Crisis Management of the COVID-19 Pandemic: The Nordic Way and the Swedish Exceptionalism

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Abstract

This chapter examines the Nordic countries crisis management of the COVID-19 pandemic by addressing the public health measures. It first outlines the Nordic context and the policy features of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden. Second, it describes the outcome of the COVID-19 pandemic in terms of infection and death rates which were much higher in Sweden than in the other Nordic countries. Third, it gives an account of how the crisis has been managed in the five countries. The focus is on how prepared the authorities were, on the strategies and policy tools used to contain the pandemic, on leadership and politics, on crisis communication, and trust in government. Fourth, it discusses how to understand Swedish exceptionalism. While the Swedes applied a soft strategy, delegating most of the handling to expert bodies, the other Nordic countries implemented more drastic measures in which the political leadership had a more prominent role to play. To understand the variation in crisis management among the Nordic countries. We apply an institutional approach drawn from organization theory. We address structural features, administrative traditions, and leadership strategies as well as governance capacity and governance legitimacy, taking contextual features into consideration. Finally, it draws some conclusions and lessons learned.

INTRODUCTION

The COVID-19 crisis is a transboundary, complex, and creeping mega crisis that has tested the limits of what public administration is organized to handle (Boin, Ekengreen and Rhinard, 2020). There are a lot of ambiguities regarding the goals and values of crisis management as well as uncertainty regarding means-end relations; in addition, the crisis requires important decisions to be taken under immense time pressure. The issue of what constitutes good public governance amid a global pandemic has increasingly become the focus of scholarly attention and comparisons of the policies adopted to combat COVID-19 are being made (Joyce, Maron and Reddy, 2020; Greer et al., 2021; Kuhlmann et al., 2021; Boin, McConnell and 't Hart, 2021). This chapter addresses what characterizes the Nordic countries' management of the COVID-19 pandemic. A main argument is that both governance capacity and governance legitimacy are necessary if crises are to be managed well (Christensen, Lægreid and Rykkja, 2016). The focus is on how prepared the authorities were for such an eventuality, on the strategies and policy tools used to contain the pandemic, on leadership and politics, and on crisis communication and trust in government. The chapter seeks to describe and explain the Swedish experiment or exceptionalism (Jerneck, 2021), which contrasts with the Norwegian, Finnish, Danish and Icelandic approaches to handling the pandemic. While the Swedes applied a soft strategy, delegating most of the handling to expert bodies, the other Nordic countries implemented more drastic measures in which the political leadership had a more prominent role to play.

To understand the variations in crisis management in the Nordic countries we use an institutional approach drawn from organization theory (Olsen, 2010; Christensen, Lægreid and Røvik, 2020; Egeberg and Trondal, 2018; Lægreid and Rykkja, 2019; Kuhlman et al., 2021). We address structural features, administrative traditions, and leadership strategies as well as governance capacity and governance legitimacy, taking contextual features into consideration. The main goal of the Nordic governments was to fight the pandemic via public health measures. But, all of them also introduced economic support packages, but attended less to social consequences. These latter aspects are not addressed here, however.

The chapter draws mainly on secondary literature concerning the management of the COVID-19 pandemic in the Nordic countries and on public documents, web sites, and media coverage as well as reports from public enquiries in Sweden, Denmark, and Norway. It first outlines the Nordic context and the policy features of the Nordic countries. Second, it describes the outcome of the COVID-19 pandemic in terms of infection and death rates. Third, it gives an account of how the crisis has been managed in the five countries. Fourth, it discusses how to understand Swedish exceptionalism. Finally, it draws some conclusions and highlights lessons learned.

CONTEXT

The Nordic countries are unitary states with small populations of roughly similar size, while the Icelandic population being particularly small. They are representative, multiparty, parliamentary

democracies and their governments are normally coalition governments. Except for Finland, minority governments are common. The Nordic countries combine centralized features with local self-government. Denmark, Finland, and Sweden are members of the European Union, while Norway and Iceland are integrated in the EU's economic union through the Agreement on the European Economic Area (EEA), but are not part of its political union.

The Nordic countries have well-developed administrative systems characterized by non-politicized, merit-based professional civil servants who enjoy a high status (Painter and Peters, 2010). They have consensus-oriented democratic traditions and a well-established cooperation between the state, civil society, and the private sector through a longstanding system of stakeholder participation in government. The decision-making style is consensual, pragmatic, and collaborative, allowing stakeholders to be represented in policymaking. There is a high level of interpersonal trust in society, of public trust in government, and of mutual trust between politicians and the administration (Greve, Lægreid and Rykkja, 2016; Lægreid, 2017). There is also high trust in experts, low risk at elite capture, low tolerance to authoritarian measures and high commitment to affirmative action (Sareen et al., 2021). The Nordic countries are also known for their large, universal welfare states with an extensive public sector delivering many services to citizens. In recent decades the Nordic countries have been rather open to New Public Management reforms, especially Sweden (Greve, Lægreid and Rykkja, 2016).

The core bodies in central government are ministries and semi-independent central agencies. The central agencies are more numerous, and their overall capacity is larger than that of the ministries. The autonomy of the central bureaucracy is higher in the Nordic countries than in the rest of Europe (Lægreid and Rykkja, 2016). Their public administration systems are characterized by strong sectorization, 'silo' organization, and strong line ministries, with rather weak overarching coordinative ministries. Horizontal coordination between different ministries is normally rather weak as is vertical coordination between central and local government. Within each ministerial area the ministry and its subordinate agencies generally work well together.

The Nordic countries share a political culture that underlines the central role of the state in managing society. There is a marked statist view of governance and a strong welfare orientation (Painter and Peters, 2010). Civil servants' actions are open to scrutiny, and there is a high level of transparency and open access to government documents. The World Bank (2015) ranks the Nordic countries at the top of the list regarding government effectiveness, rule of law, and control of corruption. Overall, their administrative capacity is high.

The differences between the Nordic countries are small, indicating that there might be a Nordic model along these indicators (Peters, 2021). There is also a long tradition of Nordic administrative collaboration, described as differentiated integration with a rather broad scope that influences both policy design and administrative reforms (Lægreid and Rykkja, 2020). Any variation that does exist in the public administrations of the Nordic states can only be understood against a background of considerable homogeneity (Jacobsson, Lægreid and Pedersen, 2004). From this common perspective, a

distinction can be drawn between an Eastern and a Western Nordic administrative model. All the Nordic countries except for Sweden apply the doctrine of ministerial responsibility, meaning that the minister is responsible for the portfolios of subordinate agencies and bodies. In Sweden, the central agencies answer to the cabinet as a collegium and not to their parent ministry, and they cannot be instructed by ministries in individual cases. In general, this dual model tends to result in strong central agencies and more pronounced separation between politics and administration than in the other Nordic countries (Peters, 2021).

The Nordic countries also share the same demographic structure, although population density varies a lot: it is very low in Iceland, rather low in Norway and Finland, slightly higher in Sweden and much higher in Denmark. Overall, the Nordic countries are culturally, economically, politically, and geographically rather similar.

The health systems in the Nordic countries are resilient and robust and are characterized by tax-based funding, comprehensive coverage, and residency-based universal access (Nanda, Aashima and Sharma, 2021). Almost all hospitals are publicly owned. In Norway, the central government owns the hospitals, which are organized into regional and local health enterprises. In Denmark and Sweden, the hospitals are the responsibility of the regional governments, while in Finland and Iceland there are specific health regions with responsibility for the hospitals.

Crisis management in most of the Nordic countries is informed by a responsibility principle (each authority is responsible for crisis management within its portfolio); a principle of proximity (a crisis should be addressed at the lowest possible level); a principle of parity (there should be the same management structure in crises as in settled situations); and a collaboration principle (there should be collaboration between different public authorities involved in crisis management). In national crises a lead ministry is assigned overall responsibility, depending on what type of crisis needs to be addressed. During the COVID-19 crisis, both Norway and Sweden had minority coalition governments. Sweden was governed by a coalition of Social Democrats and Greens while Norway had a center-right government. Finland had a majority center-left coalition government, and Denmark had a Social Democratic minority government. Iceland had a coalition government of Left Greens, the Independent Party, and the Progress Party.

In Norway, the Ministry of Justice and Public Security was assigned as the lead ministry in managing the COVID-19 pandemic, but the Prime Minister and the Ministry of Health and Care Services also played a core role together with its two subordinate central agencies, the Norwegian Health Directorate (NHD) and the Institute of Public Health (NIPH).Also the municipalities had disease expertise and authority. In Denmark, the main authorities were the Health Authority, responsible for the quality of health services and related issues, and the State Serum Institute, both subordinate to the Ministry of Health. A narrower coordination group was also set up. From the end of February 2020, crisis management was a politically driven process with the prime minister and the government in the front seat. In Finland, the Ministry of Social Affairs and Health oversees crisis preparedness, and the

Institute of Health and Welfare is the main professional authority. But there, too, the prime minister was a core actor. In Iceland the Chief Epidemiologist, the Directorate of Health, and the Department of Civil Protection and Emergence Management were key actors.

In Sweden, the PM was relatively less important than in Norway and much less so than in Denmark. The Swedish government delegated decision-making to the Public Health Agency, which also oversees healthcare systems managed by regional government together with the National Board of Health and Welfare. In addition, the Civil Contingencies Agency oversees and coordinates agencies. In Iceland, a partnership between deCODE, a human genomics company in Reykjavik, and the Directorate of Health, the government agency that oversees healthcare services, worked together, sharing ideas, data, laboratory space, and staff.

COVID-19 was declared an epidemic and later a pandemic by the World Health Organization as well as by national emergency authorities. Despite this, the Nordic countries were not particularly well prepared for it, even though they have very good healthcare systems and abundant resources. Rather little seemed to have been learned from the SARS epidemic in 2003 and the swine flu epidemic in 2009. Little had been done to build up specific capacity to deal with such a pandemic. The pandemic preparedness plans were designed for mitigation, not suppression.

THE OUTCOME OF COVID-19 IN THE NORDIC COUNTRIES

The first cases of COVID-19 in the Nordic countries were reported at the end of February 2020. Two weeks later, Denmark and Norway went into a national semi-lockdown, and Finland declared a state of emergency. Schools, public facilities, and businesses were closed, public gatherings were restricted, and national borders were closed. Despite a similar timeline and a rapid rise in infections and deaths, the Swedish authorities implemented far less restrictive measures.

A COVID-19 performance index based on cases, deaths, cases, and deaths per million people, cases as a proportion of tests, and tests per thousand, conducted by the Australian Lowy Institute based on data up to January 19, 2021, revealed that all the Nordic countries scored above the European average of 51 on a scale from 0 to 100, meaning that they all performed relatively well in coping with the pandemic. Among the ninety-eight countries covered, Iceland ranked seventh (80.1), Finland seventeenth (70.4), Norway eighteenth (70.0), and Sweden as thirty-seventh (55.5).

In general, the Australian data reveal that countries with smaller populations, cohesive societies, and capable institutions have a comparative advantage in dealing with the COVID-19 pandemic. Regime type seems to be less important for effective crisis management than whether citizens trust their leaders and whether those leaders preside over a competent and effective state and administrative apparatus (Fukuyama 2020). Thus, state capacity, leadership, and social trust are all important for the management of the COVID-19 pandemic. The Nordic countries score high on all three of these variables, but there is also significant variation in performance within the Nordic family of countries and we will examine why

this is the case. All the Nordic countries score high on trust and state capacity, but there have been variations in political leadership and regulatory measures in the pandemic.

Since the start of the pandemic the idea of a Nordic model has been difficult to sustain. By the end of March 2020, deaths per inhabitant were 50 % higher in Sweden than in Denmark. One month later they were almost 250% higher (Dahlstrøm and Lindvall, 2021). A study covering the period through November 2020 reveals that Sweden accounted for 61% of the cases and 81% of the deaths in the Nordic region. The average incidence was 990 per 100000 ranging from 337 in Finland to 1617 in Sweden, while the mortality rate was 27.6 per 100000, varying from 5.3 in Norway to 60.4 in Sweden (Nanda, Aashima and Sharma, 2021).

Table 1 shows significant variations between the Nordic countries, with Sweden as an outlier at the negative end of the spectrum, Denmark in a middle position, and Finland, Iceland, and Norway at the positive end. While Norway, Finland, and Iceland had some of the lowest mortality rates in Europe, Sweden had one of the highest, albeit lower than Belgium, Spain, and the United Kingdom.

Table 1: COVID-19 performance in the Nordic countries per 100000 until September 6, 2021 – cumulative numbers

	Infections	Deaths
Sweden	11113	145
Denmark	5973	45
Finland	2316	19
Norway	3030	15
Iceland	3178	10

Source: Coronaviruset: Status i Norden (vg.no)

The total number of deaths by September 6, 2021, was 14692 in Sweden, 2584 in Denmark, 1031 in Finland, 822 in Norway, and 33 in Iceland. The number of registered infections increased significantly in Sweden in January and May 2021, while the number of people hospitalized and in intensive care peaked in April-May 2020, in January 2021 and in April-May 2021. In Iceland there has been a significant increase in infections, hospitalized and in intensive care in August 2021. There were high regional variations in the number of cases. In all five countries the pandemic was concentrated in the area around the capital city. The Stockholm area alone had 33% of the deaths in the Nordic countries. The highest numbers of deaths were in the oldest age groups.

Overall, Norway and Finland are among the countries in Europe that have handled the COVID-19 pandemic the best. In July and August 2021 Norway was on the top of the Bloomberg COVID-19 resilience ranking while Finland was ranked 7 in July and 3 in August. Governance capacity and effectiveness, individual freedom, reciprocal trust between citizens and between citizens and government are high in the Scandinavian countries. They also have a low level of mass polarization, a cooperative society, and a cooperative political elite (Carron, Lapuente and Rodrigues-Pose, 2020). This

can help to explain the overall high performance of the Nordic countries in fighting the corona pandemic (Harring, Jagers and Løfgren, 2020), but it cannot explain the rather big differences between Sweden and the other Nordic countries. Comparing the strict semi-lockdown measures in Denmark and Norway with the more lenient approach in Sweden, it has been estimated that if Norway and Denmark had followed the Swedish example, they would have had far more patients in hospitals and a higher number of deaths (Juranek and Zoutman, 2020).

CRISIS MANAGEMENT

Norway

Preparedness. The government scored low regarding emergency preparedness. No scenarios or plans to fight such a pandemic had been made and no exercises had been carried out (NOU 2021:6). The national and regional reserves of emergency medicine and infection control equipment, intensive care beds, respirators, and testing equipment were insufficient. On the local level, 74 out of 356 municipalities did not have an operational plan for infection control, and training was lacking.

Strategies and policy tools. Up until March 12, 2020, the Norwegian government took a wait-and-see and a mitigation approach to the pandemic. After that, it pursued a containment or suppression strategy, and then followed this up with a control strategy based on testing, isolation, infection tracing, and quarantine. Major decisions were taken by the cabinet in close collaboration with the expert agencies NDH and NIPH, but deviated in some major decisions from the advice given by the NIPH, and generally opted for more radical measures, such as closing schools and kindergartens, following a 'precautionary principle'.

The national restrictions and regulations introduced on March 12 were the most drastic in Norway since World War II, but they did not amount to a complete lockdown. Most stores, schools, and universities were closed, and public events banned, in addition to a catalogue of basic hygienic advice and precautions. The Norwegian strategy was informed by restrictions similar to those introduced in Denmark two days previously and by the measures recommended by the EU. Negative learning from Italy also had some impact. The restrictions gave priority to health over economic and social concerns, and to standardized national regulations over local flexibility. They were more top-down than bottom-up and comprised a combination of mandatory regulations and softer advice (Christensen and Lægreid, 2020c).

On April 6, 2020, the minister of health announced that the epidemic was under control in Norway and from mid-April some restrictions were gradually lifted. On May 6, infections had fallen so low that the government launched a plan of gradually lifting the remaining restrictions, aiming to achieve an almost normal situation by June 15. In mid-July, the government allowed travel to and from most of Europe once again, provided the countries in question adhered to the existing strict infection rules. The opening process slowed down when the infection rate started to increase again in August, and new restrictions were gradually re-introduced in the fall and winter, with the advent of the second and third

waves and the spread of mutants of the virus. In March 2021, restrictions were basically back to the situation one year earlier, combining a rather complex mixture of national and local restrictions, but with deregulations starting again from early May.

The authorities appealed to citizens for solidarity and trust in government, which was generally loyally followed by most of the population during the first regulation phase. There was not much in the way of public debate about the restrictions concerning health matters, the education system, the closure of businesses, or the local authorities' management of the pandemic (Christensen and Lægreid, 2020b). However, during the period when measures were relaxed and then tightened again, a more lively public debate arose, questioning the logic and consistency of the measures, not to mention the allocation of vaccine which open up a center/periphery divide as well as question on social equality and ethnicity.

*Politics and leadership***.** The crisis management strategy was overall collaborative, involving stakeholders in society as well as bipartisan consultation in parliament as illustrated by the adoption of the Corona Emergency Law in March 2020. As a strategy to bolster legitimacy, the decisions on easing the regulations were based on additional advice from two ad hoc expert committees on economic issues and kindergartens/schools. There were some role conflicts and unclear responsibility relations between the NDH and NIPH and rather detailed control from the parent ministry in the first phase of the crisis management, but overall coordination at the central level was a combination of formal arrangements and informal consultation under great time pressure and significant uncertainty (DFØ, 2020).

After the government started to relax the restrictions, the media engaged in a lot of investigations into what had happened during the initial draconian regulations. They emphasized that the director of the NIPH had been sidelined by the political leadership and the director of NHD (NOU 2021:6). She was critical of this since she said that they had more extensive and relevant expertise. The authorities also struggled to justify and explain the logic behind the series of deregulations and re-regulations, and they were criticized for being too influenced by strong interest groups (Christensen and Lægreid, 2020b). With respect to the re-regulations the government was accused of an insufficient openness, a lack of consultations, making the regulations too complex, changing advice about international travel, and a lack of testing facilities and arrangements at the border, such as quarantine hotels, etc.

Crisis communication. The prime minister, the minister of health, and other ministers involved played an important role in communicating with citizens and the media through daily media briefings, together with the NDH and the NIPH, in which they appealed for solidarity using the slogan 'united we stand'. The political executive adopted a paternalistic strategy, defining the situation as dramatic and maintaining that drastic measures would lead to a better long-term outcome. They alluded to the virus threatening Norwegians' way of life and overwhelming the health system, and to the existence of widespread and untraceable cases.

The health arguments from the top executives were the most important ones for justifying the measures taken. Overall, the crisis communication was characterized by reputation management, with standardized talking-points, timely and repeated messages, and advice to citizens on how to protect

themselves and others (Christensen and Lægreid, 2020b). The government's crisis communication followed key elements of potentially effective crisis communication (Moss and Sandbakken, 2020, Van Bavel et al., 2020). First, it strove to demonstrate its ability to make major decisions and to take firm and confident action amid conditions of uncertainty, thus inspiring trust in both its ability and its intentions. Second, it openly admitted that there were things it did not know, but emphasized that it was doing its best. Third, it repeatedly acknowledged citizens' hardship with expressions of empathy and understanding for the individual costs and distress caused by the measures. Particularly during the second and third waves this communication strategy presented some challenges amid measures that were shifting, unstable, and ambiguously communicated, generating a lack of clarity about what was the right approach.

Trust. The process of making sense of the crisis played out in a context of high mutual trust between political and administrative authorities and expert bodies (Christensen and Lægreid, 2020a). The process followed the traditional Norwegian governance style of collaboration and involvement with affected stakeholders and the political opposition (Christensen, 2003). The political leadership seems to have succeeded rather well in connecting governance capacity and legitimacy. Overall, citizens' trust in government increased significantly from an already high level during this crisis. Trust in government, the health authorities, parliament, and national and local politicians increased. High satisfaction with government increased from 23% in January 2020 to 49% in March and remained stable at 41-42% through February 2021. High trust in parliament increased from 41% to 60% in the same period and trust in politicians from 24% to 41% (Ivarsflaten et al. 2021). The level of trust was especially high among people with higher education. This general increase in trust reflects the common communication strategy. The Norwegian approach was based on working together across political parties, across the political and administrative divide, across central and local government, and across the public and private sectors. During 2020, popular support for the measures was high. About two-thirds of the population supported the regulations. Overall, 95% reported that they had followed the authorities' advice and regulations. The average score on generalized trust in fellow citizens (on a scale from 0-10) was stable between 6.6 and 6.9 from January 2020 to February 2021, which shows that interpersonal trust in society remained on a high level throughout the pandemic (Ivarsflaten et al., 2021).

Denmark.

Preparedness. As in Norway, the health authorities were not particularly well prepared for the crisis. They assessed the risk of a domestic COVID-19 outbreak as low until February 25 (Rubin et al., 2021).

Strategies and policy tools. The focus in Denmark was on the impact of the pandemic on public health and like in Norway was based on the precautionary principle. On March 11, the prime minister announced a rather hard and far-reaching social distancing policy and a partial close-down for fourteen days. People were advised to work from home; kindergartens, schools, and higher education were closed; and there was a ban on public gatherings of more than 1000 people. However, the State Serum

Institute and the Health Agency disagreed about school closures. Primary schools were closed for a shorter time than in Norway.

Denmark was one of the first European countries to declare a national semi-lockdown and to close its borders. This was also a political decision not supported by the health professionals. On March 17, a lot of facilities were closed, and mass events banned. Overall, the process was consensus-oriented and characterized by consultation and an inclusive and participatory approach to policy-making (Ornston, 2021). There was more conflict between the government and the health authorities than between political parties or between the government and the parliament. The government took a selective approach to expertise. The Danish Health Authority was sidelined in favor of the State Serum Institute (Folketinget, 2020).

Like in Norway, the government decided to gradually reopen Denmark from the beginning of April 2020. There were some political conflicts regarding the pace and sequence of the reopening. Denmark likewise went through the same phases of reregulation as Norway when the second and third waves hit in late fall and early winter of 2021, respectively, with slightly stronger measures and a high level of testing. And started re-regulations from late spring.

Politics and leadership. In Denmark, the power to manage the pandemic was concentrated in the executive, with the prime minister as a driving force (Jensen, 2020). The PM claimed that the severe restrictions were based on advice from the expert authorities, which did not seem to be the case, so similar in some respects to Norway. Some said that the stringent regulations were politically motivated, and the Health Authority was instrumentalized as part of a political legitimation strategy (Folketinget 2021). Overall, the process was less open and transparent than in Norway, but the parliament granted the government power to handle the crisis and the PM had support from the party leaders in parliament which approved the emergency measures.

There was a strong power concentration (Nielsen 2021) and the Prime Minister's Office allegedly went beyond the limits of the PM's normal role. The parliamentary scrutiny commission argued in favor of maintaining a balance between decentralized line authorities and central coordination from the PM's office, as well as advocating finding a better balance between the principle of sectoral responsibility and cross-sectoral coordination arrangements (Folketinget, 2021). Overall, the government went beyond the advice of the health authorities so that the mandatory measures it introduced were stronger than in Sweden, on a par with Norway and Finland, but more modest than in many other European countries. There were more conflicts in the re-opening phase in which the center-right parties took a pro-business attitude and called for faster opening while the center-left parties urged caution (Christensen et al., 2021).

Crisis communication. The government's sense-making changed fundamentally from a 'no reason to worry' attitude until the end of February 2020, to a 'major worry' one in early March. The PM's line then was that major decisions had to be made fast to avoid a disaster, and scientific evidence alone could not be trusted as a basis for making the right policy decisions. The health authorities,

however, stuck to the more complicated sense-making frame of evidence-based policymaking. In other words, policy recommendations were updated as new scientific information became available and they changed their pandemic management strategy from containment to mitigation informed by a proportionality principle. These two sense-making frames clashed publicly, revealing a lack of common understanding and communication between them (Rubin and de Vries 2020).

Trust. There was no total lockdown or curfew, and the authorities generally applied a trust-based approach to social regulation and appealed to the common sense of citizenry (Jensen, 2020). Overall, citizens' trust in government was high and increased during the first phase of the pandemic. The population was worried but supportive (Nielsen, 2021). A study among unemployed Danes showed that trust in the Prime Minister's administration increased until the end of March 2020. The same applied to trust in the judicial system and in the public sector in general (Bækgaard, M. et al., 2020). There seemed to be a rally around the flag. Denmark's assertive strategy had an increased support in the public sentiment in phase two of the pandemic (Perlstein and Verbood, 2021) but the trust pattern seems to have changed somewhat during the two most recent waves when trust in the government decreased from 90% to 60% between February and November 2020.

Finland.

Preparedness. In contrast to the other Nordic countries, Finland had rather good reserves of emergency medicine and infection protection equipment, meaning scored high on preparedness.

Strategies and policy tools. Finland reacted rather swiftly and on March 16, 2020, the Finnish government declared a state of emergency due to COVID-19, a measure that lasted until June 16. Finland mainly followed the Danish and Norwegian strategy of reacting quickly and introducing rather proactive and strict measures. The restrictions were applied uniformly across the territory, despite the concentration of the pandemic in the areas around the capital, as in the other Nordic countries. An Emergency Powers Act passed rapidly through parliament without any opposition on March 17. This strengthened the power of the central government and obligated people over the age of seventy to practice social distancing and limit contact, thus legally requiring them to isolate. A lot of schools, institutions, and services were closed and social gatherings limited. The borders were closed and even the boundaries around the Helsinki area were closed for a period to prevent the spread of the virus. The government declared a state of exceptions that restricted individual rights, and a lockdown was declared to protect the lives of citizens (Moisio 2020), but many measures were recommendations

Over time, Finland gradually moved from strong and extensive restrictive measures towards a more hybrid strategy, shifting the emphasis to managing the epidemic and allowing for variation in containment measures between regions (Nanda, Aashima and Sharma, 2021). However, February 2021 saw a return to more restrictive measures and a three-week lockdown was announced.

Politics and leadership. The prime minister played a prominent role, but underlined that she was following the recommendations from the experts in the Finnish Institute of Health and Welfare,

apparently to a greater extent than in Norway and Denmark. A strategy of testing, tracing, isolating, and treating was adopted, and Finland was able to swiftly trace people who had been in contact with those who had tested positive (Tiirinki et al., 2020).

Crisis communication. The decision-making style was rather top-down with the prime minister as a key actor, including with regard to communication with citizens. Messages were closely coordinated at the highest executive level. The first phase of the crisis management was characterized by a national consensus, which over time shifted to increasing conflict (Christensen et al., 2021).

Trust. Overall, trust in government has been high and there has been very little opposition to the measures.

Iceland

Preparedness. In contrast to most other Nordic countries, except Finland, Iceland was well prepared with regard to testing and tracing infected persons.

Strategy and policy tools. Iceland was quick to implement restrictions and declared a state of emergency the same day that the spread of the virus was identified (March 6). Like Sweden, it did not impose any type of lockdown, but it introduced stronger restrictions than Sweden on the number of people allowed to gather. It also closed a large number of sport and entertainment facilities as well as schools and churches and introduced massive testing and contact tracing. Iceland decided from the beginning to use isolation, quarantine, and contact tracing. More tests have been carried out per capita in Iceland than in any other country. A laboratory at the university hospital began testing citizens in early February. By March 13, deCODE genetics, a private firm specialized in genomes, had begun screening citizens and was able to quickly take over much of the testing from hospitals.

Iceland has managed to prevent outbreaks, while keeping most schools and its borders open and welcoming tourists from forty-five countries from mid-June 2020 onwards. However, a new wave of infections occurred in October-November 2020. As of February 19, 2021, all passengers arriving in Iceland were required to present a negative test carried out no more than 72 hours before their arrival in Iceland followed by 5-6 days quarantine and then a second test. The new regulation also required individuals to isolate in quarantine hotels if the first border test is positive and the infected individual is unable to provide a credible plan for self-managed isolation. Iceland did not impose a lockdown, but owing to its low population density, small population, intervention strategies, and extensive testing, the country managed to maintain a very low mortality rate (Nanda, Aashima and Sharma, 2021). By February 2021, Iceland had the lowest number of infections in Europe, a low level maintained since then as a result of combining deregulations and selective re-regulations.

Politics and leadership. Somewhat like Sweden, Iceland based its measures to fight the pandemic on scientific advice. The policy response was centralized to the surgeon-general, the state epidemiologist, and the commander of civil protection operations who kept the population informed in detailed daily press briefings. Overall, government arrangements were network-based and the experts

played a core role in handling the crisis in Iceland with the political executive taking a back seat (Scudellari, 2020). The degree of politicization was low and there was a broad consensus that expert advice should be followed (Christensen et al., 2021).

Crisis communication. A team of experts and senior officials conducted daily TV briefings from late February until early May, followed by regular press conferences. In addition, government press briefings| were also held, emphasizing open and frequent communication with the public. The communication strategy was to maintain a high level of transparency, leading to a 96% approval rate for the response of the Icelandic authorities in April 2020.

Trust. Trust between people is very high in Iceland. There is a lot of societal trust and confidence in fellow citizens, meaning that the Icelandic public is taking collective responsibility for tackling the pandemic. In addition, there is a very high level of trust in the health authorities.

Sweden.

Preparedness. Sweden scored rather low on preparedness**.** Sweden's capacity regarding hospital beds and intensive care units per inhabitant were significantly lower than in Germany and France (Kuhlmann et al., 2021) and somewhat lower than in the other Nordic countries.

Strategy and policy tools. The Public Health Agency's main strategy was to mitigate the effects of the virus rather than suppress its spread. The restrictive measures had a soft touch characterized by guidelines and recommendations rather than mandatory measures, and the authorities 'nudged' individuals to change their behavior and take a conscientious approach (Pierre, 2020). The crisis management was slow and insufficient, and the Swedish authorities acted late and reactive in contrast to the other Nordic countries which reacted swift and proactive (Holmstrøm, 2021). Society remained more open than in the other Nordic countries, with voluntary measures and individual responsibility at the forefront of a strategy believed to be best suited to Swedish culture and social behavior (Pierre 2020). Except for a ban on gathering of more than 50 people, Swedes were free to carry out with their life as usual. This was reflected in the prime minister's appeal for solidarity and moral obligations. A main priority was to protect the elderly and contain the spread of virus to avoid overloading hospitals with COVID patients.

In contrast to other Nordic countries, there was no directive to close kindergartens, primary schools, restaurants, bars, or industry, and workplaces largely remained open. Testing was not a major feature and using masks was not recommended until a late stage in the pandemic; nor was there any ban on domestic travel, border closures, or use of quarantine. This was a more cautious and stable strategy, with increasing support for a containment strategy over time (Kuhlmann et al., 2021). The public health authorities underlined that this strategy was strictly evidence-based.

The government relied on personal responsibility and expert recommendations on how to change individual behavior to lower the infection rate. It sought to 'flatten the curve' to avoid healthcare capacity problems and protect vulnerable groups. Another part of the strategy was to generate 'herd

immunity', meaning that once enough people had been exposed to the virus, it would spread more slowly. More mandatory measures were introduced later and less extensively than in the other Nordic countries, at least until summer 2020. In contrast, the national response in Denmark, Finland, and Norway was stricter and included mandatory closures to varying degrees and some form of lockdown for different amounts of time (Petridou, 2020).

Sweden was the only EU member state that did not impose either a national (semi-)lockdown or school closures or quarantine, despite a high number of infections. In contrast to the other Nordic countries, Sweden only closed its border to some selected countries. It thus stands out for its reliance on more voluntary measures and the continuation of 'normal governance' (Toshkov, Yesilkagit and Carroll, 2021; Kuhlmann et al., 2021, OECD, 2020). The containment strategy in Sweden was not centered on a lockdown, but rather included more selective measures, such as avoiding visits to areas where a high density of people could be expected. Government agencies preferred recommendations and advice on appropriate social behavior to legislation or coercive measures (Capano et al., 2020). It appears that the Public Health Authority relied to a large extent on evidence from previous epidemics, without acknowledging the possibility that COVID-19 might behave differently to SARS or swine flu (Christensen et al., 2021; Argento, Kaarbøe and Vakkuri, 2020).

In contrast to the more pragmatic approach in the other Nordic countries, Sweden applied a principled approach and sticked to the soft and voluntary strategy at least until November 2020 (Boin and Lodge, 2021). It did not launch a centralized governmental crisis regime partly due to constitutional restrictions (Pierre, 2020). The crises management was placed in the Health Agency and at local administrations. Despite high death tolls there was no major adaptation of the chosen regime and Sweden did not prioritize health over other policy values to the same degree as in the other Nordic countries (Claeson and Hanson, 2020).

As infections started to rise in the fall of 2020, the government became more proactive, and the Health Authority recommended more and stricter regulations to contain the spread of the virus. For example, the government banned serving alcohol in restaurants and bars after 8pm. Nevertheless, much of the responsibility remained with local authorities and individual citizens. The rate of infections continues to rise, and hospital capacity was under pressure.

Politics and leadership. The political authorities remained committed to the soft and technocratic approach and continued to rely on independent expert bodies for scientific advice as well as for policymaking and for the management of the crisis (Maggetti, 2020). In contrast to Denmark, Finland and Norway, there was an absent of a dynamic and profiled political leadership. The Swedish strategy, formulated by the National Health Agency, imposed only minor restrictions on people's behavior and focused chiefly on infectiousness and immunity, assuming that those without symptoms could not carry or transmit the virus. It also weighed up the measures' expected effect on the spread of infection against the cost of disruptive interventions in the functioning of society. The poor performance of the Swedish containment strategy was also due to a lack of resources, training, and equipment in local

and regional government to tackle the pandemic and poor coordination in the decentralized healthcare system (Pierre, 2020).

The Swedish Corona Commission concluded that the strategy of protecting the elderly had failed (Corona commision, 2020). Nine out of ten deaths were among people aged seventy or older, with almost half of them in care homes for the elderly and a quarter in home care. The commission concluded that the elderly care institutions had structural weaknesses, leaving them unprepared and vulnerable to a pandemic. Measures to improve care of the elderly came late and were insufficient. The commission blamed the government and previous governments for the structural weaknesses, which mainly comprised insufficient and unclear regulations, fragmented organizations, a lack of coordination between care services (municipalities) and hospital services (regions), a lack of staff, medical competence and protective equipment, and unsustainable employment conditions in care institutions for the elderly.

Crisis communication. From February until June 2020 the government kept a low media profile, and press briefings were conducted by experts from the Public Health Authority and by the Swedish Health and Welfare Agency. From June, the government became more active, maintaining daily contact with the expert bodies (Statskontoret, 2020). From August, leading politicians like the PM became more visible at press briefings and in policymaking related to the pandemic. However, overall the government largely left decision-making and communication to a small group of experts in the Public Health Authority (Christensen et al., 2021) and in general the crisis communication was rather indistinct and there was a lack of early information of what the political executives wanted to do (Jernell, 2021).

Trust. The Swedish laissez-fair strategy was generally accepted by the population until mortality rates started to rise (Perlstein and Verbood, 2021), but the stricter strategy in the other countries had higher support. Citizens' satisfaction with the regulations in the initial phase was about 60%, whereas in Finland, Denmark, and Norway it was around 80%. While one third of the Swedish population in April believed that the measures were inadequate, less than 10% of Danes were of the same opinion (Rubin et al., 2021). Trust in the Swedish health authorities fell from 75% to 57% between March 2020 to February 2021. Compared to Norway the differences in trust relations are even higher.

Summing up – convergence and divergence.

Summing up, the main variation among the Nordic countries in preparedness, strategies and policy tools, politics and leadership, crisis communication and trust relations is presented in Table 2.

Table 2: Variation among the Nordic countries in preparedness, strategies and policy tools, politics and leadership, crisis communication and trust.

	Norway	Denmark	Finland	Iceland	Sweden
Preparedness	Low	Low	Medium	Medium	Low

Strategies and policy tools	Suppression strategy Precautionary principle Quick semi-lock down	Suppression strategy Precautionary principle Quick semi-lock down	Suppression strategy Precautionary principle Quick semi-lock down	Less strict lock down Strong test regime Softer regulations	Soft mitigation strategy Proportional principle No lockdown Laissez-faire
Politics and leadership	Power concentration at the top Collaborative consultation	Power concentration in the executive	Power concentration in the executive Experts also central	Network-based Expertise played a central role	Low political involvement The Health Authority dominated
Crisis communication	Appealing to solidarity United from experts and political executives	Lack of common understanding and com-munication in the first phase	Top down, political executives key actors	High level of transparency	The Public Health Agency dominated. Government had a low profile.
Trust	High	High, but decreasing	High	High	High, but decreasing

By the time the second wave of COVID-19 arrived in the fall of 2020, the Nordic countries were much more able to conduct testing and keep track of infections, especially in Iceland. A systematic strategy of testing, isolation, infection tracing, and quarantine was introduced in all countries except Sweden. Face mask recommendations and new requirements started in early fall. Reopening schedules were terminated and the easing of restrictions on gatherings was reversed. In June, when the other Nordic countries reopened their borders to European travelers, they kept them largely closed to Swedes. This gave rise to problems and tensions in the frontier regions.

Denmark's path regarding increases in the infection rate diverged from that of Norway and Finland. On December 16, 2020, Copenhagen announced a second lockdown, which came into full force on December 25. Norway pursued a policy of stricter local measures, especially in Oslo and some other areas with high infection rates, in addition to national regulations as framework regulations. It also closed its border and introduced an entry quarantine requirement. Thus, it avoided the escalation of infections seen in Denmark, with its proximity to the European continent. Finland was also rather successful in containing the spread of the virus during this period. It cancelled indoor leisure activities in the capital area at the end of November and placed serving restrictions on bars and restaurants, like in Norway and Denmark. However, in March a new lockdown became necessary in Finland. Iceland had the advantage of having a very small population on a remote island. In most Nordic countries, the strict regulations that in most cases have been in force since the fall of 2020 continue while citizens wait to be vaccinated. In Sweden there was a trend towards stronger and more mandatory regulations and the politicians came out of the shadow of the agencies (Nylen, 2021; Hyden, 2021).

Plans for a cautious reopening in several steps were formulated in Denmark, Iceland, Finland, and Norway started in early April 2021 but remained dependent on the development of the infection rate, the vaccination tempo, and the number of people hospitalized. Early June Sweden launched a five steps plan to lift its restrictions. This opening-up phase is characterized by increasing vaccination rate, increased infection rate due to the Delta variant especially by young people, but low rate of hospitalization and death. Overall vaccination policy became a more central part of the strategy to fight the pandemic. Vaccination trumps infection and is driving containment and underpinning reopening. Vaccination of teenagers have started, testing is still a major measure and some local regulations are conducted. Iceland was the first country with full opening-up in June but this resulted in a forth wave of infections and many hospitalized citizens in spite of a high vaccination rate and new restrictions had to be reinstalled. The most recent plans indicate that the Nordic countries may return to normal by September 2021.

HOW CAN WE UNDERSTAND THE SWEDISH EXCEPTIONALISM?

The Swedish exceptionalism was especially strong in the first phases of the pandemic up to the end of 2020. The combination of a liberal containment strategy and high death toll in Sweden, in contrast to the stricter strategies and relatively fewer deaths and infections in the other Nordic countries, represents a divergence that requires an explanation (Pierre, 2020; Petridou, 2020). The Public Health Agency was insulated from pressure to change course, even though the number of deaths per capita was much higher in Sweden than among its the Nordic neighbors. To understand the Swedish exceptionalism in crisis management, we draw on an organization-theory based institutional approach (Olsen, 2010; Christensen, Lægreid and Røvik, 2020; Egeberg and Trondal, 2018; Lægreid and Rykkja, 2019; Kuhlmann et al., 2021). We address structural features, administrative traditions and cultures, and leadership strategies as well as governance capacity and governance legitimacy, taking contextual features into consideration. A combination of several factors led to this Swedish exceptionalism and policy resilience (Andersson and Aylott, 2020).

First, the structure of the national public administration had a role to play. The Swedish state, built on the 'East Nordic model' is characterized by extensive delegation from the ministries and cabinet to the executive central agencies (Greve, Lægreid and Rykkja, 2016). In contrast to the other Nordic countries, the principle of ministerial responsibility is not applied in Sweden, and the agencies are accountable to the cabinet as a collective rather than to their superior ministry. They have extended formal autonomy allowing expertise to strongly influence coordination, policymaking, and implementation in a crisis like the present pandemic. However, there are significant informal contacts between the government and the agencies which enhance the government's ability to steer the agencies. In this case, the state epidemiologist in the Public Health Agency had a prominent role as an expert and he, rather than politicians, was the public face of the Swedish strategy, communicating directly with the

public (Petridou, 2020). In Norway and Denmark, politicians are more directly in charge of the administration, so it was easier for them to react quickly with political decisions and even to overrule advice from expert authorities and adopt stricter guidelines, when this was considered politically necessary (Strang, 2020). In Sweden the strong role of the Public Health Authority has depoliticized the response in contrast to the more direct role of politics in Norway (Sareen et al., 2021).

There is also significant delegation to regional and local government in Sweden. The regions are responsible for healthcare, and the municipalities are responsible for care of the elderly, so these played a core role in handling the pandemic. Coordination between the national and regional levels is generally rather weak and fragmented. Many of these services have been outsourced to private operators since the 1990s, weakening also horizontal coordination. The combination of autonomous executive agencies and weak coordination between health authorities at different levels insulated the Public Health Authority from political pressure (Andersson and Aylott, 2020). The political regime was characterized by decentralization of power and authority (Bo Yan et al., 2020). Overall, the transboundary coordination of the political-administrative system in Sweden is achieved to some degree through informal mechanisms, bargaining, consultation, information, and networking (Pierre 2020), and may also be informed by a less interventionistic and less hierarchical administrative culture (Bouckaert et al., 2020) as well as constitutional constraints on the government declaring a state of emergency during peacetime (Nanda, Aashima and Sharma, 2021). Thus, to understand the difference between the soft and voluntary regulatory measures in Sweden and the more strict and mandatory measures in Norway, one must address institutional and organizational features such as the autonomy of government agencies and intergovernmental relations related to the centralization or decentralization of disease expertise and authority (Askim and Bergstrøm, 2021).

Second, Sweden‘s political leadership was willing to delegate responsibility for policy almost entirely to the expert agency. The government was a rather weak minority government of Social Democrats and Greens. The pandemic was not very politicized, partly due to a tradition of political consensus during national crises and challenges. The cabinet ministries took a back seat and encouraged citizens to follow the experts’ advice. The prime minister was rather absent, at least in the initial months, and seemed to avoid exposure in difficult situations. Policy advice was rather decoupled from the political process. In contrast to Norway, Finland, and Denmark, the crisis communication through daily press briefings was dominated by experts and only occasionally were cabinet ministers present. The Crisis Management Coordination secretary had been shifted from the Prime Minister’s Office to the Ministry for Home Affairs in 2014.

The reactive role of the government was not inevitable. Rather, the political executive made a conscious decision to be only marginally involved in formulating the crisis management strategy until late in the pandemic. In contrast to the other Nordic countries, the political leadership saw its role as reactive and as supporting the Public Health Agency. The new laws granted the government certain additional executive powers, but it chose not to make much use of them (Hirschfeldt and Petersson,

2020), even though it could in principle have pursued a policy more like the other Nordic countries. Thus, the Swedish strategy for fighting the pandemic was a political decision and not the result of constitutional constraints (Dahlstrøm and Lindvall, 2021). |The Swedish government allowed scientific expertise to modify resolute political intervention to fight the COVID-19 pandemic (Wahlberg, 2021).

It was not until the fall of 2020 that a broader critical discussion about the crisis management strategy took place in Sweden and the political executive became more active. Thus, the divergent Swedish response to the pandemic can be understood in terms of policy advice by an overconfident Public Health Agency that had a virtual monopoly on expertise, combined with a subdued political handling and use of that advice, and the deep trust culture vis-à-vis public authorities (Kuhlmann et al., 2021). Mostly, the strategy failed through a combination of strong reliance on soft measures and lack of coordination among authorities, and poor performance by local authorities in charge of a decentralized healthcare system and an elderly care system that lacked capacity (Maggetti 2020). Thus, the Swedish case can be labelled as an example of what Bouckaert et al. (2019) call 'coronationalism.'

A third factor shaping the COVID-19 response strategy in Sweden was the country's culture, which has a low tolerance for intervention from the government in public behavior and great emphasis on individual preferences, self-regulation, and individual responsibility and risk-taking (Bo Yan et al., 2020; Nygren and Olofsson, 2020) reflecting a historical Swedish legacy. Thus, a national identity in Sweden with strong emphasis on individual freedom and less tolerance to authoritarian measures adds to understand the Swedish exceptionalism (Sareen et al., 2021). Decentralization of the healthcare system, a lack of preparedness at the local level, and government and social values that favored nudging over coercion led to a late and rather weak response and a more 'laissez-faire' approach to pandemic crisis management (Capano, 2020).

In addition, there was also a national flavor in parts of the media and public opinion, that avoided pressing for major change in the crisis management strategy, partly due to a high level of trust in the crisis management authorities. Lack of crises experiences reduced the risk awareness and added to the picture. The impact of the virus was also uneven, affecting mainly elderly people in care homes and to some extent also ethnic minorities, which left the most politically engaged people less affected.

CONCLUSION AND LESSONS LEARNED

All the Nordic countries have faced four phases of the pandemic. An initial regulation phase in March-April 2020, a deregulation phase in May-August 2020, and a re-regulation phase from September onwards, ending with a new lockdown in Denmark in December, strong measures in Norway from January 2021, and a new state of emergency in Finland in late February 2021. Finally, a reopening phase starting from May 2021.

We also see a development from a strong consensus in the first phase towards increasing conflict in the third phase, but overall, polarization and politicization were low. The government arrangements

were generally consensus-oriented but with a stronger political power concentration at the top in Denmark and Finland, and to some extent in Norway, but less so in Sweden. The crisis communication was monotonous rather than pluralistic. Whether the leadership was expert based or political, it took the form of repeating reasons for and justifying the policies that the government had chosen (Baekkeskov, Robin and Øberg, 2021). Overall, the population in the high trust Nordic countries responded favorable to extensive and swift crises strategies by communicative and visible authorities (Perlstein and Verbood, 2021), but also the more soft and reactive strategy in Sweden had general popular support, especially in the first wave of the pandemic.

All the Nordic countries scored low to medium regarding emergency preparedness and planning for the COVID-19 pandemic. But Denmark, Finland, Norway, and Iceland proved able to improvise and immediately implemented a semi-lockdown followed by a testing regime to stop the spread of the virus. In contrast, Sweden stuck to the existing emergency plans designed for regular flu outbreaks. It did not close down the country, the borders were more open and did not pursue an intense testing regime. While Sweden relied on recommendations, selective restrictions, and soft regulation, the other countries shifted to a comprehensive, mandatory, and strict social distancing policy. While Sweden adopted a mitigation strategy and the propositional principle, the other Nordic countries were guided by a suppression strategy and the precautionary principle. However, no Nordic country applied a zero-tolerance approach and curfew was not used in any Nordic country.

Despite a long tradition of cooperation, the Nordic countries crisis management of the COVID-19 pandemic was characterized by rather weak cross-country collaboration, for example regarding border closure (Hansen and Stefansdottir, 2021). When the pandemic hit, their responses were unilaterally and domestic features played a core role. In comparative perspective, the main picture is that Sweden is deviant and only their lack of school closure was seen as right by the other countries, in the aftermath. Its expert-led approach to the pandemic, meant fewer draconian and mandatory regulations and a high death toll, while the other Nordic countries had more mandatory measures and a better performance with respect to preventing infections, hospitalizations, and deaths. In Denmark, Finland, and Norway there was more collaboration between political executives and experts, while Iceland was closer to the Swedish expert-dominated approach with the political executive keeping a lower profile.

The significant differences in crisis management between some of the Nordic countries are somewhat surprising given the many common contextual features of the Nordic model, like high trust society, a reliable and professional bureaucracy, a good economic situation, big welfare state and a high quality hospital care. But, the variations found reflect mainly differences in main structure of the political system, including the autonomy of experts and variation in decentralization, but also differences in culture. In Sweden and Iceland, the expert autonomy is generally high, and the degree of politicization is rather low, while Denmark has the opposite pattern. Norway and Finland are in between on both dimensions (Christensen et al., 2021).

The main lesson learned from the Nordic countries, except Sweden, is that, despite a lack of preparedness, the government managed to control the first wave of the pandemic rather quickly and effectively by adopting a suppression strategy based on a collaborative and pragmatic decision-making style, good communication with a well disciplined public, a lot of resources, and a high level of public trust in government. Prompt responses, strong information and surveillance systems, and improved contact tracing enhanced the rather well performing crisis management (Nanda, Aashima and Sharma, 2021). The apparent success of the Nordic approach highlights the relationship between crisis management capacity and legitimacy (Christensen, Lægreid and Rykkja, 2016). Crisis management is most successful when it can combine democratic legitimacy with government capacity and leadership. Even high trust Nordic countries need to have a proper crises response strategy and institutional capacity to perform well. To handle a creeping and long-lasting crisis like COVID-19, dynamic capabilities and capacities are needed (Muzzucato and Kattle, 2020).

A second lesson is that if crisis management is to perform well, its processes and decisions must be appropriate and transparent, thus both reducing the effects of the crisis and enhancing politicians' reputations, citizens' expectations of the government authorities, and their support and trust in government (Christensen and Lægreid, 2020a). The Nordic countries generally scored high on transparency and appropriateness.

A third lesson is that transboundary collaboration between countries, policy areas, and administrative levels, and between political authorities and professional expert bodies is necessary. This was less the case internally in Sweden than in the other Nordic countries. Hybrid and complex organizational forms in which different actors work together in networks and teams in the shadow of hierarchy might be an appropriate way of managing this kind of crisis. A main challenge is to match the pace of crisis development with a requisite level of political attention (Boin, Ekengren and Rhinard, 2020). Collaboration between the Nordic countries has been rather low, however, and a controversial question creating tensions.

A fourth lesson is that a mixed decision-making regime that goes beyond narrow epidemiological expertise might be recommended as a strategy for managing a pandemic. When the existing knowledge base is uncertain, mixed decision-making, based in the top political executives, that draws on broader insights might be wise. Evidence-based knowledge is used to inform decisions rather than driving them. Norway seems to have come close to such a strategy. It did not delegate responsibility to sector specific experts as in Sweden and even if the government implemented more radical measures than recommended by the health authorities, these decisions were taken in close collaboration with the health authorities and communicated in a transparent way (Christensen et al., 2020b; Rubin et al., 2021). Denmark's policy in the initial phase was more characterized by miscommunication between the government and the health authorities. Norway was also quick to diversify its list of experts informing the decision-making process, thus including economic experts and experts on the effects of school closures on children and young people in addition to health experts. The Danish parliamentary inquiry

commission highlighted a need for system maintenance rather than system transformation (Folketinget, 2021). While a system with many health authorities could be maintained, it recommended that a permanent advisory commission for implementing pandemic measures and an external expert advisory panel for public health issues be established.

At least two critical points, that is elaborating on some of the lessons above, should be mentioned. First, in all the Nordic countries, except Sweden, the central political leadership took center stage during the handling of the pandemic, with Denmark as the most typical example, with its heavy emphasis on health issues and the precautionary principle. This is understandable in a transboundary and creeping mega-crisis, but the disadvantage is that the experts had less influence over decision-making processes. This situation was most evident in Denmark and Norway. Even though there was a lot of turbulence and insecurity, some evidence-based knowledge was consigned to the background when decisions were taken on certain major issues (Christensen and Lægreid, 2020b).

Second, health was given priority, with the economy ranked second, while social consequences, including individual freedom and civil rights, were given a much lower priority. Individual freedom of movement was heavily restricted through social distancing, border closures, internal travel restrictions, and quarantine. In Norway, for example, the authorities did not pay much attention to ensuring that the infection control measures were in line with human rights and the Constitution (NOU 2021:6). The social consequences also received little attention (Christensen, 2021). Vulnerable groups among children and young people were prioritized, but despite this they lost most of their normal safe environment because of kindergarten and school closures and the cessation of sport and leisure activities (Christensen and Lægreid, 2020b). Sweden was the only country that focused more on these problems by imposing fewer restrictions on these groups. On the other hand, Sweden proved much less able to protect another vulnerable group – elderly people – than the other Nordic countries.

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