citizens, healthcare is not simply about accessing health services but related to moral and societal conceptions around the kinds of societies in which we wish to live (Kehr, 2023). Despite encountering challenges in accessing care, citizens in this study expressed affinity towards their local HCCs and felt sidelined by policymakers as the reform implementation had meant cuts to those same facilities. In other words, the reform seemed to at least partly carry forward reifications of the past by undermining primary health care which was viewed as more dispensable than specialized health care, a pattern which is not unique to Finland (Ho et al., 2022). This discrepancy between citizens' and policymakers' vision of progress need not result in an uncritical nostalgia towards the past (Lorne, 2024). However, it raises questions on how leaders in health systems as well as policymakers are willing to listen to and trust citizens' viewpoints as

they envision and legislate the future of such systems.

It should also be separately discussed how particularly older adults viewed the reform as a critical juncture of the Finnish welfare state and what this may mean for the health system overall. While older adults are a heterogeneous group with diverse needs and situations, they nevertheless represent one of the primary populations served by Finland's public primary health care system (Satokangas et al., 2025). The experiences of particularly low-income older adults becoming a “left behind” population in public primary care during reform implementation is a cue of growing resentment (Mulligan and Brunson, 2020). The perspectives of those who fall through the cracks in the new, reformed system make visible the cultural work that reforms do and what they “reflect about equity, deservingness, and national aspirations” (Razon and Sideman, 2022). The findings pertaining older adults resemble Forkert's (2017) notion of austerity as “public mood”, resulting in a sense of fear, increased discourses of deservingness and self-reliance, and reduced expectations for the welfare state throughout society. Additionally, although Nordic welfare systems are built on reciprocity, this same logic can be used to justify exclusion – framing some as “asking too much” from the welfare state (Spalletta, 2025). The widespread experience of older adults in our study of being grouped as “undeserving” and perhaps as “asking too much” could be an anticipatory sign of a cultural shift in Finland towards harshened national discourse on deservingness and moral considerations of who is worthy of receiving care. It should be noted from prior research that such discourses on moral deservingness weaken the cultural legitimacy of and trust towards universal health care systems (McKee et al., 2013).

Thus, despite the characterizations of Finland as a high-trust society, our findings regarding the mismatch between reform objectives and citizen perceptions raises further concerns in the lack of reciprocity in trust between policymakers and citizens in Finland (OECD, 2021). The characterization of Nordic countries as high-trust societies can also become a vulnerability if this same trust is not cared for and maintained. There is a risk that policymakers, administrators, and sometimes researchers in Nordic countries take citizens' trust for granted, and underestimate how citizens' sense of distrust or feelings of being left behind by policy may impact the legitimacy of reforms (Mulligan and Brunson, 2020; OECD, 2021). We argue that this tendency can be at least partly explained through what we call *exceptionalism complacency*, that is a tendency among politicians, policymakers, administrators and sometimes researchers in the Nordic countries to view one's health system as strong and its core mission to universal health care as stable as opposed to other countries' health systems, particularly those of lower income nations which continue to strive towards universal health care systems. As a result, this may lead to system-focused analyses of Nordic health systems which disregard their social, cultural, and political aspects, as well as the broader role of health care in shaping citizen belonging or marginalization, dignity, and trust (Closser et al., 2022; Menon et al., 2025). In Finland, specifically, this has also meant exceptionalising the reform itself and trusting that once the administrative structures are in place, the health care system will be equity-focused and accessible for citizens. Studying the health care system from the bottom up, this paper's findings challenge the notion that the core mission for universal health care in Finland is stable or that reforms that alter the core functions of the welfare state would be broadly accepted by Finnish citizens.

There are several limitations to our study. Given that our work was completed as part of a larger research study, as a team-based effort and as a multi-sited ethnography, this has certainly limited the amount of thick description in our analysis in the article. However, our purpose has been to reach an audience in the broader health systems research community rather than just anthropology (Closser et al., 2022). While our methods have provided in-depth insights into citizen experiences, they are subject to researcher interpretation and potential coder bias (completed by the lead author) during the thematic analysis. To mitigate this, the analysis included multiple rounds of coding, memoing, linking the memos back to the literature, as well as presenting early findings to a

larger research group. Finally, the data gathered in the study should be complemented with follow-ups, which would allow for establishing a long-term line of research on reform in the context of a Nordic country.

## 5. Conclusion

Globally, welfare states are undergoing rapid transformations. In this study, we have turned the anthropological lens on a Nordic country (Finland), a country in which the health system is currently being reformed. We utilized a multi-sited ethnographic approach to investigate how the health system reform is perceived and experienced by its users. Interviews and observations in local health care centers in three regions indicated that citizens viewed the reform as a critical inflection point in the Finnish welfare state. These views have been exacerbated by the context of austerity politics in which the reform has been implemented, and most notably through actual or planned closing of local health care centers, a quick and broad transition to remote care, and lack of citizen engagement in the process of reform implementation. To situate our findings, we introduced the concept of exceptionalism complacency – a critique to the assumption that universal health care in Nordic countries, in this case Finland, is inherently stable. In Finland, this complacency manifests itself as the tendency of politicians, policy-makers, administrators, and sometimes researchers to take citizens' trust for granted, as system-focused analyses of the reform, and as a disregard of local needs in policy implementation. Longitudinal research is needed to examine whether citizen perceptions change over time, as well as to better understand the long-term cultural, social, and political impacts of the health and social care reform in Finland. Anthropological work can help uncover the quiet cues that may forebode larger structural shifts or paradigmatic changes in the Nordic health systems.

## CRedit authorship contribution statement

**Laura Kihlström:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Ilmo Keskimäki:** Writing – review & editing, Validation, Investigation, Funding acquisition, Conceptualization. **Henna Paananen:** Writing – review & editing, Validation, Investigation, Conceptualization. **Satu Paatela:** Writing – review & editing, Validation, Resources, Project administration, Conceptualization. **Markku Satokangas:** Writing – review & editing, Validation, Funding acquisition, Conceptualization. **Liina-Kaisa Tynkkynen:** Writing – review & editing, Writing – original draft, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization.

## Ethics statement

The research was completed in accordance with ethical guidelines of the Finnish National Board on Research Integrity of research completed with human participants. Ethical permits for data collection were first obtained from the Finnish Institute for Health and Welfare and then from each participating well-being service county.

## Declaration of competing interest

The majority of the authors of this article all have affiliations at The Finnish Institute for Health and Welfare (THL). THL operates under the Ministry of Social Affairs and Health as a state agency for epidemiological surveillance and advising on infection control for the central government, and regional and local authorities. THL also operates as a research institute. The authors of this article have conducted this research in the study "For whom are health systems designed? Political determinants of health and equity in the context of a health system reform in Finland" (POLDEQUITY) funded by the Research Council of Finland as well as in the study "STRONG - Institutionalizing Democratic

Innovations" funded by the Strategic Research Council of Finland.

## Acknowledgements

This research has been funded by the Research Council of Finland (#354745) and the Strategic Research Council of Finland (#365701). We want to acknowledge the citizens as well as staff at the participating well-being services counties and health care centers for making this research possible. Furthermore, we thank the three anonymous reviewers whose thoughtful feedback inspired the article.

## Data availability

The authors do not have permission to share data.

## References

- Ahola-Launonen, J., 2016. Social responsibility and healthcare in Finland: the luck Egalitarian challenge to Scandinavian welfare ideals. *Camb. Q. Healthc. Ethics* 25 (3), 448–465. <https://doi.org/10.1017/S0963180116000098>.
- Al Dahdah, M., Mishra, R.K., 2023. Digital health for all: the turn to digitized healthcare in India. *Soc. Sci. Med.* 319, 114968. <https://doi.org/10.1016/j.socscimed.2022.114968>.
- Alava, H., Lindroos, J., Pihlman, A., 2025. Finland's new Children's hospital and resurgent charity in a nordic post-welfare state. *Med. Humanit.* <https://doi.org/10.1136/medhum-2024-013128> medhum-2024-013128.
- Autto, J., Törrönen, J., Huysmans, J., 2022. Fear and insecurity in the politics of austerity. *European Journal of Cultural and Political Sociology* 9 (1), 83–111. <https://doi.org/10.1080/23254823.2021.1888763>.
- Bendixsen, S., Näre, L., 2024. Welfare state bordering as a form of mobility and migration control. *J. Ethnic Migrat. Stud.* 50 (11), 2689–2706. <https://doi.org/10.1080/1369183X.2023.2298540>.
- Bingham, A.J., 2023. From data management to actionable findings: a five-phase process of qualitative data analysis. *Int. J. Qual. Methods* 22, 16094069231183620. <https://doi.org/10.1177/16094069231183620>.
- Castañeda, H., 2020. In: Mulligan, J.M. (Ed.), *Unequal Coverage: the Experience of Health Care Reform in the United States*. New York University Press. <https://doi.org/10.18574/nyu/9781479897001.001.0001>.
- Chowkwanyun, M., 2022. *All Health Politics is Local. Community Battles for Medical Care and Environmental Health*. The University of North Carolina Press.
- Closser, S., Mendenhall, E., Brown, P., Neill, R., Justice, J., 2022. The anthropology of health systems: a history and review. *Soc. Sci. Med.* 300, 114314. <https://doi.org/10.1016/j.socscimed.2021.114314>.
- Conolly, J., Abraham, G.Y., Bergersen, A., Bratland, K., Jæger, K., Jensen, A.A., Lassen, I., 2025. Beyond exceptionalism: decolonizing the nordic educational mindset. *Nordic Journal of Comparative and International Education (NJCIE)* 9 (1). <https://doi.org/10.7577/njcie.5989>.
- Cordilha, A.C., 2023. Public health systems in the age of financialization: lessons from the French case. *Rev. Soc. Econ.* 81 (2), 246–273. <https://doi.org/10.1080/00346764.2020.1870710>.
- Dao, A., Mulligan, J., 2016. Toward an anthropology of insurance and health reform: an introduction to the special issue. *Med. Anthropol. Q.* 30 (1), 5–17. <https://doi.org/10.1111/maq.12271>.
- Delhey, J., Newton, K., 2005. Predicting cross-national levels of social trust: global pattern or nordic exceptionalism? *Eur. Socio Rev.* 21 (4), 311–327.
- Fiorentino, S., Glasmeier, A.K., Lobao, L., Martin, R., Tyler, P., 2024. 'Left behind places': what are they and why do they matter? *Camb. J. Reg. Econ. Soc.* 17 (1), 1–16. <https://doi.org/10.1093/cjres/rsad044>.
- Fochesato, M., Bowles, S., 2015. Nordic exceptionalism? Social democratic egalitarianism in world-historic perspective. *J. Publ. Econ.* 127, 30–44. <https://doi.org/10.1016/j.jpubeco.2014.03.001>.
- Forkert, K., 2017. *Austerity as Public Mood: Social Anxieties and Social Struggles, first ed.* Rowman & Littlefield Publishers.
- Fredriksson, M., 2024. Universal health coverage and equal access in Sweden: a century-long perspective on macro-level policy. *Int. J. Equity Health* 23 (1), 111. <https://doi.org/10.1186/s12939-024-02193-5>.
- Freedom House. (n.d.). Countries and territories. Retrieved June 13, 2025, from <https://freedomhouse.org/country/scores?type=fiv>.
- Greve, B., Blomquist, P., Hvinden, B., Van Gerven, M., 2021. Nordic welfare states—Still standing or changed by the COVID -19 crisis? *Soc. Pol. Adm.* 55 (2), 295–311. <https://doi.org/10.1111/spol.12675>.
- Harjula, M., 2016. Health citizenship and access to health services: finland 1900–2000: table 1. *Soc. Hist. Med.* 29 (3), 573–589. <https://doi.org/10.1093/shm/hkv144>.
- Ho, C.J., Khalid, H., Skead, K., Wong, J., 2022. The politics of universal health coverage. *Lancet* 399, 2066–2074. [https://doi.org/10.1016/S0140-6736\(22\)00585-2](https://doi.org/10.1016/S0140-6736(22)00585-2), 10340.
- Honkasalo, M.-L., 2008. *Reikä Sydämessä: Sairaus Pohjoiskarjalaisessa Maisemassa. Vastapaino*.
- Horton, S., Abadía, C., Mulligan, J., Thompson, J.J., 2014. Critical anthropology of global health "Takes a Stand" statement: a critical medical anthropological approach to the U.S.'s affordable care act. *Med. Anthropol. Q.* 28 (1), 1–22. <https://doi.org/10.1111/maq.12065>.

- Ingstad, B., Talle, A., 2009. Introduction to nordic medical anthropology: special issue. *Med. Anthropol. Q.* 23 (1), 1–5.
- Jauho, M., 2021. Becoming the North Karelia project: the shaping of an iconic community health intervention in Finland (1970–1977). *Soc. Hist. Med.* 34 (4), 1212–1235. <https://doi.org/10.1093/shm/hkaa057>.
- Kantola, A. (Ed.), 2022. *Kahdeksan kuplan Suomi: Yhteiskunnan muutosten syvät tarinat*.
- Kantola, A., Kananen, J., 2013. Seize the moment: financial crisis and the making of the Finnish competition state. *New Polit. Econ.* 18 (6), 811–826. <https://doi.org/10.1080/13563467.2012.753044>.
- Kantola, A., Kuusela, H., 2024. Vanguard fantasies: the wealthy upper classes as politically spirited wealth elite establishment. *Sociol. Rev.* 72 (2), 359–377. <https://doi.org/10.1177/00380261231212779>.
- Kehr, J., 2023. The moral economy of universal public healthcare. On healthcare activism in austerity Spain. *Soc. Sci. Med.* 319, 115363. <https://doi.org/10.1016/j.socscimed.2022.115363>.
- Kehr, J., Muinde, J.V.S., Prince, R.J., 2023. Health for all? Pasts, presents and futures of aspirations for universal healthcare. *Soc. Sci. Med.* 319, 115660. <https://doi.org/10.1016/j.socscimed.2023.115660>.
- Keskimäki, I., 2003. How did Finland's economic recession in the early 1990s affect socio-economic equity in the use of hospital care? *Social Science & Medicine* 56 (7), 1517–1530. [https://doi.org/10.1016/S0277-9536\(02\)00153-3](https://doi.org/10.1016/S0277-9536(02)00153-3).
- Keskimäki, I., 2010. Sosioekonomiset erot ja oikeudenmukaisuus Suomen terveydenhuollossa. *Sosiaalilääketieteellinen aikauslehti* 47 (3), 201–207.
- Kiander, J., Vartiainen, P., 1994. The Great Depression of the 1990s in Finland. The Research Institute of the Finnish Economy (ETLA). Working Paper No. 526; ETLA Discussion Papers. <https://www.econstor.eu/bitstream/10419/187143/1/dp526.pdf>.
- Kline, N., 2019. When deservingness policies converge: US immigration enforcement, health reform and patient dumping. *Anthropol. Med.* 26 (3), 280–295. <https://doi.org/10.1080/13648470.2018.1507101>.
- Kline, N., 2022. Health and immigration systems as an ethnographic field: methodological lessons from examining immigration enforcement and health in the US. *Soc. Sci. Med.* 300, 114498. <https://doi.org/10.1016/j.socscimed.2021.114498>.
- Kuusela, H., 2022. The hyperopia of wealth: the cultural legitimization of economic inequalities by top earners. *Soc. Econ. Rev.* 20 (2), 515–538. <https://doi.org/10.1093/ser/mwaa047>.
- Lashaw, A., 2010. The radical promise of reformist zeal: what makes "Inquiry for Equity" plausible? *Anthropol. Educ. Q.* 41 (4), 323–340. <https://doi.org/10.1111/j.1548-1492.2010.01095.x>.
- Lehto, J., Vrangbæk, K., Winblad, U., 2015. The reactions to macro-economic crises in nordic health system policies: denmark, Finland and Sweden, 1980–2013. *Health Econ. Pol. Law* 10 (1), 61–81. <https://doi.org/10.1017/S1744133114000243>.
- Lincoln, Y.S., Guba, E.G., 1985. *Naturalistic Inquiry*. SAGE Publications, Inc.
- Lorne, C., 2024. Repoliticising national policy mobilities: resisting the Americanization of universal healthcare. *Environ. Plan. C Politics Space* 42 (2), 231–249. <https://doi.org/10.1177/23996544211068724>.
- Mackenbach, J.P., Stirbu, I., Roskam, A.-J.R., Schaap, M.M., Menvielle, G., Leinsalu, M., Kunst, A.E., 2008. Socioeconomic inequalities in health in 22 European countries. *N. Engl. J. Med.* 358 (23), 2468–2481. <https://doi.org/10.1056/NEJMSa0707519>.
- McKee, M., Balabanova, D., Basu, S., Ricciardi, W., Stuckler, D., 2013. Universal health coverage: a quest for all countries but under threat in some. *Value Health* 16 (1), S39–S45. <https://doi.org/10.1016/j.jval.2012.10.001>.
- Menon, A., Kavanagh, N.M., Falkenbach, M., Wismar, M., Greer, S.L., 2025. The role of health and health systems in shaping political engagement and rebuilding trust in democratic institutions. *The Lancet Regional Health - Europe* 53, 101326. <https://doi.org/10.1016/j.lanepe.2025.101326>.
- Mikkelsen, H.H., 2019. Idleness: energizing the Danish welfare state. *Anthropol. Aging* 40 (2), 37–47. <https://doi.org/10.5195/aa.2019.176>.
- Ministry of Social Affairs and Health, 2024. National service reform: reform of the content and operating methods of health and social services. <https://stm.fi/en/national-service-reform>.
- Muinde, J.V.S., Prince, R.J., 2023. A new universalism? Universal health coverage and debates about rights, solidarity and inequality in Kenya. *Soc. Sci. Med.* 319, 115258. <https://doi.org/10.1016/j.socscimed.2022.115258>.
- Mulligan, J.M., Brunson, E.K., 2020. Structures of resentment: on Feeling—And being—left behind by health care reform. *Cult. Anthropol.* 35 (2). <https://doi.org/10.14506/ca35.2.10>.
- OECD, 2021. *Drivers of Trust in Public Institutions in Finland*. OECD Publishing. <https://doi.org/10.1787/52600c9e-en>. Building Trust in Public Institutions.
- OECD, 2024. Latest health spending trends: navigating beyond the recent crises [Policy Brief]. [https://www.oecd.org/content/dam/oecd/en/publications/reports/2024/12/latest-health-spending-trends\\_7332c460/df0bb1ba-en.pdf](https://www.oecd.org/content/dam/oecd/en/publications/reports/2024/12/latest-health-spending-trends_7332c460/df0bb1ba-en.pdf).
- Qureshi, K., Tichenor, M., 2024. Anthropologies of health policy. *Anthropol. Med.* 31 (1–2), 1–17. <https://doi.org/10.1080/13648470.2024.2373012>.
- Rautavuori, L., Kammonen, T., 2024. Suomesta on katoamassa yli sata terveysasemaa. *Yleisradio*. <https://yle.fi/a/74-20077808>.
- Razon, N., Sideman, A.B., 2022. The work of reform: a critical examination of health policy. *Anthropol. Med.* 29 (4), 414–429. <https://doi.org/10.1080/13648470.2022.2144805>.
- Satokangas, M., Huhtakangas, M., Kihlström, L., Paatela, S., Karreinen, S., Keskimäki, I., Tynkkynen, L.-K., (2025). *Pitkäaikaisesti paljon ensisijaisen terveydenhuollon käyttävien ja palveluja käyttämättömien tunnistaminen kansallisesta Avohilmo-rekisteristä* (No. 4; Tutkimuksesta tiiviisti). [https://www.julkari.fi/bitstream/handle/10024/150784/TuTi2025\\_4\\_paljon%20palveluja%20k%C3%A4ytt%C3%A4vien%20ja%20k%C3%A4ytt%C3%A4m%C3%A4tt%C3%A4%20j%C3%A4tt%C3%A4vien%20tunnistaminen%20Avohilmo-rekisterist%C3%A4.pdf?sequence=4&isAllowed=y](https://www.julkari.fi/bitstream/handle/10024/150784/TuTi2025_4_paljon%20palveluja%20k%C3%A4ytt%C3%A4vien%20ja%20k%C3%A4ytt%C3%A4m%C3%A4tt%C3%A4%20j%C3%A4tt%C3%A4vien%20tunnistaminen%20Avohilmo-rekisterist%C3%A4.pdf?sequence=4&isAllowed=y).
- Shore, C., Wright, S. (Eds.), 1997. *Anthropology of Policy: Critical Perspectives on Governance and Power*. Routledge.
- Saari, J., Tynkkynen, L.-K., 2019. Still holding its breath. The Finnish welfare system under reform. In: *Routledge Handbook of European Welfare Systems*, 2nd Edition. Routledge.
- Shore & Wright, 2023. Understanding power and politics. The continuing relevance of the anthropology of policy. *Rivista di antropologia contemporanea* 2, 251–262. <https://doi.org/10.48272/112567>.
- Small, M.L., Calarco, J.M., 2022. *Qualitative Literacy: a Guide to Evaluating Ethnographic and Interview Research*. University of California Press.
- Sointu, L., Lehtonen, T.-K., Häikiö, L., 2021. The public, the private and the changing expectations for everyday welfare services: the case of Finnish parents seeking private health care for their children. *Soc. Pol. Soc.* 20 (2), 232–246. <https://doi.org/10.1017/S1474746420000287>.
- Spalletta, O., 2025. Logics of reciprocity in Denmark: longing and belonging in a virtuous cycle of welfare. *Economic Anthropology* 12 (1), e12328. <https://doi.org/10.1002/sea.212328>.
- Svendsen, M.N., Navne, L.E., Gjødsbøl, I.M., Dam, M.S., 2018. A life worth living: temporality, care, and personhood in the Danish welfare state. *Am. Ethnol.* 45 (1), 20–33. <https://doi.org/10.1111/amet.12596>.
- Tervola, J., Aaltonen, K., Tallgren, F., 2021. *Can People Afford to Pay for Health Care? New Evidence on Financial Protection in Finland*.
- Tervonen, M., Pellander, S., Yuval-Davis, N., 2018. Everyday bordering in the nordic countries. *Nordic Journal of Migration Research* 8 (3), 139. <https://doi.org/10.2478/njmr-2018-0019>.
- Tynkkynen, L.-K., Keskimäki, I., Karanikolos, M., 2024. *Finland: Health system summary*. European Observatory on Health Systems and Policies. WHO Regional Office for Europe. <https://iris.who.int/bitstream/handle/10665/379912/9789289014410-eng.pdf?sequence=1>.
- Tynkkynen, L.-K., Koivusalo, M., Keskimäki, I., 2021. Finland. In: *Health Politics in Europe: A Handbook*. Oxford University Press. <https://doi.org/10.1093/oso/9780198860525.003.0010>.
- Unruh, L., Rice, T., 2025. Private equity expansion and impacts in United States healthcare. *Health Policy* 155, 105266. <https://doi.org/10.1016/j.healthpol.2025.105266>.
- World Economic Forum, 2024. *Global gender gap 2024. Insights Report*. [https://www3.weforum.org/docs/WEF\\_GGGR\\_2024.pdf](https://www3.weforum.org/docs/WEF_GGGR_2024.pdf).