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Original Research Article

Assessing the crisis management of the COVID-19 pandemic: a study of inquiry commission reports in Norway and Sweden

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Abstract

This article examines the inquiry reports from the commissions charged with investigating government crisis management of the COVID-19 pandemic in Norway and Sweden. Such postcrises commissions have been a common feature in many countries as they seek to systematize their experiences and learn from the crisis. In this article, we used various dimensions of governance capacity and governance legitimacy as assessment criteria. It reveals that the commissions' assessment criteria were not very specific in their reports, but a reanalysis of their findings shows that governance capacity and governance legitimacy dimensions are useful to assess the reports themselves. The two reports reveal a lack of preparedness in both countries, but they differ in their conclusions about governance regulation and output legitimacy.

Keywords: COVID-19, inquiry commissions, Norway, Sweden, crisis management

Studies of investigation commissions might examine their mandate, expertise, resources, thinking, focus, and role (Renå & Christensen, 2020) or else address them as diagonal accountability fora (Bovens, 2007; Bovens et al., 2010), focusing on their power and capacity (Bovens & Wille, 2021). However, the aim of this study is narrower. The overall case type is postcrises commissions evaluating the handling of the pandemic in different countries, of which we are describing and analyzing two Scandinavian country cases and their use of the assessment criteria. This is a very relevant topic since government policies and crisis management concerning the COVID-19 pandemic have been highly controversial, but not so much in the Scandinavian countries. The purpose of the article is not to shed new light on how the handling of the pandemics was addressed in the two countries, since this is already well documented in many studies (Askim & Bergstrøm, 2021; Christensen et al., 2022; Christensen & Lægreid, 2023; Pierre, 2020), but to assess the post-COVID-19 commissions reports in the two countries by applying analytically derived assessment criteria, which, in our view, is the original contribution in the article. The article reveals that the commissions' assessment criteria are rather vague and not very explicit but a

reanalysis of the reports by using specific assessment criteria dimensions linked to governance capacity and legitimacy offers a more systematic and comprehensive understanding of the contents of the reports.

The focus of the article is on the output of the commissions' works which are their reports, and not the internal working processes during their existence. The inquiry commissions' reports represent major contributions in understanding the management of this crisis, and the comparison between Norway and Sweden reveals significant differences in crisis management between two rather similar countries.

Research on inquiry commissions has not been particularly preoccupied by the assessment criteria that can be used to assess the crises management under scrutiny. This article attempts to fill this gap by clarifying the criteria for assessing the governments' crisis management of the COVID-19 pandemic in terms of governance capacity, looking at aspects such as preparedness, analytical capacity, coordination capacity, regulative capacity, and delivery capacity (Lodge and Weigrich, 2014), and in terms of governance legitimacy, measured by input legitimacy, throughput legitimacy, and output legitimacy (Schmidt, 2013). Thus, the following research questions are examined:

- How explicit were the assessment criteria used in the investigation commissions' reports?
- Did the commissions' reports address most aspects of governance capacity and governance legitimacy? If so, in what ways and to what extent?
- How did the investigation commissions' reports' assess the governments' crisis management performance according to these criteria?
- What are some of the major similarities and differences in the use of assessment criteria in the postcrises commissions' reports in Norway and Sweden?

While the first question is descriptive and aim at revealing whether governance capacity and legitimacy are explicitly used in a systematic way in the reports, the second question is about reanalyzing the commissions' reports by applying the concepts of governance capacity and legitimacy and their different dimensions. The third addresses how the reports' assessment of the crisis management performance can be understood based on governance capacity and governance legitimacy criteria. The fourth sums up some major comparative features.

The article is structured as follows. First, the main analytical approach is presented, before context and method are outlined. Then the assessment of the commissions is described based on the theoretically derived criteria, followed by the analysis and conclusion.

Analytical approach and core concepts

Dealing with crises is a core responsibility of governments. Therefore, it is essential that political and administrative executives have the skills to do so. Handling crises involves both governance capacity and an ability to influence citizens' behavior and expectations vis-à-vis government action in order to secure governance legitimacy.

The COVID-19 pandemic is an example of a creeping, transboundary, and wicked mega crisis (Boin, Ekengren and Rhinard, 2021; Boin, McConnell and 't Hart, 2021). It tested the limits of what public organizations are organized to handle and it was a stress test for crisis management. First of all, it was characterized by complexity, meaning that it was trans-boundary, sitting at the interface between countries, administrative levels, policy areas, and sectors, as well as between political bodies and experts. Second, it was a source of uncertainty regarding means-end knowledge because causes and effects were unclear and there was weak evidence-based knowledge about what would be the most effective approach (Rubin et al., 2021). Third, its values and goals were ambiguous, and decision-makers faced different trade-offs between citizens' life and health, money, and freedom. Fourth, it was urgent. Difficult decisions had to be taken under strong time pressure and there was a need to respond before the scale of the crisis grew. Finally, the government needed to address citizens' expectations, convince them to comply with the regulations and to take care of themselves and their fellow citizens. The national response was informed by government capacity to learn from previous pandemics and to build political support for the policy measures as well as by the nature of the political leadership and the organization of the government apparatus (Capano et al., 2020).

To evaluate the inquiry commissions' assessments of this crisis management, a combined approach drawn from organization theory is used (Olsen, 2010; Christensen et al., 2020; Egeberg and Trondal, 2018; Kuhlmann et al., 2021). The focus is on both structural and cultural features linked to governance capacity and governance legitimacy, and the dynamic relationship between the two. Capacity and legitimacy both depend on structural and cultural elements. The very high trust in the two countries studied is of high importance for all types of government capacity and legitimacy, especially in times of crisis (Nielsen & Lindvall, 2021).

Our argument is that both governance capacity and governance legitimacy are necessary for good crisis management (Christensen et al., 2016; Lægreid & Rykkja, 2019). Capacity is important, but it is also crucial that crisis management policy is accepted by citizens and that they follow through it. Also, the dynamics between governance capacity and governance legitimacy matter. Strong capacity may increase legitimacy and strong legitimacy may strengthen capacity, so they may reinforce each other. Conversely, weak capacity may undermine legitimacy and even strong capacity may suffer if legitimacy is low. Thus, it matters not only what the government actually does, but also what the citizen expects the crisis management apparatus to be able to do and how they assess its performance (Lægreid & Rykkja, 2019). While the governance capacity alludes to the logic of consequentiality, governance legitimacy is more about the logic of appropriateness (March & Olsen, 1989).

"Governance capacity" is a multidimensional and ambiguous concept that embraces formal, structural, and procedural features of the crisis management apparatus. It also concerns the functional features of the governmental apparatus (Nohrstedt et al., 2018) and how these features work in practice. Lodge and Wegrich (2014) discern four types of capacity—analytical, coordination, regulatory, and delivery capacity. A fifth capacity dimension—preparedness—is added in this study. Our argument is that these five types of capacity were essential for managing the COVID-19 pandemic. An effective response to the COVID-10 pandemic needs to address the following dimensions:

- "Preparedness"—this concerns material emergency preparedness related to national emergency stockpiles such as infection protection equipment, reserves of emergency medicine, appropriate and updated pandemic plans, joint training and exercises, a testing and contact tracing organization, intensive care capacity, and legal and mental preparedness.
- "Analytical capacity"—this involves analyzing information, providing professional advice, and carrying out risk and vulnerability assessments. It is about the quality of expert advice, the ability to predict and to understand the development of the crisis, to learn during the crisis, and to have good means-end knowledge to provide reliable advice about how to limit the damage (Rubin et al., 2021).
- "Coordination capacity"—this concerns the ability to coordinate between actors, administrative levels, and policy areas and between political executives, administrative bodies, and experts. At the core is horizontal and vertical cross-boundary coordination, both within the central government apparatus and externally between the central, regional, and local levels and between the public, private, and voluntary sectors, bringing together disparate organizations in joint action (cf. Egeberg, 2012).
- "Regulatory capacity"—this is about the ability to decide on crisis measures to mitigate the negative effects of a crisis and the ability to adapt these measures as the crisis progresses. Here, regulation is narrowly defined and refers to standard-setting and the capacity to introduce regulatory rules, means, and measures (Baldwin et al., 1998). It is related to the substance (what the rules say), the character (whether they are permissive or mandatory), and status (the legal force and sanctions attaching to it) of the regulatory measures as well as to their timing and tempo and whether they are stable or subject to frequent change.
- "Delivery capacity"—this is about getting things done—in other words, implementation capacity related to enforcement and the application of sanctions in order to achieve citizens' compliance and change their behavior; it is sometimes labeled intervention capacity (Noordergraaf et al., 2017). It is about the government's capacity to handle a crisis as it unfolds, exercising power and providing appropriate services and also maintaining critical societal functions in response.

"Governance legitimacy" is also a complex concept involving citizens' trust in government and it concerns responsiveness and expectations. Upholding and restoring trust in government arrangements for dealing with a crisis is a key challenge. It deals primarily with the relationship between government authorities and citizens and concerns citizens' perceptions of whether the authorities' actions are

desirable, proper, and appropriate, according to citizens' norms, values, and belief systems (Jann, 2016; Suchman, 1995). Governance legitimacy is more related to the political dimension of crisis management and, as such, addresses political accountability, organizational reputation, and cultural support for crisis management organizations and their leadership. Legitimacy affects how citizens understand the crisis management authorities, not only how they act toward them. Legitimacy refers to organizational and leadership support, in terms of responsiveness (input), procedures (throughput), and performance (output) (Scharpf, 1999; Schmidt, 2013) and concerns what people expect or demand from government, their attitudes toward government authorities during crises, and also how they understand the crisis and judge the authorities' actions. The distinction between input, throughput, and output legitimacy is not always very clear in the literature, but we will make the following distinction:

- "Input legitimacy" is about involvement and participation in and support "by" the people for the government's crisis management, so that citizens may influence policy making, decisions, and implementation. It is about trust in government, but also trust in fellow citizens. It is related to government's responsiveness to citizens' concerns, and to open, transparent, reliable, and trustworthy crisis communication and information. In the Swedish case, citizens' input, responsiveness, and trust are divided between the expert agency and the cabinet, which makes it more complex, while Norway applies the principle of ministerial responsibility, which indicates that this dual responsiveness is not that clear.
- "Throughput legitimacy" is about what is going on within the black box of government, but also to show that externally. It deals with following acceptable and appropriate processes and procedures adhering to impartiality, fairness, professionality, due process, rule-of-law, and involvement of affected stakeholders. It is about how government explain their actions, about bureaucratic practices and the efficacy, accountability, and transparency of governance processes and the degree of inclusiveness and openness of consultations "with" citizens (Schmidt, 2013). Crisis communication and information must be open, transparent, reliable, and trustworthy.
- "Output legitimacy" is about the effectiveness of crisis management policy "for" the people and the problem-solving quality of regulatory means and measures. It is related to the outcome of crises regarding life and health, the economy, social effects, individual freedom, and civil rights.

Context

The Scandinavian countries are unitary states with small populations. They are representative, multiparty, parliamentary democracies and their governments are normally minority coalition governments. They combine centralized features with local self-government and have well-developed administrative systems characterized by non-politicized, merit-based professional civil servants who enjoy a high status (Painter & Peters, 2010). They have consensus-oriented democratic traditions and well-established cooperation between the state, civil society, and the private sector. The decision-making style is pragmatic and collaborative, allowing stakeholder participation in policy making. There is a high level of interpersonal trust in society, of public trust in government, of trust between politicians and the administration, and in experts (Lægreid, 2017). The Scandinavian countries are also known for their large and universal welfare states and their solid financial situation.

They share a political culture that underlines the central role of the state in managing society and there is a statist view of governance (Painter & Peters, 2010). Civil servants' actions are open to scrutiny, and there is a high level of transparency and open access to government documents. Overall, administrative capacity is high.

The differences between the Scandinavian countries are small, suggesting that there might be a Nordic model (Peters, 2021). From this common perspective, a distinction can be drawn between the Swedish administrative model and the administrative model in other Scandinavian countries. Norway applies the doctrine of ministerial responsibility, meaning that the minister is responsible for the portfolios of subordinate agencies and bodies. In Sweden, however, 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 stronger and more autonomous central agencies and a more pronounced separation between politics and administration than in the other Nordic countries (Peters, 2021).

The health systems in the Scandinavian countries are resilient and robust (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 Sweden, the hospitals are the responsibility of the regional governments, reflecting an overall more decentralized system.

During the COVID-19 crisis, both Norway and Sweden had minority coalition governments. In Norway, the Prime Minister and the Minister of Health and Care Services played a core role together with their two subordinate central agencies, the Norwegian Health Directorate (NHD) and the Norwegian Institute of Public Health (NIPH). In Sweden, the PM was less important. The Swedish government delegated decision-making to the Public Health Agency.

The Scandinavian countries have a long tradition of public commissions. The structure and functioning of the commission system in the two countries are rather similar. These entities are either broad, encompassing representatives for the government, experts, employers' organizations, employees' organizations, and other stakeholders, or they are pure expert bodies, like with the investigative commission studied in our case (Renå & Christensen, 2020). The government tries overall to steer them through recruitment and mandates, but sometimes the mandates are open and broad, like in our case. The experts seem to have an increasing importance in the commissions' work (Christensen et al., 2022). The government do not have to follow their proposals, but often they do it some kind of way, so they are influential and often have a good reputation.

Investigative and more ordinary public commissions represent two different strands of literature, even though they are in fact not that different. They are both involved in policy making, implementation, as well as giving policy recommendations. But postcrisis inquiry commissions are different in the way that they work with specific crises addressing the politics of investigation, accountability, and learning issues (cf. Boin, McConnell et al. 2008; Renå & Christensen, 2020). In contrast to ordinary public commissions, the political decision to appoint inquiry commissions looking into public crises is influenced by short-term blame avoidance considerations, media salience, and government popularity (Sulitzeanu-Kenan, 2020).

Method

The main data base is the numerous reports from the investigation commissions in Norway (NOU, 2021: 6, 2022: 5) and Sweden (SOU, 2020: 80, 2021: 89 Volume 1 and Volume 2, 2022: 10, Volume 1 and Volume 2). We make a content analysis of those based on the theoretically derived concepts, meaning types of governance capacity and legitimacy.

Methodologically, it is at least two ways to look at comparing Norway and Sweden. First, a most similar system approach (Przeworski & Tenue, 1970) is relevant since the countries both belong to a Nordic welfare model type sharing a lot of common characteristics on the independent variables as described in the context section above but different on the dependent variable, i.e., the use of the assessment criteria. At the same time, there are significant differences that allow for variations in important explanatory variables (Greve et al., 2016). Thus, there are elements of most different system design meaning that Sweden is rather different from Norway's unitary ministerial responsibility with stronger and more independent agencies, like reflected during the pandemic (Christensen & Lægreid, 2023). Further, the Swedish health system is more decentralized and the intergovernmental relations between central and local government are more loosely coupled compared to the Norwegian (Askim & Bergstrøm, 2021). Taken together, we will use a more mixed system design combining the two outlined above (Frendreis, 1983). We believe this is appropriate because the countries will vary both on independent and dependent variables.

The commissions

The corona inquiry commissions were appointed by the governments of Norway and Sweden in April and June 2020, respectively. The Norwegian commission submitted its first report in April 2021 and the second in April 2022 (NOU, 2021: 6, 2022: 5). The Swedish commission submitted its first report in December 2020, its second in October 2021, and its third in March 2022 (SOU, 2020: 80, 2021: 89, 2022: 10). The mandate of the commissions was to assess their government's crisis management in order to learn from the crisis and to increase the understanding of how public organizations adapted to the ongoing

Table 1. The inquiry commissions: members, data base, resources, and output.

	Norway	Sweden
Delimitations	No assessment of economic measures, legal responsibility, or criminal liability. Only partial assessment of local government	The first report on elderly care was preliminary, since it primarily analyzed the first wave
Members	13 members, dominated by medical experts/professors	8 members: professors of law, medicine, political science, social science, and economics; members of the church and the military
Period under scrutiny	26 February 2020–31 October 2021	Until 7 February 2022
External reports	24	17
Data sources	Documents, graded information, and cabinet notes. Interviews with 25 key actors, formal explanations from 78, and meetings with 251 organizations	Public documents from different levels. The secretariat met 450–500 politicians, experts, and interest groups. And, 58 politicians and experts interviewed. Three expert groups
	906	3,197
Secretariat	9 employees	10 employees

challenges posed by the COVID-19 pandemic. Table 1 shows the members, data bases, and resources of the commissions.

The first Norwegian report examined the degree to which the authorities were prepared for a pandemic and how they managed the first wave of infection up to the summer of 2020. The second report focused on pandemic management after the first wave of infection up to the end of October 2021. The Swedish commission's assessment was the most extensive with three reports: the first focused on elderly care while the second and third took a much broader approach. Overall, the commissions had generous framework conditions especially with respect to resources and data as well as a broad consultation process with internal and external stakeholders. On the other hand, they also had extensive and comprehensive mandates and short deadlines for submitting their reports. The commissions lacked a Scandinavian comparative approach, and they began their assessments of the crisis management before the pandemic had ended. The reports differed in the resources to which they had access and in the composition of their members. The Swedish commission had more resources and a more mixed member composition than the Norwegian commission which had a bias toward medical experts. These differences could potentially affect the focus and results of the reports.

The Norwegian commission assessed the government's crisis management in terms of current legislation, national and international emergency preparedness plans and principles, and basic democratic and administrative values (NOU, 2021: 6, 35). But these values were not very explicit (Askim & Renå, 2022). The Swedish commission had few explicit criteria for its evaluation. It alluded to some WHO criteria, was mainly preoccupied with the precautionary principle, and its analysis was based on the underlying principle of social equality. Overall, the commissions did not generally specify which criteria they had used for many of their conclusions. They did not apply clear, objective, explicit, or predefined standards for systematical evaluation as recommended in the evaluation literature (Vedung, 2009). Rather, they took a more pragmatic approach using vague criteria informed by political relevance, dialogue, and a focus on learning (Askim & Renå, 2022). In this article, we will assess the commissions' reports in terms of governance capacity and governance legitimacy.

The inquiry commissions' reports assessments of crisis management

How and to what degree did the inquiry commissions take governance capacity and legitimacy criteria into account in their assessments? Overall, the reports addressed most dimensions, but to different degrees and not in a direct or systematic way using the same wording; moreover, the specification of the scales was rather imprecise.

Governance capacity

Preparedness

Norway: The reports revealed that the authorities were not well prepared for this pandemic. There was no overall assessment from the government about the social impact of a pandemic. The emergency response system gave each sector and municipality responsibility for assessing its own risks and vulnerability, but this was unsuitable for assessing the overall consequences of a pandemic for the whole of society. The monitoring systems for pandemic management were deficient. There was a lack of personal infection protection equipment, and emergency stockpiles, respirators, intensive care nurses, and medicine were inadequate. Overall, "the authorities did not succeed in reducing the vulnerabilities associated with an identified risk" (NOU, 2022: 5).

Sweden: The regional and local authorities were heavily criticized for being unprepared regarding elderly care and not well equipped with protective gear (SOU, 2020: 80). There was no national plan for local protective efforts, a lack of knowledge and communication about the pandemic, and ambiguous roles on the regional and local levels (ibid. 242–245). The commission revealed that this lack of preparedness had a history (SOU, 2021: 89, 160–176) and it criticized the government's failure to learn from earlier similar pandemics and crises, for its lack of planning and training, and the lack of communication during the early days of the pandemic (SOU, 2022; 10, 316). Overall, the authorities were judged to have been either unprepared or inadequately prepared.

Analytical capacity

Norway: The commission revealed that experts had been largely unable to forecast the scope of the infection and the speed with which it would spread. The monitoring systems for pandemic management were deficient, and the experts underestimated the spread of the infection before March 12; moreover, they were slow to learn. The authorities took a wait-and-see approach, and there was great uncertainty regarding the need for draconian measures. Their sense-making capacity was rather weak, and the experts had problems understanding and grasping the crisis as it unfolded. Later, in the pandemic, the scenarios from the NIPH about how the pandemic would develop were more dramatic than happened in practice. The second report criticized the government for paying too little attention to how the pandemic might develop and how that future evolution should be addressed, especially with regard to limiting the transmission of the virus into Norway via cross-border travel (NOU, 2022: 5).

Sweden: The commission stated that the authorities had not been able to forecast the spread of the pandemic well, which meant they were slow to take preventive measures. It pointed out that the flow of scientific information about the pandemic was explosive and detailed in the first wave of the pandemic (SOU, 2022: 10, 432–441). Despite this, the knowledge base in Sweden was too narrow and dominated by the Public Health Authority (PHA), and there was a lack of alternative voices. One effect of this was that some risk assessments and recommendations were either scientifically controversial or confusing for the public (ibid., 477–479). It also revealed that there was a lack of good Information and Communication Technology (ICT) systems as a basis for necessary analyses.

Coordination capacity

Norway: The commission revealed that "the government exercised strong, centralized control over the pandemic effort" (NOU, 2022: 5). Within the cabinet, a COVID-19 committee was established which led to narrower cross-sectoral deliberation and coordination than in regular cabinet meetings (NOU, 2021: 6, 216). The commission criticized the government for not utilizing the established system for crisis management (NOU, 2022: 5, 451). Within the health care sector, the Norwegina Directorate of Health (NDH) was assigned a coordination role, but in practice there was strong steering from the MH and by the end of January 2021, the NDH and the Norwegian Institute of Publich Health (NIPH) had received about 300 written assignments from the ministry, which created confusion and capacity problems (NOU, 2021: 6). There were also coordination problems and unclear allocations of responsibility and role division between the NDH and the NIPH; moreover, the NIPH was sidelined when the semi-lockdown was decided on March 12. Despite this, the commission concluded that collaboration between the two agencies had been comprehensive and good (NOU, 2021, 6, 228). In some areas, such as protecting vulnerable children and youths, the commission argued that coordination could have been stronger (NOU, 2022: 5, 388). In the Infection Control Act, coordination responsibility and role distribution between central and local government were unclear.

Sweden: The commission used a lot of space detailing how structurally fragmented regional and local health systems were, with ambiguous roles and tasks, leading to a basic lack of coordination in care of the elderly and to clearly poorer quality in the actual care (SOU, 2020: 80). It also pointed out that the ICT systems in the health sector on the regional and local levels did not communicate well, resulting in a lack of mutual exchange of information. The broader evaluation pointed to the fact that the actual coordination was difficult because of a vertically and horizontally fragmented system, with more decentralization than in Norway (SOU, 2021: 89, 148–149). The commission criticized the central political leadership for not assuming national responsibility from the start but leaving it to the PHA (SOU, 2022: 10, 26–30). It stressed that in such a major crisis, the cabinet should not have been so passive, regardless of the dual and complex organizational structure at the central level.

Regulative capacity

Norway: On 12 March 2022, the most intrusive measures in peacetime were introduced when a semi-lockdown was decided. The commission characterized this as a paradigm shift with the deployment of infection control measures of a magnitude that no one had previously imagined or planned for (NOU, 2021: 6). A mitigation strategy of "flattening the curve" was soon replaced by a suppression strategy and a precautionary principle giving priority to life and health. According to the commission, it was right to impose comprehensive infection control measures by being proactive and acting quickly (NOU, 2021: 6). Cooperation, flexibility, adaptability, and readiness to act were crucial to achieve positive results (NOU, 2022: 5). However, it criticized the government for unnecessary high time pressure, for instituting measures that were under-investigated and poorly prepared, and for not ensuring that the infection control measures were in line with human rights and the Constitution.

Sweden: In its lengthy discussion of elderly care, the commission pointed out that the government lacked legal regulatory instruments to impose restrictions in the first wave, which was a problem; this changed in the second and third waves (SOU, 2020: 80, 131–136). The commission highlighted the fact that Sweden had chosen a different regulatory path to Norway with later and less comprehensive regulatory measures (SOU, 2021: 89, 234–236). Overall, the commission's conclusions seemed to be paradoxical with regard to regulative capacity and content (SOU, 2021: 89, 27–28, 2022: 10, 20–26). On the one hand, it argued that the lack of regulation regarding many aspects of people's lives, whether keeping schools open or allowing public gatherings of various kinds, was justified. On the other hand, it concluded that some important regulatory measures, for example restricting people's movements, came far too late and did not go far enough. This adds up to a rather ambiguous conclusion from the commission (Ludvigsson, 2023).

Delivery capacity

Norway: The commission concluded that the vaccination of the population was successful, with the municipalities playing an important role in implementing the vaccination program, even though vaccine allocation focused on the epicenter of infections rather late. Some implementation problems were revealed, however. To limit the import of infection, the authorities imposed strict limitations on individual cross-border travel. However, they lacked a plan for handling imported infections, and these measures were hastily conceived and subject to continual adjustment, which produced implementation deficits. Furthermore, the authorities responsible for applying infection control locally ran into implementation problems owing to lack of involvement and information ahead of new recommendations and rules. They often received imprecise information and had too little time to prepare. Childcare, schools, and the welfare administration essentially maintained their societal functions even if the quality of their services was considerably reduced for children with special needs (NOU, 2021: 6, chapter 31).

Sweden: The commission praised the high quality of hospital care during the pandemic but criticized the fact that the regional and local authorities had problems with the quality of the care, since so many old people died in health institutions (SOU, 2020: 80, 172–174). It criticized the same authorities for starting testing and contact-tracing too late. It also addressed the effects of postponing treatment or shutting down other aspects of healthcare owing to the pandemic (SOU, 2021: 89, 506–557). The report discussed some important indirect effects of the pandemic, such as the social isolation of some vulnerable groups, and argued that the government could have done more to mitigate these effects (SOU, 2021: 89, 603–651). It praised the way the government had handled the economic challenges of the pandemic, however (SOU, 2022: 10, 117–220).

Governance legitimacy

Input legitimacy

Norway: The commission argued that "the authorities would not have been able to succeed without the population's support for the infection control measures" (NOU, 2021: 6, 25). People had a high level of trust in one another and in the authorities and this trust remained high throughout the pandemic (NOU, 2021: 6, 23). This was important both for the population's support for infection control measures and for the high rate of vaccination that was achieved (NOU, 2022: 5). The government's meaning-making strategy vis-à-vis citizens was also judged to have been successful. The commission stated that public communication had been open and honest (NOU, 2021: 6), direct and targeted, and had tended to achieve the desired behavioral changes while preserving public trust (NOU, 2022: 5). The government appealed to people to show solidarity, to make voluntary efforts, and to remain united. A large majority of the population expressed confidence in the information received from the health authorities, but the government had some problems reaching out to the immigrant population.

Sweden: Compared to the Norwegian commission, the Swedish one focused less on input legitimacy. It concluded that trust in the Swedish government's handling of the pandemic was high during the first wave, even though Sweden was criticized internationally for its alternative course of action. It did not mention, however, that this support decreased in the second and third waves. It was more preoccupied with the fact that people had limited their movements and contacts, despite experiencing a regime with fewer regulations and restrictions, which it saw as a positive sign of support (SOU, 2021: 89, 25). Concerning communication with the public by the authorities, the commission praised both the openness and the broad range of information provided but criticized the fact that the message and signals were often somewhat confusing, and that the government failed to communicate well or openly enough with immigrant groups (SOU, 2022: 10, 483–550).

Throughput legitimacy

Norway: According to the commission, Norway's social model, with a solid and well-structured economy, a public sector welfare policy, and an organized working life as well as established cooperation between public authorities, employer organizations, and unions, and the involvement of civil society organizations, proved to be a major asset in dealing with the pandemic. This consultation process and cooperation enhanced understanding of the measures imposed by the authorities among organizations and citizens alike. Regarding internal government processes, the commission strongly criticized the government for delegating the decision to enforce the semi-lockdown on 12 March 2020 to the NDH rather than taking the decision in the Council of State, which, according to the Constitution, should handle all matters of major importance. The commission also criticized the government for not ensuring that the infection control measures such as management of imported infection and quarantine hotels were legally enforceable, in line with human rights and the Constitution (NOU, 2021: 6, 26). It said top-down governance measures had been too detailed, implying micro-management and too much day-to-day involvement (NOU, 2022: 5, 74), and that regular consultation procedures and involvement of municipalities had not been followed (NOU, 2022: 5, 116).

Sweden: The commission criticized the ambiguous organization and role allocation between the regional and local (health) authorities (SOU, 2021: 89, 43–44, 447–450). It also argued that the PHA as an expert body had too much power, especially the director; this applied primarily to the first wave (SOU, 2022: 10, 327–430). The commission thought that the political executive had been too passive during the first wave and that professional and political decision-making premises should have been more balanced. It also criticized the ambiguous and fragmented structure of the central pandemic management and proposed a more coordinative function under the Prime Minister's Office.

Output legitimacy

Norway: A main conclusion of the commission's report was that overall, the authorities had handled the pandemic well, even though some of its criticisms were quite harsh. Norway had one of Europe's lowest mortality rates, one of the least restrictive infection control regimes, and one of the smallest declines in economic activity. The authorities, to a great extent, had succeeded in protecting vulnerable elderly people against infection, illness, and death (NOU, 2022: 5, 421). However, social services had been more limited, and the pandemic had exacerbated social and economic inequalities. Limitations in public services had made some vulnerable groups, such as children and youths, even more vulnerable.

Table 2. Inquiry commission scores on criteria related to governance capacity and legitimacy.

	Norway	Sweden
Governance capacity		
Preparedness	Low—despite warnings; sector-focus and not holistic; lack of criteria for using relevant laws	Low—the country was ill-prepared and ill-equipped for elderly care; lack of protective gear locally
Analytical capacity	Low/medium—not able to forecast or deliver on evidence-based handling; often dramatic scenarios decoupled from reality; slow learning	Low—not able to forecast the quick spread of the pandemic; knowledge base too narrow; need for better ICT systems
Coordination capacity	Medium—Strong hierarchical control, lack of broad cross-ministerial coordination, problems of coordination with NIPH, too much top-down detailed assignments	Low—structural fragmentation, weak coordination in elderly care, between political executives and expert bodies and between different ICT systems
Regulatory capacity	Medium/high—strong measures; combined suppression strategy with pragmatic control, measures not well prepared, changing measures in a complex pattern, infection control measures often lacked foundations	Low—the Swedish approach was in some ways justified, but some important regulations and restrictions were too soft and came far too late; lack of legal instruments to regulate elderly care, more active regulations over time
Delivery capacity	High/medium—limited implementation problems; cross-border control and services for vulnerable citizens a challenge	Medium—high-quality care in hospitals despite extraordinary pressure, testing and tracing started too late
Governance legitimacy:		
Input legitimacy	High—strong trust in authorities, active and transparent meaning-making from the government	High/medium—strong trust in government, but declined over time; adaptive behavior despite fewer restrictions
Throughput legitimacy	Medium—criticized for not making 12 March decision in the formal cabinet meeting; consultation with employers' and employees' organizations worked well, but some problems with municipalities	Low/medium—too much power to PHA, lack of collaboration with central political leadership and need for reorganization, unclear role division between regional and local health authorities
Output legitimacy	High/medium—low mortality rate, relatively moderate restrictive control regimes and minor decline in economic activity; increasing social inequality	Medium/low—high mortality rate in Nordic perspective, minor decline in economic activity, increased social inequality, more individual freedom

According to the commission, the Norwegian economy managed well during the pandemic. The government established generous economic support and compensation arrangements. The negative economic side effects were rather modest, which contributed to a sustainable output legitimacy.

Sweden: The commission put more emphasis on the fact that Sweden scored better than the European average concerning death rates, while playing down the fact that Sweden had far more deaths than the other Nordic countries (SOU, 2022: 10, 221–238). However, it was generally more satisfied with the way the Swedish government had handled the economy than with how it had handled the infection control measures (SOU, 2022: 10, 53–220). The commission argued that social inequality had increased during the pandemic and said that citizens with fewer resources and those suffering from other diseases and facing other challenges had been at a clear disadvantage during the pandemic (SOU, 2021: 89, 561–586).

Table 2 sums up the main results for all the assessment criteria in both countries.

Discussion

The main similarities between the two countries, according to the respective inquiry commissions' reports, were that the authorities were poorly and inadequately prepared for the pandemic and that analytical capacity was low. The COVID-19 pandemic revealed that evidence-based decision-making can lead to diverse policies; the authorities may get it wrong, and there might be inadequate learning between contexts (Rubin et al., 2021). The main difference between the two countries, as seen in the use of the assessment criteria, was stronger regulatory capacity and higher score on output legitimacy in Norway, two factors that are connected. In the dual system in Sweden, the central expert health body was running the show allowing people to go on with their daily lives, i.e., they did not come up with strict regulatory measures like in Norway (Christensen & Lægreid, 2023). Adding to this, a more decentralized hospital system in Sweden and looser intergovernmental relations between central and local government also had negative impact on the governance capacity even if the loosely coupled arrangements between central and local governments were tightened somewhat through the dominant central public health agency (Borraz & Jacobsson, 2023). This was reflected further in much higher death rates, especially among older people, in the short run, but not necessarily in the long run (Juul et al., 2022). The focus on the three first waves until Spring 2021 might have underestimated the benefits of a Swedish strategy emphasizing long-term sustainability (Ludvigsson, 2023).

The Norwegian government used strong hierarchical coordination and political centralization, which strengthened the government's power to act. The downside of the detailed day-to-day top-down assignment regime was a lack of cross-boundary coordination between government ministries and agencies as well as weak overall strategic considerations. Overall, the reports revealed that governance informed by experts as in Norway tends to strengthen hierarchical governance arrangements while governance by experts as in Sweden tends to enhance more network-based arrangements (Christensen et al., 2022).

In contrast to the Swedish government, which was criticized for doing too little too late when it came to regulatory measures (Nygren & Olofsson, 2020), the Norwegian regulatory response was to impose a quick and mandatory semi-lockdown. While Sweden applied the proportional principle and a voluntary mitigation strategy, Norway's regulatory approach was based on the precautionary principle, giving first priority to life and health. While the Swedish commission's reports were mixed and somewhat inconsistent in its evaluation of the regulatory strategy in Sweden, the Norwegian commission mainly supported the strategy applied. While Sweden stood firm on a principled approach until the end of 2020 (cf. Boin & Lodge, 2021), the Norwegian regulatory regime was more pragmatic and made several adjustments over time. In contrast to Norway, Sweden did not establish a governmental crisis regime marked by centralization and it also refused to prioritize public health over other policy areas (Claeson and Hanson 2020). According to the commission, the government bears a responsibility for having accepted largely uncritically, right up to the late autumn of 2020, the assessments of its expert agency, and for having failed on the outbreak of the pandemic to issue directives calling on the agency to correct its course (SOU, 2022: 10, p. 19). This difference in policy response was conditioned by preexisting structures in the political-administrative system such as the autonomy of the PHA in defining and implementing policy measures, which made it difficult for political leaders to overrule expert advice (Christensen & Lægreid, 2023; Laage-Thompson & Frandsen, 2022). According to Pierre (2020), local and regional government staff lacked the necessary training and equipment to tackle the pandemic. Together with coordination problems in a decentralized healthcare system, this may explain some of the differences in the use of assessment criteria in the inquiry reports in the two countries.

The Norwegian inquiry reports were more positive about delivery capacity than the Swedish commission, mainly owing to the smoother relationship between the central, regional, and local levels. Stronger municipal responsibility in Norway with Infection Control Doctors in every municipality who had the legal power to decide temporary local infection-control measures enhanced a balance between top-down and bottom-up decision-making and yielded a more fruitful balance between national and local measures (Fosse et al., 2022). Thus, whether infectious disease expertise and authority were located at the local level mattered (Askim & Bergstrøm, 2021). Overall, delivery capacity at the municipal level was stronger in Norway, while this posed major problems in Sweden. The Norwegian system for testing, infection tracing, and isolation worked pretty well, while the testing regime in Sweden was characterized as "a complete failure" (SOU, 2022: 10, p. 18). However, the vaccination programs were successful in both countries.

Both Sweden and Norway ran into some problems regarding throughput legitimacy. In Sweden, this was mainly related to the strong role of the expert body and to weak involvement by the government and the political executive but also to ambiguity regarding the roles and responsibilities of local and regional authorities (Christensen et al., 2022). In Norway, there was criticism of the consultation practice and for not following appropriate processes and procedures within the central government. In particular, the commission criticized the government for not making the major decision to impose a semi-lockdown in a formal government meeting, but instead delegated it to a subordinate expert body. It was also criticized for not taking human rights and constitutional concerns more into consideration when adopting mandatory regulatory measures.

When it came to input legitimacy, citizens in both Norway and Sweden had a high level of trust in government throughout the pandemic, despite different regulatory measures. However, crisis communication was better in Norway, where political and administrative executives and experts communicated jointly with the public, than in Sweden, which, to a greater extent, left crisis communication to the expert body (Christensen & Lægreid, 2020b). Norwegian citizens had a higher level of trust in the authorities than Swedish citizens did, owing to differences in transparency management beyond information disclosure (Ihlen et al., 2022).

Regarding output legitimacy, Norway scored better on mortality than Sweden. Sweden had particular problems protecting the elderly population. On the other hand, Sweden scored higher on individual freedom. Both countries performed well economically but faced increasing social inequality as a result of the pandemic.

Summing up, the investigation commissions' reports revealed that good crisis management entails the authorities' doing as much as can be expected from them in extraordinary situations and that they were given credit for that. Instead of talking about successes or failures, the reports revealed shades of gray. They showed that good crisis management does not mean that everything is perfect, but that overall, more is done right than wrong. It is about following relevant and appropriate processes for crisis management, decision-making, and implementing decisions that minimize the damage done by crises, sustaining the government's political reputation and matching citizens' expectations of the political leadership so as to maintain trust (McConnell, 2011).

Conclusion

This study has revealed that it is meaningful to apply criteria related to governance capacity and governance legitimacy to revisit the reports by the COVID-19 commissions in two Scandinavian countries (cf. Christensen et al., 2016). Even if these criteria were not used actively, directly, or systematically in the reports, they did, to varying degrees, describe and illustrate how the commissions assessed governance capacity related to preparedness, analytical capacity, coordination, regulation, and delivery. They also assessed governance legitimacy issues related to input, throughput, and output legitimacy in the three countries (cf. Lodge & Wegrich, 2014). However, the relationship between governance capacity and governance legitimacy was not addressed in any depth and this is a weakness of the COVID-19 commissions' reports. Overall, the reports tend to be rather descriptive providing a comprehensive review of the government's crisis management, mapping and assessing the crisis management in each country, but explaining the patterns observed rather briefly. Their assessment was of the management of an ongoing pandemic. Nevertheless, they did present some lessons learned and some guidelines for future pandemic management, suggesting that incremental and agile changes rather than major reforms were necessary. That said, the reports also revealed that the ability of government to recognize a slowly unfolding crisis, deliver a response, work with experts, and maintain public support varied between the two countries (see Boin, Ekengren, et al., 2021; Formgren et al., 2022). While the scientific evidence and the lack of crisis preparedness applied to both countries, regulatory capacity seemed to be shaped more by structural and institutional factors and leadership than by the magnitude of the crisis (Christensen & Lægreid, 2023; Egger et al., 2021).

What lessons can we learn from the commissions' assessments of crisis management (see also Askim & Renå, 2022)? First, disagreement about policy measures is unavoidable when there is uncertainty about efficacy, conflict over values, and strong time pressure. Second, more pluralism, openness, and transparency regarding policy advice are a good thing. Third, trade-offs between different values such as life and health, the economy, and individual freedom should be the remit of political executives rather than experts. According to the Swedish commission, "the Government had a too one-sided

dependence on assessments made by the Public Health Agency. Responsibility for those assessments ultimately rests on a single person, The Agency's Director-General. This is not a satisfactory arrangement for decision-making during a serious crisis in society" (SOU, 2022: 10, p. 4). In a democratic perspective, governance informed by experts is preferable to governance by experts (Christensen & Lægreid, 2020a, 2022). Fourth, citizens can tolerate disagreement among experts and between experts and politicians during this kind of crisis. Finally, while the efforts of citizens themselves play a crucial role, even countries with a high level of trust in government need a well-functioning response strategy and institutional capacity to perform well. It could be added that the welfare states in both countries have been strengthened by strong political and economic support through the pandemic (Greve et al., 2021).

An overall observation is that these commissions were not much politicized or polarized in the two countries, like seen with the investigation commission after the terrorist attack in Norway in 2011. Their establishment was according to normal procedures and mandates were not much debated in the two countries, or their reports, neither in the media nor in the parliaments. The first report from the Norwegian commission was submitted in April 2021 5 months before the general election but the government's crisis management was not a big issue in the campaign. In Sweden, the inquiry reports were not high on the agenda neither in the process leading up to change of Prime Minister in November 2021 nor in the campaign before the general election in September 2022. In both countries, neither the incumbent parties nor the opposition parties differ in their assessment of the Commissions' reports. A consensus-indicating feature is also that in Norway the reports were sent on a consultation round to the affected actors, which was a wide catch, and that did not result in much disagreements while in Sweden they were not sent for formal consultations at all. In this respect, the reports were submitted in the context of a cooperative political elite and a cooperative society (Charron et al., 2022).

A remaining question is where do we go from here? How and to what degree will the recommendations of the COVID-19 reports be followed up? (Boin and 't Hart, 2022) argue that this is a question of framing, and they distinguish between learning and adaptation, political blame games, and exploitation and reform. The main framing strategy so far seems to be learning and adaptation, characterized by depoliticization, expert domination focusing on rational adaptation and evidence-based learning, but also a need for a robust government response to turbulent problems, allowing for flexibility, experimentation, and pragmatism (Ansell, Sørensen and Torfing 2020; Carstensen et al., 2023). Normalization seems to be primary (Maggetti & Trein, 2022), implying that policy measures developed in response to the crisis might become part of a more permanent policy practice that focuses on increased transboundary coordination, better preparedness, better knowledge about effects, and a better cross-sectoral policy mix that combines health policy with policy in other areas (Capano et al., 2022).

Conflict of interest

None declared.

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