DUTCH
SAFETY BOARD

Summary

Approach to COVID-19 crisis

Part 3: January 2020 through to September 2022

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The Dutch Safety Board

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N.B: The full report is published in the Dutch language. This summary contains English translations of the most relevant parts. If there is a difference in interpretation between the Dutch and English versions, the Dutch text will prevail.

CONTENTS

SUMMARY

In May 2020, the Dutch Safety Board decided to investigate the Dutch government's approach to the COVID crisis. Due to the protracted nature and scale of the crisis, the Board chose to publish its investigation findings in several sub-reports. This is the third and final sub-report in the series, following the reports presented by the Board in February 2022 and October 2022.

This report looks back at the entire crisis period, including the previously unexamined period from July 2021 to September 2022. This retrospective ties in with the research question of this sub-report, namely how the government managed public health and safety risks during the crisis. By looking back at the entire crisis period, the reader will gain insight into how the government arrived at its choices under ever-changing circumstances.

The description follows the chronology of the crisis, reflecting on the government's strategy, how it kept track of developments and on the basis of which considerations it chose to increase or relax measures at specific moments. The reconstruction and findings provide tools to be better prepared for a future pandemic. They also provide insights for improving the management of other long-term crises, both within and outside the health domain.

A new virus

In late January 2020 the government, on the advice of the Outbreak Management Team (OMT), categorised COVID-19 resulting from the SARS-CoV-2 virus as an 'A disease'. This gave the Minister of Health, Welfare and Sport (VWS) additional powers to contain any virus outbreak in the Netherlands. At that time, the virus had not yet been detected in the Netherlands. In late February 2020, the first patient in North Brabant was diagnosed with the SARS-CoV-2 virus. At that time, municipal public health services (GGDs) and the National Institute for Public Health and the Environment (RIVM) assumed that there would be a few isolated cases of COVID, especially amongst people who have been to northern Italy, where there was a major outbreak at the time. From Bergamo, Italy, poignant images made their way around the world in early March, as the local hospital could not handle the flow of COVID patients. The government wished to avoid such a terrible situation in the Netherlands.

When the number of infections in the Netherlands rose, the government activated the national crisis structure on 3 March 2020 and a Ministerial Committee on Crisis Management (MCCb) convened for the first time. This meant that the government as a whole would bear responsibility for dealing with the crisis, and the crisis was no longer be the business of the Minister of VWS only, being the most immediately concerned relevant minister. The MCCb ministerial crisis team jointly determined the crisis approach, using the powers held by individual ministers in their portfolios. However, the Safety

Board's investigation shows that the Minister of VWS and the administrators involved considered the acute crisis approach to be the direct responsibility of the Minister of VWS, even after activating the MCCb. This created ambiguity about the ownership of the crisis and the relationship of the Ministry of VWS towards other departments in the aftermath of the crisis. According to interviewees, this manifested itself in later stages of the crisis in escalating interdepartmental tensions over the crisis approach, as the government maintained a focus on short-term infectious disease control, which was mainly in the VWS domain, at the expense of paying attention to longer-term societal consequences that affected the domains of other departments.

In early March 2020, the RIVM and GGDs became aware that the virus was spreading much faster than initially estimated. The approach to contain the virus through testing and source and contact investigation was proving inadequate and the virus was increasingly being spotted outside the North Brabant region. The government felt compelled to promulgate increasingly stringent measures in a short space of time. Whereas on 9 March, the government mainly called for working from home and taking hygiene measures, on 15 March, the government moved on to coercive measures. The decision-making process gained momentum when the government announced that evening that schools, hospitality establishments and other facilities would be closed.

To guide policy from then on, the government would use a strategy based on three objectives. The first objective was that acute (and other) care should not be overloaded, to guarantee people a place in an intensive care unit (ICU) when needed. Besides focusing on ICU capacity, the government wanted to protect the vulnerable and maintain insight into the virus.

The goal of not overburdening care remained the key indicator on which the government steered throughout the crisis. Every time ICU capacity threatened to reach its limits, the government announced measures. Conversely, when ICU capacity increased the government's preference was to phase out measures quickly, to minimise the burden on society. This approach was called 'maximum control': controlling virus spread without exceeding maximum acute care capacity.

At the beginning of the pandemic it was difficult for the government to make decisions pertaining to its approach, as there is a lot of uncertainty about the characteristics and spread of the virus. This was partly explained by the pandemic preparedness at the time: the government was not prepared for a health crisis of this scale. Moreover, it applied a limited case definition, describing the strict criteria for who may be tested for the virus. Only people who travelled from affected areas abroad and had a fever were eligible for a COVID test. Because of the scarcity of testing resources, limited available testing infrastructure and the case definition used, the objective of maintaining insight into the virus was achieved only to a limited extent at the beginning of the crisis.

In addition, problems arose in data sharing. Organisations recorded data differently and experienced technical problems amongst each other due to working with different data recording systems, which were not aligned nor set up to process and exchange large amounts of data. Moreover, parties wishing to exchange data concerning the test

programme interpreted the applicable privacy rules differently, often creating obstacles. The limited insight into the virus created uncertainty amongst advisers and ministers whose task it was to take decisions on the crisis response. Gradually, insight into the virus improved as testing policies and other monitoring methods were expanded and organisations exchanged data more frequently, but different interpretations of privacy laws and regulations continued to hinder optimal information sharing.

In national press conferences, the government explained the measures it was promulgating based on the chosen strategy. In the months following the first outbreak, the government's crisis policy was strongly focused on virus control and maximum containment of the virus. The OMT was the main advisor to the government and relied on infectious disease models from the RIVM. Uncertainties in the models and data used created wide margins of uncertainty in the projections for infection rates and hospital and ICU admissions. The OMT highlighted the uncertainties in their opinions, but the government mostly assumed the median (middle) value of the forecast as the most likely scenario for short-term decision-making. To a limited extent, the government was investigating and considering more extreme scenarios, which could have major consequences despite the small chance of their becoming a reality.

The OMT's advice focused mainly on the development of the virus and its immediate effects over the next three weeks. From April 2020, planning agencies and advisory councils such as the Social and Cultural Planning Office, the Bureau for Economic Policy Analysis and the Netherlands Environmental Assessment Agency would provide solicited and unsolicited advice on the societal consequences and long-term effects of the virus and the policies pursued. Those opinions, especially at times when infections were on the rise again, did not carry as much weight in policy-making as the OMT's advice on short-term virus control.

The quiet summer of 2020 and new wave in the autumn

In April 2020, the number of infections stabilised, after which the government gradually relaxed some strict measures. After the first wave, there was hope amongst the government and in society that the worst was over. In the summer, the national crisis structure was scaled down. In August and September 2020, however, the number of infections increased rapidly. Insight into the virus had improved, as there was now more testing and laboratory capacity and all people with symptoms could be tested. In numerous ways, such as through the Infection Radar, GP polling stations and the further development of germ and sewage surveillance, the RIVM was gaining a better understanding of the spread of different variants of the virus.

During the new wave of infections in autumn 2020, the pressure on care increased. In the *Hand aan de Kraan* (hand on the tap) consultations, the Minister of VWS spoke with all healthcare umbrella organisations about patient care during the pandemic. In that consultation, healthcare parties warned several times about the high workload in the sector. After the intense spring, the healthcare sector was struggling with high absenteeism, leading to bottlenecks caused by rising infections. The government decided on a partial lockdown to take effect on the evening of Wednesday 14 October 2020. The hotel and catering industry had to close, the maximum number of attendees

at gatherings was set at thirty and shops were to close at eight in the evening. Due to alarming signals from the healthcare sector, in November 2020 the government chose to intensify the partial lockdown by closing cultural institutions and leisure parks, swimming pools and libraries, even though hospital and ICU admissions were declining. In this way, the government was using the space created to catch up on deferred care. It turned out to be a one-off choice and the government was doing less and less about growing staff shortages in healthcare. The government relied on the resilience and improvisational capacity of the entire healthcare chain, which made the crisis approach vulnerable.

The decline in ICU admissions achieved after the measures turned out to be temporary. As infections rose again, the government would again be forced to resort to a lockdown in mid-December 2020. In a speech from his office in December 2020, the Prime Minister announced new measures. These included the entire education system – from primary schools to universities – returning to distance learning. Only shops for basic necessities would remain open, while most publicly accessible venues would close and adults would have limited access to sports venues. Whereas in the first period there was a lot of support for the restrictions, a part of society found these increasingly hard to accept.

Start of vaccinations in 2021 and emergence of alpha variant

Vaccination of the oldest age groups started in January 2021, in line with the vaccination programme. The proclaimed lockdown would be tightened further with the imposition of a curfew that would eventually remain in force for three months. Meanwhile, more insight into the societal impact of the crisis was emerging, including the side effects of measures, for example on people's mental well-being. Calls from society to ease measures were growing louder. However, infection rates, hospital and ICU admissions did not yet allow for this. The emergence of a new virus variant brought uncertainty. However, there were high hopes that the crisis would be over within a few months once a large part of the population had been vaccinated. With the widespread use of antigen testing *(Testen voor Toegang*) and the rise of self-testing, the government saw more opportunities for a controlled reopening of society.

Processing and sharing of data between all parties involved remained a recurring problem during this period. This applied to infection and testing data, as well as to vaccination data and COVID-related mortality rates. Once again, data exchange was facing bottlenecks due to different interpretations and application of privacy laws and regulations and shortcomings in legal frameworks. For instance, positive test data from commercial laboratories *(Testen voor Toegang)* proved difficult to share with government parties due to such differences in interpretation. It took more than half a year for test data from the GGDs to be shared with Statistics Netherlands, which was stopped after six months due to a discussion about the legal basis for sharing these data.

Rising vaccination coverage and more space

Despite rising vaccination rates, pressure on care remained high in the spring of 2021, partly due to staff cuts. Once the oldest and most vulnerable had been vaccinated, the government experienced increasing pressure from society to open up and phase out the strictest measures. In April 2021, the government would take a lead on the OMT's advice by easing measures at the first signs of a stabilisation in infection rates, rather than

waiting for the decline in infection rates to actually kick in. Curfews would no longer apply from 28 April 2021, events would be allowed and schools would reopen.

The government introduced an opening plan to gradually reopen society. Vaccines played a big role in this, which the government regarded as game changers for policy. Despite bottlenecks in data sharing for the purpose of monitoring vaccination coverage and vaccine effectiveness, it was clear that vaccines were highly protective against serious illness and hospitalisation. The government was optimistic because an increasing percentage of the populace had been vaccinated and there was a degree of control over the number of infections through *Testen voor Toegang*. In June 2021, the government even decided to accelerate the opening plan, estimating that access to acute care was no longer at risk. The space created in the ICUs would not first be used to enable a catch-up of deferred care, but used directly to reopen society.

But there was a downside to the phasing out of measures. If the virus was allowed to circulate, health risks in terms of hospitalisation and mortality would increase for people who had little or no immunity. In addition, consequences such as the risk of post-COVID or deferred care affected basically everyone. At this stage of the crisis, the government gave more weight to societal risks than to these health risks.

Recalibration of the autumn approach in 2021 and the emergence of omicron

Initially, the coronavirus appeared to be on its way out by summer 2021. The government was targeting a new phase in which the scarcity of vaccines was no longer a problem and everyone who wants to be would be fully vaccinated from September 2021. The vaccinations reduced the risk of acute care being overloaded again. However, the pressure on care remained high. Government advisers pointed out the consequences of higher virus circulation. Infections would not always lead to ICU admissions, but could lead to serious health damage, such as the aforementioned post-COVID or through delayed care. The government chose to recalibrate its approach to arrive at one that better suited this phase. In doing so, however, it did not want to change the 'rules of the game' and aimed to keep society open. In practice, this meant that the variables on which the government steered remained the same, but changed in value. In doing so, the government chose not to extend the crisis approach with policies to mitigate new risks, such as post-COVID. Health damage that does not lead to pressure on the ICU was not included in the crisis approach, but was covered (at least partially) in flanking policies.

In the autumn of 2021, the delta variant caused an uptick in infection rates. The infections, combined with the threat of the infectious omicron variant in December 2021, made strict measures and another lockdown inevitable. The government saw ICU occupancy move back towards the maximum available capacity. 'Code black' was looming in hospitals; not because of a shortage of ICU beds, but because of the reduced number of healthcare staff available to care for patients after two intensive COVID years. At this stage, 38 per cent of hospitals reported that they could no longer deliver critical planned care within six weeks. This had major implications for those waiting for their treatment.

Meanwhile, reports by Statistics Netherlands showed that from August 2021 to the last week of December 2021, there would be excess mortality amongst all population groups.

Again, it was mainly privacy-related bottlenecks that made it take over a year to exchange the relevant data that Statistics Netherlands and other researchers needed to conduct further research on the causes of coronal excess mortality.

From the omicron peak to easing measures

The omicron variant caused high infection rates. Because little was yet known about the characteristics of this virus variant, the government had to continuously weigh the risk of whether the high numbers might overburden healthcare. If the omicron variant were to reduce hospital and ICU admissions, there would be room to relax and let the virus circulate. The government asked sectors to prepare plans that they could deploy if the virus unexpectedly revived and would cause more serious illness again. In doing so, the government placed more emphatic responsibilities for crisis response on society than before.

Government communication paid little attention to the health risks remaining for individual citizens when the Netherlands were to go 'back to normal'. This did not properly enable citizens to make sound risk assessments at the individual level. The crisis entered a final phase for the government when it presented a long-term approach in April 2022.

ICU capacity as key indicator

Looking back at the government's approach to the COVID crisis, it is notable that the government maintained the objectives chosen in March 2020 for more than two years. Not overburdening acute care, protecting the vulnerable and maintaining insight into the virus remained the basic principles of government policy throughout this period, even as conditions and health risks changed. Despite rising vaccination rates, increasing awareness of the risks of post-COVID, growing societal problems as the crisis lasted, and increasing health problems due to delayed care, the approach was not substantially changed. As soon as the virus threatened to overload ICUs, the government took drastic measures. When the risk decreased again, the open society took priority. This decision-making framework remained unchanged throughout the crisis. However, reopening society does not mean that all damage is repaired immediately. Some of the societal problems are long-term and it will take time to alleviate them or repair the damage in the post-crisis phase.

Not only the government, but also the populace have a responsibility in dealing with the pandemic. During the long crisis, the government has had to continuously weigh values within the chosen strategy. The Safety Board notes that these – sometimes ethical – considerations were not always made publicly, nor shared with parliament. Lack of clarity about the considerations amongst the public meant that it did not always understand why measures were not taken earlier, later, or differently. The government did not always clearly include society in the choices it made regarding the risks for different groups in society. For example, it remained unclear what risks to individual and public health remained when measures were fully scaled down. As a result, citizens were not always empowered to take well-informed action to minimise risks to their own safety and that of those around them.

CONSIDERATION

The COVID period of 2020-2022 has shown that our society may face a protracted crisis that affects almost everyone in the Netherlands personally and which has a stubbornly unpredictable course. Many were physically confronted with a virus that spread quickly. Millions became infected, hundreds of thousands fell ill or are still ill, and tens of thousands died. Behind these figures are personal and often harrowing stories: on the loss of loved ones, on the suffering of people in hospitals and nursing homes or at home, about the people who continued to help other people daily for two years with great commitment and improvisation. About fear, frustration, upset and powerlessness.

Not only the virus, but also its control had profound consequences for countless people. The government's measures restricted freedom and social intercourse between people. Societal and economic activity were hampered. The relatively peaceful diversity that so characterised Dutch society revealed a polarising flip side that hardly anyone could escape. The crisis was so comprehensive that it could be experienced very differently depending on one's personal circumstances, which could also change suddenly.

Since then, we have put the COVID crisis behind us. Society seems to have largely bounced back after the substantial impact of the pandemic and its measures on individual citizens, organisations and sectors. Globally, other crises have since been demanding attention, such as climate change and the war in Ukraine. The COVID crisis may seem like a long time ago, but it still has far-reaching consequences for those who have lost loved ones, suffered chronic symptoms from the virus or become incapacitated or unemployed or remain vulnerable for other reasons. Furthermore, the healthcare sector has not yet recovered from the prolonged overload during the crisis. Every day, many people within healthcare, ministries, academia, patient associations and other organisations are still dealing with the aftermath of the crisis. They are catching up on backlogs, trying to repair damage incurred or, together, ensuring that the Netherlands will be better prepared for future pandemics. The Safety Board realises that for all those people, the story does not end the moment this three-part investigation is completed.

Citizens were largely dependent on the government for their health and safety from the beginning of the COVID crisis. This placed a heavy responsibility on the government and parties that had to fight the crisis. In the initial, acute phase of the crisis, a lot of improvisation had to be done, as existing structures and plans did not provide for such a massive pandemic. Lessons from this phase of the crisis response are contained in the Safety Board's first sub-report (February 2022). The complexity of an acute health crisis broadening into a broad social crisis is evident in the second sub-report, published in October 2022. Despite increasing knowledge about the virus and the arrival of effective vaccines, the impact of the pandemic continued to spread. This third sub-report focuses on both the contiguous period (from July 2021 to September 2022) and the crisis as a whole, where the Safety Board has examined what lessons can be learned from how the government managed risks during the COVID crisis.

Government leadership

The government faced the highly complex task of guiding Dutch society as safely as possible through a health and social crisis of unprecedented magnitude. Citizens were not only dependent on the government to deal with the crisis, the government was also dependent on how citizens took their own responsibility in dealing with the crisis. In society, there were increasing counter-reactions to the government approach. Social unrest was noticeable almost daily in media coverage, on social media, in parliament and in demonstrations. Oppositions between groups and between individuals sharpened and social cohesion in the Netherlands was severely tested. The government's approach also faced increasingly fierce criticism. In some cases, government members, advisers and policy implementers even faced personal threats.

All this made very high demands on the leadership of the responsible ministers. The government has made great efforts to fulfil its leadership role. Thanks in part to the efforts of many implementing parties – in particular healthcare workers – those efforts have helped control health and safety risks. Thus, the vaccination campaign led to reduced morbidity and mortality from corona.

In the interest of preparing properly for a future pandemic or other protracted and large-scale crisis, the government should consider what lessons can be learned from the handling of the COVID crisis. The Dutch Safety Board assumes that with this aim in mind, the government wants to make the best use of those lessons from the COVID crisis. The investigation reveals some insights on how the government has managed health and safety risks.

From acute to long-term crisis: changing course

One of the key lessons from the corona period is that an acute crisis can develop into a comprehensive societal crisis. Moreover, the context in which the government had to combat the crisis was constantly changing due to new virus variants, the availability of vaccines, societal resistance to containment measures and the emergence of new risks such as post-COVID and the consequences of delayed care.

These pandemic developments had a major societal impact, but the government did not change its track. The crisis response objectives and strategy remained essentially the same, while there was reason to test and possibly adjust them. ICU occupancy continued to guide implementing or relaxing measures. As a result, crisis policy focused to only a limited extent on new risks that did not affect ICU occupancy rates.

An integrated approach is necessary

Another pattern that emerged from the study is that the ministers directly involved mainly let the Minister of Health, Welfare and Sport take the lead in crisis response, even when it became clear that the acute health crisis had broadened into a large-scale and protracted societal crisis. The complexity of such a crisis calls for shared responsibility by the entire government. After all, all ministers and secretaries of state are affected by the consequences of such a crisis in one way or another. Their contribution to crisis response based on the knowledge in their domains is therefore indispensable.

It is the Prime Minister's responsibility to promote the integrated nature of the crisis approach. This includes ensuring a clear division of responsibilities (with the ministerial crisis team focusing on strategic policy) and clearly communicating with parliament and society about decisions, policies and risks. The challenge here is to include all relevant perspectives in the crisis approach, while maintaining the necessary momentum and effectiveness.

Key areas of focus include independent advice, reflection and dissent, which must be firmly established in crisis management. This does not alter the fact that the government itself is ultimately responsible for the decisions it takes.

For future crises, the government will have to consider more explicitly how it wants to provide leadership. The type of leadership appropriate to combat the crisis may also change over time. Now that the COVID crisis is largely behind us, there is ample opportunity to develop the integrated approach outlined above and secure it in such a way that, in the event of the next large-scale and protracted crisis, the government will be able to set it up quickly from the outset.

Leveraging social-science knowledge in crisis response
The COVID crisis has shown that fighting a pandemic is not only a health issue, but also a behavioural one. Human behaviour is highly determinant of, for example, virus spread, compliance with measures and the effectiveness of vaccination policies. Behavioural knowledge from the social sciences is therefore indispensable when dealing with a large-scale and protracted crisis. Regular opinions on societal matters were offered by the Corona Behavioural Unit (RIVM) and the Social and Cultural Planning Office. However, medical-epidemiological knowledge and opinions were dominant in the decision-making. In this regard, the Safety Board notes that the advice and method of advising from the social sciences could be better aligned with what is needed in crisis decision-making. It is important to give a clear action perspective to decision-makers. Further investment in quality and usability of advice from the social sciences should lead to its becoming equivalent to epidemiological knowledge and advice. It is then up to the government to use those social science advice effectively in crisis management.

Scenario thinking in preparation for what may happen
Another focus is the professionalisation of scenario thinking in preparation for and during a large-scale and protracted crisis. After the acute phase of the crisis, one can expect the government to take into account various scenarios and uncertainties. The first infections took the Netherlands by surprise, but the government's anticipation of subsequent developments was limited.

Scenarios are meant to outline and think through various possibilities in the course and effects of a crisis (including in the medium and long term), so that the approach can anticipate them. During the COVID crisis, the government appeared to focus mainly on the – in the eyes of ministers – most likely scenario and tailored its policies accordingly. However, scenario thinking is meant to consider also less likely scenarios (low probability, but high impact). This creates more agility to respond appropriately to developments under different circumstances.

Managing risk and dealing with vulnerable groups: open communication about risks and considerations

After the first phase, in which everything had to be aimed at containing the virus, the government chose to let the virus circulate to some extent. In this, the maximum scaling-up capacity of the ICUs acted as the limit. When the effects of the virus threatened to overload the ICUs, drastic measures were taken. Once that threat diminished, keeping society open took priority.

With widespread vaccination and increasing immunity amongst the population, the risk of overloaded ICUs became increasingly manageable. The government used this space to ease and phase out measures. This came in response to increasingly loud exhortations, including through the media (including social media), to keep society open again as much as possible. That call was prompted by various societal problems that arose as a result of restrictive measures, such as lockdown, curfews and school closures.

This approach by the government is explicable, but it also has a downside. Letting infections go up went hand in hand with health damage in a part of the population, for instance through post-COVID and delayed care. These risks and the underlying considerations were not clearly shared by the government as part of democratic accountability in parliament or in dialogue with the rest of society. Citizens could have used the insights into risks for their own considerations and choices, in the interest of both their own safety and health and that of others.

Citizens need a clear picture of the risks they face or will face during a crisis. They also benefit from understanding the considerations underlying policy choices. Choices in risk management can come at the expense of specific groups in society, as the COVID crisis has shown. In such cases, the government has a responsibility to carefully deliver uncomfortable messages about the acceptance of risks or impact of measures, recognise the harmful consequences for vulnerable people and be receptive to their concerns and needs. Such active involvement of the government can contribute to potentially reducing adverse health and safety impacts, not only of vulnerable people, but of society as a whole.

Data availability and sharing: taking responsibility

During the COVID crisis, sound insight into the spread of a pandemic virus and its public health implications proved indispensable. During the COVID crisis this insight improved, but the investigation reveals a key area for improvement. Problems with sharing data on testing, vaccination and mortality (including excess mortality) persisted throughout the crisis. The data infrastructure was already fragile before the crisis, with a variety of data recording systems and varying data definitions making unambiguous data exchange difficult. Furthermore, the capacity of the systems was inadequate for processing and exchanging large amounts of data. Moreover, stakeholders used different interpretations of European (and other) laws and regulations. As a result, the exchange of data needed for adequate risk management stagnated. It took too long for the parties to resolve these issues to some extent.

To avoid such a situation in the next large-scale and protracted crisis, the government – together with the parties involved – must ensure that a smooth exchange of data is possible during a crisis. Of course, the legal rules on privacy protection are the starting point. This requires a fundamental balancing act between the importance of protecting personal data and the importance of effective crisis management. Examples from abroad can serve as inspiration. Other European countries managed to share data more decisively and effectively under the same European laws and regulations. The aim of the consideration should be to provide an up-to-date and as complete as possible picture of risks and other relevant developments, always within the legal frameworks. This is essential for the government to shape and underpin its crisis approach, monitor implementation and make adjustments if necessary.

Government and parliament interaction during the crisis
Apart from the government, parliament has also explicitly addressed COVID policy. In its role as the government's overseer, the House of Representatives critically followed developments and the government's approach to the crisis. It put on the agenda what was going on in society and alerted the government to important risks that were underexposed, such as post-COVID.

The House of Representatives also regularly debated packages of measures. Notable in this were discussions at the detail level, for instance on whether the curfew should be an hour earlier or later. As a result, discussions on the overriding goals of the measures – such as preventing disease and mortality – and on the consideration of values or fundamental rights that were at stake tended to fade into the background. Furthermore, ministers were frequently called to the House to explain the crisis approach and answer a large number of parliamentary questions. This is an important part of the democratic accountability of both the House and ministers, but it is questionable whether their frequency and scale during the COVID period enhanced the government's decisiveness and timeliness of action in dealing with the crisis.

The Safety Board did not investigate further the role of parliament during the COVID crisis. That is primarily a responsibility of parliament itself. It therefore endorses the proposal of the House of Representatives temporary COVID committee to investigate the functioning of the House of Representatives during the COVID crisis.

After the crisis: focus on damage repair
The COVID crisis harmed many people and exacerbated existing social problems. These impacts have not been remedied with the removal of measures. Restoring society also requires active policies, as the government conducted with the national education programme. The importance of integrated post-phase and recovery policies is described in the national crisis management handbook.

It is for the government to assess the severity and extent of the various forms of damage caused by the COVID crisis. It must then assess which societal problems require active recovery policies. Its implementation will require firm direction from the government, in close cooperation with the relevant implementing organisations.

The state of the healthcare sector deserves special attention at the moment. Prior to the COVID pandemic, this sector was already under considerable pressure, partly due to staff shortages. There were few buffers to cope well with peak loads. The COVID crisis then took another toll on healthcare workers, both in hospitals and in nursing homes, in home care and in other places where care was needed. Under hectic conditions, they were ready day and night to help tens of thousands of seriously people ill and assist the dying. In the process, healthcare workers were at increased risk of contracting a coronavirus infection and falling ill themselves while working. The commitment and dedication of care workers is impressive and deserves much appreciation. At the same time, their resilience has been called upon for too long: for the healthcare sector, the COVID crisis was a war of attrition. The sector is still facing a high workload due to understaffing (including due to long-term staff cuts) and catching up with deferred care.

This raises questions about equipping care for the next pandemic or other major health crisis. These questions must be answered, followed by policies and measures to restore care to an acceptable level. That is, adequate care for everyone who needs it, even if a major health crisis presents itself. As the latter is certainly not unthinkable, the government can be expected to take the initiative – together with the healthcare sector – to this end energetically.

In closing

Combating a large-scale and protracted crisis requires a large-scale and long-term collective effort by government and society. This requires the government to fulfil its public responsibilities in crisis response, but also citizens to take responsibility for their own safety and health and that of their fellow citizens. The COVID crisis has shown that this is possible – by trial and error – but also that there are lessons to be learned. What has gone well should be preserved and, if necessary, developed further, such as the new forms of virus monitoring, the distribution and treatment of patients and the vaccination logistics of the GGDs. What could be improved is evident from the many evaluations and investigations, including the three sub-investigations by the Safety Board.

The international context has been very important in the fight against this pandemic. The virus was not restrained by country borders. Nationwide measures are only a small part of the global pandemic response. They do not prevent the arrival of variants from abroad or the emergence of other virus variants. There is a high level of interdependence that necessitates alignment and cooperation. Joint European vaccine development and procurement is a good example. Further learning from each other can be done in an international context. Several countries have been successful in their approach in different aspects and at different times. While it is true that each country has its specific context in which measures have been taken, identifying best practices can be an important addition to any experiential knowledge gained.

Meanwhile, several initiatives and actions have already been taken to translate the lessons from the COVID crisis into improvements in handling a large-scale and protracted crisis. The threat of another pandemic is very real. For example, there are serious risks in the development and spread of avian flu. We also have to consider other types of crises, such as microbiological, chemical or radioactive or environmental crises. That there will

be another crisis is certain, though what kind of crisis and when is unknown. This is precisely why it is necessary for government and society to now take the time and space to draw both specific and more generic lessons and embed these in policy and crisis organisation design. Because during a crisis, there is no time left for preparation.

RECOMMENDATIONS

The following are recommendations based on the present report. This sub-investigation looked back at the entire crisis period up to September 2022. Partly because of this, some of the recommendations are in line with those in the sub-reports *Aanpak coronacrisis* 1 and 2. Sub-investigation 3 shows that improvements are still needed on those themes, or parts of them, in preparation for a possible new protracted crisis with national impact. As Sub-investigation 3 focused on how the government managed the risks to public health and safety during the corona crisis, the Dutch Safety Board focuses all its recommendations on the government.

1. Review and adjustment of strategy and objectives
The government maintained the objectives it set at the beginning of the crisis, while the context changed as the crisis unfolded. Risks that manifested themselves at a later stage were not part of the original objectives and thus did not become part of the crisis response.

During a protracted crisis, reflect regularly and explicitly on the chosen objectives and assess whether they are still appropriate for the course of the crisis. In doing so, identify and assess risks not only within the applicable targets, but also outside them, and determine whether it is desirable to adjust targets. In doing so, organise a dialogue aimed at recognising and challenging assumptions and underlying values.

2. Ensuring broad ownership and integral considerations
Despite a widening of the crisis and an increase in the number of parties involved, the Minister of VWS retained ownership of the crisis. The Safety Board notes that the government's decision-making continued to approach the crisis mainly as an acute health crisis.

a. When scaling up to a national crisis structure, ensure that ownership of and responsibility for the crisis approach are effectively shared government-wide, so that the integral nature of crisis policy is unmistakable.
b. Ensure that responsibility is taken at the ministerial level for input and decision-making on inter-ministerial themes, such as the long-term perspective, societal impact and post-crisis phase.

3. Thinking through scenarios
The RIVM's epidemiological models played a central role in the decision-making. Partly as a result of this, image and decision-making focused mainly on the most likely short-term scenario of epidemiological trends. Scenarios for less likely developments with potentially high impact – including in broader areas and in the longer term – remained underexposed throughout the crisis.

Anticipate changing circumstances by professionalising scenario thinking within crisis counselling and decision-making during protracted crises with national impact. During a crisis, develop and think through less likely scenarios for the course, risks and impacts on a regular basis as well, to be better prepared to respond to bottlenecks and decision points.

4. Explaining considerations, risks and consequences for society
Measures had a major societal impact. At times of high ICU occupancy, the government accepted those consequences. The downside of scaling down measures was higher virus circulation. In doing so, the government accepted more infections, putting more people at risk of post-COVID or other long-term consequences, such as resulting from delayed care. Choices and considerations were not clearly explained to society.

During a protracted crisis, explicate the dilemmas, the weighing of risks and interests, and the choices involved in decision-making. Make clear to society the downside of the strategy, a decision or measure, what risks are accepted, for whom and why. This enables citizens to act accordingly and take responsibility for their own safety and that of others.

5. Improving information provision
Adequate pandemic control required optimal insight into the spread of the virus, its public health impact and the impact of measures. The quality of insight increased during the crisis. To prepare for future infectious disease outbreaks and other types of crises, improvements are still needed.

a. In cooperation with implementing parties, establish and guarantee a crisis-proof data infrastructure for the purpose of recording, sharing and modelling data.
b. Create the preconditions for the quick resolution of bottlenecks in interpreting and applying privacy laws and regulations around data sharing between involved parties in the next crisis.
c. In cooperation with implementing parties, secure the developed testing infrastructure so that it is equipped for a new acute crisis of large scale. In doing so, pay attention to availability of materials and scalability of take-up capacity, laboratory capacity and logistics.
d. Encourage structural partnerships to reflect more broadly on form, assumptions and outcomes of leading models during a crisis, including using different types of models and insights from multiple modellers (or modeller groups) in the Netherlands.

6. Leveraging social-science knowledge
Pandemic control was not only an epidemiological issue but also a societal and behavioural one. The success of pandemic response depends heavily on citizens' compliance with advice and measures. To strengthen the position of behavioural and social-science knowledge in crisis counselling and decision-making, important steps have been taken, for example by setting up the Behavioural Unit and establishing the MIT. The position of social and behavioural science knowledge can be strengthened further.

a. From the beginning of a protracted crisis, exploit social and behavioural science knowledge in modelling, advising the government, crisis consultations and policy-making, including the design of measures and recovery policies.
b. In collaboration with knowledge institutes, promote applicable social and behavioural science research that enables rapid translation of knowledge into action perspectives during a protracted crisis with national impact.

1 INSIGHTS INTO RISK MANAGEMENT DURING A COMPLEX AND PROTRACTED CRISIS

Introduction

The COVID pandemic led to a complex and protracted crisis worldwide. What started as a health crisis expanded into a broader crisis, having impact on all of society. It took more than three years for the World Health Organization (WHO) to declare the pandemic over.[1] The majority of infections resulted in mild symptoms. Nevertheless, 140,000 people were hospitalised in the Netherlands and nearly 20,000 COVID patients ended up in intensive care.[2] [3] In the Netherlands, an estimated 48,000 people died from the virus. Over time, it was found that the virus could also cause long-term damage to organs[4] and bodily functions. The influx of COVID patients led to great pressure throughout the healthcare chain, resulting in absent (due to infection and other causes) and departing healthcare staff. Hospitals repeatedly scaled down some non-acute planned care.

The economic and social effects of the crisis were felt early on. The livelihood security of many groups in society declined. Self-employed people, flex workers and young adults – especially those who were low-skilled or had a migrant background – saw their incomes decrease.[5] Amongst schoolchildren and students, psychological well-being decreased and learning deficits increased.[6] The elderly struggled with loneliness.

Many sectors and companies experienced revenue losses. While, at the beginning of the pandemic, there was a sense of solidarity and the population largely supported the measures, this changed from the summer of 2020. Confidence in the government and the authorities dropped. The number of protests and riots increased. This first concerned the introduction of the curfew in January 2021 and, later that year, in November, the

1 WHO, *Statement on the fifteenth meeting of the IHR (2005) Emergency Committee on the COVID-19 pandemic*, 4 May 2023. https://www.who.int/news/item/05-05-2023-statement-on-the-fifteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic [accessed on 10 May 2023].

2 Stichting NICE, *COVID-19 op de Nederlandse Intensive Cares*, 30 March 2023. https://www.stichting-nice.nl/COVID_rapport/COVID_rapport_20230330.pdf [accessed on 25 May 2023].

3 The central government's Corona Dashboard publishes figures on hospital occupancies. https://coronadashboard.rijksoverheid.nl/landelijk/ziekenhuizen-en-zorg

4 Mokhtar, Hassani, Ghaffari et al., 2020. COVID-19 and multiorgan failure: A narrative review on potential mechanisms. *Journal of Molecular Histology*, 51:613-628.

5 *Eindverslag Werkgroep Sociale Impact van de Coronacrisis*, 17 May 2020. https://vng.nl/publicaties/eindverslag-werkgroep-sociale-impact-van-de-coronacrisis [accessed on 25 May 2023].

6 Sociaal en Cultureel Planbureau (SCP), Een jaar met corona. *Ontwikkelingen in de maatschappelijke gevolgen van corona*, 3 March 2021. https://www.scp.nl/binaries/scp/documenten/publicaties/2021/03/03/een-jaar-met-corona/Een+jaar+met+corona.pdf. [accessed on 17 June 2023].

containment measures and 2G policy (in which entrance passes would only be given out to those who were either vaccinated or had recovered from an infection). It was proclaimed increasingly often and loudly that there was more to life than virus containment.

The government faced the task of preventing mortality and health damage amongst the population as much as possible. At the same time, it wanted to keep society as open as possible because of societal and economic interests and other values, such as the protection of fundamental rights. At the same time, it was important to ensure continued public support. The combination of the short-term and long-term consequences of virus infections and the containment measures produced a diffuse risk analysis with many uncertainties. Risk management by the government was thus ultimately an epidemiological, political and societal task, in which limiting health harm had to be weighed against other possible forms of harm on an ongoing basis.

The previous six chapters, including their analytical periodical descriptions, laid out how the context changed over the course of the crisis and how the government addressed the crisis within that changing context. The context changed – sometimes as a result of the virus, sometimes as a result of dealing with the crisis. In this chapter, the Safety Board analyses the findings from the entire period. In doing so, it looks at how the government managed risks to public health and safety during the COVID crisis. As in the period chapters, the Board uses three perspectives as a common thread: strategy, insight and action. It examines what goals and strategies the government pursued and how it kept track of the virus and its impact on society. In doing so, the Board investigates how the government used that insight (or did not use it) in its crisis decision-making. As concerns the implementation or easing of measures (and its timing), the Board looks at what information (knowledge and insight) the government used to reach its decisions. The focus is on understanding the government's decisions within the context in which they were made. This synthesis yields a number of insights.

First of all, the Board examines the operation framework for increasing or easing measures that the government used during different periods of the crisis. ICU occupancy was the main criterion for the government to determine when to intervene by implementing measures. In Section 1.1, the Board describes factors that explain why the government chose to use this criterion and what its implications were. In addition, the Board offers some observations on the analysis of insight into the virus and side effects (Section 7.2). The Board details the development of this insight, as well as the associated limitations. It also describes the factors that explain why the insight into collateral and long-term effects was of limited use in the crisis response. Finally, in Section 7.3, the Board analyses why the government – despite the changing context, new risks and a changing risk allocation – stuck to medically-oriented strategic goals and what the implications of that choice were.

What a future protracted crisis might look like cannot be predicted. Conditions will be different from the period of this pandemic (early 2020 to autumn 2022). The Board's aim is to learn from incidents and make recommendations to improve safety. Any insights obtained can contribute to effective risk management during the next pandemic where citizens depend on other parties, including the government, for their safety and health.

1.1 Intervention based on maximum ICU utilisation

The government's COVID approach – the government spoke of the strategy of 'maximum control' – focused on three strategic objectives: insight into the virus, protecting the vulnerable and preventing care overload.[7] [8] The term 'maximum control' used by the government is not an existing concept in infectious disease control. According to associated officials, the term 'maximum control' gave the appearance of a certain manageability.[9] [10]

Within the 'maximum control' strategy, ICU occupancy was the main criterion for determining when the government should intervene by implementing (restrictive) measures. In practice, this meant that the restrictions ensured that ICU occupancy remained manageable. They were aimed at controlling the spread of the virus by limiting contacts between people, reducing the number of infections and keeping the reproduction (R) value around 1. The government only deployed heavier restrictions with more societal impact when maximum ICU apacity was soon to be reached. Once ICU occupancy stabilised or appeared to be decreasing, the government prepared to ease restrictive measures. This was the dominant decision-making framework during the different phases of the crisis (between February 2020 and March 2022). The government's insistence on this framework is explained by the Board based on a number of factors explained below.

1.1.1 Explanatory factors for the decision-making framework

'No Bergamo' as ultimate goal

The government wanted to prevent COVID and non-COVID patients from dying as a result of not receiving proper medical care. The poignant situation at Italy's Papa Giovanni XXII hospital in Bergamo in March 2020 played an important role.[11] In Bergamo at the time, the influx was so large that patients could no longer be admitted to the ICU. People died in the corridors of the hospital. Previous experiences from the swine flu in 2009 also played a part. At the time, children's ICUs filled up quickly.

Keeping acute (and other) care available was the main goal of the government's approach.[12] [13] Therefore, ICU bed occupancy was used as a measure of healthcare burden. In practice, this narrowed the government's objective from 'preventing care overload' to 'preventing *acute* care overload' and was less concerned with the consequences of the policy on pressures in GP care, home care and long-term care.

7 Prime Minister Rutte, TV speech, 16 March 2020.
8 OMT, *Advies naar aanleiding van 65e OMT vergadering*, 20 April 2020. For the first time, government targets are mentioned in the Outbreak Management Team (OMT) report: 'The three pillars as named by the government.'
9 J. de Vrieze, 'Beter vandaag handelen dan morgen spijt', *De Groene Amsterdammer* no. 43, 27 October 2021.
10 Decision on *Wob* request on the TV speech of 16 March 2020. https://wobcovid19.rijksoverheid.nl/publicaties/f302ea548db6360a784e8a5e365efe3e [accessed on 6 June 2023].
11 Footage from this hospital went global via Sky News in March 2020. https://news.sky.com/story/coronavirus-inside-the-red-zone-the-desperate-fight-italy-hasnt-seen-since-the-plague-11963915 [accessed 17 May 2023].
12 Prime Minister Rutte, TV speech, 16 March 2020.
13 OMT, *Advies naar aanleiding van 65e OMT vergadering*, 20 April 2020. For the first time, government targets are mentioned in the OMT report: 'The three pillars as named by the government.'

Keeping society open for as long as possible

According to interviews, internal and public documents, the government wished to create as much space as possible to keep society open.[14] They did not want a stricter approach than necessary to keep ICU occupancy within maximum capacity. In a memo for the Catshuis deliberations, the government explained that 'the brute force of measures' that would be needed to completely prevent infections would lead to 'incalculable damage to the economy and society'.[15] The Outbreak Management Team (OMT) also mentioned in April 2020 that 'minimising adverse impacts' and 'maintaining support' were part of the strategy.[16] [17] [18] The largest deviation from this decision-making framework occurred in autumn 2020, when the government announced additional measures to use the vacant space in ICUs to catch up with deferred care. Typically, the government chose to create room for society when infection rates were declining.

Building immunity

The 'maximum control' strategy was the 'middle scenario' between the two extreme scenarios:'doing nothing' or 'immediately suppressing any upsurge of the virus'. Maximum control meant letting the virus circulate in a 'controlled manner', within the limits of maximum ICU capacity.[19] A desired side effect of this was that, while waiting for a vaccine, the population would build up a certain degree of natural immunity against serious disease, the government stated.[20] [21] In his speech, the Prime Minister spoke of 'herd immunity'. There was much confusion and ongoing debate amongst experts and in the media about the feasibility and desirability of pursuing herd immunity. This is a well-known concept in infectious disease control and, according to interviewees, with respect to COVID, mainly meant immunological protection within the population against serious disease: if fewer people became seriously ill, ICUs would be less likely to be overloaded and fewer restrictions would be needed in the long run. This is not the classical meaning of herd immunity, which is the indirect protection of a non-immune individual against an infectious disease due to the fact that a large part of the population is immune and the infection cannot spread or is difficult to spread.

In general, for infectious diseases, heterogeneous immunity in the population, created by vaccination and by past infections - and preferably built up against different types (and subtypes) of the pathogen -, provides longer-lasting and better protection against

14 National press conference, 21 April 2020. 'Of course there are other questions involved: can society cope and can the economy cope? Questions that become more pressing the longer the crisis lasts. We realise that. But this is really the order: first public health and then the rest.' '

15 Catshuis documents, *Covid-19; Hoe verder?* https://open.overheid.nl/documenten/ronl-a89903a3-f779-48c3-a118-fecb1a7752d9/pdf [accessed on 19 May 2023].

16 OMT, *Notulen 63e OMT vergadering*, 6 April 2020.

17 OMT, *Notulen 64e OMT vergadering*, 14 April 2020.

18 OMT, *Notulen 57e OMT vergadering*, 27 February 2020.

19 OMT, *Notulen 65e OMT vergadering*, 20 April 2020. 'Maximum control or On-and-off. Maximum control involves 'a combination of the above measures [lockdown and source and contact tracing], less stringently implemented where restrictions on travel and avoidance of physical contact are reduced to the necessary level required to control the outbreak based on predefined targets.'

20 *Parliamentary Papers II* 2019/20, no. 64 item 2. https://www.tweedekamer.nl/kamerstukken/plenaire_verslagen/detail/2019-2020/64

21 Following the outcry that arose in the House of Representatives and society about herd immunity, the Prime Minister stated that herd immunity is not an 'objective of the policy, but an effect of the chosen strategy'. *Parliamentary Papers II*, session year 2019/20, no. 64 item 2.

infection by new variants of the virus and disease than immunity by vaccination alone. However, from the beginning of the pandemic, the WHO maintained that herd immunity should be achieved through vaccination and not by circulating the virus, as this would be associated with more morbidity and mortality.[22] The WHO advocated maintaining restrictions, combined with testing and source and contact tracing, to contain the circulation of the virus.

Prevention paradox

According to internal documents and interviews, the government assumed that the parliament and society would not accept earlier or longer interventions – even with lower ICU occupancy. Administrators mentioned the principle of the prevention paradox as an explanation: the apparent contradiction that precisely because a preventive measure works well, many people perceive it as unnecessary or excessive because the positive effect of measures taken (for example fewer infections) creates less visible urgency.[23] From this perspective, support for far-reaching measures only arises when the pressure on ICUs becomes high. Without visible urgency, people would be less likely to accept the imposition of restrictive measures, if at all, the government assumed. By taking the prevention paradox as a given and not as a reason to engage in a dialogue with society on the usefulness and necessity of the measures, the government missed opportunities to build support.

Proportionality of measures

The fact that the government intervened as soon as ICU occupancy became urgent is also related to the government's desire to take proportionate measures. Legally, proportionality is about whether means deployed (restrictive measures) are in reasonable proportion to the achievement of the objective pursued. Several government members argued against earlier, stricter or longer intervention, stating that there would be little support for it and that it would not be legitimate. Indeed, measures may infringe various fundamental rights and other essential needs of citizens.[24]

The government used the term 'proportionality' in different ways. The government considered proportionality as the balance between the two main goals, namely virus control and relieving pressure on acute (and other) care on the one hand, and keeping society open on the other.[25] At other times, the government translated the concept of proportionality into whether there was support; whether people would accept and

22 WHO, *Coronavirus disease (COVID-19): Herd immunity, lockdowns and COVID-19*, 31 December 2020. https://www.who.int/news-room/questions-and-answers/item/herd-immunity-lockdowns-and-COVID-19 [accessed on 20 April 2023].

23 Incidentally, in preventive medicine, the prevention paradox is understood slightly differently; namely, that most cases of a disease occur in the group of people at low risk of that disease, rather than those at high risk. This is because the former group is much larger than the latter.

24 Advies afdeling Advisering Raad van State en Nader rapport Tijdelijke wet maatregelen covid-19. *Parliamentary Papers II*, session year 2019/20, 35 526, no. 4.

25 MCCb meeting, 21 April 2020, 'Care was paramount during the first phase; now a more prominent proportionality consideration emerges that includes other disciplines. Decision-making takes place after discussion on the OMT/BAO's advice and on the basis of integral consideration'.

comply with the measures. The OMT also considered the proportionality of measures.[26] [27] The OMT looked at proportionality from a medical perspective. Restrictions were 'proportional' if they ensured achievement of the epidemiological goal of keeping R at or just below 1, so as not to overload the ICU. In the discussion on proportionality, these meanings or readings of the concept ended up being interchanged.. This is problematic, because proportionality underpins decisions to manage risks, which require balancing the various medical and non-medical risks and short and long-term interests.

1.1.2 Implications of the decision-making framework

The above factors explain why the government chose ICU occupancy as the main criterion within the decision-making process for implementing and easing restrictions. The government called this 'sailing close to the wind'. However, sticking to this decision-making framework had its implications. Rising infection numbers would usually take two to three weeks to translate into rising ICU occupancy and a little longer before to turn ICU occupancy critical. Intervening on the basis of ICU occupancy instead of on rising infections meant that the government accepted a certain level of virus circulation before stepping in. This posed risks. The risk of disease and mortality is higher than in a containment strategy. The virus' exponential growth means that the increase in infections is easily underestimated[28], makingits spread faster than expected.

The delay in addressing this by responding to ICU occupancy resulted in the need for increasingly onerous restrictions compared to focusing on infection rates to bring the R value back to below 1. By using forecasts of modelled hospital and ICU occupancy that were two to three weeks ahead, this delay was partly overcome. However, due to uncertainties in the models and considerations by the government for the chosen timing of restrictive measures, these risks could not be completely avoided.

The decision-making framework also had implications for the healthcare sector. The healthcare sector went all out to increase ICU capacity during the first wave. That intervention provided short-term relief, but caused long-term attrition. Alarming signals about this found a steadily decreasing response from the government after autumn 2020. The government's focus was relaxing restrictive measures again as soon as it could. In spring 2021, the Dutch Healthcare Authority and the Health and Youth Care Inspectorate warned that the sector needed time to catch its breath. However, these cautionary sounds were drowned out by political and societal pressure to ease restrictions. One year after the start of the corona crisis, the government found itself torn between the alarming signals from the healthcare sector on the one hand and society's need for more space on the other. The search for a balance in the crisis approach between relieving pressure on care and keeping society open characterised the entire approach. For that, insight into the spread of the virus and its effects formed an important basis.

26 OMT, *Notulen 57e vergadering*, 27 February 2020. 'There will have to be a continuous assessment of the extent to which containment of the spread is still possible in order to justify – or continue to justify – the proportionality of measures.'

27 OMT, *Advies naar aanleiding van 64e vergadering*, 14 April 2020.

28 The Centre for Evidence-Based Medicine. *Exponential growth: what it is, why it matters, and how to spot it.* https://www.cebm.net/covid-19/exponential-growth-what-it-is-why-it-matters-and-how-to-spot-it/ [accessed on 7 June 2023]

1.2 Insight into the virus and risks within society

For policymakers, it was very important to continually define the picture of the pandemic crisis. This allowed them to assess whether restrictive measures were needed and, if so, which ones. Insight into the virus included knowledge of properties of the virus, how the virus spread amongst the population, the impact of the virus and the effect of measures taken on the virus's circulation. Insight into the virus and insight into the effects (and side effects) of the measures were essential to determine whether it was necessary or possible to adjust the approach or strategy.

1.2.1 Insight into the virus and its effects

Insight into the virus
Due to limitations in case definition, in testing infrastructure and testing policies, in compliance, and technical and privacy-related bottlenecks in data availability and data sharing, the government was forced to make decisions based on incomplete understanding of the virus.

In the initial phase of the crisis, there was little insight into the virus, its spread by people with and without symptoms and its impact on health. The use of a limited case definition linked to limitations in testing capacity and issues with scaling upthe test chain (partly due to the government's late deployment of commercial laboratories) meant that insight did not increase as quickly as desired. Since insight into the virus was the basis for decision-making on taking or easing measures, the limited insight into the virus complicated the government's risk management. Because many infections remained unnoticed, spread of the virus and exposure to it were less well prevented. This posed health risks.

During 2020 and 2021, insight into the spread of the virus improved rapidly. This was partly due to scaling up in testing and source and contact tracing capacity by the municipal public health services and the municipal public health services (GGD GHOR Nederland). The expansion of laboratory capacity by the National Diagnostic Chain Coordination centre and the development of monitoring and surveillance systems by the National Institute for Public Health and the Environment (RIVM) and NIVEL, for example, also contributed. This helped the OMT and government to assess and manage risks.

The reliability of virus visibility and effectiveness of testing for infectious disease control depended on compliance with testing policies. This was influenced by citizens' sense of urgency, responsibility and participation.[29] The way the government communicated the testing policy and measures was not always helpful in this. Frequent changes in policy and the interchangeable use of, for example, the terms 'isolation' and 'quarantine', sometimes made people unable to understand what was asked of them.

29 RIVM, *Thuisblijven, testen en quarantaine*. 15 July 2020. https://www.rivm.nl/gedragsonderzoek/thuisblijven-testen-quarantaine [accessed on 14-09-2021].

There were also technical and privacy-related bottlenecks in data availability and data sharing.[30] Because the test chain was not equipped for a pandemic, much of it had to be developed and adapted in a short period of time. That meant prioritising, and not everything could be taken up at once. This affected data sharing, leading to delays. Data recording systems in healthcare and within the test chain were diverse and not aligned. Scaling up the test chain under high pressure led to vulnerabilities in registration systems, security, continuity and data quality. In addition, various parties within the government disagreed for months on the interpretation and application of privacy laws and regulations when drafting necessary legal frameworks for the purpose of sharing telecom data for monitoring people's movement and the deployment and set-up of the CoronaMelder app. The way stakeholders dealt with privacy regulations also prevented or delayed the sharing of personal data in many cases. For example, it took until April 2021 for test data to be shared by municipal public health services with Statistics Netherlands and stopped again in November 2021 due to a changed view on the legal status of test data. Supplying test data from the Open Nederland foundation to the municipal public health services got off to a difficult start due to differences in interpretation of privacy regulations. Privacy-related bottlenecks also meant there was less insight into vaccination coverage and vaccine effectiveness than possible, while vaccination coverage played an increasingly important role in the government's approach during the crisis.

Many bottlenecks in data recording systems were resolved through mutual consultation during the crisis. However, privacy laws and regulations and their application remained a recurring problem in the data exchange between involved organisations. Each organisation had to make its own considerations for each specific data-sharing situation. The parties involved in information sharing – such as the Dutch Data Protection Authority, the Ministry of Health, Welfare and Sport (VWS) and the state attorney, and the links in the information chain – regularly disagreed on the interpretation of privacy laws and regulations and on the important value considerations concerning data sharing. Besides societal suspicion concerning government data sharing (which also affected test willingness and consent to data sharing), privacy concerns made government and other agencies reluctant to cooperate. The RIVM relied on information from other organisations to provide advice. As a result, bottlenecks in data exchange and limitations in the data infrastructure caused the use of – sometimes alternative – data sources of lower quality, leading to larger uncertainty margins in the RIVM models. This greater uncertainty increased the likelihood that the actual course of infections and ICU and hospital admissions would differ from the scenario anticipated by the government. There was also less visibility of effects in specific high-risk groups, such as residents of care facilities.

Insight into mortality and excess mortality

Mortality is one of the most important outcome measures when dealing with a crisis like the COVID pandemic. The ultimate goal of restrictions to reduce virus spread was to prevent morbidity and mortality from COVID. Yet, the government did not use the COVID mortality rates as a direct indicator for short-cycle crisis decision-making. There are

30 KNAW, *Met de kennis van straks. De wetenschap goed voorbereid op pandemieën*, 25 September 2022. https://www.knaw.nl/publicaties/met-de-kennis-van-straks-de-wetenschap-goed-voorbereid-op-pandemieen [accessed on 13 April 2023].

several reasons for this. The government wished to base its crisis approach on early observable epidemiological changes, such as the spread of the virus, the changing properties of the virus and the impact of infections on health (including public health). Because mortality is at the tail end of the impact of the virus, mortality rates do not lend themselves well to early detection and hence short-term policy adjustments. In addition, modelling mortality was difficult because of uncertainty in the data and their delayed availability. Nor were mortality rates an appropriate indicator with the government's goal of preventing overload in acute (and other) care. Thereby, the outcome measures of 'infections' and 'hospital and ICU occupancy' were predictors of trends in mortality, according to those involved. The available COVID-related mortality rates were, however, monitored and fed back to the government on a weekly basis.

Besides direct mortality rates, excess mortality within a period is a measure that can provide an estimate of mortality due to the virus. The Safety Board notes that figures on the causes of excess mortality during all periods of the crisis were incomplete. Thorough research into the causes and reasons for excess mortality was slow to be implemented due to the government's hesitant attitude to identifying the causes of unexplained excess mortality, ambiguities in the laws and regulations on the secondary use of health data, and limited initiative from stakeholders to jointly tackle bottlenecks. This left opportunities to adjust policy accordingly in the medium and long term based on insights into excess mortality unused.

1.2.2 Insight into side and long-term effects

Besides insight into the virus, the indirect consequences of the virus, such as increasing pressure on the entire healthcare chain and delayed care, post-COVID syndrome and societal impact, became increasingly visible during the crisis.

Insight into increasing pressure on the care chain and deferred care

On up to four occasions, a critical care situation arose (phase 2d), with critical planned care scaled down nationwide and a real threat of 'code black'.[31] [32] Governmental measures were to ensure that this 'code black' was not reached. The required reduction of planned care led to ever-increasing deferred care. Absenteeism amongst healthcare staff increased during the crisis, reducing capacity to cope with the impact of the COVID pandemic within the healthcare chain. Also, in making visible the burden on healthcare, a problem was that privacy laws and regulations were not always interpreted uniformly by healthcare parties. Information about this burden reached the government primarily through the *Hand aan de Kraan* ('hand on the tap') meetings. Once – in November 2020 – the government decided on additional measures, such as the closure of museums, sex clubs, theatres, cinemas and libraries, to relieve pressure on hospital care so that delayed

31 The COVID-19 coordination & scaling-up plan describes 'code black' as the phase in which almost all regions indicate they can no longer fully ensure acute and semi-acute care. Source: LNAZ, Coördinatie- & opschalingsplan COVID-19, December 2022. https://www.lnaz.nl/cms/files/221223_coordinatie_en_opschalingsplan_covid-19_def.pdf [accessed on 5 June 2023].

32 'Code black' is a popular name for phase 3c, but the term is also used for all of phase 3. Phase 3 will be declared when all ICU capacity is fully utilised *across the country*. This situation may also arise if the outflow of patients from hospitals and ICUs stagnates. During the COVID crisis, there were also reports that 'code black' had occured locally, but if there was still space elsewhere it rather indicated poor patient distribution.

care could be made up. Following that, the signals about the urgent situation in care did not outweigh the need to ease restrictions as soon as ICU occupancy allowed.

Insight into post-COVID syndrome

Insight into post-COVID[33] remained limited throughout the crisis. In cases of post-COVID syndrome, the symptoms did not disappear after a viral infection but persisted for a long time. This explains why it took some time to gain a better understanding of the extent and severity of post-COVID complaints. The medical view of post-COVID was hampered by the fact that symptoms were diffuse and not unambiguous. There was no clear definition. For the government, this remained the reason not to push for registration of post-COVID patients.

It was mainly the House of Representatives that brought and tried to keep post-COVID on the political agenda. Responding to their questions, the government initially focused on complementary (or flanking) policies for healthcare workers who experienced long-term symptoms after an infection in spring 2020. In October 2020, after the WHO reported on long-term complaints after COVID infection, the Ministry of VWS set up a foundation called C-Support to support people with post-COVID complaints.

The OMT first mentioned post-COVID in its advice of 7 December 2020, as a risk of the burden on care. In April 2021, the OMT wrote 'that the post-acute symptoms of COVID-19 (as far as is known) also present a large disease burden in all age groups'.[34] In the face of rising infection numbers and at various points in the crisis, the OMT warned about the potential long-term health damage following infection. Those warnings led to the government intervening once, when infections were rising faster than anticipated, after the Minister of Health promised young people that they could go dancing just after getting their vaccination ('Dansen met Janssen'), in July 2021. During the rest of the crisis, post-COVID failed to be an argument for the government to intervene pre-emptively. To the extent that the government developed policy, it primarily involved providing funding to support healthcare workers with post-COVID and to dacilitate research on treatment methods.

Insight into societal impact

As the crisis went on, the government, including through the RIVM's Behavioural Unit, the planning agencies and the Society and COVID-19 programme directorate (DGSC-19), gained increasing insight into the toll that the crisis and the restrictions were taking on society: loneliness and mental pressure, learning disadvantages, financial stress, and indirect health damage due to social and economic impacts.

Societal concerns were addressed as soon as there was room for them from an epidemiological perspective. In the course of 2021, that 'COVID usable space' ('coronagebruiksruimte')[35] increased due to such factors as the epidemiological situation,

33 At the beginning of the crisis, the term 'long COVID' was used, a term later replaced by 'post-COVID'.
34 OMT, *Advies naar aanleiding van 109e OMT*, 19 April 2021.
35 The perceived space there was for the relaxation of restrictions, given the prevailing epidemiological situation, deployment of tests, and vaccination coverage and effectiveness.

vaccines and wider deployment of tests. From mid-2021, the government increasingly tried to mitigate societal side effects and economic damage by opening up society and keeping it open as much as possible. The OMT usually advised to wait for a more favourable virus trend before implementing relaxations, but the government was more likely to anticipate that development from 2021 and already put relaxations in prospect. The 'open society' became – alongside complementary policies beyond crisis decision-making – the way to limit collateral damage. Once epidemiological space was available, pressure on the government to use it arose from the various departments and sectors. This pressure increased the risk that the influence of sectoral interests would determine government policy, rather than an integrated consideration of societal interests. It is notable that the government continued to talk about 'the search for a precarious balance between easing pressure on care on the one hand and easing pressure on society on the other'.[36] The government tended to posit the two interests as opposing rather than as extensions of each other.[37] [38]

In addition to opening up society, the government also focused on mitigating the impact of the restrictive measures afterwards. In societal and economic sub-areas, the government made several interventions to mitigate the outlined hardship, including the deployment of the economic support packages for entrepreneurs and financial schemes to reduce the impact of school closures.

Mitigating harms resulting from COVID policies intended to control hospital and ICU occupancy (such as pressure on the care chain, delayed care, post-COVID, and socio-economic, mental and land-based harms) became *flanking* policies for the government. These were not part of the crisis approach, although planning agencies and advisory councils repeatedly advised the latter.[39] The distinction between the crisis approach and complementary policy is that the crisis approach involved determining which damage to prevent and which to accept, while complementary policy was about mitigating the consequences of the choices made.

Putting medical-epidemiological knowledge in the centre of the decision-making is understandable at the beginning of the crisis. Gradually, however, circumstances changed and new risks presented themselves. A broader perspective on the impact of the crisis also emerged. New information on collateral and long-term effects, such as long-term health damage and delayed care, was utilised for crisis decision-making to a lesser degree than indicators that aligned with the government's objectives. Insights into societal impact weighed only when epidemiological space allowed. Moreover, increasing

36 Parliamentary Papers II, 2020/21, 25 295, no. 1179.
37 National press conference, 21 April 2020.
38 CPB note, *Review Referentiekader Covid 19*, 4 September 2020. https://www.cpb.nl/review-referentiekader-covid-19 [accessed on 13 April 2023]: 'If the main problem is to prevent healthcare from overflowing, that gives a different set of solution directions than when asking what is a good trade-off between health, economic and social impact. Furthermore, measures can also have longer-term effects beyond the transition phase and it seems unwise to disregard those.'
39 Letter of Advice from the Institute for Social Research and the Council of Public Health & Society, 25 January 2022. https://www.scp.nl/publicaties/publicaties/2022/01/27/briefadvies-corona-sociaal-en-cultureel-planbureau-en-raad-voor-volksgezondheid--samenleving Accessed on 16 June 2023.

information about wider risks did not lead the government to question whether the targets were still appropriate for the expanding impact of the crisis.

1.2.3 Explanatory factors for the limited use of insights in crisis decision-making

That the above signals about pressure on care and deferred care, post-COVID and societal side effects had limited – or no identifiable – effect on decision-making is related to a number of factors, which are explained below.

Cockpit
First, a small circle of ministers prepared the main decisions of the ministerial crisis commissions (MCCb and MCC-19). Several interviewees speak of the 'cockpit' for the crisis response, consisting of the Prime Minister, the Minister of VWS, the Minister for Medical Care and the Minister of Justice and Security. They saw the crisis primarily as a health crisis, for which the Minister of VWS held the main responsibility or 'ownership'. As a result, occupancy in hospitals was prioritised.[40] Internal VWS documentation also shows that the Ministry of VWS itself felt that VWS was responsible for the crisis.[41] Interviews and internal documentation show that there was not always enough room for dissent on the policies pursued by the government (the 'cockpit').

Relying on the models
Because of the way image and decision-making in crisis management was set up, advice from the OMT was given greater weight than signals about longer-term effects of the virus, societal effects and effects on regular care.[42] In this, the RIVM models played a central role in recommendations by the OMT. This was also true for the resulting projections for the course of infections and hospital and ICU admissions under calculated collected restrictive measures. Model projections for the impact of measures on epidemiological outcome measures had wide margins of uncertainty. The OMT highlighted these uncertainties, but the government mostly took the 'average' estimate as a point of departure. The government considered the model projections as 'scenarios' for how the pandemic would develop in the short term. It used them as underpinnings for decisions and not as building blocks for independent political consideration, which included more than epidemiological and direct health effects of the restrictions. This gave models and forecasts a defining role in the decision-making.

Societal welfare advice did not have an equal position
Until the end of September 2022, the government did not have permanent advisers in socio-economic and societal fields who had input and impact similar to that of the OMT chair in the various crisis consultations. The OMT called for the establishment of a Societal Impact Team (*Maatschappelijk Impact Team*, MIT) in April 2020. Measures involve a balancing of values. The establishment of the MIT was a low priority for government

40 Dutch Safety Board, *Aanpak coronacrisis Deel 1: tot september 2020*, 16 February 2022.
41 Mail exchange between officials of DGSC-19, Ministries of VWS and Finance.
42 KNAW, *Met de kennis van straks. De wetenschap goed voorbereid op pandemieën*, 25 September 2022. https://www.knaw.nl/publicaties/met-de-kennis-van-straks-de-wetenschap-goed-voorbereid-op-pandemieen [accessed on 13 April 2023].

ministers (the 'cockpit'), as they were busy managing the acute health crisis. The focus was on acute care, so broad and long-term effects of the measures received little attention.

The Directorate-General for Society and COVID-19 (DGSC-19), which brought in the social and medium- and long-term perspectives, worked interdepartmentally and therefore did not have its own minister acting as political portfolio holder of this focus area.[43] The Board's investigation shows that opinions on the societal impact of measures on society were not given an equal position in the decision-making of the MCC-19 compared to the OMT opinions submitted by the Minister of VWS.[44] [45]

Knowledge from the social sciences is different in nature from medical-epidemiological knowledge. The OMT's medical-epidemiological knowledge was quantitative and updated daily or weekly. The qualitative (and quantitative) data brought in by, for example, the Social and Cultural Planning Office – which help to understand mechanisms in society – concerned developments manifested in the longer term. After all, loneliness, for example, does not happen overnight. That knowledge was perceived by the government as slow and not up to date. According to several interviewees, social-scientific knowledge did not provide sufficient perspectives for action.

This led to social-scientific knowledge not being used in decision-making with equal weight to that of medical-epidemiological knowledge.[46] The government mainly made decisions based on measurable indicators and unambiguous numbers (especially from the RIVM and OMT). This gave the administrative approach to the COVID crisis a technocratic slant, and other types of knowledge and interests that could not be captured in numbers and values were overlooked.[47] [48] [49] [50]

Behavioural Unit not put 'in position'

What was true for the DGSC-19's knowledge was also true for the Corona Behavioural Unit's knowledge. This advisory body was established in March 2020, but never formally became part of the crisis structure. The Scientific Council for Government Policy recommended in October 2020 to give communication and behavioural experts a permanent place at all decision-making tables. The government did not follow that advice. Behavioural scientists did not partake in the various crisis meetings throughout

43 Presentation: *Opdracht en aanpak LT2 Voorbereid de crisis door – def*, DGSC-19. https://wobcovid19.rijksoverheid.nl/publicaties/1a314fbe3b96ef93509cf8135517d632/bijlage-3-5-documenten-november-12-tm-19.pdf [accessed on 13 April 2023].

44 Dutch Safety Board, *Aanpak coronacrisis. Deel 1: tot september 2020*, Section 8.2, 16 February 2022.

45 Procedurally, the OMT advice is part of the administrative reconciliation consultative body (BAO) that advises the Minister of VWS. OMT opinions were sent to the Director-General of Public Health of the Ministry of Health.

46 This changed with the establishment of the MIT in August 2022.

47 Wiarda Beckman Stichting, Van technocratie naar beleid met een hart, 1 August 2020. https://www.wbs.nl/publicaties/van-technocratie-naar-beleid-met-een-hart [accessed on 13 April 2023].

48 Joram Feitsma, *Manoeuvreren tussen pandemie en oorlog vereist democratische stuurmanskunst*, 8 July 2022. https://www.socialevraagstukken.nl/manoeuvreren-tussen-pandemie-en-oorlog-vereist-democratische-stuurmanskunst/ [accessed on 13 April 2023].

49 KNAW, *Met de kennis van straks. De wetenschap goed voorbereid op pandemieën*, 25 September 2022. https://www.knaw.nl/publicaties/met-de-kennis-van-straks-de-wetenschap-goed-voorbereid-op-pandemieen [accessed on 13 April 2023].

50 Dutch Safety Board, *Aanpak coronacrisis Deel 1: tot september 2020*, 16 February 2022.

the crisis. Until January 2021, behavioural reflections were not discussed in the Council of Ministers or the Catshuis deliberations either. These were later included in the societal overview and societal test contributed by the National Coordinator for Security and Counterterrorism (NCTV). The Behavioural Unit did not have a representative in the OMT, nor were the Behavioural Unit's studies, such as the epidemiological status and the findings of the modelling group, systematically discussed in the OMT. The Behavioural Unit did have a permanent representative on the RIVM COVID-19 Response Team, where the epidemiological status and the unit's findings were discussed prior to the OMT. However, this representative was not given insight into the confidential agenda of – and hence questions to – the OMT. Therefore, the Behavioural Unit had no insight into the extent to which behavioural science input was utilised and was a part of discussions within the OMT. According to the modellers, their data were less suitable for use in the models. Signals about compliance with measures did come up in the OMT, but it left their weighing in the final draft of the measures to the government.

For the Behavioural Unit, it was unclear how behavioural science knowledge was shared with the Minister of VWS and what its impact on policy was. The unit had no regular affiliation with the ministry at at directors or Board level. Also – unlike the OMT – the unit was not present to provide interpretation to the Administrative Coördination Body (BAO). The request to change this was repeatedly rejected on the grounds that the Behavioural Unit was not formally part of the crisis structure. The Behavioural Unit tried to overcome this by placing a liaison officer at the Ministry of VWS to support the translation of behavioural science knowledge into policy decisions. Ultimately, the RIVM did not receive structural funding for this purpose and the commitment ended in spring 2022.

Interviews and official documents show that advisers and decision-makers sometimes assumed their own ideas on behaviour and underestimated what behavioural expertise could add. Besides being a virological and socio-economic issue, the fight against the COVID pandemic was primarily a behavioural one: the success of the approach depended on public compliance. 'Pandemic fatigue'[51] (the demotivation of citizens to keep following protective measures) is a well-known phenomenon in a pandemic. Behavioural research is important for countering pandemic fatigue and for building support. The Safety Board notes that – despite advice and guidelines from the WHO[52 53] and the European Centre for Disease Prevention and Control (ECDC)[54] and signals from the OMT, Red Team,

51 WHO, *Pandemic fatigue Reinvigorating the public to prevent COVID-19. Policy framework for supporting pandemic prevention and management*, 2020 [accessed on 14 June 2023]

52 WHO, *Behavioural and social sciences are critical for pandemic prevention, preparedness and response, Open letter to the Bureau of the Intergovernmental Negotiating Body to strengthen pandemic prevention, preparedness and response*, 23 February 2022 https://www.who.int/news-room/commentaries/detail/behavioural-and-social-sciences-are-critical-for-pandemic-prevention-preparedness-and-response [accessed on 10 June 2023].

53 WHO, *Pandemic fatigue Reinvigorating the public to prevent COVID-19. Policy framework for supporting pandemic prevention and management*, 2020 [accessed on 14 June 2023]

54 ECDC, *Behavioural Insights research to support the response to COVID-19: a survey of implementation in the EU/EEA*, 17 February 2021 [accessed on 14 June 2023].

scientists[55] and other experts – behavioural and social scientists did not gain a position of importance for pandemic control until September 2022.[56]

Tight focus on government goals
That prevention of post-COVID syndrome or prevention of delayed care, for example, did not become part of the crisis approach, is a political choice; the government focused its approach on keeping acute care accessible. For this reason, other risks were not included in considerations of whether or not to relax restrictions, either at decision-making moments or when designing medium-term approaches (see the opening plan and the recalibrated autumn approach of 2021 as well as the high peak in omicron infections in 2022). Post-COVID syndrome and deferred care were risks accepted by the government.

1.3 Adaptive ability

1.3.1 Dashboard & roadmaps

The government's approach was to control ICU occupancy. However, the government also relied on insights into the course of infections, hospital admissions and the R value. The timing of intervention or relaxation of measures was not always predictable - neither to politicians, nor to society. During the crisis, the government tried in various ways to make policies predictable and compehensible. To that end, the government introduced the Corona Dashboard and roadmaps. However, the continuously changing conditions, due to new variants, the level of immunological protection in society and the willingness to comply with measures, limited the predictive value and applicability of the roadmaps. The tension between predictability and a flexible management of uncertainty remained. Because the roadmap was not a 'neutral decision tree', it made the policy seem seem more plannable than what it could live up to. Because of this, the government's approach was not always comprehensible to politicians and society, whose support did not grow, as a result. The government struggled to 'read' and apply the roadmap as a tool for greater predictability, given the ever-changing circumstances and considerations. In January 2021,with the decision to review the roadmap once every three weeks, the government sought a better balance between predictability and flexibility.

1.3.2 Fourth objective

A new phase of the crisis dawned from mid-2021. The government saw vaccines as a game changer in its COVID approach, as vaccination protected people better against the risk of serious illness and hospitalisation. This allowed more infections to be accepted before maximum ICU occupancy would be reached. With the opening plan of April 2021, the government responded to calls from society for more perspective and more 'space'. Societal risks and pressure from society started to weigh more heavily towards decision-making in this period than previously. This also translated into the expansion of the

55 Van Bavel et al., 'Using social and behavioural science to support COVID-19 pandemic response', *Nature Human Behaviour 4*, 460-471, 2020 [accessed on 6 June 2023]
56 KNAW, *Met de kennis van straks. De wetenschap goed voorbereid op pandemieën*, 25 September 2022. https://www.knaw.nl/publicaties/met-de-kennis-van-straks-de-wetenschap-goed-voorbereid-op-pandemieen [accessed on 13 April 2023].

objectives of the testing policy. Testing for entry *(Testen voor Toegang)* facilitated the opening of society in addition to keeping track of and controlling the spread of the virus.

By adding the fourth objective to keep society open in May 2021, the government intended to mark that the structural economic and societal damage of the virus and the measures to control it had a clear place in decision-making. In fact, this did not change the crisis approach, as an 'open society' had always been an objective, albeit implicitly. Models showing the need of restrictions to maintain ICU care were still prioritised in political decision-making. The government made this objective explicit to demonstrate the integral nature of their decision-making to society and the parliament.

Although the NCTV was strongly committed to considering societal and economic interests, internal documentation and interviews show that the NCTV indicated that it was legally problematic to make the societal aspect explicit as a fourth objective within the strategy. The COVID-19 (Temporary Measures) Act was based on the three objectives originally formulated. Under this Act, societal and economic considerations had a place in the proportionality and subsidiarity considerations concerning the measures to be taken. Despite those objections, the Council of Ministers decided to add the target to the government's approach anyway. Later, it was no longer mentioned in letters from the House of Representatives. The Safety Board observes that there were two parallel worlds: the political reality, in which the government wanted the fourth objective to underline that it was paying attention to societal impact; and the legal reality, in which limiting societal harm could not be a formal objective within the strategy. Interviewees state as a possible explanation that 'core administrators' feared that it would lead to the down-playing or weakening of public health-related goals. In their view, the primary focus of the crisis response was to contain the virus. The discussion and ambiguity about the status of the fourth objective show how the government continued to approach the crisis as an acute health crisis.

1.3.3 Tenability of original policy goals

During 2021, virus circulation within the partially reopened society increased. The government accepted a higher infection rate. This led to increased risks, such as of post-COVID syndrome, but also to a new risk allocation. Particularly vulnerable people who had not built up immunity, such as the unvaccinated and immuno-compromised, were at greater risk of health damage from that point on. In addition to direct health risks, indirect health risks also increased. The growing demand for care – due to virus circulation – led to a further increase in deferred care and pressure on care, not only in hospitals, but also at GPs, nursing and care homes, care for the disabled, and home care – which was further exacerbated by staff attrition.

The OMT discussed the various risks created by the increased virus circulation. In the summer of 2021, it was discussed that the risks for vaccinated and unvaccinated people from then on were 'diverging'. OMT members questioned whether the three original government objectives were still appropriate to the stage the crisis was in. Some members suggested that other effects of virus circulation and the crisis as a whole should also be looked at, such as post-COVID and mental health. Interdepartmental crisis teams also pondered whether the objectives were still the right ones and whether they focused

too much on short-term health and too little on long-term wellbeing and health effects. Yet, the government did not adjust its targets.

Internal documents and interviews reveal that the government's prevailing thought was that they 'could not change the rules along the way'. This meant that during the crisis the government could not add new targets to the strategy. The previously added fourth objective was presented as a 'new' objective, but had in fact always been an implicit part of the strategy. The government assumed that society and parliament would not accept other strategy changes or new policy goals. Health damage that did not lead to pressure on the ICUs did not include the government as part of the crisis response. In addition to preventing post-COVID syndrome, other goals were conceivable that could have been achieved with the deployment of additional measures, such as creating space for catching up with deferred care. Yet the government chose not to focus on other or additional objectives after the intervention in autumn 2020. All room available was used to open society. Health damage such as post-COVID was seen as inevitable, because even in the endemic phase everyone would eventually become infected with the coronavirus once.

1.3.4 Addressing the endemic phase: new risk allocation and transfer of responsibility

Revision of objectives
In February 2022, the government nevertheless conceived a revision of the objectives and formulated two new so-called 'ancillary' objectives, namely 1) social and economic continuity/vitality, and 2) access to the entire healthcare chain for all.[57] In the parliamentary letter, the Minister of VWS spoke of a 'fundamental revision' of the original four objectives. In fact, this was a restatement: keeping care accessible had been the objective from the beginning of the crisis, albeit that the government had previously focused mainly on the accessibility of *acute* care.

Policy would 'no longer be conducted primarily from the point of view of the burden of care, but from a broader perspective on both the societal and socio-economic side and on care'.[58] However, the government had been taking that broad perspective for some time, and to make that explicit, the government had added the fourth objective in May 2021. The objective of 'protecting the vulnerable' seemed to have been dropped with the new objectives. However, according to the government, it was contained in both objectives, with the protection of socially vulnerable people falling under the first objective and that of medically vulnerable people under the second.

Window of opportunity
The government's decision in March 2022 to quickly and rigorously ease restrictions was motivated by the idea that vulnerable people (in particular the elderly) were at that time optimally protected by the last booster round of the vaccination campaign (the 'window

57 Parliamentary letter on the short-term approach to COVID and long-term outlook. Parliamentary Papers II, session year 2021/22, 25 295, no. 1780.
58 Parliamentary letter on the short-term approach to COVID and long-term outlook. Parliamentary Papers II, session year 2021/22, 25 295, no. 1780.

of opportunity'). The infectivity of omicron was so high that the R value could not be brought below 1 by measures: the surge was inevitable. The high level of immunity in the population would keep the pressure on ICUs contained. Prolonged use of stringent measures was no longer considered proportionate by the government during this period, given society's desire to ease measures. The government opted for a short, high peak of infections rather than a longer wave with a lower peak of infections.

Shifting risks and responsibility
Acceptance of high infection rates meant increased – and in some cases unavoidable – risks to medically vulnerable people and the possible forced isolation of people who did not (or could not) acquire immunity.[59] The OMT called for clear communication on consequences, including longer-term consequences, of infection for individual citizens.[60] [61] The Social and Cultural Planning Office also asked that communications pay attention 'to the significance of people's shared (and personal) responsibility for their health and that of others'.[62] The government clearly explained that the risks to the availability of ICUs had decreased and what high infection rates could mean for healthcare as a whole. In government communication less attention was paid to informing the population about individual health risks and how to deal with them. The government did not prepare citizens for their assigned responsibility to make well-informed decisions about their individual health and that of others.[63]

With the government making society co-responsible, (commercial) sectors were also given an important role in the long-term approach. They were expected to make plans that could effectively combat infections in their own sectors. However, these sectors were ill-equipped to make well-founded plans. For instance, they lacked insight into the effectiveness of measures. The government expected the RIVM to calculate and assess the plans on effectiveness, but according to the RIVM, the effectiveness of measures on virus spread per sector was not easy to predict. In addition, several sector plans included the COVID Certificate *(Coronatoegangsbewijs)* for access, even though there was no legal basis for it.

1.4 Looking forward

1.4.1 Working with scenarios

In addition to its strong impact on people who were vulnerable to the virus, the crisis also reinforced vulnerabilities that existed before, such as inequality of opportunities in education, lack of capacity in care, insufficient visibility of help needs from the social

59 The transfer of responsibility to citizens was allegedly not accompanied by the necessary community engagement; see Mooy et al., *Uit isolatie. Samenleven ondanks corona. Suggesties voor langetermijnstrategie aanpak COVID-19*, 15 June 2022. https://www.ginnymooy.com/wp-content/uploads/2022/06/Uit-isolatie-_-Samenleven-ondanks-corona-Verdieping.pdf [accessed on 14 April 2023].
60 OMT, *Advies na 142e OMT*, 14 February 2022.
61 OMT, *Advies na 139e OMT*, 24 January 2022.
62 SCP, letter to NCTV *Sociaal-maatschappelijke reflectie mogelijke maatregelen Covid-19*, 12 January 2022.
63 Mooy et al., *Uit isolatie. Samenleven ondanks corona. Suggesties voor langetermijnstrategie aanpak COVID-19*, 15 June 2022. https://www.ginnymooy.com/wp-content/uploads/2022/06/Uit-isolatie-_-Samenleven-ondanks-corona-Verdieping.pdf [accessed on 14 April 2023].

domain, and the vulnerable position of some groups of employees.[64] [65] In addition, the Social and Cultural Planning Office identified new groups that the crisis left vulnerable. As early as the spring of 2020, planning offices argued in favour of linking short-term crisis policy to long-term ambitions, and to address such societal tasks explicitly and *integrally* in the crisis approach, amongst other things to maintain support.[66] [67]

The advisory councils repeatedly underlined the importance of thinking through bad scenarios during peaceful times[68] and the importance of a broad societal consideration of measures, not avoiding complex choices. Various forms of long-term thinking, such as working with scenarios, were initiated during the course of the crisis (e.g. by the Scientific Council for Government Policy[69]), but were not reflected in crisis decision-making until February 2022. The government maintained a short time horizon, focused on tackling ever new acute problems, and struggled to set its sights on longer-term issues.

1.4.2 Explanatory factors for the limited focus on the long-term perspective

This study reveals several factors that contributed to the fact that the government's focus on the long-term (and the associated strategy) was slow to take off. This had to do with mental space, ownership of the crisis, cruising on short-term forecasts and wishful thinking.

No mental space
Several interviews reveal that the core ministers, the so-called 'cockpit', were preoccupied with dealing with the acute health crisis. They had hardly any mental space for long-term policies, or limiting social and economic impact *within* the crisis approach.

Ownership of the health crisis
From the moment that the MCCb or MCC-19 was activated, it was no longer the relevant minister who determined the approach, but it was up to the government to determine what measures were needed and how to manage the crisis broadly.[70] The relevant minister retained his own powers, but applied them in line with the wishes of the broad crisis team. The government expressed a different interpretation of the regulations

64 Social and Cultural Planning Office. *Adviesbrief Sociaal en Cultureel Planbureau. Bouwstenen voor sociaal herstelbeleid.* 9 April 2021. https://www.scp.nl/binaries/scp/documenten/publicaties/2021/04/09/adviesbrieven-maatschappelijke-effecten-corona/SCP-2021+953+Adviesbrief+Sociaal+en+Cultureel+Planbureau++Bouwstenen+voor+sociaal+herstelbeleid.pdf [accessed on 13 April 2023].
65 Council of Public Health & Society, *Applaus is niet genoeg. Anders waarderen en erkennen van zorgverleners*. 10 November 2020. https://www.raadrvs.nl/binaries/raadrvs/documenten/publicaties/2020/11/10/applaus-is-niet-genoeg/Advies+RVS+Applaus+is+niet+genoeg.pdf [accessed on 13 April 2023].
66 Social and Cultural Planning Office, *Aandachtspunten voor een herstelbeleid: Briefadvies COVID-19 Overleg Planbureaus*. 28 May 2020. https://www.scp.nl/publicaties/publicaties/2020/05/28/aandachtspunten-voor-een-herstelbeleid-briefadvies-covid-19-overleg-planbureaus [accessed on 13 April 2023].
67 Letter of advice from the Social and Cultural Planning Office and the Council of Public Health & Society, 25 January 2022. https://www.scp.nl/publicaties/publicaties/2022/01/27/briefadvies-corona-sociaal-en-cultureel-planbureau-en-raad-voor-volksgezondheid--samenleving [accessed on 13 April 2023].
68 Scientific Council for Government Policy, Council of State, Council for Public Administration and the Council of Public Health & Society, *Coronascenario's doordacht: Handreiking voor noodzakelijke keuzes*, WRR publication, 4 September 2022.
69 WRR &KNAW, *Navigeren en anticiperen in onzekere tijden*, 2 September 2021 [accessed on 13 April 2023]
70 See also the system description in the annex.

governing the scaling-up of the national crisis structure.[71] Throughout the crisis period, the Minister of VWS continued to see the acute crisis approach as his responsibility. He did not favour 'broadening the perspective' because that would complicate the crisis approach.

According to interviewees, uncertainty about ownership of the crisis and discussion about 'broadening the perspective' contributed to rising interdepartmental tensions. Tensions were particularly evident between officials in charge of dealing with the acute crisis and those responsible for the long-term approach. Hence, scenario development at DGSC-19 got off to a difficult start. The medium- and long-term perspective of DGSC-19 was regarded as 'not immediately urgent'. The programme directorate's self-assessment confirmed this picture. DGSC-19 ultimately had limited influence on the crisis decision-making, as the government prioritised short-term interests as expressed by the Ministry of VWS.[72]

Navigating on short-term forecasts from the OMT

As is usual in an infectious disease outbreak, the government relied on the OMT's opinions. These opinions were based on the forecasts of the infectious disease models. These models always looked two to three weeks ahead. Due to the incubation period and the time between first symptoms and becoming seriously ill, it took two to three weeks before the effects of measures on virus spread and its knock-on effects on ICU occupancy were observable in the data. Therefore, the government did not look beyond that period to evaluate and possibly adjust measure packages. This mechanism contributed to a short-cycle decision-making process. Until February 2022, there was limited focus on long and longer-term scenarios, which would be desirable in a longer-term crisis. Documents and interviews show that there were different perceptions amongst ministers about the meaning and purpose of scenarios. When it comes to taking into account different scenarios, ministers referred in particular to the projections of infections and hospital occupancies based on the RIVM models. Within the OMT, there were repeated requests by members to work on long-term scenarios, but according to the chair this was outside the OMT's remit and responsibility.

Wishful thinking

Within society, but also amongst administrators and politicians, wishful thinking (or normalcy bias) also played a role, as the analysis by the Scientific Council for Government Policy (WRR) showed. [73] Normalcy bias is the tendency to downplay a potential threat. This is an understandable and human reaction, but as a starting point for policy and collective action that tendency is inappropriate. In summer 2020, when infection rates and hospital utilisation were decreasing, many people, including administrators and

71 In particular, this concerns the interpretation of the MCCb establishment decree and the national crisis management handbook.

72 NSOB, *Wordt Vervolgd!? Lessen over opzet en werking van het interdepartementale programmadirectoraat-generaal Samenleving en COVID-19 (DGSC-19)*, December 2021. https://www.nsob.nl/denktank/overzicht-van-publicaties/wordt-vervolgd [accessed on 14 April 2023].

73 WRR, *Coronascenario's doordacht: handreiking voor noodzakelijke keuzes*, 4 September 2021. https://www.wrr.nl/publicaties/publicaties/2022/09/05/coronascenarios-doordacht-handreiking-voor-noodzakelijke-keuzes [accessed on 13 April 2023].

politicians, thought the worst was over and society could return to normal.[74] [75] Wishful thinking led to the government being repeatedly surprised by developments to which it had to respond ad hoc.
At times when scenario-based thinking did take place (such as in the opening plan and the recalibration), the government often chose only the most likely scenario – in many cases also a relatively favourable one. The government did so – in its own words – because of the importance of the open society, or for economic and social reasons.[76] Thinking through different, less positive scenarios and long-term strategic choices garnered little attention, which meant that new acute crises kept presenting themselves.[77]

1.5 In conclusion

Value and other considerations
Due to the manner of operating described in this chapter, the government often had to adjust planned and chosen measures. This led to citizens and civil society perceiving the approach as inconsistent, as research by the Behavioural Unit showed. It was often unclear to citizens which direction the government wanted to take exactly with the measures they implemented and what its considerations were in doing so.[78] [79] [80]

Public confidence in the government and support for the measures declined during the crisis. After all, public support benefits from policies and decisions that are explainable, effective and, as far as possible, predictable. Striving to control the virus and keep care accessible, while keeping society as open as possible, required a continuous consideration of values. Scaling down regular care at higher virus circulations could lead to health damage, as care had to be postponed. The question is to what extent society is prepared to accept this, if it can prevent the negative social and economic consequences of restrictive measures.

Social distancing for the sake of the health of one vulnerable group comes at the expense of good and healthy living (and living together) for many other vulnerable groups, which

74 WRR, *Coronascenario's doordacht: handreiking voor noodzakelijke keuzes*, 4 September 2021. https://www.wrr.nl/publicaties/publicaties/2022/09/05/coronascenarios-doordacht-handreiking-voor-noodzakelijke-keuzes [accessed on 13 April 2023].
75 VNG, *Eindrapport van het expertiseteam COVID-19 van de VNG, Voorbij de crisis in coronatijd, Lange termijnstrategie COVID-19 vanuit lokaal perspectief*, 9 June 2022. https://vng.nl/sites/default/files/2022-06/Voorbij-de-crisis-in-coronatijd.pdf [accessed on 13 April 2023].
76 Parliamentary Papers II, *session year 2021/22, 25 295 no. 1468*.
77 WRR, *Coronascenario's doordacht: handreiking voor noodzakelijke keuzes*, 4 September 2021. https://www.wrr.nl/publicaties/publicaties/2022/09/05/coronascenarios-doordacht-handreiking-voor-noodzakelijke-keuzes [accessed on 13 April 2023].
78 Letter of advice from the Social and Cultural Planning Office and the Council of Public Health & Society, 25 January 2022. https://www.scp.nl/publicaties/publicaties/2022/01/27/briefadvies-corona-sociaal-en-cultureel-planbureau-en-raad-voor-volksgezondheid--samenleving [accessed on 13 April 2023].
79 Behavioural Unit, *6e brief - Gedragsreflecties op maatregelenpakket* to NCTV and DG of Public Health of the Ministry of VWS, 12 April 2021. Parliamentary Papers II, *session year 2020/21, 25 295, no. 1105*.
80 Behavioural Unit, memo *Draagvlak en vertrouwen, het belang van ervaren rechtvaardigheid*, 18 November 2021. https://www.rivm.nl/documenten/draagvlak-en-vertrouwen-belang-van-ervaren-rechtvaardigheid [accessed on 14 April 2023].

actually benefit from proximity and contact.[81] Measures to control the virus and its health effects sometimes come at the expense of citizens' fundamental rights.

Such fundamental questions and value dilemmas were mentioned in official memoranda, but the government did not always communicate them to society. The government mentioned that there were dilemmas and that the choices made could lead to disappointment for certain groups. The rationale (or selection criteria) for what did and did not fall within the focus of the crisis approach was not made transparent. In other words, it remained unclear on what basis certain forms of damage or risk were deemed acceptable or unacceptable or were valued.

The government chose not to make widely publicly explicit the ethical frameworks and associated discussion of values that lay beneath concrete decisions. It did not initiate a societal dialogue on what values and desires were central to groups in society. The Safety Board moreover hardly registered any fundamental values discussions during the debates following the technical briefings and other debates in the House of Representatives. Instead, discussions there tended to focus on the details of specific measures, such as whether the curfew should be an hour earlier or later. After requested adjustments, proposed packages of measures were sometimes inconsistent. Interviewees indicate that in this way – and also through many parliamentary questions – parliament had a negative impact on the government's effectiveness in the crisis.

Determining an acceptable level of risk and desired societal developments requires fundamental value discussions with society, in addition to a wide range of knowledge sources. Citizens' lives were turned upside down, but it was difficult for them to participate in the considerations – other than afterwards, by banging on pans and carrying banners. The protests and riots about 2G and the curfew, for example, showed people's need to be heard in terms of their wishes and values. Where the government was aiming for cooperation from society, it failed to make sufficient use of an important opportunity to obtain such cooperation permanently.

Of course, it should be noted here that by no means all expressions of resistance stem from a lack of value discussions or have constructive elements. During the crisis, government ministers, OMT members and other visible stakeholders were frequently threatened personally. This is not acceptable under any circumstances.

Adaptive ability and ownership

Throughout the crisis, the government took the OMT projections on current and expected trends in ICU and hospital occupancy as its point of departure. Steering information on the long-term health effects of the virus, the pressure on the entire care chain and deferred care, and the societal impact of the crisis were considered less in crisis decision-making than indicators that aligned with the government's strategic objectives. As a result, an optimal feedback loop with new information ensuring that the

81 Council for Public Health & Society, *(Samen)leven is meer dan overleven. Breder kijken en kiezen in tijden van corona*, 3 May 2020. https://www.raadrvs.nl/documenten/publicaties/2020/05/03/goed-samen-leven-in-tijden-van-corona [accessed on 14 April 2023].

set objectives and strategy were evaluated and adjusted in the interim was also missing. Because of that, the government's adaptive ability was hampered. The Safety Board made that observation in its first report on addressing the COVID crisis, which covered the period up to September 2020. The Board notes that even in the subsequent phases, new steering information (the 'broad view') was used to a limited extent to test whether the strategy of 'maximum control' was still appropriate to the ever-changing circumstances.[82]

During the crisis, the government wanted to take charge, stay on course and exude control.[83] When implementing measures for long periods of time it focused on top-down steering, with an emphasis on enforcement. The Association of Dutch Municipalities referred to this as a 'safety approach'.[84] In the acute phase of the crisis, such central control was logical and desirable. In the longer term, however, it is not sustainable. The Social and Cultural Planning Office repeatedly raised the collective action issue, i.e. the importance of measures being supported by society and experiencing shared ownership. Initially, people saw the benefit and necessity of taking action for public health and their own health. But as other factors (social, societal, economic) became more important, that changed and compliance with measures decreased.[85] In the course of the crisis, it became clear that controlling the virus and the crisis also requires the crisis approach to be adjusted.[86] It is important in times of a prolonged crisis and great uncertainty that the government prepares for different possible scenarios and finds a balance between providing guidance and involving society in fundamental integral value (and other) considerations. This will contribute to public support for policies pursued and enable a sense of co-ownership and 'togetherness' as long as COVID is still amongst us.

82 Dutch Safety Board, *Aanpak coronacrisis Deel 1: tot september 2020*, 16 February 2022.
83 See also the choice of the term 'maximum control' and the 'man on the moon' strategy cited in sub-report 1.
84 VNG, *Eindrapport van het expertiseteam COVID-19 van de VNG, Voorbij de crisis in coronatijd, Lange termijnstrategie COVID-19 vanuit lokaal perspectief,* 9 June 2022. https://vng.nl/sites/default/files/2022-06/Voorbij-de-crisis-in-coronatijd.pdf [accessed on 13 April 2023].
85 *Parliamentary Papers II*, session 2021/22, 25 295, no. 1638.
86 Dutch Safety Board, *Aanpak coronacrisis. Deel 1: tot september 2020*, Section 4.3, 16 February 2022.

2 CONCLUSIONS

In this chapter, the Safety Board draws conclusions from the government's management of the risks to public health and safety during the COVID crisis in the period from January 2020 to September 2022. These conclusions can help address a future pandemic or protracted crisis with a national impact. They also serve as the basis for the recommendations in Chapter 9.

1. Manoeuvring between acute care and an open society
The government manoeuvred between keeping acute care accessible and political and social pressure to open up society. This was a tricky position, because managing risks on one side created or exacerbated risks on the other. Freedom restrictions reduced health damage from the virus, but exacerbated loneliness and mental health problems, for example. Opening up society alleviated societal problems, but increased viral circulation with associated health risks, especially for vulnerable people. The government had to persistently weigh up conflicting interests, where freedom for one could lead to a lack of safety for another.

2. Risk management opportunities constrained by poor data
In infectious disease control, it is essential to have insight into the spread of the virus and its impact on public health. This insight was inadequate during the first virus outbreak because testing and laboratory capacity and data infrastructure were not sufficient for a pandemic of this magnitude. Moreover, every time a new virus variant emerged, there was a period of uncertainty about its properties. As the crisis deepened, insight into key parameters became better and more detailed. However, the interpretations and application of privacy laws and regulations were a recurring barrier to data sharing between involved parties. This included the exchange of test and vaccination data and the linking of mortality data to other data for the purpose of scientific research. Optimal insight on the basis of which the government could adjust crisis policy where necessary was lacking.

3. Models as short-term steering guide
Because of the desired scientific underpinning of policy recommendations, the RIVM's epidemiological models played a central role in decision-making. Although the OMT highlighted the margins of uncertainty in its modelling results, the government used the forecasts as steering scenarios for the following three weeks. This resulted in image and decision-making being focused on the short-term perspective. The government's approach in this regard generally focused on the median (the middle) value of the forecast. This resulted in the government being surprised a number of times, when developments deviated from it due to the erratic course of the crisis.

4. Risks that manifested later were not part of crisis response
The government set crisis response targets based on infectious disease control protocols in March 2020, during the first COVID outbreak. Later, the context of the crisis changed with the emergence of new virus variants, the introduction of vaccines and the increase in negative social consequences. In that changing context, the government maintained the objectives it had set at the beginning of the crisis. Risks that manifested themselves later in the crisis or increased with time were not part of the original objectives. To these new risks, such as post-COVID and deferred care, the government's crisis approach offered no answer.

5. Societal crisis and long-term policy complicated by VWS ownership
In its first sub-report on the Approach to COVID-19, the Safety Board concluded that when the national crisis structure was activated, there was no explicit transfer of the leadership role from the Minister of VWS to the Ministerial Committee for Crisis Management. In practice, the Minister of VWS maintained a central role in crisis response, which did not highlight the need for a broader view and integrated approach to the crisis and kept the perspective of infectious disease control dominant. In this third sub-report the Safety Board concludes that, despite a widening of the crisis and an increase in the number of parties involved, the Minister of VWS retained ownership of the crisis. The government continued to view the crisis mainly as an acute health crisis. Broader perspectives and long-term scenarios brought in as the crisis progressed did not fit within the crisis approach, according to the government. For long-term effects and wider societal problems, flanking policies had to provide the solution in the eyes of the government.

6. Crisis approach not adjusted based on signals from overburdened care
By choosing the maximum ICU occupancy rate as an indicator for intervention through measures, the government placed great reliance on the resilience and improvisational capacity of the entire healthcare chain. Healthcare organisations, including home care, general practitioners, nursing homes and hospitals, increasingly faced high patient inflows, staff shortages and backlogs due to delayed care during the COVID crisis. With few exceptions, the government did not demonstrably use signals concerning this from the healthcare sector to evaluate and adjust the crisis approach. For two and a half years, counting on the resilience of an overstretched sector made both the sector itself and the government's crisis approach vulnerable.

7. Limited use of social-science expertise
Throughout the crisis, the government called on society to follow advice and measures to prevent infections. Support for and compliance with these measures were prerequisites for controlling the virus. Pandemic control was thus as much an epidemiological as a behavioural issue. Knowledge and expertise were available from the social sciences to examine and respond to this issue. The government hardly used this expertise in designing measures or creating support. As such, social-science insights played a limited role in crisis management.

8. Citizens were given limited ability to assess risks and make choices

To manage the risks of virus spread, the government instituted collective measures. With vaccination rates rising and the emergence of a less pathogenic virus variant and accumulated immunity, ICU occupancy was no longer an issue during 2022, and the government eased restrictive measures. The government accepted high virus circulation, increasing the risk of infection and associated health damage, especially for vulnerable people and those without immunity. By emphasising the positive development that society could reopen, the government was not sufficiently transparent about the increased risks people faced from then on. Without such information, citizens were unable to assess the residual risks to themselves and others and adjust their actions accordingly.

9. Value dilemmas were not made sufficiently explicit

During the crisis, the government faced major challenges to ensure the safety of society, in particular vulnerable citizens. In doing so, the government had to constantly weigh values. The Safety Board notes that the government has done so on several occasions, either based on advice provided or not. These value considerations underpinned concrete decisions on far-reaching measures. However, the government did not always make publicly explicit the ethical frameworks and associated discussion of values that lay beneath concrete decisions. For example, the government did not routinely share these with parliament. Thus it remained unclear how the government weighed the potential risks to various groups of people when reopening society or why the space created by increased vaccination coverage was used in the way chosen. As a result, society – especially as the pandemic continued – was not sufficiently able to understand how the government arrived at the considerations that it made. This contributed to misunderstanding and declining support.

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