Chapter 2
Summary

2.1 A resilient society

On Wednesday 26 February 2020 the first case of COVID-19 was confirmed in Norway. This marked the beginning of what would prove to be the greatest crisis in Norway since World War II. All parts of society have since been affected. The vaccination rollout has begun, but much uncertainty remains. No one knows how long it will be before the crisis will pass.

As the Coronavirus Commission concludes its work, more than 600 COVID-19-related deaths have been registered in Norway. About 100 000 people are fully unemployed, almost twice as many as before the pandemic.

The pandemic weighs heavily on children and young people, and the effects may prove long-lasting. Still, international comparisons indicate that the domestic infection control measures have been less intrusive in Norway than in most other high-income countries.[1] Thus far, Norway is among the western countries to date, Norway has had one of the lowest mortality rates and relatively modest decline in economic output (see Figure 2.1).

Due to Norway's location at the northern periphery of Europe and its relatively scattered population, the coronavirus has spread more slowly in Norway than in many other countries (OECD, 2020a). Nonetheless, according to the Commission's findings, there is reason to attribute most of Norway's success to date to various other factors. This report concludes that Norway's public authorities should have been better prepared on several fronts when the pandemic struck. It also points out weaknesses in how the authorities handled the crisis as it unfolded.

The Commission's overall assessment, however, is that the Norwegian authorities have handled the COVID-19 pandemic well. Yet, the authorities would not have been able to succeed without the support and cooperation of the population. This general support reflects several aspects of Norwegian society that made it possible to confront the COVID-19 pandemic. In this subchapter we highlight distinctive features of Norwegian society that we believe make it resilient.

Trust and solidarity

International comparisons have long shown that Norwegians, and Nordic residents in general, have greater trust in one another and in the authorities than people in other countries (European Social Survey, 2018). A high level of public trust has been a strength in dealing with the COVID-19 pandemic. OECD (2020a) points to this as one explanation for Norway's low infection level. In a speech to the Norwegian people on 18 March 2020, Prime Minister Erna Solberg emphasised the importance of trust:

> When freedom has come under threat, Norwegians have given their all for one another. This has given the country an advantage more powerful than any weapon, and more valuable than any petroleum fund: our confidence and trust in one another.
> Erna Solberg in a televised speech, 18 March 2020

In the weeks before the widespread shutdown of activities announced on 12 March 2020, a decline was noted in the share of the population reporting trust in the authorities' handling of the COVID-19 crisis.[2] After the closures, trust returned quickly and has remained high throughout the pandemic.

[1] Data from the Oxford COVID-19 Government Response Tracker shows that the extent of e.g., school closures and closed workplaces during 2020 has been less widespread in Norway than in most other high-income countries. However, the cross-national comparison does not capture all relevant nuances of the imposed infection control measures. Thus, there is uncertainty with the results.

[2] This is according to the Norwegian Directorate of Health's Koronatracker, conducted by Mindshare and Response Analyse. See also Figure 14.1 in Chapter 14 of this report.

Without this trust, the authorities might have found it more difficult to persuade people to follow government recommendations and orders. Chapter 16 discusses social trust in more detail.

One key characteristic of the novel coronavirus is that it is relatively harmless to those who are young and healthy, but dangerous to older people and those with pre-existing health conditions. For young people themselves, there would be little risk in having close social contact during the pandemic. But it would entail a high risk of spreading the virus to people who are likely to fall severely ill if infected. In May 2020, the absence of Norwegian upper secondary school graduates celebrating in the streets spoke volumes about the younger generation's sense of solidarity with the elderly and sick. Surveys show that a high percentage of the population has been 'worried about infecting others' during the COVID-19 pandemic.[3]

The Nordic model

In 2013 The Economist magazine proclaimed the Nordic model to be a 'supermodel', noting that the Nordic countries consistently score high on metrics such as competitiveness, social health and happiness.[4] The model rests on three pillars: economic governance, public-sector welfare policy and organised working life (Fløtten and Trygstad 2020). During the pandemic, the model has been a strength for Norway in multiple ways.

First, Norway's comprehensive welfare schemes have proved important, especially the

[3] Since the beginning of September 2020, the following question has been included in the Directorate of Health's Koronatracker: 'To what degree are you worried about infecting others with the coronavirus?' The proportion responding 'a high degree' or 'a very high degree' varied between 61 per cent and 75 per cent through the end of the year.

[4] 'The Nordic countries: The next supermodel', The Economist, 2 February 2013.

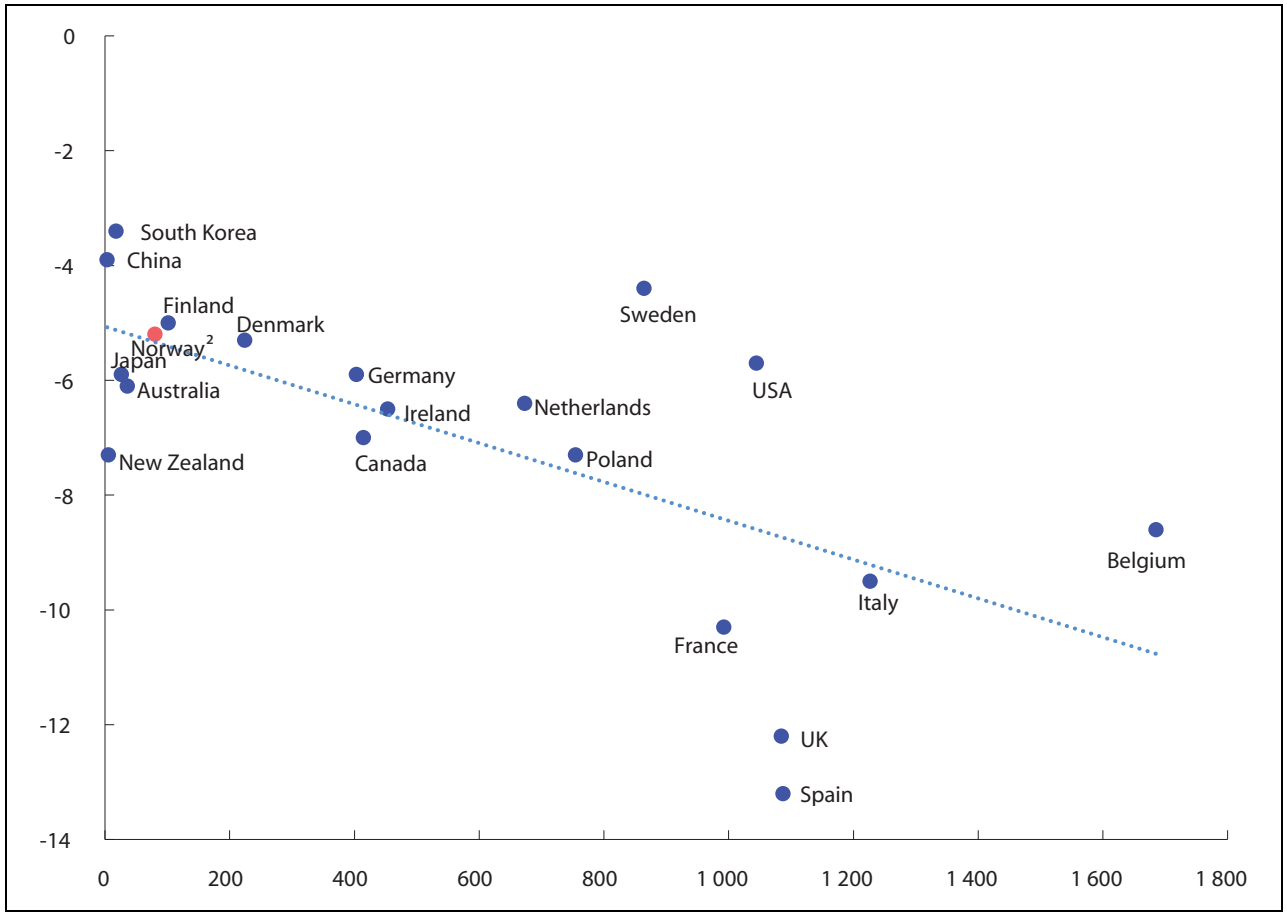

Figure 2.1 Number of COVID-19-related deaths per million inhabitants (horizontal axis) and percentage change in GDP[1] (vertical axis). Selected countries, 2020.

[1] Measured as the difference between the OECD's 2020 growth estimates for GDP as issued in December 2020 and November 2019.

[2] Mainland Norway.

Source: ECDC and OECD

provision of full sick pay. This has enabled most employees, without personal cost, to follow the official advice to stay home when sick and go into quarantine if viral transmission was suspected. Compliance with official recommendations and orders of this kind might have been lower if complying had meant losing money (Fevang and Mamelund 2020).

During the course of 2020 the authorities have implemented economic measures to an extent that is unprecedented in modern Norwegian history (Ministry of Finance 2020). The purpose of these measures has mainly been to compensate companies and workers for lost income due to the pandemic. That society at large bears the brunt of the income loss for those who have been hit hardest financially, has likely promoted public support for the authorities' handling of the pandemic.

The established cooperation between public authorities and the social partners has been yet another national strength. This tripartite cooperation implies regular meetings between government, employer organisations and unions. They know and trust one another. Throughout 2020, their collaboration was actively maintained and proved a strong asset in dealing with the pandemic. When the Prime Minister summoned a group of ministers to a meeting to discuss economic measures at the Prime Minister's residence on Wednesday 11 March 2020, the participants made plans for meetings with the social partners.[5]

The impression we are left with after input from the organisations is that the tripartite cooperation has served a number of important functions during the pandemic. The meetings have provided a key arena for the parties in working life to suggest adjustments to the infection control measures and comment on economic response measures. The ability to exchange views was likely of value to the authorities as well, informing them of the ramifications of the pandemic and the infection control measures. There is also reason to believe the cooperation has increased understanding of the measures imposed by the authorities among the organisations.

A good health system

The health care services have played a key role in the pandemic response. Norway has a well-developed health system that ranks high in international comparisons. Access to health care services is high, and Norway has one of the lowest mortality rates in the world from preventable and treatable diseases (OECD 2019a). Switzerland and Norway are the OECD countries that invest most heavily in their health care systems as a share of GDP. Among OECD countries, Norway has the highest number of nurses and the fourth-highest number of physicians by population (OECD 2020a).

Access to equitable, high-quality health care services irrespective of gender, age, functional ability, place of residence and socioeconomic background has been a fundamental principle of Norwegian health policy for decades. Norway has well-developed primary health care services that are accessible in the areas where people live. Municipalities are responsible for local infection control and public health work. Health systems with strong primary health care services have a positive effect on public health and life expectancy (WHO 2018). During pandemics primary health care has an important role in infection control, providing health services and care for elderly and people with chronic conditions.

Digitalisation and the ability to work from home

When Norway closed down, several hundred thousand employees started working from home (Confederation of Vocational Unions 2020). Newspaper production, processing of unemployment benefits and various consulting activities all moved to kitchens and living rooms in people's homes during the spring of 2020. This was also the case for teaching, with schools and universities all closing their doors. In Chapter 35, we note that approximately half of all employees in Norway worked remotely in March 2020.

A key reason this was possible is that most Norwegians have internet service at home. According to the OECD (2020b), some 80 per cent of Norwegian households had broadband connection in 2018. A large proportion of the jobs performed in Norway, moreover, can be performed from home (Dingel and Neiman 2020). The fact that roughly half of all employees were able to continue doing their jobs without using public transport or interacting with colleagues face-to-face meant that most economic activity could continue while still complying with infection control measures.

The widespread digitalisation of Norwegian society also allowed pupils and students to continue receiving instruction when all the schools and universities closed down. The Director-Gen-

[5] According to a letter dated 1 July 2020 from the Office of the Prime Minister to the Coronavirus Commission.

eral of the Norwegian Directorate for Education and Training, Hege Nilssen, emphasised this in an interview with the Commission:

> We are one of the countries in the world that has good infrastructure and a good general technical environment for providing large-scale digital instruction.
> Hege Nilssen, in an interview with the Commission, 13 January 2021

Adaptability and effort

Throughout the pandemic we have witnessed numerous examples of workers, organisations and individuals contributing well beyond what could be expected. Civil society organisations, for example, have played an important role during the pandemic, whether assisting in emergency preparedness, communicating with various groups or maintaining social support services and activities. Personnel in health care services, schools, municipalities, central government administration and other actors in public and private sector have demonstrated a formidable ability to adapt and perform under challenging circumstances.

2.2 The Commission's conclusions

1. Overall, the authorities have handled the pandemic well. In a demanding situation for the country, the authorities adapted quickly and took decisions of crucial importance to the evolution of the crisis. A year into the pandemic, Norway has one of the lowest mortality rates and its economy is among the least affected in Europe. The authorities would not have been able to succeed without the population's support of the infection control measures. In Norway, people have a high level of trust in one another and in the authorities. This is one of the factors that equipped the Norwegian society to deal effectively with the crisis.

2. The authorities knew that a pandemic was the type of national crisis most likely to occur and to have the greatest negative impact. Yet they were unprepared when the COVID-19 pandemic arrived with widespread, severe effects. The Government is responsible for emergency preparedness planning of appropriate scale. The Act relating to control of communicable diseases gives the Norwegian Directorate of Health the authority to close schools and other establishments in all or parts of the country to reduce contagion. Still, no scenarios or plans have been created, and no exercises carried out, that incorporate the use of such measures. Under Norway's national pandemic preparedness plan, large proportions of the population would become infected without the authorities deciding to take forceful action. Thus, municipalities and society in general have not had the opportunity to prepare for suppressing the spread of a communicable disease and holding infection rates low over a prolonged period.

3. In its emergency preparedness efforts, the Government has paid little attention to how risk in one sector is affected by risks in other sectors. A crisis preparedness system in which each sector evaluates its own risks and vulnerabilities, will fail if no one takes responsibility for evaluating the sum of the consequences for society at large. There is a need for a cross-sectoral system that can accommodate the interaction of risks across all sectors. This is a lesson applicable to preparedness in general.

4. The Government knew it was highly likely that obtaining personal protective equipment would be difficult during a pandemic. The Directorate of Health pointed this out when it evaluated both the SARS epidemic in 2003 and the Ebola outbreak in 2015. Neither of these outbreaks developed into a pandemic. Still, the Government did not take steps to stockpile equipment. The entire spring of 2020 was marked by major equipment shortages, especially in the municipal health services, but also in the specialist health services. Protective equipment was eventually obtained, thanks to the vigorous efforts of many parties. In distributing the equipment, the Ministry of Health and Care Services paid too little attention to the needs of municipalities.

5. In the Commission's view, it was right to impose comprehensive infection control measures on 12 March 2020. At that time, little was known about the effect of infection control measures, and there was great uncertainty about the virus situation itself. It is our assessment that being decisive, rather than waiting for more information, was the correct course to follow. However, we have no basis for determining whether the combination of measures imposed was the most effective. While we believe that taking action was the right thing to do, the package of measures chosen was underinvestiga-

ted and poorly prepared. While the situation was undeniably chaotic, the time pressure built up more than it needed to. The Norwegian Institute of Public Health warned at the end of January that the epidemic would come to Norway. In mid-February, the Directorate of Health began discussing the possibility of closing schools and other establishments. As we see it the Directorate would have had time to consult experts in other sectors and prepare appropriate measures. The process and evaluations carried out before deciding to impose the 'most sweeping measures Norway has seen in peacetime' have not been documented in writing.

6. The decisions to introduce comprehensive infection control measures on 12 March 2020 should have been taken by the Government, not the Directorate of Health. Under Article 28 of the Constitution of the Kingdom of Norway, matters of importance are to be taken up in the Council of State. The decisions to introduce what the Prime Minister described as the 'most sweeping measures Norway has seen in peacetime' affected all of society, undermined citizen rights, and clearly constituted a matter of importance. The Minister of Health and Care Services and the Prime Minister were involved in the process leading up to the shutdown, and although time was of the essence, there would have been time for the Government to adopt a decision in the Council of State.

7. At the beginning of the COVID-19 pandemic, the authorities did not ensure that the infection control measures were in line with human rights and the Constitution. During crisis situations, there is a greater risk of violations of the Constitution and human rights guarantees, and of infringements on citizen rights. Hence, it should have been an automatic reflex for the authorities to ensure that the pandemic was addressed within the frameworks set by Norway's Constitution and general human rights. That did clearly not occur when the pandemic broke out. Neither central nor local authorities did much to weigh the infection control measures against constitutional and human rights constraints. As the crisis has unfolded, the authorities have become more deliberate about assessing the constitutional and human rights aspects of the imposed measures.

8. During the COVID-19 pandemic, Norwegian authorities have employed infection control measures to an extent no one had previously imagined or planned for. To suppress the virus and then keep the infection rates low, the authorities have used powers granted under the Act Relating to the Control of Communicable Diseases, among other legislation, to impose a number of measures that have intruded significantly into the private domain and undermined the rights of Norwegians. No Western country had foreseen tackling a pandemic in such a way. There has been a paradigm shift. Before the outbreak, the plan had been to deploy infection control measures to slow down transmission and 'flatten the curve' to keep too many people from falling ill simultaneously. In the case of the SARS-CoV-2 virus, this deceleration strategy proved too hard to implement, and the contagion easily eluded control. One result of the Government's strategy to suppress the spread of COVID-19 and contain infections at a low level is that few people acquire immunity. The strategy therefore depends on the relatively quick arrival of a vaccine or an effective treatment.

9. The Commission believes that the authorities must regularly evaluate their strategic approach to the pandemic. The Government's goal is to keep the virus under control until the population is immunised. Vaccination began at the end of 2020, and as the Commission concludes its work in March 2021 the Institute of Public Health anticipates that the adult population will be vaccinated by the end of summer 2021. However, there is a risk that new variants of the virus or reduced access to vaccines may prolong the pandemic. The cost of the pandemic to society and individuals is enormous. Strict infection control measures help to protect the elderly and other high-risk groups from illness and death. At the same time, measures strict enough to suppress the virus have major detrimental effects that increase in strength as their use is extended. The longer the COVID-19 pandemic lasts, the greater the dilemma for the authorities as they attempt to distribute the burden of restrictions across society. So far, the control strategy appears on balance to be the least-cost approach for society. As the outlook for treatment, vaccines and immunity changes, this assessment may change as well.

10. Substantial municipal-level responsibility for infection control in Norway is a strength. Familiarity with local conditions is important when municipalities perform contact tracing, evaluate the severity of upsurges in transmission and

implement infection control measures. Norwegian municipalities have been instrumental in containing local outbreaks by such means as testing, isolation, contact tracing and quarantine (whose initials in Norwegian form the acronym TISK), and by taking actions authorised by the national Act Relating to the Control of Communicable Diseases. However, the Government and the Directorate of Health have been slow in informing municipalities and obtaining their input about decisions to be carried out at the local level. The Government has made demands of the municipalities, and should have made it easier for the municipalities to meet those demands.

11. Norway's Act Relating to the Control of Communicable Diseases has been crucial in addressing the crisis, but should be amended. The Act Relating to the Control of Communicable Diseases has rendered sufficient powers to the central and municipal authorities to allow them to manage the pandemic. Provisions of the Act enable municipalities and the Directorate of Health to act expeditiously when infection control considerations warrant this. The Commission believes these provisions must remain in force to protect the population against future serious pandemics. However, the Commission also believes the Act is not explicit enough in requiring democratic control when quick decision-making is needed to address a communicable disease. In addition, the division of responsibility between the central and municipal levels of government is not made sufficiently clear in the law.

12. The authorities have largely succeeded in communicating to the population. The Government has communicated openly about the uncertainties over how the pandemic would develop and how well the infection control measures would work. The Government has made public the expert recommendations and has not hidden the fact that the decisions made are of a political nature. In our view, this openness has helped to promote trust. A large majority of the population expresses confidence in the information received from the health authorities during the pandemic. The fact that the population has changed behaviour during the pandemic is a clear indication that the authorities have succeeded in getting their message across in general. So far, however, the authorities have had less success reaching segments of the immigrant population. The authorities ought to have a plan for establishing contact with specific groups in crisis situations.

13. The Government lacked a plan for handling imported infections when a new wave of the transmission emerged in Europe in autumn 2020. One characteristic of Norway's pandemic response has been a tendency to push minor decisions upwards in the administrative hierarchy. This practice may have affected the Government's ability to view issues in an overall perspective. As the Government eased restrictions going in to summer 2020, it made numerous individual assessments. The Government did not assess its relaxation policy as a whole, and had no plan for responding to an increase in cross-border transmission.

14. The pandemic has affected everyone, but the effects have varied. While some municipalities have not had any COVID-19 cases, the toll on Oslo and several other municipalities has been heavy, as has the burden of infection control measures over prolonged periods. Older people and those with pre-existing health conditions have been at greater risk of serious illness and death. High infection rates have emerged in some immigrant groups. The risk of infection has been high in certain industries. In some business sectors, the financial ramifications of infection control measures have been substantial, and have led to many dismissals and layoffs. Unemployment has been highest among people with less education, low incomes and birthplaces outside of Norway. The restrictions on social contact have been especially burdensome for children, young people, residents of institutions, and people who live alone. The unequal impacts of the pandemic are something the authorities must take into account in ongoing impact assessments.

15. The pandemic weighs heavily on children and young people, and the effects may prove long-lasting. Home schooling and digital instruction can result in lower motivation and subpar learning conditions, leading in some cases to higher dropout rates and/or a lasting impact on job opportunities later in life. At-risk children and young people have been particularly vulnerable during the pandemic. A number of important services were wholly or partly discontinued in the spring of 2020. There is concern that cases of neglect, violence and abuse may have increased during the pandemic, but there are no definitive statistics thus far. Plans must be developed to

ensure that vulnerable children and young people are identified and cared for in future crises.

16. The cost of the pandemic to Norway's economy will be high. The COVID-19 pandemic triggered Norway's most severe economic recession since World War II. The tourism industry and arts and culture have suffered particular hardship. In March 2020, registered unemployment quadrupled in a matter of weeks. Over the spring and summer, the rate then declined. However, by the end of the year the number of people without jobs remained twice as high as before the pandemic. If in March 2020 the authorities had delayed introducing comprehensive measures against the virus, the negative impacts on the labour market and business in general would have been even greater.

17. It is too early to draw conclusions about the long-term effects of the pandemic. Experience has shown that unemployment has a tendency to persist. While many unemployed people will return to work when economic activity normalises, there is a danger that some may be permanently pushed out of the labour market. The curtailment of educational services during the pandemic may undermine job opportunities for today's young people. Reduced social contact and less physical activity may have long-term effects on health. Inequalities in the risk of infection and severity of disease and the economic and social consequences of the pandemic may reinforce each other and lead to increasing health inequality in the population. At present very little is known about the potential extent of these negative effects.

2.3 The sections of the report

Part 1 of the report opens with an introduction. A key part of the Commission's work has been to investigate what happened during the hectic, gruelling days of March 2020 when the most sweeping measures Norway has seen in peacetime were adopted. It has been important for us to understand the situation the authorities faced, how serious they believed it to be, and the time pressure they experienced. The introduction contains a detailed description of what occurred and when, and who took part in the decision-making processes in the days before the shutdown 12 March 2020. After the introduction, we explain our central conclusions and describe some of the strengths of Norwegian society that made it resilient while handling the pandemic. We also explain how we have understood and delimited our mandate, and we describe our approach to the task.

In Part II we assess Norway's pandemic preparedness at the time the COVID-19 pandemic struck the country. As background for this assessment we present the basic elements of emergency preparedness in general and pandemic preparedness in particular, and describe the stakeholders, roles and responsibilities involved in pandemic preparedness. We approached pandemic preparedness at the national level by examining central government risk assessments of pandemic threats as well as training exercises and the full hierarchy of existing plans. We assess the preparedness of municipalities in the field of communicable diseases and the degree to which they were prepared to handle a pandemic of the kind we have witnessed.

In Part III we outline and assess the authorities' response to the COVID-19 outbreak through the first wave of infections. We shed light on decision-making prior to the restrictions imposed on 12 March 2020, and on the strategies adopted by the authorities to address the infection situation. We also look at the Government's approach to the reopening of society after the first wave of infections passed, and at communication with the population. We conclude this part of the report with an account of how the authorities have dealt with testing, isolation, contact tracing and quarantine (TISK).

In Part IV we outline and assess how the authorities organised themselves during the COVID-19 crisis and how they worked to bring the pandemic under control. We also examine cooperation among the various stakeholders, including local and central government authorities. The collaboration and division of responsibilities between the Directorate of Health and the Institute of Public Health are also evaluated in this part of the report.

In Part V we assess infection control measures imposed during the pandemic in the perspective of democratic processes and the rule of law. The Commission also looks into some of the legal aspects of the official pandemic response. It is essential that the authorities act at all times within the boundaries established by our democracy if the legal safeguards of Norwegian inhabitants are to be protected and respected even in times of crisis. The assessments presented in this part of the report are largely related to the many specific measures passed and regulations adopted, both

nationally and locally, pursuant to the Act Relating to the Control of Communicable Diseases. We have also examined the use of municipal-level restrictions on visits in residential care facilities, in accordance with the Storting's petition resolution calling for an overview of the official use of visiting restrictions and the halting of visits to homes for the elderly and persons with disabilities during the pandemic.

In Part VI we look at how the pandemic has been dealt with in the specialist health services and in the municipal health and care services. We describe how hospitals dealt with the closure policies and the scaling up of capacity, and we compare hospital activity from the time of the closures through the end of 2020 against data from 2019. A similar comparison of activity is made for the municipal health services (primary general practitioners and urgent care). We also examine the way certain hospitals and other municipal care services handled implementation of the infection control measures. Part VI is concluded with some Nordic comparative perspectives on the organisation of elderly care in light of the pandemic.

Part VII addresses vital societal functions. We look closely at how the Government defined vital societal functions during the pandemic and how well those functions were maintained. Certain societal functions and activities are given special attention.

Part VIII focuses on the consequences of the COVID-19 pandemic. Following an introductory chapter, we describe the pandemic's health-related consequences, starting with those who became ill from the virus before moving on to other groups. We have emphasised the impacts for population groups that did not receive health services because of the priority given to COVID-19. Adopting a broad public health perspective, we also look at whether mental health and lifestyle habits in general may have been affected. The consequences for children and young people are also discussed, in which we distinguish between the impacts of lost education and the impacts for at-risk children and youth. In conclusion we discuss the economic effects of the pandemic.