

Summary

In comparison with the rest of Europe, Sweden has come through the pandemic relatively well and is among the countries with the lowest excess mortality over the period 2020–2021. This is to be welcomed, of course, but in order to learn lessons we must not forget what the situation was like in the spring of 2020. At times during that period, Sweden had death rates that were among the highest in Europe. The infection spread to many residential care facilities for older people, some older people did not have their care needs assessed by doctors, the guidelines issued meant that older people sometimes did not receive the hospital treatment that could have helped them, and many people died with no family member or any other person by their side.

The events of that period are one of the reasons why the Commission focuses to some extent on the handling of the pandemic prior to and during the first wave in spring 2020. The shortcomings that emerged at that time revealed both a lack of material preparedness and inadequate mental preparedness on the part of decision-makers. Another reason is that early action in a pandemic outbreak is of great, even decisive, significance for the subsequent development of the crisis.

More than 15 000 people in Sweden have died of COVID-19¹ – a number that conceals thousands of personal tragedies which many in the country can directly relate to. The new virus and the steps taken to combat it have also encroached on many other aspects of people’s lives, affecting not only their health and livelihoods, but

¹ The Commission is referring here to the National Board of Health and Welfare’s statistics on COVID-19 deaths. These only include cases where a doctor has determined that COVID-19 was the underlying cause of death. The Public Health Agency of Sweden, which up to and including 7 February 2022 had reported 16 441 deaths, uses a different procedure that permits more rapid updates, but risks including individuals infected with COVID-19 who died of other causes.

also their social interaction with family and friends. The pandemic has thus attacked our way of life. The spread of the virus and its indirect effects, moreover, have had very unequal impacts on different groups. To a large extent, groups that were already disadvantaged have been hardest hit by COVID-19 in terms of severe illness and death. The fact that different groups have been differently placed to protect themselves and their families may have contributed to the larger burden of disease on already disadvantaged sections of the community. The pandemic has also hit such groups harder in several other ways, for example with regard to cancelled and postponed health care, loss of earnings and unemployment. The authorities have a responsibility to design measures for the population as a whole. Advice to work from home is easier to follow for someone not living in overcrowded housing, with a job that can be done using a computer. People in a wide range of occupations – for example, in health and social care, services and education – are unable to perform their duties from home. A person who cannot afford a car of their own has to use public transport. Someone living in a multi-generational household will meet their parents daily on returning from work. The measures introduced have thus often been better suited to a well-educated middle class, well placed to protect themselves from infection, navigate the health care system and work from home. Different measures may be needed to safeguard the lives and livelihoods of groups with more limited options.

A crisis like the one we have gone through threatens not only basic values such as life, health, and social and economic security, but also more existential ones, like confidence in the government institutions underpinning our society, trust in other people and belief in the future. The inquiry which the Commission has been entrusted with is thus not only concerned with the specific issues set out in its terms of reference, relating to health, health care, the economy and so on; some of its conclusions also have a bearing on more fundamental and existential values.

The pandemic is not yet over. Once it has eventually ebbed away, further research and some distance in time will be needed to be able to draw firmer conclusions. This report sets out the Commission's final assessments, based on what it has found in its inquiry. One hope is that these assessments will be able to form a starting point for further, later evaluations.

The Commission returns several times to discussions about the “precautionary principle”. This can be seen as a basic attitude in responding to a threatening situation when the information available is highly uncertain and incomplete. The principle implies that, in such situations, decision-makers should not passively wait for a better understanding, but actively take steps to counter the threat. It means, in other words, that it is better to act than to wait for better data for decision-making. Later it will be possible to modify one’s actions, as new knowledge becomes available. The Swedish Disaster Commission (set up following the tsunami of December 2004) aptly described how, at an everyday level, this principle guides fire and rescue operations. The basic rule in that context is to deploy sufficient resources for a relatively major incident and subsequently stand some of them down if it turns out that they are not needed, rather than send a single vehicle and only later deploy more if the situation so requires.

The Commission’s overall assessments, based on the inquiry carried out and presented in this and earlier reports, are as follows:

- The early choice of path in the area of economic crisis management, with a focus on rapid and vigorous monetary and fiscal policy interventions – where speed took priority over precision – was a correct strategy.
- The choice of path in terms of disease prevention and control, focusing on advice and recommendations which people were expected to follow voluntarily, was fundamentally correct. It meant that citizens retained more of their personal freedom than in many other countries.
- The measures taken were too few and should have come sooner. In February/March 2020, Sweden should have opted for more rigorous and intrusive disease prevention and control measures. In the absence of a plan to protect older people and other at-risk groups, earlier and additional steps should have been taken to try to slow community transmission of the virus. Such initial measures would also have bought more time for overview and analysis.

- The Government should have assumed leadership of all aspects of crisis management from the outset. It should have been able to overcome the obstacles to clear national leadership that currently exist: government agencies with a degree of autonomy, self-governing regional and municipal councils, and the Government Offices' normal procedures for preparing government business. The Government should also have assumed clearer leadership of overall communication with the public.
- The Government had too one-sided a dependence on assessments made by the Public Health Agency of Sweden. 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.
- The Public Health Agency should have communicated its advice and recommendations as clear rules of conduct.

Sweden's handling of the pandemic

The pandemic has constituted a serious crisis affecting the whole of society. The Government and public authorities have adopted a range of measures in different areas to limit its consequences. As far as measures to mitigate the economic consequences were concerned, these were swift and essentially achieved their principal aims – to limit the impacts of an impending recession on the overall economy and on individual businesses and households, and to prepare for rapid economic recovery. The early, vigorous action that informed economic crisis management emphasised rapid rather than precisely targeted interventions. Measures in the area of disease prevention and control, on the other hand, were marked by a different approach. Here, instead of acting rapidly in accordance with the precautionary principle, the focus was on precision, with reference to the requirement of evidence and proven experience.

Economic measures

On 11 March 2020 – the day after the Public Health Agency had upgraded its assessment of the risk of community transmission from

moderate to very high – the Government and its support parties announced that they were agreed on an additional amending budget. This put central government in a position to retroactively compensate municipalities and regions for extraordinary measures and extra costs linked to the coronavirus. This first amending budget was quickly followed by several more, incorporating vigorous measures in support of Swedish businesses, private individuals and households. The proposals involved support for short-time work, deferral of tax payments, rental support and reduced social security contributions, together with increased unemployment and sickness benefits. The Riksbank, Sweden's central bank, was also very active. It created a number of loan facilities, purchased large quantities of bonds to increase market liquidity, and intervened in corporate bond markets to keep down interest rates and risk premiums.

Historically, Sweden has avoided providing direct support to individual businesses, as this impedes the ongoing structural transformation that occurs in a healthy economy when inefficient enterprises go bankrupt. Business support schemes may limit this process, thereby slowing the gradual improvement in our standard of living. But the pandemic gave rise to a new kind of economic crisis, not contingent on underlying structural problems. The various forms of business support were therefore justified as temporary, exceptional measures.

Earned income for the population as a whole between the ages of 20 and 64 fell sharply in the spring of 2020, before recovering in the later part of the year. During the pandemic months of March–December 2020, earned income per person per month decreased by almost 3 per cent on average, compared with previous years. Overall, however, incomes only declined at just over half that rate, largely thanks to existing and reformed welfare systems. The degree of protection – the extent to which welfare provision compensated for the fall in earned income – was more than 40 per cent. Just over half of that protection came from existing forms of support and a little less than half from special pandemic measures. The two most important such measures within the welfare sector, as regards protecting earned income, were a higher ceiling on unemployment benefits and a new payment to cover the waiting-period deduction in the sickness benefit scheme.

The first weeks and month of the pandemic were a hive of activity in terms of both monetary and fiscal policy. Never before in modern times had Sweden seen so many resource-intensive economic policy decisions in so short a time. This activity continued, though at a slower pace, throughout the first year of the pandemic, 2020. An indication of just how vigorous these initiatives were is that, in the end, only half of the more than SEK 300 billion allocated to special pandemic measures under the central government budget in 2020 was actually used.

While there are some differences in detail, Sweden's measures in the economic sphere largely resemble those of other nations. Many countries have supported individual businesses, and all have intervened on a historically large scale. All the Nordic countries introduced their measures from early on, and compared with most other countries those measures imposed a small burden on their public finances.

The Commission considers that the early choices of path in economic crisis management, with a focus on rapid and vigorous interventions, were a correct strategy. The measures taken in 2020 helped to slow the fall in the economy and to speed the recovery in 2021. It was reasonable for the Government to opt for a mix of traditional measures within the existing welfare system and new types of direct support to businesses.

The policies pursued have, however, had certain shortcomings in terms of ensuring that support, both for businesses and for individuals, has benefited those in need or reached the right recipients. In part, this is because the bodies administering the schemes lacked the capacity to handle large quantities of applications sufficiently quickly, and because the processes involved were sometimes unnecessarily complicated, especially for new forms of support. One problem was the rules on payments for the waiting-period deduction, whereby individuals themselves had to apply for payment to cover a deduction that had already been made. It would presumably have been better if the deduction had temporarily been removed and the payment made to the employer. Nonetheless, the final assessment of the Commission is that, overall, this side of managing the crisis has been successful and largely produced good results.

Disease prevention and control measures

The Commission noted in its second interim report that, in spring 2020, Sweden opted for a different approach to disease prevention and control from many other countries. In the Commission's view, Sweden's choice of path differs less in its description of the overarching aim than in the measures used to achieve that aim. In so far as it is possible to talk about a kind of "ideological" difference between the Nordic countries in terms of the measures chosen, it has more to do with their response to the precautionary principle's requirement to act despite incomplete information.

The approach chosen by Sweden was based on voluntary measures and personal responsibility, rather than more intrusive interventions. The Commission also stressed in its second report that disease prevention and control had been marked by a slowness of response. Our Nordic neighbours and many other countries introduced rigorous measures, such as various forms of lockdown and bans on entry, more or less immediately.

Sweden's disease control measures have largely been based on a voluntary approach and the responsibility of each individual. They have also been guided by the Communicable Diseases Act's requirement that such measures must be proportionate and based on science and proven experience. Both the Government and the Public Health Agency have emphasised that the measures decided on must be sustainable in the long term and accepted by the population.

The Commission considers that the focus on recommendations which people are expected to follow voluntarily has been fundamentally correct. Sweden's choice of path has had the significant benefit that people have not been forced to the same extent as in many other countries to comply with regulations restricting their personal freedom. By and large, they have been able to move freely in society, although it has been painful at times not to be able to receive visits or visit relatives in residential care facilities for older people or to attend large political, religious or cultural gatherings or events. The Swedish health care system managed to adapt rapidly and was for the most part able to offer care to those falling ill with COVID-19, although this required significant sacrifices by staff and came at the price of cancelled or postponed surgery and other treatment. Pre-schools and compulsory (primary and lower secondary) schools

have been able to remain open, and children in the age groups concerned have received the teaching they need to prepare them for the future.

In the Commission's view, however, this focus on recommendations and a voluntary approach should not have prevented Sweden, in February/March 2020, from opting for more rigorous and intrusive measures to slow community transmission of the virus. The chosen approach was based on a belief that it was possible to protect older people and other at-risk groups from infection, an approach that emerged fairly quickly as more of a hope than a plan of action that could in fact be implemented. In the absence of such a plan, earlier and additional steps should have been taken to try as far as possible to slow the spread of the virus in the community. With such measures, the Government and public authorities could probably also have gained a better overview of the situation and more time to decide how it should be managed. In line with the precautionary principle, the measures introduced should also have been designed to allow for the possibility that the aim of protecting at-risk groups might not be achieved.

In late February/early March 2020, it was known that the virus had taken hold in Europe and that the north of Italy, in particular, was badly affected. Many Swedes were spending their winter sports breaks in northern Italy and the risk of imported cases was judged to be very high. Not only Sweden but several other European countries as well had winter breaks during this period and many people were travelling. It was also known that older people ran a particularly high risk of contracting and dying of COVID-19. In view of this, more active reception arrangements should have been put in place for people returning from winter breaks after week 9 (the last week in February), and they should have been provided with clearer information and instructions to home-quarantine for at least seven days. Individuals who developed symptoms on their return home or over the next seven days should have been strongly urged to be tested, with concrete guidance on where and how. To prevent home quarantine causing greater absence of health and social care staff than necessary, such staff could have been called on to take a test straightaway, regardless of symptoms, and another one five days later, so as to be able to return to work somewhat earlier if possible. In addition, a temporary ban on entry to Sweden should

have been introduced no later than mid March 2020. There was good reason to assume at that point that such a ban could prevent some import of the virus from other EU/EEA countries, and it would also have resulted in a common Nordic approach.

Many other countries have, unlike Sweden, introduced various types of lockdown of society. The Commission is of the opinion that the right balance was struck in keeping preschools and compulsory schools open and switching to distance learning at upper secondary schools and universities. However, it believes that in the middle of March 2020 there should have been temporary closures of a number of indoor settings where people gather or come into close contact, such as shopping centres, restaurants, cultural and sports events, hairdressing salons, swimming pools and the like. By then, a legal basis for implementing such closures should have been in place.

Furthermore, the Commission considers it remarkable that it took until 29 March 2020 for the limit on public gatherings and events to be lowered to 50 people.

Rigorous initial measures next time a pandemic looms would offer greater scope to analyse the seriousness of the threat, mobilise an emergency organisation, make emergency stockpiles available, strengthen protection for those particularly at risk, and introduce other disease prevention and control measures, such as large-scale testing, organising contact tracing and preparing facilities for quarantine and isolation.

In the light of current knowledge, however, the Commission is not convinced that extended or recurring mandatory lockdowns, as introduced in other countries, are a necessary element in the response to a new, serious epidemic outbreak. First of all, many countries that have pursued such an approach have experienced significantly worse outcomes than Sweden, indicating at present, at least, that it is highly uncertain what effect lockdowns have in fact had. Second, long-term and recurring lockdowns restrict, not to say practically remove, people's freedom in a way that is hardly defensible other than in the face of very extreme threats. And third, the argument about measures sustainable in the long term, which people can be expected to accept, carries significant weight here. In many parts of the world, including countries close to our own, we have seen protests, even violent ones, when new lockdowns have been imposed in response to growing transmission of COVID-19.

In the early autumn of 2020, the spread of the disease was rising in several European countries, but there was no such increase as yet in Sweden. Here too, though, there was good reason to fear a more serious trend. At a preparatory meeting on 8 October, the Government was provided with information suggesting a worse situation than the Public Health Agency's "worst-case scenario". By the beginning of November 2020, community spread was once again extensive and, following something of a decline, there was a third wave during the winter of 2020/21.

Decision-makers need good data in support of their decisions, regarding both what is most likely to happen and what the worst outcome might be in the immediate future. The public at large also need information about and an understanding of how the situation might develop. It is strange, therefore, that in July 2020 the Government was content to have the Public Health Agency draw up three possible scenarios for a whole year ahead, and did not request regular analyses until late November. The Government did of course have other data as well, but the Commission still has difficulty understanding why it did not demand more of its expert agency.

Given the experience of spring 2020, better preparations should have been made for possible developments during the autumn. The Commission has already pointed out that, on forming the view that the Authorisation Act from spring 2020 was difficult to use, the Government should immediately have initiated other legislation providing access to more extensive and mandatory disease prevention and control measures. But work on the temporary Pandemic Act did not begin until August 2020, and it was only thanks to a mobilisation of resources in late December 2020 that it was able to come into force in January 2021. The Commission considers that, as early as the beginning of October 2020, there were good disease control reasons for the Government to accelerate its efforts to introduce the temporary Pandemic Act.

On 8 October 2020, moreover – when it learned that a more serious infection situation was possibly to be expected – the Government should immediately have introduced and planned additional measures beyond the Public Health Agency's recommendation of family quarantine.

The Public Health Agency should not have dismissed the use of masks as a disease prevention and control measure in indoor settings

and on public transport. Rather, as soon as the shortage had been remedied, it should have recommended their use in those settings.

Communication relating to disease prevention and control

In several instances, the general advice issued by the Public Health Agency was unclear – in particular, the way it was communicated. The advice given was that everyone should “keep a distance from one another”, while staff in workplaces were to maintain “a suitable distance” and restaurant guests were to keep “a sensible distance” from fellow guests. In the run-up to Easter 2020, advice about avoiding unnecessary travel was communicated in terms of “think about whether your trip is necessary” and “think about whether you could save a trip until next Easter”. People were also advised to “refrain from participating in larger social contexts such as parties, funerals, baptisms, celebrations and weddings”.

Discussion arose as to what was meant, and it is the Commission’s view that, in the spring of 2020, there was often significant scope for people to make their own interpretations. It would have been much better to issue clearer rules of conduct, such as immediately recommending a distance of two metres and urging people to “stay at home this Easter”. The advice to avoid large gatherings should have been replaced with “only mix socially with people in your own household”.

Advice and recommendations of this kind also make even greater demands when it comes to communicating with people with a first language other than Swedish, or who for other reasons have difficulty taking in the message. This means that the information not only has to be provided in a large number of other languages, for example, it also has to be worded in a way that is clear to all the groups it is aimed at.

National leadership in a crisis

A societal crisis calls for clear national leadership, especially when it affects a range of sectors and stakeholders and different levels of society. Sweden is a highly decentralised country, with welfare provision implemented largely, in purely operational terms, at the local

and regional levels. In earlier interim reports, the Commission has drawn attention to the fragmented and decentralised organisation both of health care and care of older people and of disease prevention and control. It has also noted that such a decentralised and divided structure results in unclear responsibilities and is difficult to manage. In a crisis, it is not sufficient to rely on rules about and organisational arrangements for collaboration. It is the Government's job to govern the country, and its responsibility for national leadership becomes even more important in a crisis. In a democracy, citizens can call their government, but not a government agency, to account.

Crisis management in the economic sphere

In the early spring of 2020, it quickly became clear that a serious societal crisis was unavoidable. Regarding the economic aspects of managing that crisis, the Government took the lead from early on. From late February 2020, dramatic developments were seen on financial markets, with rapidly falling stock prices and rising risk premiums. At the beginning of the pandemic, insufficient data was available to understand and predict how it would unfold. There was great anxiety, further heightened by a realisation that this was a new type of economic crisis, driven not by traditional economic shocks but by the impending spread of a disease. The conventional tools of economic policy, designed to stimulate demand, were seen to be either ineffective or unsuitable. The fears that now arose also reflected experience of the deep financial crisis many countries had undergone just a decade or so earlier. It had been possible to pull through that crisis thanks to resolute action by various central banks and a declared readiness to act.

As early as March 2020, the Government initiated a historically vigorous commitment to a range of measures to protect businesses and individuals from the impacts of the crisis. The measures implemented in this area were designed with an emphasis on speed rather than precision. The Commission is of the view that not only the fiscal but also the monetary policy pursued reflected an application of the precautionary principle by those responsible. They acted swiftly and resolutely at a time of great anxiety and uncertainty, in

an attempt to minimise the risks of a financial and economic melt-down.

Crisis management in the area of disease prevention and control

Government leadership in handling the pandemic with regard to disease prevention and control, on the other hand, was unclear. Until the beginning of the second wave in November 2020 at least, the Public Health Agency was essentially the driving and leading force in managing the virus outbreak. It was clear that the Agency was setting the pace, and that the Government had no objection to it doing so.

A sign of unclear leadership on the part of the Government was the “strategy” published on its website on 7 April 2020, when Sweden was already well into the first wave. This document did not set out the Government’s position on what coherent national crisis management should look like. Its material content was also fairly generally worded: reduce the rate of spread of infection, balance efforts to combat the disease with impacts on society and public health, allay concern, and “take the right action at the right time”. As the strategy was not decided on by the Government, moreover, it could not formally serve as a national statement of direction.

The Commission is not claiming that the Government has abdicated its responsibility for disease prevention and control during the pandemic. It has been kept continuously informed about the situation by its expert agencies, issued a series of directives to several authorities, given its backing to the Public Health Agency’s advice and recommendations, issued the regulations requested by the Agency, essentially without delay, and taken a very large number of pandemic-related decisions. The various aspects of the crisis have also been the subject of ongoing discussions in the Government Offices – at virtually daily lunchtime meetings between the responsible state secretary at the Ministry of Health and Social Affairs and the directors-general of the Public Health Agency and the National Board of Health and Welfare; in the Government Offices’ Crisis Management Coordination Secretariat, headed by the state secretary responsible there; at recurring meetings of different ministries’ directors-general for administrative affairs; and at meetings, daily at

times, of the Strategic Coordination Group (GSS). Discussions about infection rates and possible measures have also taken place among ministers at a large number of preparatory Government meetings.

During the second and third waves, the Government's leadership on disease prevention and control became clearer. Certain measures were put in place in the late autumn of 2020 without a prior request from the Public Health Agency (for example, the ban on alcohol sales in restaurants and the limit of eight people at public gatherings and events). But a long way into the pandemic it was undoubtedly the Public Health Agency that set the pace for crisis management relating to disease prevention and control. Both the overall approach of the Agency and its initiatives and proposals for measures were what guided efforts in that area.

Obstacles to clear leadership can be overcome

The Swedish administrative model has often been cited as an obstacle to clear leadership on the part of the Government. Several ministers have also referred to this concept when commenting on the relationship between the Government and the Public Health Agency. In certain fields and in certain respects, at least, the administrative model employed in Sweden may make it harder for the Government to exercise its leadership. But the Commission believes that these obstacles could have been overcome. The Government is able to exercise quite far-reaching control over administrative authorities. Nor is regional and municipal self-government an insurmountable problem, although clearer control would require legislation.

Another obstacle to clear leadership by the Government is the internal organisation of the Government Offices. There, too, the "principle of responsibility" applies, which means that the ministry whose area of responsibility is impacted by the effects of a crisis is also responsible for tackling those effects during the crisis. This in turn means that only the ministry responsible is expected to have dealings with the public authorities reporting to it, and that no ministry accepts any other ministry's authority on issues within its own sphere of responsibility. It is, however, accepted that the Prime Minister's Office, headed by the Prime Minister, has a higher-

ranking position and “passes judgment” on matters when differences of opinion arise. Tackling questions of coordination is particularly important in a wide-ranging societal crisis like the pandemic, with effects extending over several areas.

During the pandemic, application of the responsibility principle in the Government Offices has meant that information from the Public Health Agency and the National Board of Health and Welfare has been submitted to the Ministry of Health and Social Affairs. It has then been collated and passed on to the Strategic Coordination Group (GSS) and the Crisis Management Coordination Secretariat (RK/KH). The Strategic Coordination Group has subsequently discussed the matters raised, but – as has been carefully pointed out to the Commission – this group is not a decision-making body or even one tasked with preparing government business. The agencies’ reports have thus had to be given further consideration, above all, within the Ministry of Health and Social Affairs. The Crisis Management Coordination Secretariat, which came under the Ministry of Justice, was thus unable to obtain information directly from the agencies reporting to the Ministry of Health and Social Affairs.

On that ground alone, the Commission considers that the decision to move the Crisis Management Coordination Secretariat from the Prime Minister’s Office to the Ministry of Justice weakened the Government’s capacity to exercise active leadership in a composite crisis. It goes without saying that the Secretariat must be able to obtain information directly from the responsible agencies, regardless of which ministry they happen to report to. The Government Offices, guided by the principle of responsibility and a requirement to prepare business jointly, are better designed for good and careful preparation of business under normal circumstances than for rapid decisions on complex issues in a crisis.

For a government to be in a position to lead, it must for one thing have access to the best available data in support of its decisions. Apart from the position of the Crisis Management Coordination Secretariat, the Commission has identified two problems in that respect.

One is that the Public Health Agency has stressed that, particularly in the initial phase of the pandemic, its risk assessments were primarily to be regarded as snapshots, rather than forecasts of what

might occur at a later stage. To begin with at least, this does not appear to have been clear to everyone, including the National Board of Health and Welfare and the Swedish Civil Contingencies Agency.

The other problem is that the Government has essentially relied on information and assessments from its expert agencies. The Commission appreciates that the Government cannot sit in judgment on matters of scientific controversy. But in a situation where knowledge is recognised to be uncertain and incomplete, different views within the scientific community must be taken into account. This has only been done to a limited extent. Drawing on the expertise of others is important, if only to understand the degree of uncertainty and consider whether the precautionary principle might require different measures from those currently advocated by the expert agencies.

The vicarious leadership of the Public Health Agency

The Public Health Agency has a wide-ranging mandate covering public health in the broadest sense. This broad remit partly reflects an endeavour to refine government agencies' responsibilities and an earlier merger of functions entrusted at the time to the Swedish Institute for Infectious Disease Control and the National Institute of Public Health. With such a broad mandate, the Agency has an obligation, as it seeks to prevent and control disease, to weigh possible measures against their impacts on other aspects of public health. As a result, requests and information to the Government have been communicated following deliberations within the Agency weighing up different societal interests, following a dialogue with the country's county medical officers, and ultimately following decisions and positions reached by the Agency's Director-General.

A heavy responsibility has thus rested – and continues to rest – on the Public Health Agency and ultimately on a single individual, its Director-General. In the Commission's view, this concentration of responsibility is inappropriate, given the difficult balances that need to be struck between a wide range of societal outcomes.

The combined experience and expertise of the Agency were put to difficult tests during the outbreak of the pandemic, in a situation of great uncertainty. It would have been reasonable, therefore, to do

more to try to bring in other expertise and draw on knowledge and assessments from the scientific community outside the Agency. The Public Health Agency admittedly decided on 17 April 2020 to appoint an advisory reference group. But by then the Agency's overall approach had already been decided. What is more, the frequency with which the group met scarcely suggests that full use was made of its collective expertise. The Commission is of the opinion that the Agency should have secured input from an even wider range of voices, including critical ones.

The Government has essentially been dependent on the Public Health Agency's assessments as a basis for its positions in the area of disease prevention and control. This has not provided a good enough basis for decisions and positions during a serious societal crisis marked by great uncertainty.

Questions of responsibility

Any assessment of whether a decision-maker or authority should have acted differently has to be based on what was – or should have been – known when the person or body responsible took, or failed to take, the action in question. A discussion of responsibility also needs to consider whether decision-makers and authorities did what could reasonably have been expected of them in the situations they had to manage. The Commission is not adopting a position on questions of legal responsibility or accountability, but simply stating its views on what, in its best judgement, has happened, what shortcomings have occurred, and whether anyone can be considered responsible for those shortcomings.

The Government, government agencies, regions and municipalities are of course responsible for their decisions, directives, guidelines and measures. The three reports of the Commission contain criticism aimed, in various respects, at decisions etc. on all these levels. The Commission has now focused its attention chiefly on the bodies with overall responsibility for disease prevention and control in this country, i.e. the Government, the Public Health Agency and the regions.

Disease prevention and control measures

The Commission noted in its second interim report that the process of establishing testing on a large scale had been far too slow. Its criticism was levelled above all at the way a discussion about responsibility and funding had played a part in preventing any large-scale testing getting started until the first wave was over – a discussion which the Commission referred to as a “complete failure”. Certain regions, but in particular their representative body, the Swedish Association of Local Authorities and Regions (SALAR), bear a significant share of responsibility for more extensive testing and contact tracing not being in place until the first wave was at an end, despite the regions’ clear responsibility for disease prevention and control and despite a promise of funding. The regions demanded this promise in writing and insisted on generous funding in order to make a start.

Limiting measures essentially to recommendations, which the population are expected to follow voluntarily, is fundamentally a correct approach, but it must not stand in the way of more rigorous action that may be required in particularly critical phases. In the Commission’s view, one such critical phase arose as the infection was entering the country, when more intrusive measures would have bought time and enabled other steps to be considered.

To begin with especially, the Public Health Agency adopted a position informed by a demand for evidence – rather than a precautionary approach – and had a defensive view of the prospects of slowing the spread of the virus. As a result, it introduced and advocated limited, late and not very vigorous measures, which failed to sharply reduce the transmission of the disease. Responsibility for this rests with the Agency’s then Director-General.

Awareness of the uncertain state of knowledge and the lack of proven experience must also have existed within the Government. It must be assumed that the reason the Government, unlike its Nordic counterparts, did not introduce disease control regulations on its own initiative in spring 2020 was that it considered the measures adopted and proposed by the Public Health Agency to be the best for the country. The Commission is nonetheless of the opinion that the Government of 2020 bears a responsibility for having – as far as the Commission has been able to ascertain – accepted largely un-

critically, 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. The Government therefore cannot avoid ultimate responsibility for the fact that the measures initially taken were limited and late, and for the consequences this may have had for the community spread of the disease.

The Government was actively involved in the decision not to close preschools and compulsory schools during the first wave. But apart from that it is unclear, to say the least, whether at that time it was the Government that struck the final balance between different interests in society. It is also unclear whether it actively evaluated Sweden's disease prevention and control measures in relation to the decisions of other governments. In a crisis, there must be no uncertainty about who is in charge. The Government is also responsible for these uncertainties.

Systemic shortcomings

In its earlier interim reports, the Commission concluded that this and previous governments were responsible for the failure to remedy earlier-identified shortcomings, such as known structural deficiencies in care for older people and the inadequate pandemic preparedness highlighted in the wake of swine flu in 2010. Individual regions and municipalities have a responsibility for their own pandemic plans, which were sometimes lacking and had often not been updated or rehearsed. Regions are responsible for the fact that the stockpiles required by their responsibility for disaster medical preparedness were not in place. The Public Health Agency is responsible for national pandemic planning having been geared to the expectation of an influenza pandemic. Earlier governments bear responsibility for failing to set up an inquiry into constitutional preparedness without delay, when the proposals of the Inquiry on Constitutional Reform were judged to require further consideration. Had that work been completed before the pandemic struck, there would probably have been a better legal basis for handling the virus outbreak.

Lessons learned and proposals

By far the most important aim of the Commission's work is to seek to contribute to better management of the next crisis affecting health and society. It is the Commission's view, moreover, that the lessons learned should not only be a matter of ensuring that we are better prepared next time. They must also allow for the possibility that we may then face an even more infectious and deadly disease.

The Commission's key overall observations and lessons for the future are:

- Preparedness – material, organisational, mental and also legal – must be substantially strengthened before the next crisis.
- A crisis like the pandemic requires clear, honest and consistent communication aimed at all sections of the population.
- The principles of crisis management – responsibility, similarity and subsidiarity – are not sufficient. They should be supplemented, at least, with a precautionary principle or principle of action.
- The question of far-reaching administrative reform, advocated by earlier inquiries, must as soon as possible be made the subject of new, open-minded deliberations.
- A body providing clear national crisis leadership should be established, reporting directly to the Government.
- A cross-party committee of inquiry should consider changes to both the principles and the organisation of crisis management. Its basic aim should be to make the Government's responsibilities clear.
- The Government must have as complete and satisfactory a set of data as possible for weighing the different factors involved and reaching the decisions required in a pandemic. The Public Health Agency therefore cannot have sole responsibility for providing the Government with decision support data on the issues involved in fighting a pandemic.
- The Government Offices' documentation of their crisis management efforts must be substantially improved.

- International cooperation on disease prevention and control must be strengthened.
- Readily accessible, detailed data is indispensable if the authorities are to be able to monitor an unfolding crisis in real time and design precisely targeted measures. At present, some important data is lacking, for example, on primary care, residential care for older people, municipal health and social care, and short-term sick leave. In addition, integrated medical record systems are not in place. These problems should be investigated further and addressed before the next crisis strikes.
- There needs to be more cross-boundary and truly cross-disciplinary research into the effects of the pandemic on medical, economic and social outcomes among different groups in society and, eventually, into its long-term impacts.

Strengthen preparedness

In its second interim report, the Commission judged Sweden's pandemic preparedness to be inadequate and drew attention to a number of shortcomings. It noted that national preparedness in terms of maintaining stockpiles and purchasing essential products needed to be significantly improved. In its first interim report, the Commission took the view that care services for older people were unprepared when the pandemic struck and that this had its roots in a variety of structural shortcomings.

National emergency stockpiles are needed as a complement to those existing within the EU. There should also be a statutory requirement on regions to maintain stockpiles of a certain size, and not just general provisions on their responsibility for disaster medical preparedness. In addition, pandemic plans are needed that are based on new underlying assumptions. They should be geared towards long-term crises affecting large parts of society, on at least the same scale as the pandemic. This means that different authorities need to make preparations for mutual cooperation, for example by sharing important data with one another. For such cooperation to work, it must begin in normal times, with joint analysis and exchange of information. There is also a need for training and exer-

cises, to develop a mental preparedness to act in time and take vigorous – and presumably costly – decisions based on uncertain data. Such planning must involve and engage with civil society organisations.

Functioning pandemic preparedness also requires a dormant testing and contact tracing organisation that can quickly be mobilised.

Legal preparedness has not been adequate, either. The overarching lesson learned is that there needs to be some form of constitutional preparedness that gives the Government sufficient room for manoeuvre during a serious peacetime crisis.

In its second interim report, the Commission expressed the view that the Communicable Diseases Act was insufficient to handle a virus outbreak potentially affecting large parts of the population. It now also concludes that the Act's requirement that disease prevention and control measures must be based on science and proven experience can hardly be applied when an unknown virus is spreading a disease posing a danger to society.

Communicate clearly and honestly

A coordinated national strategy for communication was put in place at a very late stage, and advice and recommendations were often communicated in an unclear manner. Among other things, it was some time before translations into languages other than Swedish were made available.

Communication with the general public is fundamental to all crisis management and must be improved for next time. It is important in maintaining trust and confidence and hence in promoting resilience and endurance. To work in that way, communication has to be honest, factually correct, as complete as possible, and at the same time easy to understand.

Next time around, the overriding aim cannot be to “allay concern”. Even if this was not the intention, an aim expressed in such terms can mistakenly be understood to imply that the authorities are not averse to withholding information that might cause people to worry. Such an attitude is virtually the opposite of the transparency and honesty that should inform communication. The Government

and public authorities must be open about what they know and what they do not know. The latter approach also indicates a readiness to reconsider decisions and can thus prepare people for the possibility of instructions being changed.

Supplement the principles of crisis management

Crisis management in Sweden is to be based on the principles of responsibility, similarity and subsidiarity, principles that may seem reasonable in normal times. A far-reaching societal crisis, however, is almost by definition a situation that affects the responsibilities of many stakeholders and therefore calls for coordination. The Commission has previously noted that responsibility for disease prevention and control and pandemic management is spread over many different actors, and that such a system is both difficult to manage and involves a danger of individual actors disregarding the national consequences of the measures they take. There is also a risk that a body responsible for a given activity in a crisis, but not fully capable of shouldering that responsibility, could find it hard to express the difficulties it experiences.

During the pandemic, 290 municipalities have borne responsibility for control of the virus outbreak in their care services for older people; 21 regions for medical support to care for older people, for infectious disease care and intensive care, and for disease prevention and control; and one central administrative authority for coordinating disease prevention and control efforts, another for supporting health care and care for older people, and yet another for, among other things, the impacts of the pandemic on other activities crucial to society. A number of other administrative agencies, such as the Swedish Work Environment Authority and the Health and Social Care Inspectorate, have also had important areas of responsibility. County administrative boards (central government agencies operating at the regional level) have had a coordinating role. And in reality, to coordinate and support many of these bodies with individual responsibilities, the membership and employers' association SALAR has also had to take on responsibility. Furthermore, there are a number of private providers of municipal and regional services.

The picture outlined here shows that the challenges in coordinating these scattered responsibilities into a coherent system of national crisis management have, to say the least, been appreciable. In addition, it seems that, at the level of national leadership too, the principle of responsibility has been maintained quite rigorously between different ministries within the Government Offices.

The system of preparedness is based on geographical responsibility for specific areas. But this arrangement can become unclear in a crisis centred on health care and disease prevention and control. At a regional level, area responsibility rests on county administrative boards, while health care and disease control are handled by regional councils in the same geographical areas. It is far from evident how this lack of clarity should be reduced.

In the Commission's opinion, experience of the pandemic has highlighted the importance of the proposals for regional-level administrative reform and clearer central government control, repeatedly presented by earlier inquiries. The Commission considers that the question of far-reaching administrative reform, advocated by those inquiries, must as soon as possible, and in earnest, be made the subject of new, open-minded deliberations.

In view of the problems mentioned, the Commission believes that the principles of responsibility, similarity and subsidiarity are not sufficient in a crisis. They need to be supplemented, at least, with a precautionary principle or principle of action.

Such a precautionary principle should have been applied in every aspect of crisis management, and not only in handling the economic crisis and adapting the health care system. The generally worded requirement of the Communicable Diseases Act that measures are to be based on science and proven experience is of course important as a basis for managing known infectious diseases. However, when scientific knowledge is limited and proven experience lacking, but disease control measures still need to be introduced, those responsible must not allow such a provision to stand in the way of measures that may be assumed to limit the spread of the disease. The precautionary principle should be virtually self-evident in responding to an imminent threat. Whoever is responsible for a given activity thus not only has cause, but should also have a duty, to apply this principle when faced with a far-reaching threat to society. To avoid misunderstandings about what the principle entails and how it should be

applied, it is possible to speak rather of a principle of action. That is to say, action should be taken which, based on available knowledge, may be assumed to limit the spread of the disease. In so far as such action could also adversely affect other important societal interests, it is the task of the political leadership to decide whether any other interest should take precedence over protecting life and health.

The Commission is of the view that, 15 years on from the proposals of the Disaster Commission, it is now time to establish the principle that a precautionary approach, understood as an obligation to act at an early stage in the face of great uncertainty, should serve as a guide to all crisis management.

Make national crisis leadership clear

In a crisis, it must be clear to all concerned who is ultimately leading the response and what vertical lines of responsibility look like. In other words, there should be a crisis management organisation with a clear centre, responsible for analysis, decision-making and directives, i.e. what the Disaster Commission chose to refer to as a principle of simplicity. Earlier inquiries, too, have stressed the need for clear central leadership in a societal crisis.

The Commission's impression is that the Government Offices' regular working arrangements, with a strict application of the responsibility principle, do not create an adequate basis for such leadership.

The Commission believes that consideration should be given to establishing a new, centrally located body with substantial powers, reporting directly to the Government. During a serious societal crisis in peacetime, this body would be able to obtain information from all relevant stakeholders, lay down clear guidelines for their work, and where necessary – when it is not possible to await a Government decision – issue binding directives to public authorities to carry out a measure judged to be necessary.

The Commission considers that both the principles and the organisation of crisis management, and also its legal basis, need to be examined in greater depth than has been possible under its own terms of reference. It will then also be possible to consider these issues in the light of overall experience once the pandemic has sub-

sided. A cross-party committee of inquiry should therefore be appointed to deliberate on changes to the principles and organisation of crisis management. Its basic aim should be to make the Government's responsibilities clear.

The pandemic has demonstrated the breadth, complexity and importance of the area of disease prevention and control. It is a field requiring expertise, experience, commitment, and a capacity to continuously monitor and evaluate rapidly changing research. At the same time, disease control measures can clearly affect other important aspects of public health and other societal interests. Balancing such opposing interests is a political issue. It is important that, in future, disease prevention and control in a broad sense are organised in such a way that the Government receives adequate data from more than one authority, enabling it to weigh up the factors relevant to fighting a pandemic. The Public Health Agency therefore cannot have sole responsibility for providing the Government with decision support data on such matters. Further consideration should be given to how arrangements to this end could be put in place.

Strengthen the Government Offices' documentation

A crisis requires orderly documentation on an ongoing basis. This can be achieved by means of logs, notes and minutes and by keeping track of, printing and archiving important communication by email, for example. For this to be possible in intense phases of a crisis, when one meeting follows close on the heels of another, there needs to be a predetermined system and division of labour. If it is not possible to take formal minutes, a trusted individual should at least be designated to make notes of important meetings at which possible decisions are discussed. It is not enough to rely solely on participants in such meetings recording their impressions or recollections in their own notebooks.

The Commission has had difficulty gaining access to the documentation it has considered necessary to evaluate measures taken by the Government and crisis management within the Government Offices. Owing to the Government Offices' initial reluctance to assist it, the Commission has found it difficult to establish a clear picture of, on the one hand, what documentation exists but the

Government Offices have been unwilling to share with it and, on the other, what documentation simply does not exist.

In all crisis management, documentation is vitally important, both in preserving a kind of institutional memory during the crisis itself, and for review and learning once it is over. The Commission therefore considers that the Government Offices' documentation of their own crisis management efforts needs to be substantially improved.

Strengthen international cooperation

Preparedness needs to be built up in Sweden, but also in cooperation with other countries – globally, within the EU and in the Nordic region.

In the EU, protection of health is the responsibility of member states. After a somewhat shaky start, however, coordination within the EU has come to play an important part, not least in coordinating efforts to develop, procure and distribute vaccines. The European Commission has also set up a new body, the European Health Emergency Preparedness and Response Authority (HERA), and strengthened the mandate of the European Centre for Disease Prevention and Control (ECDC). Of particular importance for the future is the building of joint emergency stockpiles within RescEU, one of which has been placed in Kristinehamn.

International cooperation, globally and across the EU, is also needed to ensure that cross-border supply chains can as far as possible be maintained in a crisis.

No structure exists for civil emergency preparedness at the Nordic level. The lack of coordination between the countries at the political level was evident during the pandemic. There is cause to initiate closer cooperation in civil emergencies between the Nordic countries. Cooperation on emergency stockpiles could also be considered.

Improve the data on which crisis management is based

In both this and earlier reports, the Commission has drawn attention to the necessity of good data. It has among other things pointed to

the need for action by regions and municipalities to establish integrated medical record systems. In addition, the Commission has highlighted the decisive importance of IT systems in achieving efficient data flows in the area of testing and analysis, and how a lack of digital systems poses a real obstacle to effective follow-up of statistics relating to contact tracing.

Detailed data with a short time lag, for example on health or economic conditions in different parts of society, is also crucial to being able to monitor a crisis while it is in progress and rapidly decide on appropriate measures to manage it. An obvious illustration of this is the unclear picture of the spread of the virus in the early weeks of the pandemic, discussed by the Commission in its second interim report.

Without rapidly available, detailed data, there is also a risk of the measures introduced being less precise. A clear example is detailed information about which sectors were hit hardest by the spread of the disease, which would have enabled business support schemes to be more precisely targeted. In some cases, gathering of data has not clearly fallen within any given authority's area of responsibility, and this has sometimes caused problems.

At present, some important data is lacking, for example, on primary care, residential care for older people, municipal health and social care, and short-term sick leave. Such data needs to be available in the next crisis.

There is a danger that measures introduced will be less precisely targeted and offer greater scope for fraud if the authorities are unable to share certain data or have no legal basis for collecting it.

These problems should be investigated further and addressed before the next crisis strikes.

Encourage new, broad research into the pandemic

The Commission has previously highlighted the need for further follow-up and research on a number of more specific issues, such as the indirect consequences of the pandemic for the well-being of different disadvantaged groups, the effects of postponed and cancelled care, post COVID-19 condition (long COVID), and the effects of distance learning on the knowledge and future prospects

of students. Several of these issues are important in understanding the long-term impacts of the pandemic.

Research can also play an important part in enabling us to understand the crisis from different perspectives. Future research into the pandemic could usefully adopt a broad, genuinely cross-disciplinary approach, to provide an understanding of the pandemic and its effects from a medical, social and economic point of view.

Closing remarks on this final report

One difficulty that has marked the work of the Commission is that it has had to carry out its evaluation amidst a constantly unfolding sequence of events, in which new waves, variants and issues have arisen as the work has progressed. The Commission has not been able to undertake any evaluation of the most recent, fourth wave, which has involved considerably greater transmission than earlier ones, this time of the milder Omicron variant of the virus.

Under its terms of reference, a key task of the Commission has been to evaluate “the measures taken by the Government, the administrative agencies concerned, the regions and the municipalities to tackle the outbreak of the virus and the effects of the outbreak”, and how “the crisis management organisation at the Government Offices of Sweden, administrative agencies concerned, regions and municipalities has worked during the pandemic”. The Commission has not, however, been in a position to evaluate either the handling of the pandemic or the organisation of crisis management within each individual region, municipality and county administrative board. In that respect, it has had to confine itself to more overall assessments.

Another aspect of pandemic management that has not been considered is various issues relating to vaccinations. These issues were not included in the terms of reference, but have assumed growing significance the longer the pandemic has continued.

This final report brings the work of the Commission to an end. The fact that the pandemic is not over means that it can only be regarded as a provisional balancing of the books. The Commission has presented analyses and conclusions based on a large body of data, and developed new knowledge concerning the pandemic and its

effects in several different areas. But there is still a great deal we do not know, and in many respects it is difficult to draw definite conclusions. The discussion will continue about what we can learn from the pandemic and how we can best equip Sweden for future pandemics and crises.