Rivista Italiana di
Public Management

Vol. 4, n. 2 | 2021

A comparative study of Covid-19: a purposeful agent, a myopic political leader

Uno studio comparativo di Covid-19: un agente determinato, un leader politico miope

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Abstract

This article offers insights into the Covid-19 Pandemic by comparing the experiences of Norway and the UK. The Norwegian case study has distinctive characteristics. It offers evidence of an agile government at work and evidence of a successful clinical experience with the Norwegian management leading the Covid pandemic. This was a successful approach with low mortality rates and a protected population. By contrast, the UK experience was quite different. Clinical expertise was available to politicians who managed the pandemic, but this relationship was tense and contested over the pandemic. The political steering of the UK pandemic was erratic and unpredictable. The Government was initially keen on herd immunity but discarded this approach in early 2020 when it became clear that the fatalities would be grim. The UK Prime Minister is a member of the libertarian

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The authors of this article salute the dedicated courage and professionalism of the health care professionals of Bergamo and Milan who were the first Europeans to face this new and unknown disease.

wing of his political party which opposes to the principle of intervening in the lives of citizens. This meant the UK Prime Minister was in a conflicted position. This was evidenced by his reluctance to have lockdowns and the slowness with which lockdowns were initiated and, according to experts, this cost many lives. The fatalities in the UK were among the worst in the world.

Keywords:*Crisis management, Agility, Government, Covid-19, Clinical expertise.*

Introduction

Italy was the first European country to be hit by the Covid-19 virus. This was before the WHO declared a Pandemic, at a time when the world had little understanding of this virus or how to treat it. The world looked on in horror as the virus hit Italy, with total respect for the bravery and resilience of Italian health care workers as they fought this virus. This research is intended to advance Public Management thinking on how to manage crises, such as the Pandemic. This article presents the results of a comparative study of how the authorities in two different countries (Norway and the UK) have governed through the Covid-19 pandemic. Our study discusses how public accountability has been affected by the pandemic as a crisis. Specifically, we reveal how the conduct of government authorities and their agents during the crisis may have impacted on people's trust in government, and the effect of public perceptions on the outcomes of the pandemic.

The Covid-19 situation may be defined clearly as a crisis, as it is

« […] *a situation in which there is a perceived threat against the core values or life-sustaining functions of a social system that requires urgent remedial action in uncertain circumstances*» (Rosenthal *et al.*,1989).

The ability of governments to manage Covid-19 is challenged by several of the key inherent char-acteristics of a crisis: The situation is a perceived threat, meaning that there is a subjective el-ement in the definition of the crisis, and people may perceive the severity of this threat dif-ferently. The degree of urgency compels authorities to act quickly, measures must be imple-mented without an in-depth analysis, and decisions must be made under high levels of uncer-tainty about the course of the crisis and the possible consequences of measures taken. This clearly contributes to a particularly challenging control situation.

Many studies have demonstrated the significance of calculative practices (particularly accounting) in the shaping of policy changes in public sector study settings (Lapsley & Miller, 2019). By offering measurability and transparency through output metrics, accounting may be considered as an ideal means of public accountability by providing measures of success for policies that are chosen. However, during the Pandemic, the calculative practice of ac-

counting has been replaced by the calculations of epidemiology (identification of Ground Zero patient, the number of cases of infections, the reinfection rate (R), mortalities and excess deaths) which has dominated the narrative of all discourse on the Pandemic. A major feature of this phenomenon was the emergence of a group of experts on the national political stage alongside politicians. These experts had a specialist understanding of the medical nature of the Pandemic which facilitated the displacement of financial calculative practices by those calculative practices derived from medicine.

In a crisis, politics and politicians are depicted as the central actors in undertaking essentially political decisions on priorities, on processes and the mitigation of risk (Christensen *et al.*, 2016a). This may conflict with the conventional depiction of public accountability as representative politics at work (Cooper & Lapsley, 2021). This conflict is underlined by governments and government agencies being granted extraordinary powers to deal with the pandemic which may extend to suspension of certain forms of political oversight. One specific manifestation of this was the emergence of televised daily government press briefings with questions from journalists and occasionally citizens, not by politicians. This format gave prominence to experts alongside politicians and raises questions about the effectiveness of public accountability in the pandemic.

In dealing with the Covid Pandemic, citizens' response to measures that are put in place is fundamentally crucial to the outcome. The maintenance of public accountability, i.e. the extent to which elected representatives and the officers who work for them are accountable towards local citizens, is therefore very important. If the population does not have the necessary trust in the authorities and the policies pursued, successful management of the crisis is impossible. In this study, we ask the following research question: How has public accountability been affected by the Pandemic crisis?

This comparative study reveals both processes of accountability and distinct outcomes in the case study countries of Norway and the UK. In Norway, tight, respectful, and transparent cooperation between clinical expertise and the government and clearly conveyed expectations and demands placed on the population by the authorities have been critical to their success. In the UK, the fragile coalition of clinical experts and their political masters revealed tensions over a deeply disappointing outcome of Covid-19 infections. Although calculative practices appear to be identical in the two countries, our findings suggest that differences in the governance context contribute to quite different impacts on public accountability.

This research makes several contributions to the public management literature. This research responds to the need for Covid-19 research on the management of pandemics. Our findings also contribute, more generally, to the field of crisis management, particularly in the case of central government. This paper also contributes to the growing field of interdisciplinary research in public management with a demonstration of theoretical

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pluralism which is mobilised to interpret the findings of this study. By introducing ideas of government agility and a nuanced interpretation of social agency research to the crisis management literature, and to the public management literature in the context of policy formation in the pandemic, we contribute to interdisciplinary research (Guthrie & Parker, 2012; 2017; Jeacle & Carter, 2014; Jacobs & Cuganesan, 2014) and more specifically in the public sector literature (Hoque *et al.*, 2013; Lowe *et al.*, 2012; Jacobs, 2012; 2016). Specifically, this study identifies two dimensions of social agency; the one exercised by *purposeful agents* (responsive, agile actors) within government and the alternative of *myopic agency* which does not capture the crisis unfolding in the population and the public debate in its response of myopic behaviour. The tensions underlying myopic agency may escalate conflict and undermine public accountability.

1. Theorising crisis management in the pandemic

This study draws on multiple frames of reference in its interdisciplinary scrutiny of the Pandemic. This includes crisis management where the topic of central government is relatively neglected (Bundy *et al.*,2017). Also, crisis management is often studied at the level of individual organisations, often by specific subject areas like operations management (Bernardes & Hanna, 2009) or human resource management (Ahammed *et al.*, 2020). These approaches generate multiple interpretations and definitions of key concepts which are subject-related, and which undermine the cohesion of crisis management studies (Bundy *et al.*, 2017). Within the field of crisis management an emergent approach - agility - is of increasing importance in the study of organisations in crisis. This includes accountability, policy formation and issues such as information overload (Mergel *et al.*, 2018). This frame of reference is of specific relevance to this paper and is discussed further below. Also, another theoretical framework of particular interest is that of social agency (Barnes, 2000). Within discussions of such agency, we focus on issues of purposeful actions and myopia, as discussed further below.

1.1. Crisis Management

Crisis management has been depicted as organisational crises by Bundy *et al.* (2017). In their view, studies of organizational crises tend to focus on internal (management processes) and external (stakeholder) perceptions of the organisation with little or no evidence of a more holistic approach to crisis management. However, the adoption of a narrow focus is not confined to organizational researchers. For example, Christensen et al. (2016a) focus on governance and legitimacy. They regard legitimacy as a fundamental feature of governmental activity, which it certainly is. But their main focus is the building of government capacity for governance. Now governance is an important dimension of crisis management. However, to exclude any discussion of public management interventions is rather narrow, in our view.

There is a wider literature on crises and their management. For example, Lerbinger (1997) identified eight different types of crises but only one - natural disasters - fits the scope of this paper. However, James (2008) observed that crises may erode public trust in leaders. This research shows the importance of leadership traits, such as integrity, transparency, capabilities and respectful actions may foster public trust if handled carefully. Crump (2019) has stressed the need for avoidance strategies and carefully thought out and rehearsed contingency plans for crises. These are also elements of good leadership. Shrivastava et al. (1988) argued for the importance of clear and effective communications based on the experiences of the Bhopal disaster. These studies underline the necessity of leadership in public sector crises which citizens find calm and reassuring, with a clear understanding that politicians understand the nature of the crisis and have a plan to deal with it (Liu *et al.*, 2015). All levels of government may have to address crises - their nature, the capacity to resolve crises and reach out to citizens during and after crises (Boin *et al.*, 2007). This research by Boin *et al.* (2005) offers the most perceptive exposition of the decision-making challenges facing political leaders:

« […] *crises present leaders with choice opportunities that combine a number of characteristics:*

- *They are highly consequential: they affect core values and interests of communities and the price of both "right" and "wrong" choices is high - socially, politically, economically and in human terms.*

- *They are more likely than non-crisis situations to contain genuine dilemmas that can only be solved through trade-off choice, or "tragic choices" where all the options open to the decision maker entail net losses.*

- *They are baffling in that they present leaders with major uncertainties about the nature of the issues, the likelihood of future developments, and the possible impact of various policy options.*

- *Choices have to be made relatively quickly: there is time pressure -regardless of whether it is real, perceived, or self-imposed- which means that some of tried-and-tested methods of preparing, delaying, and politically anchoring difficult decisions cannot be applied».*

While the above observations are helpful to understand the significant elements of public management to be mobilised, they do lack highly specified action plans for dealing with crises. Furthermore, the crises addressed in the extant literature appear rather outdated and most importantly, none have the sheer size and scale of the Covid-19 pandemic.

While governments and government agencies have not been studied systematically within the literature on crisis management, there is a strand of contemporary theorising of crises which may be productive for a study such as this. In the beginning of this material to theorise what is the Pandemic and what lessons can be learned for future crises, the potential of agile management was highlighted. This is discussed further here, particularly in its relation to government departments.

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1.2. Agility

Much of the literature addresses organisational agility (Harraf *et al.*, 2015; Bernardes & Hanna, 2009, Ahammad *et al.*, 2020). However, there are aspects of this idea of agility which may be applicable to governments or Government agencies. A common focus within the literature on agility is the speed of response to a crisis (see for example Ahammad *et al.*, 2019; Bernardes & Hanna, 2009; Winby a& Worley,2014). The extent of the rapid response may require a quick system reconfiguration in the face of unforeseen changes (Bernardes & Hanna, 2009). A strategy perspective is advocated by Ahammad *et al.* (2020). They depict agility of the organisation as a strategic agility which is an organisational capability to recognise and seize opportunities and to take advantage of changes - a quick, decisive, and effective anticipation of change and its implications (Ahammad *et al.*, 2020). However, a review of the literature revealed a lack of common definitions and clarity of ideas of responsiveness, flexibility and agility. Furthermore, the literature on agility has been regarded as uncritical in the advocacy of this approach. But the possible defects of 'agility' have been noted by Mergel *et al.* (2018):

- « […] *less predictability due to the inability to quantify the full level of effort required.*
- *More time commitment necessary due to the close communication required across teams involved in the effort.*
- *Greater demands on developers and clients (e.g., training, participation).*
- *Lack of necessary documentation, due to the just-in-time nature of development.*
- *Potential for projects to get off track due to continually redefined needs*».

Despite such reservations, advocacy of "agility" continues unabated. For example, Harraf *et al.*, (2015), have elaborated upon the pillars of an agility framework. This includes: a culture of innovation, an attitude of opportunity seeking and alertness, empowerment to effect change, tolerance for ambiguity, vision, strategic direction, change management, communication, market analysis, operations management and structural fluidity. Whilst this set of attributes may be hard to object to, the identification of these constructs falls well short of an operational guide for "agility" implementation. However, these pillars make it evident that while speed of response is an important part of agility, it is not sufficient to merit categorisation as "agile". This framework identifies the importance of supportive structures within organisations, but there is also an expectation that the act will be more than rapid- it will be decisive, strategising, and innovative, with a capability to do things differently to achieve its aim.

A simpler model of agility has been offered by Winby & Worley (2014). Their model is centred on sound management practices of routine activities such as resource allocation, budgetary control and human resource management. On this platform, Winby & Worley (2014) superimpose the constructs of (1) strategising (2) perceiving (3) testing and (4) implementing. In (1), there is an expectation that there is a well-designed purpose, with a shared strategy in the organisation in which (2) there is a deep and continuous monitoring of the environment. According to Winby & Worley (2014), these four dimensions constitute the routines of agility. An even simpler concept of agility is offered by Barnardes & Hanna (2009). They see agility as primarily flexibility of response to known situations and where unpredictable phenomena are evident the agile response will be innovative - new procedures, processes which address the challenge of unpredictable changes. These different interpretations of agility may not apply exactly to the Pandemic – yet these constructs are highly relevant to crisis management.

However, while the above studies re-affirm the merits of the agility model, Mergel *et al.* (2018) observe that it remains an open question whether the agile actions of private organisations can translate to government bureaucracies and agencies. In their study, Mergel *et al.* (2018) observed that governmental bureaucracies may reduce the motivation of managers to attempt agility. Also, they observed that many government organisations may have inadequate resources to establish agility models, given the continuous exposure to New Public Management ideas and their exposure to a decade of austerity before the Pandemic. In their view, effective agile practices may require a more holistic approach to innovation and leadership. Mergel *et al.* (2018) concede that the prerequisites of agility in the traditional command-and-control model of government bureaucracies are not designed for open collaborations. These observations support the need for greater research into government structures and characteristics and their impact on agility. Nevertheless, in the era of the Pandemic necessity drives the relevance of agility to addressing the challenges of Covid-19, as our case study discussions demonstrate.

1.3. Social agency

Crisis management in the Pandemic constitutes a case of "wicked issues" in which policy choices may not be obvious and this provides a context for agency in action to address the crisis (Scott & Baehler, 2010). In studying governments, there is always a concern with legitimacy in public sector studies, which are, fundamentally, about government and politics (Deephouse & Suchman, 2008; Christensen *et al.*, 2016a; 2016b). This study, however, takes a different turn. Given the nature of the crisis and the need for urgency, the study of key actors in the advocacy and implementation of policy, merits scrutiny, in the context of this pandemic.

This perspective has been advocated by Barnes (2000), Weick (2001) and by Nair & Howlett (2017). We acknowledge that the issue of agency in social theory has been con-

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tested by those who believe in structural determinism, where little scope is left for significant individual agency (see for example Bourdieu, 1990, and Giddens,1976). However, the contention of this paper is that in the specific destabilising influences of crisis situations, there is scope for individual agency to influence events. Specifically, we examine the potential for impact of "agency in crisis" as proposed by Scott & Baehler (op.cit.), There are two strands to this study of agency in action: (1) purposeful agency and (2) myopic agency, as discussed next.

The purposeful agent is an individual who can exercise choice, who can "act otherwise" (Barnes, 2000), can transform, resist, or act unpredictably. The knowledge and expertise of the purposeful agent may be transformative, particularly in crisis situations (Weick, 2001) where the purposeful agent may prevent or contribute significantly to the management of crises. In a crisis, ordinary systems are put out of play. Central actors, authorities, have any number of mechanisms put in place to govern society (everyday life) outside of crises. When crises occur, these mechanisms do not suffice, due to uncertainty and the degree of urgency. This, in itself, creates a larger scope of opportunity for decision makers (government, ministries, directorates). The purposeful agent in a crisis will challenge mechanisms made for control in everyday life and make room for more agency (Weick, 2001). Individuals and groups may gain influence through institutional entrepreneurship defined as the 'activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or to transform existing ones' (Maguire, Hardy, & Lawrence, 2004). An early study of how the Covid-19 crisis was managed by the South Korean government, highlights a case of purposeful agency at work in effective crisis management (Moon, 2020).

However, as noted above, the interventions of purposeful agents may be unpredictable. Indeed, Nair & Howlett (2017) have observed the potential for influential agents to be disruptive or deleterious instead of resolving problems and challenges. As Nair & Howlett (2017) observe this myopia arises, particularly in crises, because of an inability to see the shape, contours, and details of policy enactments. This means that, in the determination of policy, the myopic agent may attribute primacy to factors of limited significance, may be unable to estimate the trajectory of the crisis and may be responsible for policy failure. In exploring this tension, the location of calculative practice is of special interest. The medical domain has distinctive calculative practices which are quite different from public sector accounting. The importance of these different narratives in the discharge of public accountability is a crucial factor in understanding the effective management of this crisis.

2. Research design

This research is a form of participant observation (Jorgensen, 1989) in which the authors lived in the countries included in this study throughout the Covid-19 pandemic. The

approach taken was influenced by the idea of shadowing key phenomena (Czarniawska, 2007) to offer critical reflections on emergent policies. The selection of our case studies is based on the theoretical perspective adopted (Van Thiel, 2014). These studies reveal the significance of agency in crisis situations.

We explored crisis management in both country settings, using a critical incident perspective (Chell, 2004). In this comparative case study approach, some key measures of 'success` were studied in this investigation:

1. Was the government decisive? What was the time between ground zero patient (s) and lock-down?

2. How did the government manage the process - scope for citizen interaction, the R score, citizen compliance, mobilisation of Experts?;

3. What was the outcome?

The approach of the UK Government has been heavily criticised (Horton, 2020). Based on mortality statistics and the incidence of infections, we regard Norway as a success, with the UK as a comparative failure (see Table 1). The UK's Chief Scientific Officer said that 20,000 mortalities would be a reasonable result (Vallance 2020). One of the UK Government advisers observed that an earlier lockdown would have saved over 20,000 lives (Ferguson, 2020). The U.K. has the worst fatalities in Europe at around 140,000. If you adjust for population (cases per million) the only country in Europe which is comparable is Italy -the first European country to face the Covid-19 pandemic. By contrast to the UK, Norway was faster into lockdown, had fewer cases and fatalities and has emerged from lockdown with minimal Covid-19 infection.

Tab. 1 Case Study Settings: The Initial Scenarios.

	Norway	UK*
Ground Zero Patient (date)	26 February 2020	30 January 2020
Date of Lockdown*	12 March	23 March
Easing of Lockdown	20 April	23 June

*: The UK had multiple lockdowns as discussed below.

The researchers were immersed in the policy developments and practices as they unfolded throughout the crisis. A major source of information was documents (Lee, 2012). The documentary sources allowed the gathering of information which was not a mere receptacle for passive information – the richness of this data allowed a nuanced interpretation of the pandemic from a qualitative, interpretive perspective (Prior, 2003). This

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research was undertaken by the use and analysis of government websites, government reports, relevant social media and newspaper coverage of the pandemic. This includes the live television daily press briefings by the UK Government and by the Norwegian Government. The authors also used reported and live interviews with key actors during the pandemic. Table 1 is a snapshot of the impact of Covid-19 in its early stages.

3. The Norwegian Case Study

In this case study we examine six dimensions of the Norwegian case study: (1) the Norwegian context, particularly the political context, (2) experts initiate early shutdown, (3) Government strategy, accountability and transparency, (4) The emergence of a purposeful agent, (5) critical incidents in the Norwegian experience of the pandemic and (6) Accountability by press conference: the public gaze.

3.1. The Norvegian context

Norway is a small country with high welfare and a well-developed democracy. Just before Covid19 occurred, Norway was characterized by the Oecd as follows:

« […] *Wellbeing in Norway is high; Gdp per capita is among the top-ranking countries and the country scores well in measures of inclusiveness*» (Oecd, 2019).

High trust in political institutions is often seen as a necessity for a well-functioning democracy. Norway is at the top among European countries when it comes to trust in the Government. On a scale from 1-10 (where 10 is highest), the Norwegian population scores 6.2, whilst the UK score is around 4 (Ssb, 2016). Voting turnouts in elections are also very high, about 75 per cent (UK about 66%), and support for national guidelines, such as vaccine programmes, is usually high.

Characteristics such as being a wealthy state, having a low degree of conflict between political parties and also between various government bodies and -levels, helps to enable rapid and flexible interventions in a crisis situation.

3.2. Early shutdown initiated by experts

The first case of Covid-19 was confirmed on the 26th of February.13 days later, on the 10th of March, Norway was amongst the European countries with the highest infection rates with 277 cases per 1000 citizens and a reproduction rate of 3.The Director of the Directorate of Health (Doh), Guldvog, highlighted the sense of urgency; “We are, perhaps, in the greatest crisis society must handle since WW2”, urging the Prime Minister (Pm) and Minister of Health (Mh) to address the severity of the situation (Regjeringen,

2020a). In a meeting on the 11th of March, the Pm, the Mh and the director of National Institute of Public Health (Niph), in unison agreed upon the need for a plan of action. All these agencies had the same agreed measures to respond to Covid-19. On12th of March Guldvog, met the PM who asked him; "I guess it is now we press the big button?" (Vg, 2020), receiving the director's confirmation. The same day the country was closed down. The PM stated, "Today the Norwegian government introduces the strongest and most invasive measures we have had in Norway in peacetime. This is absolutely necessary" (Regjeringen, 2020b).

Through the first months of managing the pandemic the Norwegian government pursued a strategy of preventive cautiousness, following the advice of experts in the Norwegian health authorities. They formed a strong alliance, headed by emerging key actors from the health authorities fronting the strategy laid out to face the pandemic. On the 27th of April, the number of new cases per day was less than 50, the reinfection rate was 0.67, and Norwegian society was carefully starting to re-open. In August, a national barometer on trust, showed a substantial increase in people's trust in government. One of the most prominent commentators in Norway claimed, "The corona crisis has given the government a huge confidence boost" (Aftenposten, 2020). This case study reveals how this success story was achieved.

3.3. Government strategy, accountability and transparency

The Government sought to control the spread of Covid-19 (measures + testing / tracking) and ensure sufficient capacity in the hospitals, especially with regard to respiratory treatment (Regjeringen, 2020). Measures included closing borders with quarantine (14 days) for travellers from abroad, closing all pre-schools, primary and secondary schools, and campuses of higher education. All events, arrangements in sports and culture were shut down. Psychologists, hairdressers, and beauty salons were all closed, as well as bars and restaurants that could not facilitate required distancing. All health care institutions introduced access and visitation restrictions. The following days brought further measures, discouraging any travels abroad (14.03), escalating border controls (16.03), banning all overnight stays outside home municipalities (19.03), and avoiding any gathering of more than 5 people.

Surveys conducted during the lockdown period have shown a high degree of confidence in the government and health authorities and their management of the pandemic. On the 6th of April, leading newspapers reported that as many as 89% percent believed that the measures were working, and as many as 86% supported the prolonging of invasive measures even beyond Easter (Dagbladet, 2020). This supports the general impression of the peoples support of and compliance with the implemented measures and rules, which is backed by few reported violations.

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3.4. The Emergence of a purposeful agent

The leader of the crisis committee for preparedness against biological events (Ncb), Nakstad, were early advocates of action, with strong recommendations for the immediate introduction of invasive measures. Nakstad was later appointed Deputy Director of Health. He had a key role in following up on measures and their effects, as well as communicating with the public and the health services. He won the peoples' trust, resulting even in the establishment of fan-sites on social media. In a leading newspaper he was portrayed as a hero, where he was depicted as having "achieved the work of art by becoming a beloved bureaucrat" (Aftenposten, 2020). He was later granted various honorary awards, such as "Name of the year" (in several national newspapers i.e. Vg, Dagbladet), Citizen of the year (Oslo), award for good leadership (HR Norway), and an award for clear language (Norwegian Language Council).

Nakstad was first recruited as Deputy Director for two weeks, when the majority of the Doh management was quarantined on the 13th of March 2020. He later got this position permanently. He was recruited from his position as chief attending physician and researcher at Oslo University Hospital, where he was the chief of a research centre focusing on emergency preparedness for the spread of biological infections. Nakstad has specialized in respiratory diseases, he is also a jurist and has considerable experience in crisis management. When the first Norwegian infected with the Ebola virus was being transported to Norway, he managed the entire operation and was also given the responsibility of convincing the people that the disease would not spread.

Based on his extensive experience Nakstad has written a textbook on crisis management (Bjelland & Nakstad, 2018). We clearly see that the authorities have followed the basic advice proposed in the book. Among other things, Nakstad claims that the establishment of a quick, correct and common understanding of the situation is absolutely crucial for good crisis management. This common understanding of the situation includes both "Perception of the environment: What are the current facts? Recognition of the situation: What is actually going on? Prediction of the situation development: What will most likely happen if […]? Assessment: What should (we) do?" In addition, an overview of resources and the ability to make decisions are emphasized as important. The book also presents a list of general advice for good crisis communication with the public through the media largely consistent with the strategy adopted by the authorities in communicating about the pandemic:

« […] *It will always be beneficial to show that you have empathy ("a warm heart"), a good overview and structure ("a clear head") and are on your game as the situation requires ("active hands")*».

However, Nakstad interestingly in his book also elaborates by stating "Do not state anything you risk having to later redact, as this quickly can undermine the trust in how the

crisis is handled". This statement underlines the importance of honesty and cautiousness in handling and distributing information in the management of crisis situations.

Nakstad has considerable experience as a speaker and lecturer. His pedagogical competence has been evident and has contributed to his extraordinary popularity and legitimacy amongst the people. Between the 16th of March and the 23rd of June, Nakstad took part in 21 press-briefings, emphasizing communication of the foundation and reasoning behind the introduction of measures, to create an understanding of the authorities' strategy to manage the crisis, as well as the necessity of introducing and maintaining measures. He has also emphasized the importance of demonstrations of the effect of measures and in this manner elicited the help of people and health services participation in "voluntary work" to support official advice.

3.5. Critical Incidents in Norway's experience of the pandemic

The four critical episodes discussed here are:

- Later Restrictions
- A Breach of Trust?
- The Vaccination Programme
- Reopening Society

Critical Incident 1: Later restrictions

After the first lock down, there have been periods of strong restrictions on society also in Norway. Some of these have been national, for example restrictions on social gatherings, entry restrictions (quarantine upon arrival) and mandatory use of face masks. But the strictest regulations have been regional or local, such as closing schools and kindergartens, ordering use of home offices and closing restaurants, gyms, etc. These have been enforced through municipal regulations so that violations may be prosecuted.

Critical Incident 2. A Breach of Trust?

On the 25th of February 2021, the Norwegian Prime Minister was to celebrate her 60th birthday. She invited the family, and a party of 13 people dined at a local restaurant. The Prime Minister herself did not attend. The rules at the time implied that private events at restaurants were limited to 10 people, even though the restaurant had a much larger capacity. However, the Prime Minister's family had ordered dinner served at three

different tables for three cohorts with separate menus. It was therefore highly unclear whether the event was in fact in violation of current regulations.

The media took a great interest in the case. In an early interview, Solberg stated: "I think it is important that if I have violated the rules, then I will also pay a fine on an equal footing with other people who would receive a fine in such a situation" (Vg, March 19, 2021)

Based on statements by the Prime Minister, the police chose to conduct an investigation to find out if the regulations had been violated. The investigation concluded that the group had broken the rules, and the prime minister was fined NOK 20,000. The restaurant, however, was not fined. The Prime Minister commented on the punishment as follows: "The biggest damage this has done is that it damages the trust in us who are generally responsible for these things. I think that is very sad, because people have lined up to a very large extent in these times" (Solberg to Vg 19 March,2021).

In a Facebook post, on her public page, the PM the day before issued a lengthy apology, detailing the events. Where the incident caused media attention, Solberg, unlike the Minister of Health in New Zealand and Irelands Minister of Agriculture who, like several other politicians worldwide, withdrew from their positions having acted against restrictions, chose to stay in her position. In the media, commentators have explained how Solberg had not faced the necessity of considering her position on the basis that she put all available information on the table at once, avoiding speculation to develop over time, knowing that what creates scandals is not necessarily the crime, but the cover up. Whilst the parties of the opposition raised critical voices, there were never loud cries for her dismissal.

Critical Incident 3: The vaccination programme

Norway received its first 10.000 doses of vaccines on the 26th of December 2020, the first injection was given in a primary care facility on the 27th. Elderly inpatients living in municipal primary care facilities were prioritized in the vaccination programme. The Niph was put in charge of developing the national vaccine programme and was afforded the responsibility for purchasing and distributing vaccines, whilst the Doh is responsible for the availability of necessary equipment, including syringes. Vaccination was made available for any person present in Norway, but on a voluntary basis, and free for recipients. Purchasing has happened through the EU purchasing apparatus, based on forward sales through Sweden. Through the winter of 2020/2021 vaccine availability was highly uncertain, where supply fluctuated considerably. In January the Doh, through director Guldvog (https://www.dagbladet.no/nyheter/i-dagens-tempo-tar-det-25-ar/73254855), raised concerns that the current rate of vaccination would take 2.5 years until satisfying levels of vaccination. At the time, the government and authorities were regularly criticised for lacking tempo and urgency in vaccination.

Throughout 2021, infection rates fluctuated considerably across the geographic regions, where certain (often urban) areas saw considerably higher rates of infection, and serious cases of disease. On the 19th of May, the government issued a stronger policy regarding geographical prioritization of vaccines, where 24 municipalities that had been under heavier pressure over time would receive approximately 60% increases in deliveries (https://www.regjeringen.no/no/aktuelt/regjeringen-har-besluttet-en-geografisk-omfordeling-av-vaksiner/id2850061/). Hereunder the cities of Oslo and Bergen. […] In the same period, a policy was issued prioritizing members of parliament, government, supreme court and his Majesty's court in the vaccination programme, starting considerable turbulence in the public sphere and media. A series of parliamentary members chose to decline prioritization, arguing the arrangement could propel distrust in politicians. On the 25th of May, the Minister of Health, Høie, even declined to skip the line. Others, such as the Minister of Justice, argued she and other politicians had a responsibility to maintain preparedness.

Critical Incident 4: Reopening society; "Data not date"

The Government's plan from the Norwegian Directorate of Health and the National Institute of Public Health was announced in April 2021. According to the government, the plan will "contribute to predictability in a situation that is still characterized by uncertainty" (Regjeringen 2021). The plan set out a four-step reopening process, with clear priorities between different areas. For example, it was stated that children and young people would be given priority over the business and jobs. In this planning process, the government was clear that they will not set dates, but constantly assess the situation based on established data. "Data, not date" has become a slogan.

"There may be new mutations that change the rules of the game. It is somewhat uncertain how fast the vaccines arrive and how well they work against the spread of infection. It is therefore not appropriate to time the various steps in the plan" (Regjeringen 2021).

Data that are emphasized are about the infection situation and disease burden, capacity in the health service and vaccination. For example, one goal has been set for 90 per cent of the population over the age of 18 to be fully vaccinated before full reopening (level 4). As the vaccination program has taken somewhat longer than planned, the government has postponed level 4 on several occasions with reference to the fact that this particular goal has not been met.

The Norwegian population has traditionally shown good faith in vaccine programs recommended by the authorities. Although many were skeptical when the first Covid-19 vaccines were developed and tested, more than 90 per cent of the population over the age of 18 received their first dose by September 13th, 2021.

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3.6. Accountability by press conference: the public gaze

The Norwegian strategy had four measures: testing, isolation, tracing, and quarantine. This became known as Titq and was used as template for the official press-briefings. Nakstad, taking on a key role as a spokesperson and representative of the Doc and the joint efforts of the health authorities was highly visible a prominent member of assembled experts. When the Minister of Health hosted a live interactive session of "Peoples questions" he was joined by Nakstad as one of two experts. Nakstad answered many of the questions, either alone or elaborating on the Minister's answers.

During the entire period, from the 10th March, until 25th June, a span of 15 weeks, different members of the government were invited to 75 press-briefings. The press-briefings became key in the government and health authorities' communications with the general public. On average, the press briefings lasted 40 minutes, including Q&As with press representatives, and had a panel of four participants, two ministers, the Director or Deputy Director of the Doh, and one from Niph.

Ministers hosted the press briefings: The Minister of health, and the Minister of justice attended the most press-briefings, respectively 47 and 37. The PM hosted 21 of the briefings, mainly regarding specific measures and financial arrangements, presenting the governments decisions.

Most of the press-briefings were on the general development and management of the pandemic, where the Doh and Niph played key roles. Niph deliberated on the development of the Pandemic presenting key figures including the number of infections, testing, admissions in hospitals, patients receiving respiratory treatment and number of deaths, in addition to commenting on trends and comparisons to other countries. These presentations also focused on communicating the results of different efforts to synthesize research and reports as the knowledge base of the introduction of measures, and specific steps to chart the development of the pandemic, such as in example apps for tracing infections. The Doh, through the director and Nakstad, focused on the assessment and follow-up of implemented measures, responses from the general public and capacity within the health services.

Specifically, Nakstad focused on the identification of key results and the development of new facets of Titq. The DoH often criticised the general public in providing advice, but also praised the public and different groups for their efforts in fighting the pandemic. The Doh, especially when fronted by Nakstad, took on a pedagogic and motivational role, encouraging the public in the task of keeping infection rates down. At the later stages, the Doh also had a considerable part in communicating how the crisis was not over, despite declining and later low infection rates. Further evidence of the purposeful agent, Nakstad, as a researcher and doctor became evident, as the representative of a strong alliance of unified health authorities and the Norwegian Government.

Where our account emphasizes the ability of actors to unite and assert joint actions as key to what is argued to be a successful, agile, management of the Pandemic-crisis, tensions have been lurking underneath the surface, as one would expect. In September, Camilla Stoltenberg, the Director of NIPH, published her book "Camilla Stoltenberg: the year that would never end" (our translation) (Søhusvis, 2021). This book contained her views, thoughts and accounts of managing the Pandemic. The book suggests that beneath the surface of mutual efforts, lies more muddled waters. It hit the bookstores during the same period as restrictions again were being lifted, and the same week as NIPH and the DoH classified Covid-19 as a non-critical threat to society. The book presents a personal account of professional and personal tension concerning many of the critical events that unfolded, and provides insight into the differing standpoints between i.e., the Directorate of Health and NIPH, and between Stoltenberg and Nakstad – to of the key actors in our account. It suggests there have been considerable disagreement on the accountability of different efforts, who should receive credit, and a sense of perception where some actors, Nakstad, in particular, had taken too much of the limelight from NIPH and their experts. While the existence of such personal rivalries is hardly surprising, it is particularly interesting that such conflicts remained largely internal throughout the intense periods of managing the pandemic. Nevertheless, these simmering resentments could potentially change future debate on the management of the pandemic.

4. Case study: The UK and The Myopic Political Leader

In this case study we examine four elements of the UK case study: (1) the UK context, particularly the political context, (2) Government Strategy and Parliamentary Accountability, (3) Critical Incidents in the U.K. experience of the pandemic, and (4) Accountability by Press Conference: The Public Gaze.

4.1 The UK context

The UK political scene is dominated by one man - the Prime Minister, Boris Johnson. Johnson is a complex character. This complexity contributed to the UK Government's management of Covid-19 as a somewhat complicated and messy reality. His actions are not those of a purposeful agent. He is a part of the libertarian wing of his political party which opposes government interventions in public life, viewing them as unacceptable. His preoccupation with Brexit gave him an intense focus making him a myopic political leader. Some of his governments' actions, such as vaccination programmes, may indicate an agile government. However, overall, this Government has been hesitant and indecisive, and it has been torn between the libertarian instincts of the Prime Minister and his closest political allies and the need for interventionist actions which instruct citizens and business leaders how to behave in the Pandemic.

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One of the main reasons for Johnson's current prominent position in U.K. politics was his central role in the Brexit Referendum, where he received considerable attention and criticisms towards his behaviour. His biographer identified Johnson as being narcissistic (Bower, 2020), as self-absorbed and selfish with an inflated sense of his own importance. Bower identified Johnson as a serial liar, similarly Oborne (2021) also accused him of being a compulsive liar (for details see Oborne, 2021). And it has been suggested that living in the *post Brexit world*, the U.K. was living with a government which persistently lied (see Dittert, 2021) to the point of rewriting its history.

4.2 Government strategy and parliamentary accountability

The Government's strategy was to protect the NHS by (1) switching patients from hospitals into care homes, (2) enhancing personal protective equipment (PPE) capability and (3) ramping up Covid-19 testing.

On (1), the Government sought to increase capacity in hospitals by discharging 25,000 elderly patients from hospitals into care homes (Committee of Public Accounts, (CPA 2020)). On 17 March, the NHS used emergency powers to discharge these patients to care homes. These patient transfers to care homes were made without a Covid-19 test. Transfers even continued when it was understood that people could transfer the virus without having symptoms. There was no requirement for Covid-19 testing until 15 April. This policy was described as "reckless and negligent" by CPA (op. cit., p.11). The CPA estimated that almost 40% of care homes in England had a Covid-19 outbreak and this in care settings for particularly vulnerable citizens, which contributed to the UKs high rate of mortalities, with almost 19,000 attributable to care homes (CPA, op. cit., p.11). On 19 May, the then Secretary of State for Health, said the Government had put a protective ring around care homes in a Parliamentary debate (Hancock, 2020a). This was met by disbelief from political opponents.

On (2), the UK sent PPE to Wuhan in January 2020 to assist it in its crisis. The UK stocks had not been maintained after years of austerity. The Government failed to stockpile PPE in January and February. It turned to global markets. It opened a portal on the government website in which companies which offered PPE could be registered as official suppliers. However, there are accusations of government purchasing PPE which never arrived. This matter is now under investigation by the National Audit Office (Kember, 2020). The Committee on Public Accounts said there had been a lack of transparency on the availability and supply of PPE and a tendency for Government to over promise and under deliver (CPA, 2020).

On (3) testing for Covid-19, containment was the initial policy. Any citizen who contacted medical services with symptoms had contacts traced and checked for Covid-19. This activity ceased on 12 March, when the UK only had the capacity to test 5 suspected

Covid-19 patients per day (Donnelly & Morgan, 2020). In April, the Government was developing testing capacity in line with WHO guidance. In Parliament, the Sec of State for Health reaffirmed his goal of 100,000 tests a day by the end of April (Hancock, 2020). This target was achieved, but it included home tests which had been posted but not necessarily used in homes, often without return labels. Hancock was reprimanded twice by the Director of the UK Statistics Authority for manipulation of these results. Also, there was concern that care homes were not receiving sufficient tests. The Prime Minister, under pressure from the Leader of the Opposition, stated on 20 May that by the 1 June the country would have a world beating track and trace system in place (Johnson, 2020). This bravura statement was not realised and while testing capacity has increased, the testing app for smart phones was not available until the end of 2020.

The most recent report of an investigation of the government`s handling of Covid-19 was published in September 2021 (Health and Social Care Committee and Science and Technology Committee, 2021). This report reaffirmed the criticisms made by earlier reports on the failures of the UK test and trace system, the problems and lack of transparency over PPE contracts and the fatal transfer of untested elderly patients from hospitals into care homes. This report also criticised the UK government for being too slow in starting the first lockdown, but it did not comment on the slowness of the Government to start Lockdowns 2 and 3, nor did it comment on the speedy relaxation of restrictions after each lockdown.

Despite sustained pressure in parliamentary debates and by parliamentary select committees, the Prime Minister`s substantial majority of 80 seats protected him and his government ministers.

4.3 Critical Incidents in the UK experience of the pandemic

The six critical episodes discussed here are:

- Closure of a high-level Risk Scanning Unit
- Lockdown 1
- Lockdown 2
- Lockdown 3
- The Indian variant in the UK
- The vaccination programme

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Critical incident 1: Closure of a high-level Risk Scanning Unit

Most risk management commentators (Deloach, 2018; Lapsley, 2020) recommend the use of a high-level environmental scanning unit to detect potential risks to entities. The UK Government's THRCC (Threats, Hazards, Resilience and Contingency Committee) was established to do this. It consisted of cabinet level ministers, a high-powered cadre to address dangers such as Covid-19. However, on becoming UK Prime Minister, one of Johnson's first acts was the closure of THRCC to get his cabinet more focused on BREXIT (Walters, 2020). The existence of THRCC would have helped the government respond more rapidly to the threat of Covid-19. The closure of this committee was a high-risk action by the UK Prime Minister. It looks like a fixation on BREXIT more than anything else.

The lack of a high-level unit for environmental scanning left the UK exposed. There are reports of early Covid-19 cases in neighbouring countries to China before the public declaration of this dangerous coronavirus. The benefits of this early warning system would have been the devising of a plan. This would have looked at the likelihood of the virus going global. It would have examined how Asian countries had dealt with previous dangerous viruses like SARS and Mers. This would have identified the need for a sophisticated track and trace system. Instead of devising one on the hoof as they did during the pandemic, there would have been an opportunity to devise a scheme before the pandemic started.

Critical Incident 2: Lockdown 1 (started 23 March 2020, concluded 23 June 2020)

In an interview on 24 July 2020 with the BBC Political Editor (Kuenssburg, 2020), the UK Prime Minister confessed that in the early days and months of the Pandemic, the Government did not understand the virus. This position has a certain plausibility, but there is an alternative more compelling rationale for the Government`s behaviour, as discussed below. The UK government had been focussed on BREXIT for years. On 30th January, the UK ground zero patient for Covid-19 was identified. But the government was fixated on the 31 January - BREXIT day, when the U.K. exited the EU.

This laidback perspective had Ministers presenting a "business as usual" image. From 1 Feb until 23 March the UK Government was reluctant to lockdown. There were allegations that the Prime Minister had personal priorities which deflected him from the Covid-19 threat. Mr Johnson had taken time off to negotiate a divorce from his second wife and had a working holiday with his newly pregnant partner, who became his fiancée (Calvert *et al.*, 2020). The Prime Minister attended an England rugby match on 7 March at Twickenham. The Prime Minister was seen shaking hands with other supporters at this match. The Culture Secretary had authorised the Cheltenham Festival to take place from 10-13 March 2020. Local elected officials had expressed concern about this

Festival going ahead to Ian Renton, the Director of this Festival. Renton reassured these concerned officials that he had been given explicit permission to hold this event by the government which reiterated its policy was for the business of the country to continue as usual (cited in Calvert & Arbuthnott, 2021). There was an official attendance of 250,000 at Cheltenham. There was no social distancing at Cheltenham, where a party atmosphere prevailed (Barnes, 2020). Also, Liverpool FC hosted a Champions League final-16 match against Atletico Madrid who brought thousands of supporters from Madrid, a city which had a high Covid-19 infection rate.

At one level, this can be interpreted as an uncertain Government which was unsure of the appropriate course of action to take. However, an alternative interpretation has been offered by the Prime Minister`s former Chief Advisor, Dominic Cummings, in his contribution to a Parliamentary Select Committee meeting at Westminster on 26 May 2021 (Cummings, 2021). In his evidence, Cummings stated that initially, the UK Government had a policy of herd immunity. This observation has been challenged by Farrar, a member of the Scientific Advisory Group for Emergencies (Sage), the Government`s advisory committee on the pandemic, who has stated (Farrar & Ahuja, 2021) that Sage never recommended the adoption of the brutal policy of herd immunity and if it had, he would have resigned from the committee. However, there were growing expressions of support for herd immunity by other members of Sage and by government spokesmen. On a BBC Newsnight interview, Medley, a member of Sage, said we needed to generate herd immunity and advocated a nice big epidemic to achieve herd immunity (Horton, 2020). On 10 March 2020, Halpern, the head of the Government`s so called "nudge" unit at 10 Downing St, took a robust pro herd immunity policy stance in an interview with BBC News (cited in Farrar & Ahuja, 2021).

An analysis by the BBC News Fact Check team (BBC News, 2020) found a series of statements by authoritative figures at or near the top of Government who made further supportive statements on herd immunity at this time. This included the Prime Minister on 5 March 2020 on ITV's This Morning, when he discussed "taking it on the chin", by allowing Covid to move through the population without taking so many draconian measures. It also included the UK Government's Chief Scientific Adviser, Sir Patrick Vallance on 9 and 10 March 2020, when he appeared alongside the Prime Minister, he said (BBC Reality Check Team, 26 May 2021): "We could not suppress the virus completely. It is not possible to stop everybody getting it and its actually not desirable because you want some immunity in the population to protect ourselves in the future".

On 13th March 2020, Vallance explicitly mentioned herd immunity on BBC Radio 4's Today programme. He stated that it was necessary to build up a degree of herd immunity to make people more immune to this disease. On 13th March, Vallance also appeared on Sky News where he said that 60% of the population would have to contract Covid to establish herd immunity.

However, in his evidence to the Joint Select Committee on Health and Technology, Dominic Cummings was alarmed by the potential outcomes of a herd immunity policy. He contacted Timothy Gowers, a Professor at Cambridge and a world leading mathematician and asked him for advice. Gowers produced a five-page document – Questions About Coronavirus Policy. This short document challenged the herd immunity policy as being unsound because (1) there was evidence of people being reinfected, (2) There was no evidence of lasting immunity if you caught Covid, and (3) We do not have the resources to implement herd immunity in a non-disastrous way. In terms of outcomes, Gowers estimated there could be as much as 800,000 people needing intensive care, but only 4000 ICU beds were available at that time. Gowers thought that the NHS would be over-whelmed, and thousands and thousands of people would die untreated. At this time Vallance estimated deaths at between 117,000 and 390,000 from herd immunity. Cummings stated he discussed Gower's comments with Downing Street insiders and the Prime Minister on 13-14 March 2020. The Prime Minister was then convinced of the need for a lockdown. Next day on the BBC's Andrew Marr Show on 15th March, the then Health Secretary, Matt Hancock stated that Herd Immunity was not Government Policy. He repeated this the next day in Parliament (BBC Reality Check, 26 May 2021). On 23 March 2020 the first lockdown commenced. Cummings, in an eight-hour marathon giving evidence to this Select Committee, assured the committee that herd immunity was the original Government policy. Cummings remains adamant that he was right and the sheer volume of media appearances by the upper echelons of the UK Government suggest he has a case.

Critical Incident 3: Lockdown 2 (5 November 2020 to 2 December 2020)

After the first lockdown, Kuenssberg's (2021) investigation revealed what happened behind the scenes. She interviewed 20 key players, including Government ministers, senior civil servants and insiders at the heart of the UK Government. This investigation revealed a consensus that the Government should had had a second lockdown early in September 2020. Kuenssberg's (2021) informants referred to the summer of 2020 after the first lockdown as exuding a false optimism. In their view the summer did not feel like a country in the grip of the pandemic. Indeed, one senior Cabinet Minister expressed significant doubts about the wisdom of this new mood. In his view, a second wave was going to happen and the Government knew this. This summer of optimism was described as the biggest rush of blood to the head (Kuenssberg, 2021) – a reference to the ebullient overconfident Prime Minister.

The decision on the date of the second lockdown was taken entirely by the Prime Minister. There were many, many attempts by Downing St insiders, by members of the Sage Committee advising the Government on the Pandemic urging the Prime Minister to call a second lockdown in early to mid-September (Cummings, 2021; Kuenssberg, 2021). This included the formal guidance of the Sage Committee in early September.

When this was made public in October, the Leader of the Opposition demanded an immediate circuit breaker lockdown. However, as Cummings observed the Prime Minister was primarily motivated by considerations of the impact of Covid on the economy and not its impact on illness and mortalities (Cummings, 2021, Q1010). Indeed, Cummings confirmed that when the Prime Minister was being pressurised to declare another national lockdown, he stated that the Covid virus was only killing 80-year-olds who had lived their natural lifespan and he would let the bodies pile high (Cummings, 2021, Q1170). These comments were denied by Downing St, but Cummings had maintained they were witnesses to this outburst. It also became clear that the Prime Minister had been consulting with the libertarian wing of Conservative MPs and that the Prime Minister had promised them that there would be no more lockdowns (Kuenssberg, 2021). After prevaricating for weeks, the Prime Minister agreed to a lockdown on 31 October, and this took effect on 5 November 2020 for four weeks. This delay was longer than the delay in calling the first lockdown.

Critical Incident 4: Lockdown 3 (6 January 2021, scheduled to end 21 June 2021, extended to 19 July 2021)

When the second lockdown ended on 2 November, the forthcoming Christmas celebrations were on the Prime Minister's mind. His plans for the public having Christmas celebrations were severely to reduce to one day "bubbles" of family members, as the Delta variant spread rapidly. In the autumn the Government had initiated a tiered system of restrictions in an attempt to account for different regional variations in infection rates. These tiered restrictions were regularly revised. One government minister told Kuenssberg (2021) that the tiered system was tying the Government in knots as it tried to exert control. Yet another government minister described the tier system to Kuenssberg (2021) as completely unintelligible to any normal human being. This Cabinet member described the complexity of the tier restrictions as both Byzantine and way too slow. During this period, the Delta variant was surging through the country. By 19 December, 38 million (68%) of the population in England were facing the severest restrictions. By 30 December, 78% of the population were under the most severe restrictions. The Prime Minister delayed a lockdown in the face of this overwhelming surge of the Delta variant. On 4 January, the Prime Minister announced there would be a third national lockdown from 6 January 2021.

Critical Incident 5: Delta- The Indian variant in the UK

The Delta Variant of Covid (formerly referred to as the Indian Variant) is a highly infectious variant of the Covid virus. Currently this the major variant of Covid-19 in the UK and it is responsible for the spread of sustained high levels of Covid infection, with daily new cases at 40,000 in October 2021. One critical incident over the spread of this variant is a delay in the closure of the UK: India borders. On 9 April, the UK Government closed its borders to travellers from Bangladesh and Pakistan but not India. Bangladesh

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had the South African variant, Pakistan did not have any of the high-risk variants, but India had the South African variant, the Brazil variant and its own `Indian` variant. Also, on 9 April 2021, Pakistan had a seven-day average of 21 cases per million people, Bangladesh had twice as many cases and India had four times as many cases (see BBC News, Reality Check, 19 May 2021). Therefore, it is surprising that on 9 April only Bangladesh and Pakistani travellers were banned from travelling into the UK. Indeed, Indian travellers were not banned from entering the UK until 23 April 2021. During this period there were significant travellers coming from India to the UK and it is feared that many of them brought the Indian variant with them. Why was this?

Political opponents (such as Yvette Cooper, Chair of the UK Parliament's Home Affairs Select Committee) were quick to point out that The UK Prime Minister`s planned trade trip to India on 19 April was dangerous because of the rising Covid infection levels in India. On Sunday, the Shadow Communities Secretary, Steve Reed, said the trip should be abandoned due to the situation with Covid. Speaking on Sky's Sophy Ridge on Sunday, Reed said Johnson should abandon his trip because "all of us in public life need to try and set an example". He said: "There are new variants emerging all around the world. The government is telling people don't travel if you don't absolutely have to travel. I can't see why the prime minister can't conduct his business with the Indian government by Zoom. (Fleming, A., 2021).

Critical Incident 6: The vaccination programme

The UK vaccination programme has been described as the success of the UK Government`s management of the Pandemic, but it is more complex than that. The first Chair of the UK Vaccine Taskforce praised the scientists, the manufacturers and the volunteers who made this programme a success, but she decried the UK Civil Service as unresponsive (Bingham, 2021). By 6 March 2021, there had been almost 21 million people who had been vaccinated in the UK. This included almost 40% of the UK adult population. However, the initial impetus on this programme was not maintained. A subsequent Chair of the UK Vaccine Taskforce (Dix)argued in April 2021 that the UK had lost its preeminent position because the UK did not have specific proposals for dealing with new variants (Savage, 2021).

The UK Government's supply of vaccine reveals an extraordinary gamble, not only on the sheer volume of vaccine doses which it ordered, but its willingness to order vaccines which had neither been approved by the manufacturers nor by the authorising medical bodies in their country of origin. This description of "the gamble" was attributed to the Government's vaccine policy by a senior government Minister (Kuenssberg, 2021). This includes (see O'Neill and Whipple, 2021): (1) 100 million doses of Astra-Zeneca vaccine and (2) 40 million of the Biontech - Pfizer vaccine. Both these vaccines had been approved and were being used in many countries. In addition to this, there was an order for 17 million

Modena vaccine doses, which had been approved but not yet deployed. The UK orders also included vaccines which were awaiting regulatory approval. The UK had a total of 407 million vaccine doses on order. It progressed its programme by age group and vaccinated children and offered boosters to citizens over 70 years old in Autumn 2021.

While this success story is attributed to the UK government, its origins are with Oxford University (O`Neill, 2021). As Oxford University was developing its vaccine, it was evident that it only had the capacity to develop 10 litres of vaccine. They sought the advice of Netty England, a manufacturing expert at the UK Biological Association. Within days she had organised a consortium of potential manufacturers of vaccines. This group became the internationally acclaimed UK Vaccine Task Force. The task force drew on industry and science experts to build a portfolio of potential vaccines which speeded up contracts. This included contracts to both assist with development funding and agreeing to indemnify the manufacturers against unintended vaccine side effects - a provision other countries, including the EU, baulked at. Their activities included reserving the entire capacity of Wockhardt's new factory in Wrexham which had not yet opened. It also included strong advice which the task force identified as the vaccine which was most likely to be the first effective vaccine. This task force had four Government Ministers on its Investment Committee. This entity has now been absorbed into the Government after its significant success as a task force.

4.4 Accountability by press conference: the public gaze

On 16 March, in response to criticisms of a lack of government accountability and transparency, the Government initiated a series of daily press briefings. There were 92 press briefings, and they ran until 23 June, when the Government decided they were no longer necessary. These briefings were used to inform the public of changes in the infection rate (R) of Covid-19, hospital admissions, the numbers of infected people, the numbers of fatalities and their geographical spread. Members of the Government chaired the press briefings accompanied by experts – generally medical experts. A variety of Government Ministers chaired these press briefings. Latterly, the Ministers chairing these meetings often appeared without expert medical advisers, which underlined the fragility of the coalition of politicians and experts.

On 24 March, there was a lockdown of most organisations. Only suppliers of food, pharmacies, post offices and banks remained open. Only short distance travel was permitted – travel to other countries was banned. But significant numbers of citizens from other countries entered the UK without any checks. As the lockdown started, senior officials succumbed to Covid-19. In their many public appearances there was little sign of social distancing by these key actors involved in Pandemic management.

The Prime Minister's principal advisor had Covid-19 symptoms and broke lockdown restrictions. On 5th April, he drove 260 miles to his parents' farm in the North of England.

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staying in a nearby cottage. Lockdown advice was to stay at home if you had symptoms and not to travel long distances. He did have Covid-19 and recuperated at the farm. He was reported by the Government as self-isolating at his home. On his wife's birthday, Cummings drove a 30-minute journey to a beauty spot on 13 April. Another breach of lockdown. He said that he made this journey to test his eyesight to see if it was suitable for the journey to London. (In the UK driving with defective vision is a Road Traffic Offence). This breach of lockdown arrangements which he had helped to devise was met with public anger. Conservative MPs beset by angry constituents asked for his resignation. The Downing Street Covid-19 press briefings have a section for questions by journalists. This was dominated by the breach of lockdown regulations by Cummings.

At the 25 May press conference, the Prime Minister chaired the meeting. He declared the Dominic Cummings affair over – "end of story". He said Cummings had "acted responsibly, legally and with integrity". When the first journalist (Kuenssberg, BBC) asked a question about Cummings, she was told it "was over" and was muted. An expert on the Sage committee said the Prime Minister's defence of Cummings had threatened the UK's fight against coronavirus. He tweeted (Twitter@ReicherStephen): "I can say that in a few short minutes tonight, Boris Johnson has trashed all the advice we have given on how to build trust and secure adherence to the measures necessary to control Covid-19, Be open and honest, we said. Trashed. Respect the public, we said. Trashed. Ensure equity, so everyone is treated the same, we said. Trashed. Be consistent we said. Trashed. Make clear "we are all in it together". Trashed".

Shortly after Reicher's tweet, three other government advisers, two also on Sage, echoed his anger. This was a clear divide between politicians and "the science".

On 27 May the Prime Minister gave evidence to a Select Committee. A major focus of the MPs was on the Cummings affair (Liaison Committee, 2020). The Prime Minister stone-walled, saying the matter was closed.

At the press briefing on 30 May, the medical expert was Professor Van-Tam, Deputy Director of Public Health. He was asked about lockdown rules. He replied there is only one set of rules, and they should apply to everyone. He never appeared at another press briefing. On 1 June, the Chief Nursing Officer for England was to be the medical expert. In rehearsals she was asked how she would respond if she was asked the question on lockdown restrictions put to Professor Van-Tam. She said she would repeat his answer. She was dropped and never appeared at the press briefings again (Smyth, 2020).

A subsequent study reported the Prime Minister's political intervention to protect Cummings had negative and long-lasting consequences for public trust and the willingness of the public to indulge in risky behaviour (Fancourt *et al.*,2020).

The demise of press conferences and sporadic appearance in 2021, reveals continuing problems of differences between the government and medical experts. These events had enhanced public accountability despite their evident stage management.

Concluding thoughts

The Covid-19 pandemic has revealed a collective failure to take pandemic prevention preparedness and response seriously and prioritize it accordingly. It has demonstrated the fragility of highly interconnected economies and social systems, and the fragility of trust. It has exploited and exacerbated the fissures within societies and among nations. It has exploited inequalities, reminding us in no uncertain terms that there is no health security without social security. Covid-19 has taken advantage of a world in disorder (WHO, 2020).

During the UK management of the Pandemic there was one hugely successful message for citizens – Stay at Home and save our NHS. However, when the UK management of the Pandemic was taking place during different tiers this mechanism was described as unintelligible (Kuenssberg, 2021). Major events such as the shortage of PPE, the extreme pressure on hospital beds and the surges in new variants, particularly the Indian or Delta variant created lots of friction between politicians, scientific advisers and the media. The numbers of infected patients remain high (see Tab. 2). The UK is one of the countries with the highest rates of infection and Covid mortalities. The UK approach has been to make a big gamble on vaccinations. However, while the UK was initially an international leader, its vaccination rates have been overtaken by other European countries. Tab. 2 shows comparative Covid outcomes for Norway and the UK. This a successful Norway and a poor UK performance.

Tab. 2 COVID OUTCOMES
(Sources: Comparative Covid outcomes for Norway and the UK at 22 October 2021. Sources Norway: FHI, 2021, UK: gov.uk, 2021).

	Norway	**UK**
Total Cases (per 100 000)	3 719	12 928
Daily new cases (per 100 000)	14	73
Total mortalities (per 100 000)	17	207
Daily new mortalities (per 100 000)	0,02	0,17
Cumulative Number of Covid patients in hospital (per 100 000)	101	846
Current Number of Covid patients in hospital (per 100 000)	2,25	11,90
Daily new Number of Covid patients in hospital (per 100 000)	0,17	1,43
% of population fully vaccinated	69 %	79 %

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But these countries have very different populations (Norway 6 million; UK 66 million). Additional insights on the UK performance can be gained from international statistics. On 22 October 2021, the John Hopkins University statistics reported the UK had the second highest increase in new cases in the world; total UK Covid mortalities were 8th in the world; UK Covid mortalities per million of population were 18th in the world (World Update, 2021). Now the world awaits the impact of the latest Covid-19 variant, Omicron, from South Africa.

The Norwegian case places emphasis on the efforts of a multitude of actors to manage the Covid-19 pandemic in Norway. The Norwegian case is characterized by an overarching climate of collaboration between government representatives and the health care authorities, a trait associated with agility (cf. Harraf *et al.*, 2015). In this story, some actors emerged as particularly central as spokespersons for the joint efforts to manage the pandemic. Herein, key actors paved the way for a joint purposeful agency, which can be seen as important for the successful outcomes of efforts to manage crises.

It is evident that there were distinct differences between these countries in addressing the challenge of the Pandemic. While Norway was fast and decisive, characteristics of an agile approach (cf. Ahammad *et al.*, 2019; Bernardes & Hanna, 2009, Winby & Worley, 2014), the UK was hesitant and uncertain. While external experts were evident in both countries, Norway had a deputy Director of Public Health who was uniquely qualified for the task, while the relationship between the UK government and its experts is described in this paper as a fragile coalition. The Norwegian medical expert had experience of managing Ebola in Africa and was the author of a book on crisis management. This man emerged as a purposeful agent: with a high level of understanding, a clear message to communicate and was articulate enough to gain the cooperation and respect of leading Norwegian politicians, and the people. This coming together in Norway, coalescing around a clinician-led action plan for the nation was a key to its success. Clinical experts, the health authorities and politicians across parties, despite differing opinions, managed to stand united in presenting interventions. Differences and tensions were largely kept out of the public as the crisis intensified. This aided in maintaining a high degree of trust in the government and the strategies devised. This shaped public accountability, and aided in maintaining the ability to act rapidly and flexibly.

By contrast, the UK was dominated by a Prime Minister who had led his party to a landslide 80 seat majority in Parliament on a Brexit manifesto. He is a member of the libertarian wing of his political party which is inherently opposed to direct interventions in everyday living. This tension can impose conflicts on politicians who have divided loyalties in managing crises (Boin *et al.*, 2005). This Prime Minister had insisted that any member of his cabinet should be willing to leave the EU on 31 December 2020 without a trade deal with the EU. This has made his government less experienced than its predecessors. There is no doubt that this Prime Minister was the key figure in his

government and in UK politics. However, with a Prime Minister focussed on Brexit Day of 31 January and with other distractions, he has admitted publicly that for the first few days and months, his government did not understand the challenge of Covid-19. The previous government had initiated a major simulation of a pandemic which showed that the UK was ill prepared, but the current government showed little or no awareness of this. The Prime Minister had closed a Cabinet committee with a remit to look at crises. Also, as the pandemic unfolded it became evident that there were differences of view between politicians and experts. While experts thought the lockdowns should have been earlier and the easing of lockdowns were too soon. The major outcome for the different approaches taken by these countries was the difference in fatalities. While Norway had very few fatalities from Covid-19, the UK was the worst in Europe as measured by total fatalities and even when standardised for size of population.

There is an interesting public policy and research agenda here. This study looked at two countries – one small and one large. The smaller country outperformed its larger neighbour. We have highlighted the opportunity for purposeful or myopic agents to emerge in crisis situations as one aspect of the differences. This is an important finding in this study which merits further investigation in different countries. There is also a case for examining whether smaller countries are naturally more resilient in addressing crises because of faster lines of communication and shared understandings over strategies. This has important implications for large countries with devolved regional governments and the capacity of these regional governments to facilitate agile and purposeful management in crises.

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