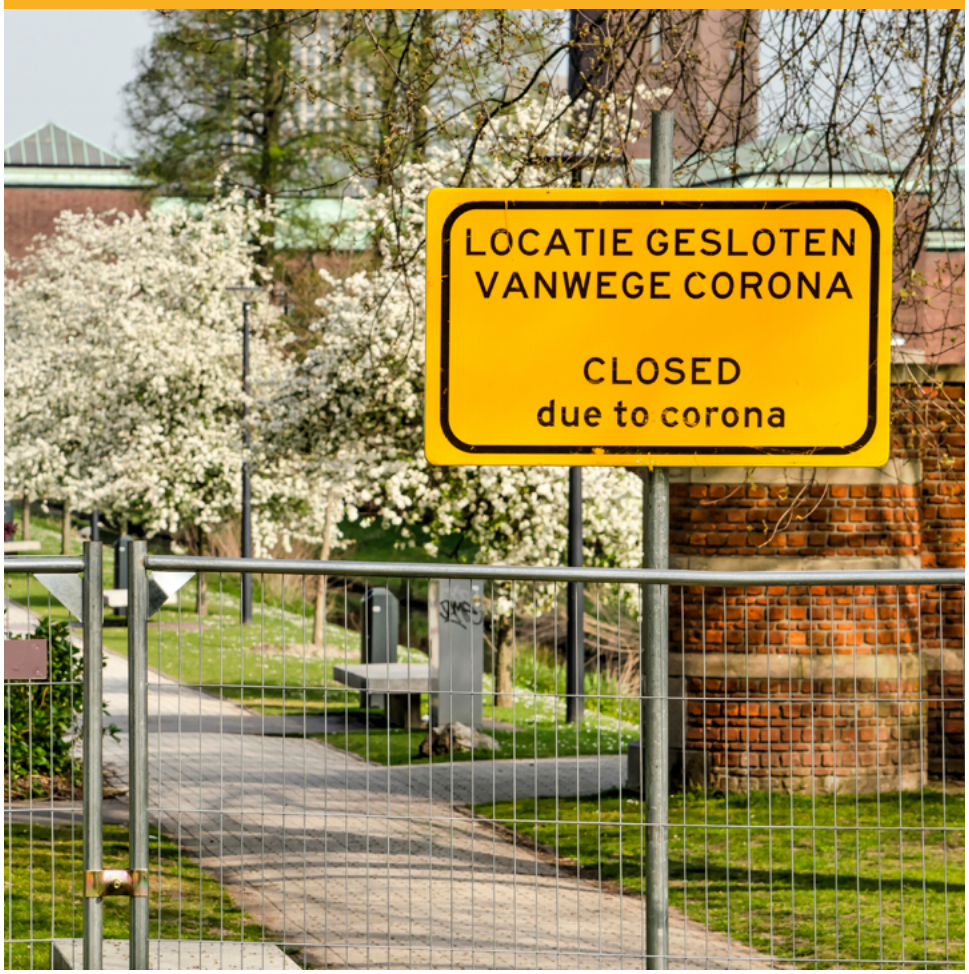
DUTCH
SAFETY BOARD

Summary

Approach to COVID-19 crisis

Part 1: through to September 2020



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Part 1: through to September 2020

The Hague, February 2022

The reports issued by the Dutch Safety Board are publicly available on www.safetyboard.nl.

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The Dutch Safety Board

When accidents or disasters happen, the Dutch Safety Board investigates how it was possible for these to occur, with the aim of learning lessons for the future and, ultimately, improving safety in the Netherlands. The Safety Board is independent and is free to decide which occurrences to investigate. The Dutch Safety Board focuses particularly on situations in which people are dependent for their safety on third parties, including government or companies. In certain cases, the Safety Board is under an obligation to carry out an investigation. Its investigations do not address issues of blame or liability.

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.

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SUMMARY

The COVID-19 pandemic has resulted in a protracted, international crisis. What started as a health crisis rapidly expanded to become a crisis encompassing the whole of society, on a scale previously unprecedented in post-war Netherlands. The first report of a virus outbreak in China was received in late 2019. On 27 February 2020, the first patient tested positive for the coronavirus in the Netherlands. In response, the government launched a series of measures to tackle the crisis, to mitigate the risks and to develop new knowledge; at the same time, citizens had to learn to deal with the reality of the virus and its consequences for society.

This first sub-report is a description and analysis of the approach to the crisis by the various involved parties in the Netherlands. It covers the preparations for and the approach to the COVID-19 pandemic up until September 2020. Further sub-reports for the subsequent periods deal with the events, measures and interventions characteristic for those periods. The primary objective of all aspects of the investigation is to reconstruct the events and actions taken during the COVID-19 crisis; to subsequently be able to understand and where possible explain why things happened in the way they did. This, finally, in order to learn lessons for the crisis approach now, as well as in the future. A future in which similar or different types of protracted crises that lead to serious disruption in society are entirely plausible.

The lessons from the investigation provide tools for tackling both the current COVID-19 crisis and other, future crises. The Dutch Safety Board is also conducting this investigation for all parties wishing to better understand the Dutch approach to the crisis. It is, after all, an occurrence that affects the whole of society. This report should therefore *not* be read as a final judgement nor as a final evaluation of the crisis approach. However, it *does* offer insights into how the approach developed during the initial crisis period in the Netherlands, and how decision-makers, advisors and other involved parties can learn from these events for tackling the still ongoing COVID-19 crisis, and future crises.

Preparation

Until recently, the Netherlands had no immediate experience of a national, disruptive crisis brought about by infectious diseases. The parties most closely involved in infectious disease control in the Netherlands (the Ministry of Health, Welfare and Sports, the National Institute for Public Health and the Environment (RIVM) and the Municipal Health Services (GGD)) were prepared for relatively small-scale and restricted outbreaks of infectious diseases, the consequences of which affected only healthcare. There were scenarios aimed at the advent of a socially disruptive pandemic, but they did not result in preparation for a protracted crisis with broad national impact. This can partly be explained by the fact that the parties involved used recent experiences with infectious disease crises as a reference: a crisis such as the COVID-19 pandemic is unprecedented in the post-war Western world. In addition, the priority given to infectious disease control on the administrative and political agenda has fluctuated over the years.

The Ministry of Health, Welfare and Sports (VWS) has a central role in the crisis approach in the face of outbreaks of serious infectious diseases. During exercises for the preparation for infectious disease control, this crucial role for the Ministry was never really considered. There exists no scenario that describes the relationship between the national and the regional approach. Together with other parties VWS was forced to improvise in tackling the crisis, which resulted in the establishment of a whole raft of coordination structures.

Right from the first few months of the pandemic, the involved parties experienced problems in upscaling resources and capacity to control or to manage the crisis. On the basis of combined efforts and resilience during the course of the crisis, the healthcare parties and VWS together ensured that gaps could be filled in the structure and organization of crisis management in the healthcare sector. To a large extent, this adaptability compensated for the fact that the preparations were not aimed at a protracted national infectious disease crisis with wide-ranging social consequences.

Crisis organization

Infectious disease control was a challenge that in some areas exceeded the problem-solving capacity of individual care providers at the regional level. It required national agreements and management. Neither the regular healthcare system nor the crisis management organization were equipped for these challenges. Capacity problems in healthcare also played a role. The different choices made by VWS in its management approach to different issues did not result in a clear picture of how national management for the healthcare sector was organized during the crisis. It regularly resulted in a lack of clarity and irritation within the healthcare field. Moreover, the coordination necessary to create and actually secure the functioning of national cooperation was at the expense of the speed required in the acute phase of a crisis.

The existing national crisis structure makes no distinction between the approach to acute crises and protracted crises such as the COVID-19 pandemic. In addition, in the process of upscaling to the national crisis structure, there was no explicit transition from the leading role of VWS to the Ministerial Committee for Crisis Management (MCCb) chaired by the Prime Minister. As a consequence, the national crisis structure remained firmly focused on infectious disease control. However, the approach focused on the acute crisis phase and an approach focused on long-term effects in a protracted social crisis impose clearly different demands on the crisis organization and the decision-making structure.

Given the broad scope and long duration of the COVID-19 crisis, ever growing numbers of people joined the crisis teams within the national crisis structure, in particular within the MCCb. As a result, swift and effective decision-making was threatened. For that reason, the Prime Minister decided to make an adjustment to the national crisis structure by organizing the coordination process in a smaller assembly, in the informal consultation sessions in his official office in The Hague, which became known as *Torentjesoverleg* and informal consultation sessions at his official residence which became known as *Catshuisoverleg*. Management of the crisis thus shifted informally to consultation bodies other than the MCCb. This resulted in both a formal and an informal structure for decision making, and at the same time in a diffuse crisis organization. It was not always clear how the changes to the national crisis structure actually related to the formal decision-making route.

The multitude and variety of coordination structures and decision-making bodies led to uncertainty about responsibilities, specifically at administrative level, and to questions about who was coordinating and managing the overall process.

This national crisis structure was replaced at the end of June 2020 by a more limited, nation-wide programme structure. One consequence was that from that moment onward, the crisis approach was scaled down and transferred elsewhere in the form of a programme. With the loss of the crisis structure, uncertainty grew within the safety regions and Ministries about the distribution of roles, tasks and responsibilities. As infection rates once again started to rise in the summer months, the safety regions called for national frameworks, but since the national crisis structure had been scaled down, coordination of national measures proved difficult. Moreover, the programme structure was not equipped to tackle acute bottlenecks in the crisis. While the programme structure was still being established, the Netherlands found itself in the second wave of the COVID-19 crisis. In the summer of 2020, signals of the imminent arrival of a second wave did not result in the reactivation of the full national crisis structure. Criteria for re-establishing (parts of) that national crisis structure were absent.

Decision making

For the Cabinet, infectious disease control was the most important starting point for the crisis approach. The idea was that by tackling the underlying causes, the negative consequences would also be removed. The greater the severity of those consequences, the more important it became that the Netherlands complied with the measures, with the potential 'reward' that space would be created to ease the restrictions. The fact that the focus remained fixed on the perspective of infectious disease control influenced the decision-making process and was reinforced by the position of the Outbreak Management Team (OMT) as the team of leading experts and the advisory role of the chair of the OMT in practically all crisis teams. This strict focus on infectious disease control hindered the careful consideration and inclusion of interests in other policy areas as well as in other sectors within healthcare.

Throughout the period investigated through to September 2020, there were considerable uncertainties. Decisions had to be taken on the basis of a (scientific) information deficit, with limited possibilities for modelling and prolonged uncertainty about how the virus would spread. It was uncertain which measures would achieve the best expected result, what the side effects would be - also beyond the healthcare sector - and what those measures would mean for the support within the Dutch population. This resulted in uncertainty in the advices issued, and in the decisions based on those advices. The decision-makers themselves recognized the need to reduce uncertainties as much as possible. There was a tendency to focus strongly on the information and quantitative figures that were available. These figures (R-value, infection rates, Intensive Care and hospital admissions) appeared solid, but in practice were above all indicative of the delayed (knock-on) effect of the incubation time of the virus and the restricted test capacity available in the spring of 2020. In reality, the understanding of the virus was still limited.

Within this clear field of tension, qualitative signals, with their inherent uncertainties, were quickly set aside. Especially at the start of the crisis, the effects on the psychological

wellbeing of vulnerable individuals and the socioeconomic consequences could not be supported by quantitative data. Moreover, wider-ranging social advisory bodies were granted no permanent role in the decision-making process. This meant that outside the healthcare sector, the impact of the crisis and the measures taken in tackling it were less clearly represented. In addition, indicators and advices on the practical implementation of those decisions received less attention in the decision-making process. In part due to the absence of a broad-based implementation assessment, a number of decisions were taken that subsequently proved problematic in the implementation phase.

The exponential growth in the number of infections demanded rapid and adequate intervention. Due to the need for decisiveness, the *Catshuisoverleg* and *Torentjesoverleg* acquired an increasingly prominent position in the decision-making cycle, despite the fact that these consultation sessions were not normally an integral part of the crisis organization. This in turn changed the role of the bodies that would normally occupy a regular position in the crisis organization. The need for effective decision making within a smaller consultation body may be understandable, but it also concealed the inherent risk of reducing the degree of care necessary in the decision-making process. The informal changes meant that the in-built control mechanisms were effectively put out of play.

Crisis communication

Communication with the public was a crucial element in the approach to the COVID-19 crisis since that approach called upon all Dutch people to comply with the imposed measures aimed at preventing the spread of the virus. The crisis communication helped ensure a high level of support for the measures, through to May 2020. The government failed to maintain that level of support. The analysis has revealed a limited match between the communication approach and the characteristics of the COVID-19 crisis. One key contributing factor was the heavy reliance of the communication approach on the experience and knowledge acquired in relatively short-term disasters and crises, with a clear start point and end point. Because the COVID-19 crisis had no clear starting point, and initially remained somewhat below the radar, the national government adopted a wait and see attitude in its public communication at the start of the crisis period. In the period during which the virus was not yet actively identified in the Netherlands, communication from the RIVM was mainly reassuring, while lagging behind the need for information from the population.

During the initial period of the COVID-19 crisis, the emphasis within the communication approach was placed on the top-down informing and instructing of the general public. National government provided limited attention to the diverse nature of the target groups that had to be reached. Although from May 2020 onwards government did pay more attention to target groups with specific communication needs, including people with functional illiteracy, it had only a limited understanding of the extent to which these groups were actually informed, convinced and activated throughout the investigated period. At the same time, the government was faced with growing concern among citizens suffering financial, social or psychological difficulties as a result of the crisis, and the effects of the measures on their personal and professional situation. Although the government did focus more attention on these aspects as the crisis continued, there was no systematic implementation or application of a form of so-called 'connecting communication' (in which government showed a willingness to enter into discussion

about the questions, concerns and difficulties of people suffering as a result of the measures and the consequences of the crisis) despite the fact that specifically that approach was sorely needed.

The government attempted to include the general population in the uncertainties and dilemmas it was facing. The government also tried to offer hope and future prospects by making promises and creating expectations. However, because they were often based on uncertain assumptions, in many cases government was unable to live up to those promises and expectations. This eventually contributed to declining societal support for the crisis approach. In addition, with its focus on informing, convincing and activating the public, the communication became increasingly mismatched with the long-term effects of the crisis.

Nursing homes

Nursing homes in the Netherlands were particularly hit hard during the first months of the COVID-19 crisis. More than half of all deaths in the Netherlands in the period up until September 2020 occurred in nursing homes. The vulnerable elderly residents of nursing homes were susceptible to the virus, but the focus of the crisis approach was also a contributing factor to this. At the start, the bottlenecks in nursing homes received limited attention and priority. Investigating the nursing homes generated insights into the impact of the crisis approach in practice. The investigation revealed lessons that are potentially also important for other vulnerable groups.

Preparation for national (infectious disease) crises is focused heavily on acute care and hospital care. From the start, there was less clarity about the consequences of a national infectious disease crisis for the care provided in nursing homes. The crisis approach adopted by VWS was primarily based on the input from the healthcare field, in which the *cure* sector is more heavily represented than the *care* sector. The approach to the crisis focused on hospital and in particular intensive care occupancy levels. In the first instance, there was less focus on bottlenecks within the nursing home sector. The crisis approach was guided by the prevailing dynamism in the healthcare field, and at the start that dynamism set the course for the distribution of scarce resources. This approach proved unsuitable for achieving the goal of protecting the most vulnerable groups. The majority of the scarce resources were shared among the hospitals and acute care, and only to a limited extent found their way into nursing homes. This increased the likelihood of the introduction and spread of the virus among vulnerable elderly care recipients. As a consequence, the number of coronavirus outbreaks in nursing homes rose sharply.

In the end, a nation-wide ban of visitors to nursing homes was announced, to be able to protect residents and staff. Although this visitor ban was successful in reducing the spread of the virus in nursing homes, the measures also had a huge impact on the wellbeing of many residents. Based on resilience and solution-oriented actions, the nursing homes have been able to mitigate but not to fully prevent the impact of the crisis and the measures.

The COVID-19 crisis has revealed a clear area of tension between medical treatment and the importance of a broader focus on wellbeing. Both perspectives are essential in meeting the needs of vulnerable elderly care recipients.

A crisis that affects everyone

By September 2020, worldwide almost one million people had died of the consequences of the coronavirus, among them ten thousand Dutch citizens. The number of people struggling with physical and mental suffering was many times greater. Behind the figures were at least an equal number of personal stories. The numerous interviews held by the Dutch Safety Board for this investigation revealed heart-wrenching images. Many of the interviewees looked back with mixed feelings and emotions on the first few months of the COVID-19 crisis. Interviews with individuals involved in hospitals and nursing homes, for example, revealed great sadness about the loss of patients and residents. There was anxiety and anger at having to work without protection due to shortages of protective equipment. One other notable feature was the dedication shown, not only in hospitals and nursing homes but in all sectors responsible for the crisis approach, as well as in society as a whole: throughout, there was a sense of everyone putting their best foot forward, and finding ways to deal with the problems and uncertainties of the crisis as effectively as possible.

Individuals involved in all sectors worked hard and were also in their private lives forced to confront the consequences of the crisis and the measures taken. It emerged from interviews how intense the sometimes far-reaching threats had been with which (health) care professionals and public figures were faced in their efforts to deal with the crisis. Cooperation was needed on all fronts. As the process evolved, coordination was sought and employed. Organization and improvisation were two sides of the same coin, and were achieved simultaneously. Initiatives with a positive outcome should be retained for the future. The resilience demonstrated and the efforts made by so many do not detract from the fact that improvements in the approach to the crisis are both possible and necessary.

Unprecedented crisis requires an unprecedented approach

This report focuses on the approach to the COVID-19 crisis in the Netherlands and not on its international aspects. At the same time, the international dynamic of the pandemic had clear consequences for the Dutch approach. After all, the spread of the virus did not stop at national borders. At the same time, all countries are autonomous and responsible for their own national healthcare. Such themes as the shortage of personal protective equipment and medical equipment and the sending of patients to hospitals in neighbouring countries did require international cooperation. Insights such as these have a broader relevance, also with regard to other major crises. They raise questions about how dependent the Netherlands *wishes* to be and how independent it *can* be. The Netherlands needs to consider questions such as these in the near future. It is essential that policy makers consider and reflect on the role of the international context in transboundary crises. They then need to take action, for example by defining the critical factors in respect of which the Netherlands wishes to be independent.

In terms of duration and scope, the COVID-19 crisis is one of the most far-reaching crises that the post-war Netherlands has had to deal with. What started as an acute crisis in the healthcare sector developed within a few weeks into a crisis with far-reaching consequences for the whole of society. It led to problems that went beyond regional, sectoral and even national boundaries. It claimed numerous victims; freedoms of individual citizens were restricted. Diverse interests had to be set off against each other and consideration had to be given to new ways of dealing with the crisis. In that sense, even to this day, the COVID-19 crisis is different from other crises in that the prepared structures and working methods did not match the problems and dilemmas that emerged during the first months. A crisis of this kind requires a fundamentally different approach to management, implementation, cooperation, decision making and communication. Explanation, justification and accountability, as well as reflecting on and learning from the crisis, need to be recognized as crucial aspects of the crisis approach.

During the first few months, the approach to the crisis revealed serious dilemmas. Should the nation's social life be locked down or not? Should the provision of regular healthcare be downscaled? The decision-makers were faced by these and numerous other dilemmas. They were required to make choices at crucial moments. Choices that were not always popular and which could result in unforeseen effects and consequences in other areas. Moreover, they had to make those choices in a limited timeframe; the pressure was immense. On top of that came the long duration of the crisis, leading to fatigue and exhaustion at all levels, which in turn threatened the quality of the approach. It was understandable that the decision-makers gave priority to infectious disease control at the start of the COVID-19 crisis. It was also understandable that this first step was followed rapidly by attention for the economic consequences, in the form of economic support packages. Yet at the same time, the social effects in all layers of society were gradually perceived as increasingly restrictive. Unlike the economic impact, effects on society cannot be easily taken into account with formulae and distribution ratios. It is vital for public confidence in the approach to the crisis that decision-makers focus attention on these problems too, and that they be visibly taken into account in the decision-making process.

This report examines how the involved parties encountered problems in upscaling resources and capacity. Dealing with rapid changes and unexpected situations always places demands on the capacity for improvisation. It is relevant to recognize that many of the parties involved struggled with this situation, given that they are structured to deliver a high degree of efficiency. This not only applies to hospitals and municipal health services but also for example to educational institutions. A structure that is so-called 'lean and mean' offers clear advantages in a period of predictability, but becomes vulnerable as soon as something unexpected occurs. Capacity and stocks then quickly become insufficient, or delivery times too long. In such a situation, fixed working methods and protocols offer little flexibility. Improvisation quickly deteriorates into overexploitation and increasingly the need to constantly play catch-up. As the approach to the crisis is chosen, these aspects cannot be compensated for. To improve the approach to protracted crises with national impact in the future, consideration must be given to how structural buffer capacity can be achieved in vital sectors, and how working methods can be adjusted to deliver greater flexibility.

Interaction with society

In the early period of the COVID-19 crisis, society demonstrated understanding for the primary emphasis of the approach to the crisis being placed on restricting and controlling the virus. As the social impact grew, and discomfort in society increased, the tone of the social and political debate also changed. The more the approach to the crisis becomes a visible element of a societal, democratic process in which interests and dilemmas are shared and balanced, the more it plays a role in maintaining public confidence. Decision-makers never make choices independently without any form of prior assessment, nor are they called upon to account for their actions after the event. Nonetheless, in its controlling and correcting role in the acute crisis phase from March 2020 onwards, parliament appeared to adopt a reticent position. In the first instance there was broad support for the Cabinet's efforts. As the summer approached, the swelling demands to take more account of the growing consequences for society gradually translated into more critical debate within Parliament.

During the first period of the COVID-19 crisis, an intensive media debate emerged rapidly. A debate in which experts and opinion makers constantly contributed divergent opinions. Every Dutch citizen personally experienced the consequences of the pandemic and was confronted with numerous ever-changing recommendations and opinions. Within that context, it was no surprise that support for far-reaching measures or apparently inconsistent policy fluctuated, nor that, as the crisis continued, resistance within certain parts of society grew. This also applies in a broader context. Numerous people and parties emerged with proposals that – in their opinion – represented the best way out of the crisis. Against the background of that wide range of ideas, experiences and perspectives, making choices becomes complex. This applied both to the decision-makers and their advisors, as well as to other involved parties and individual citizens.

The top-down approach in communication on policy choices during the investigated period proved insufficient to maintain public confidence. Support gradually declined. As a consequence of personal suffering and diverse interests, people were unable to remain in favour of the policy choices made - no matter how crucial they were in protecting society. Any discussion on these issues cannot be limited to content but must specifically also consider the suffering and uncertainty with which people were confronted as a consequence of the crisis and the measures taken. This is something that society must (learn to) deal with. It means that in its communication to and with its citizens, government must emphasize that discomfort and uncertainty cannot (fully) be alleviated through policy choices. It is almost unavoidable that the way out of the crisis will require some form of trial and error. It requires understanding and patience from the whole of society. However, this refers not only to the relationship between government and individual citizens but also to the sense of loyalty and solidarity between individual citizens themselves. That in turn requires citizens to sometimes set aside their personal opinions and preferences in favour of the health and welfare of others.

A 'silent disaster'

During the first period of the COVID-19 crisis, a 'silent disaster' took place in the nursing homes. This was not only reflected by the figures, which indicated that approximately half of the in total ten thousand deaths through to September 2020 took place in a nursing home.

It was also reflected in the harrowing stories emerging from the nursing homes. Situations in which family members were afraid to say their goodbyes due to concerns about their health, or were unable to pay their last respects as a result of the measure which closed all nursing homes to visitors. The Dutch approach to the crisis focused above all on preventing the overburdening of hospital care. As a consequence, the protection of specific groups of vulnerable individuals received less attention during the initial crisis period, despite this being one of the primary objectives of the chosen strategy. Above all, elderly care recipients in nursing homes were the unintended victims of this approach.

Because groups other than nursing home residents may be the vulnerable in future crises, lessons must be learned in a broader sense from protecting the vulnerable. That is why it is important to pay structural attention to the protection of the vulnerable in the crisis organization. This must be done by both the government and other involved parties. Despite estimates what generally are the most vulnerable groups, it remains uncertain in future crisis situations how those groups might get into a blind as a result of a particular crisis approach. Every crisis may have other vulnerable people. How they will be affected, is difficult to predict. All in all, this calls upon decision-makers to actually go in search of where the bottlenecks can arise, both prior to and during the crisis itself. In that process they must actively focus attention on both stronger *and* weaker signals.

Conclusion

At the moment of publication of this first sub-report, the COVID-19 crisis is still going on. The Dutch Safety Board will continue to monitor and investigate the approach to the crisis. The second sub-report will deal with the approach during the period between September 2020 and July 2021. Its aim will be to investigate how the approach to the COVID-19 crisis developed during that period and how the tasks and challenges identified in this first sub-report manifested themselves in that second period. A third sub-report will consider how the COVID-19 crisis developed in the period thereafter and how it was dealt with.

RECOMMENDATIONS

In this first sub-report the Dutch Safety Board investigated how the COVID-19 crisis was dealt with in the Netherlands, through to September 2020. The crisis started as a public health crisis. Within a few weeks it expanded to be a crisis on an unprecedented scale, with broad societal impact. The Board wanted to know: why did it develop in the way it did, and what can be learned from that process?

At this point in time, issuing recommendations requires a degree of restraint because the COVID-19 crisis is still continuing and follow-up investigations are still underway. Nonetheless, the Board has prepared a number of recommendations on the basis of this sub-report so that the approach to the current COVID-19 crisis and future protracted crises with national impact can be improved. Given its responsibility for the approach to crises of this kind, the Board has addressed its recommendations to the Dutch Cabinet.

Protracted crises with an uncertain course: prepare and adapt
Uncertainty is inextricably linked to crises, in particular to crises that continue over a long period of time and have broad consequences. In order to better deal with uncertainties in protracted crises and to reinforce the preparation for large-scale crisis scenarios, the Board issues the following recommendations:

1. Reinforce the preparation for protracted socially disruptive crises by elaborating scenarios with all conceivable consequences and determining the way in which those consequences can be tackled. Then reach decisions on the desired state of readiness and monitor the way in which that state is achieved.

2. Develop the capacity to improvise, including by training this capacity in crisis preparation. Expand the possibilities for improvising by organizing buffers in capacity and a variety of procedures. During the crisis itself, regularly mark, communicate and reflect on interim adjustments to the approach and organization.

3. During a crisis, continue to map out various scenarios, including less likely scenarios with high impact, and anticipate their occurrence. Within the scenario outlines, explicitly identify the degree of uncertainty. Name assumptions made and specify the validity or limitations of the information used, both in advices and decisions.

4. Ensure that high-quality, up-to-date quantitative and qualitative data, as well as less certain information, are included in advices and decisions. In doing so, provide the best possible up-to-date vision on the course of the crisis, and generate insight into the implementation and effectiveness of the measures.

5. Identify (new) vulnerable groups during crises. Recognize the specific risks for these groups in a timely fashion, and respond appropriately. On a structural basis, assess whether the approach for these groups is effective.

The national crisis structure

The uncertainties and - partially unforeseen - problems that emerge during a protracted crisis call for a crisis organization capable of responding flexibly. To ensure effective governance and control, the crisis organization must remain clear to all parties. The Dutch Safety Board therefore makes the following recommendations:

6. Describe in explicit terms the Cabinet-wide responsibility if a crisis shifts from a single department to a national crisis structure. Formulate a department-overarching strategy and make the task of solving the problems a shared responsibility.

7. Adapt the national crisis structure in the following respects, so that it is better equipped to tackle a protracted crisis:
   - Safeguard the unity of government policy by establishing and maintaining close ties with the safety regions during a national crisis.
   - Improve the implementation of strategy and decisions by performing an operational implementation test, in advance, and through continuous feedback about the process of implementation.
   - Organize parallel and separate advice on acute and long term problems. Ensure that both types of perspective are explicitly taken into account in the decision-making process.

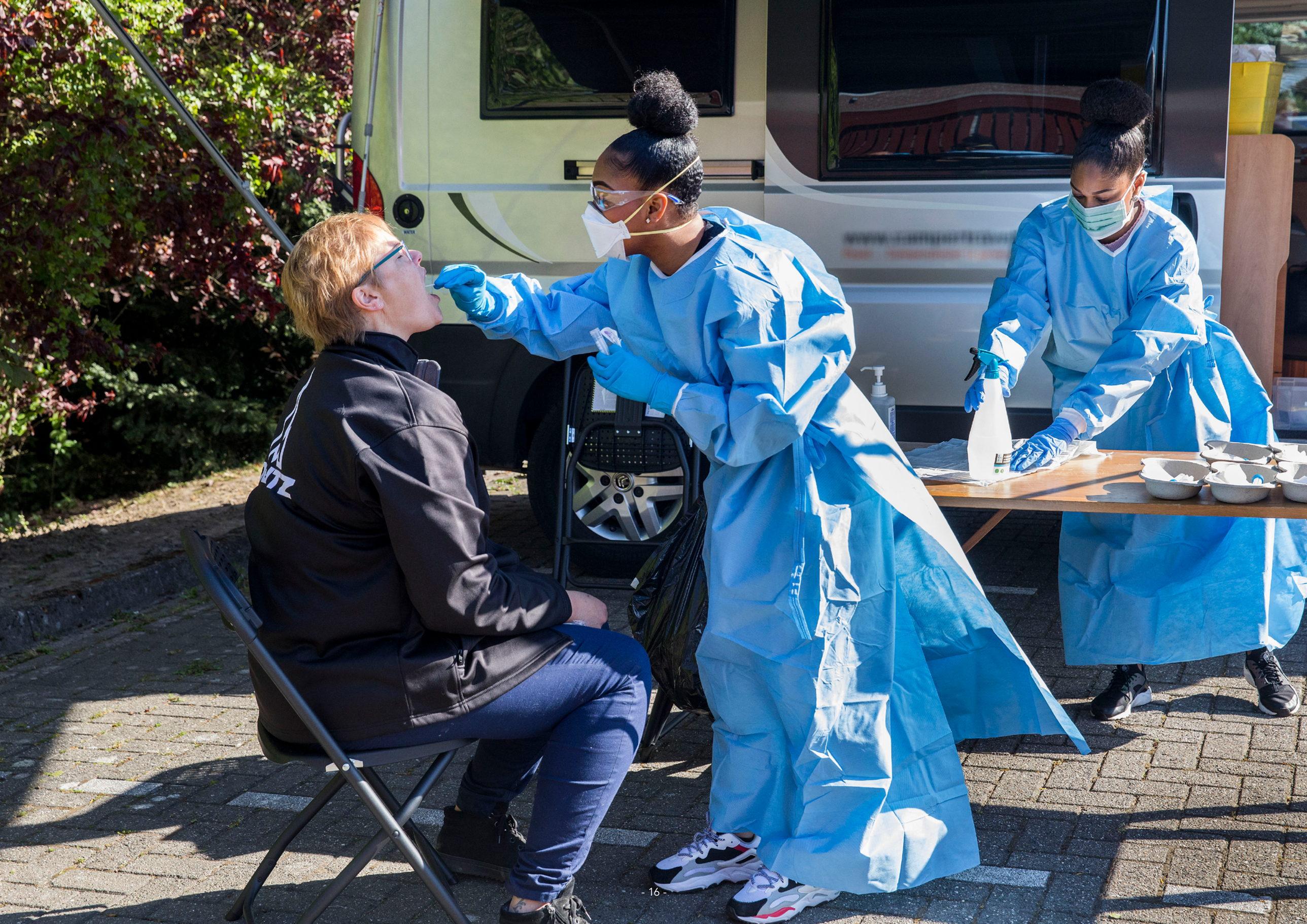
8. Adjust the crisis structure for the healthcare field so that the Minister of Health, Welfare and Sports is given authority to effectively tackle problems that go beyond the boundaries of individual sectors, regions or institutions, in any case including directly binding instructions.

9. Monitor the task focus and secure the independent position of administrators as decision-makers and experts as advisors. A clear division of roles contributes to understanding for and traceability of government actions and reinforces the democratic legitimacy of decisions.

Societal support

In a protracted national crisis, support for the approach to that crisis is essential. Crisis communication must reach out to all relevant target groups, and that communication must represent an effective response to the concerns and questions of citizens. To reinforce crisis communication, the Board issues the following recommendation:

10. In a protracted crisis, anticipate a decline in societal support and adjust the communication strategy accordingly. With that in mind, take the following actions:
    - Satisfy the information needs of all target groups and in reaching out to these groups, make use of parties close to them;
    - Encourage government parties and officials to identify uncertainties concerning the crisis and the effectiveness of measures, with a view to avoiding unrealistic expectations;
    - Guarantee the input from social and behavioural sciences in crisis and communication policy;
    - With the support of local parties, seek systematic dialogue with citizens, to ensure that their concerns, questions and needs are given a clear place in crisis and communication policy.



8 INSIGHTS FROM A PROTRACTED CRISIS WITH NATIONAL IMPACT

Introduction

The COVID-19 pandemic has resulted in a protracted (inter)national crisis. What started as a health crisis rapidly expanded to become a crisis encompassing the entire society, on a previously unprecedented scale. Within a very short timeframe many people were affected, and the healthcare sector came under severe pressure. Dealing with a crisis of this nature and magnitude placed huge demands on everyone. Many people did their utmost to make a conscientious contribution to tackling the virus and managing the crisis. This too became visible during the course of this investigation, and it deserves considerable appreciation and respect. Especially in the light of the uncertainties on the basis of which far-reaching decisions had to be taken. A crisis is uncertain by its very nature, and will in most cases turn out differently than expected; this applies all the more to a crisis of this nature and magnitude. Improvisation and adaptation are essential to deal with unexpected bottlenecks. Because uncertainty and unpredictability are not unique to the COVID-19 crisis, lessons must not be learned from the *prevention* of uncertainty, but rather from the way in which the various parties involved coped with uncertainty. In this investigation, in which the Dutch Safety Board examined the preparation for and the initial period of the COVID-19 crisis (through to September 2020), various obstacles have become visible.

Victims and patients

The death of approximately 10,000 people as a consequence of the virus during its first wave was extremely poignant. They all died within a short period of time. They were all meaningful for the people in their environment and for their loved ones, who in many cases were unable to pay their last respects. It is painful that many of the people who died were extra vulnerable because they were dependent on third parties for their daily care, for example in nursing homes. It proved impossible to sufficiently protect either the vulnerable care recipients or their carers. This left a deep impression on both family members and care personnel. In addition, thousands of people fell ill. Some of them so seriously that they had to be admitted to hospital, sometimes for a long stay in an intensive care ward. Many have since recovered, many others are still struggling with the consequences.

Capacity for anticipation in the strategy

During the COVID-19 crisis, the degree of uncertainty in a number of different areas was greater than in previous crises the national government had to tackle. The government is expected to set out a strategic course and to deal with the crisis, also in uncertain circumstances. The World Health Organization's (WHO) signal on 7 February 2020 about impending worldwide shortages of personal protective equipment did not directly result in preparations for the scenario that also in the Netherlands a scarcity of protective equipment could arise. When the virus reached the Netherlands, the initial course was

aimed at curbing its spread. In addition, the experts were surprised by the scenario of an unpredictable virus that had spread more extensively than expected, below the radar. This was partly due to a strictly applied case definition, which meant that in the first instance, people who could not be linked directly to (travel from) Northern Italy or China were not tested. It was not until experts realised that the virus had spread much more extensively in the province of Noord-Brabant, that policymakers switched to a so-called mitigation strategy. This transition from containment to mitigation was a fundamental change in strategy.

The government strategy consisted of three anchor points: 1) insight into and counteracting the spread; 2) keeping the burden on the healthcare sector manageable; 3) protecting the vulnerable. With regard to all three themes, it can be seen that the government acted strongly on the situation of the day. Capacity for anticipation lagged behind. The carnival season, in combination with the return of holidaymakers and party-goers from Italy, created a hotbed. It dawned on policymakers that keeping COVID-19 outside the Netherlands had become unfeasible. Despite this, the government did not anticipate a national outbreak: the aim was to limit the outbreak to the province of Noord-Brabant as much as possible. On 10 March 2020, residents of Noord-Brabant were advised to work from home whenever possible. This strictly regional advice proved untenable after just two days, and was replaced by an advice to work from home for the entire country. When infection rates started to rise again in the summer of 2020, policymakers again demonstrated a lack of ability to anticipate the situation. Rising infection rates are first indicators for a rise in intensive care occupancy rates. The Cabinet only acted when ic-occupancy figures actually were rising.

According to the Dutch Safety Board, the future need for testing capacity and hospital capacity could have been better anticipated from the moment the mitigation strategy was applied with the aim of actually executing the strategy. By only testing on the basis of a strictly applied case definition, the Cabinet's strategic objective of acquiring a clear insight of the virus was insufficiently achieved. The protection of the vulnerable also showed an insufficient degree of anticipation on the way in which the strategy could actually be put into effect. The nursing home sector was forced to provide care with minimal protection, a situation that was diametrically opposed to the operating principle that residents of nursing homes needed protection.

The government operated strongly from day to day, but the need to anticipate the medium-term was underexposed in the initial period of the crisis. Due to the focus on acute crisis management, little attention was paid to scenario's that were considered undesirable but were not improbable for the (near) future, or for preparing for the consequences of those scenarios. This also applies to the preceding period, when the virus had already been detected in China. Policymakers assumed that the Netherlands was well prepared. This assumption led to the loss of valuable time, which could have been used for actually implementing a chosen strategy.

Shortages

The shortage of resources during the initial period of the crisis led to risks that were not immediately clear or solvable, and where the chosen allocation keys resulted in new bottlenecks and risks. The reluctant approach to testing was partly a strategy but partly

also the consequence of shortages with a multiplier effect, in which laboratory capacity emerged as a particular point of discussion. The available intensive care capacity came under severe pressure, and all non-urgent care had to be postponed to allow for the admission of COVID-19 patients. The shortage of personal protective equipment such as face masks and protective clothing during the early weeks of the outbreak of the pandemic posed additional risks for the further spread of the virus, especially in combination with the lack of sufficient knowledge about the way in which the virus spread. This made the vulnerable even more vulnerable. The prioritization of making resources available for acute care in hospitals appeared feasible, but the fact that at the same time a so-called 'silent disaster' was taking place in the nursing homes was extremely painful.

Advice
Available data regularly lagged behind the actual situation. These data were of limited predictive value. Nonetheless, in the advice and decisions based on that data, this fact was not always transparent, and the consequences and risks of the resultant uncertainties were insufficiently taken into account.

Lack of overall management structure
In a crisis situation, the structuring of the Dutch healthcare system does not relate well to the way in which in normal circumstances a crisis would be handled. The far-reaching decentralization and fragmentation of the healthcare landscape makes a uniform management approach to a crisis of this scale a complex task. The lack of central management on crucial elements of the substantive approach to the crisis led to uncertainty, regional differences in the approach, and bypasses in the structure.

Declining support
Initially, support for the crisis approach among the population was large. The same applied to the support for healthcare workers and the approach to the crisis. For the most part, the measures taken were understood and complied with. For a number of reasons, this support declined from the summer of 2020 onwards. Communication with certain groups of the population proved insufficient and some sectors felt insufficiently heard.

Reading guide
The identified obstacles make it clear that it is vital to want to learn from the way in which this crisis was tackled. Based on the analyses in chapters 4 through to 7, in chapter 8 the Dutch Safety Board makes a broader analysis of the way in which this widespread, protracted national crisis was handled, in the period through to September 2020. This chapter 8 describes the key insights from this period. Below, for each theme, an outline is given of the weak points that emerged, followed by suggestions for the potential solutions for a different approach in the future. 8.1 deals with the preparation for a crisis; 8.2 considers the governance during the crisis; dealing with uncertainties is discussed in 8.3; and 8.4 focuses on public support during the course of the crisis. Finally, the value and necessity of reflection during a widespread crisis of this kind in relation to the previously considered points, is discussed in 8.5.

8.1 (Carefully considered) preparation for a protracted crisis with national impact

A protracted infectious disease crisis with national impact

Before the COVID-19 pandemic, within the system of infectious disease control in the Netherlands numerous parties involved were preparing for outbreaks of infectious diseases. In comparison with other countries, the Netherlands achieved a relatively high score for its pandemic preparations. Since the 1990s, the national government had established a scale up structure specifically for outbreaks of infectious diseases; regional exercises were held annually to test the preparedness for infectious disease control and acute disasters; several scenarios were in place, with procedures to be implemented during an outbreak.

As concluded in chapter 3, the parties most closely involved in infectious disease control in the Netherlands (the Ministry of Health, Welfare and Sports (VWS), the National Institute for Public Health and the Environment (RIVM) and the Municipal Health Services (GGD)) were prepared for relatively small-scale and restricted outbreaks of infectious diseases, the consequences of which affected only healthcare. However, the preparations for tackling an outbreak of an infectious disease were not aimed at a crisis with national impact, such as the COVID-19 crisis. As a consequence, during the initial months of the pandemic the parties involved suffered problems in scaling up resources and capacity to tackle or manage the crisis. VWS acquired a central role in the approach to the crisis, but during the exercises to prepare for infectious disease control the central role for VWS had not been discussed. VWS was therefore forced to improvise with the other parties to tackle the crisis, which resulted in the establishment of coordination structures including the National Coordination Centre for Patient Distribution (LCPS), the National Consortium for Medical Devices (LCH) and the National Testing Capacity Coordination Structure (LCT).

In addition, the organization of the national crisis structure makes no distinction between the approach to acute crises on the one hand and protracted crises on the other. The COVID-19 crisis can be characterized as a protracted crisis, with a *start-up phase* (period of threat) from December 2019 through to the end of February 2020, an *acute phase* in March, which was initially characterized by curbing the number of infections and subsequently turning around the upturn in hospital admissions, followed by a *protracted phase* starting in April, in which the impact of the measures on society became increasingly prevalent. The summer of 2020 marked the lead up towards a new acute phase when the number of infections once again started to rise, resulting in the 'second wave'.

The current organisation of the national crisis structure is aimed primarily at the acute phase of a crisis. Within that structure, the parties involved are required to take rapid and effective decisions and to initiate actions based on incomplete knowledge and advice. During the early period of the COVID-19 crisis, it became clear that also during the start-up phase, (part of) the structure could be meaningfully put to use. The aim was to implement activities in the framework of preventing the outbreak of the virus, such as the careful repatriation of passengers from high-risk countries, and actively monitoring developments. A protracted crisis with broad consequences for society demands a

broad-based contribution from different areas of expertise and angles of approach to allow a well-balanced choice to be made between dilemmas, in a diligent manner. However, the current layout of the system does not provide mechanisms for facilitating the necessary broad-based contribution for a protracted crisis. For example, there is no room for coordination between a large number of parties involved, for identifying the role of the political factor, for demonstrating accountability, and for the necessary time needed for reflection. Wherever these aspects were given a place in the existing structure, for example in the form of new consultation structures, it was the result of ad hoc improvisation by the parties involved. They were not the consequence of a well-laid plan.

An approach focused on the acute crisis phase and an approach focused on long-term effects in a protracted crisis impose different demands on the crisis organization and the decision-making structure. At the same time, the COVID-19 crisis has revealed that it is not always possible to make a clear distinction between the phases: they often coexist. An effective approach to a crisis of this kind requires mechanisms for identifying and facilitating the necessary adjustments to the crisis organization and the decision-making structure.

Scenario preparation and agendas

Preparation for future protracted crises with national impact starts with identifying new and existing (worst case) crisis scenarios. Those scenarios must be concretized by mapping out the potential consequences of the scenario, and assessing what is needed to face up to those consequences. Examples of those needs are crisis structures, planning, the development of skills among the various parties involved and upscaling or surge capacity for the approach to the crisis. In 2019, the National Coordinator for Counterterrorism and Security (NCTV) drew up the *National Security Strategy*. Within that strategy, the NCTV mapped out threats that could affect national security interests and cause social disruption, with a focus on increased resilience to these threats. This document contains an inventory of probable scenarios, but provides no specific elaboration of the broad social consequences of these scenarios, or what is needed to mitigate their consequences.

To subsequently convert the elaborated scenarios and their consequences into actions in the form of preparations, it is essential that an organization or person is able to place the preparations for the elaborated crisis scenarios on a relevant agenda, both in the political and the public debate. The aim is to ensure that the affected administrators are made aware of the identified scenarios, so that they become aware of their importance, and are able to imagine exactly what these scenarios involve. Those administrators can then prepare a risk assessment and make explicit choices in terms of priorities and investments needed to prepare for such crisis scenarios. Accountability for these decisions in public debate helps increase the visibility of the problem, and expands the common sense of responsibility (beyond the boundaries of individual government departments). The ultimate aim is to ensure that attention for the preparation for these scenarios does not become snowed under in everyday affairs.

Preparing by drawing up plans and holding exercises on the basis of a range of crisis scenarios creates a foundation for crisis management. Nonetheless, during a crisis the

capacity of individuals and organizations involved in tackling the crisis to improvise and adapt will always be called upon. By its very nature, a crisis is uncertain and in most cases will develop differently than expected. Improvisation and adaptation are essential to an approach geared to tackling a current crisis and dealing with unexpected bottlenecks. In other words, preparation for a crisis approach can be reinforced by training the parties involved to improvise and to implement changes according to a planned approach during crisis situations. This creates adaptive capacity, which must ensure that improvisation in a crisis and implementation of changes to the crisis organization can be carried out in a carefully considered and structured manner, instead of being left to chance.

Conditions for deploying adaptive capacity during a crisis

Any organizational or decision-making structure devised in advance on the basis of preparations will in many cases not fully match the needs that emerge in tackling a specific crisis. This certainly applies in the face of a protracted crisis with national consequences in multiple areas. The parties involved in the crisis structure will be required to make changes to the crisis structure in order to achieve an intended result. A protracted crisis with national consequences therefore requires a crisis structure that reinforces adaptability in order to be able to respond to the specific crisis situation. At the same time, this type of crisis calls for a form of adaptability that ensures that, wherever necessary, the crisis structure is adapted.

To be able to make optimum use of the adaptability, it is essential in the preparation phase a method is developed that facilitates adaptation. The parties involved in the crisis organization must continuously assess whether the structures they have deployed on the basis of their preparations continue to be effective, or whether they reveal potential obstacles. Wherever necessary, the parties can adapt the existing structure. It is essential that the affected manager in the crisis structure explicitly and specifically identifies and marks the necessary changes. This helps prevent ambiguity emerging with regard to the roles and positions in the adapted structure. At the same time, the various parties must understand that adaptions impose demands on the flexibility of the originally conceived structure. Adaptations may for example require a change in behaviour, or different skills. By pointing out any unease with the situation during the course of the crisis, the task of learning to work in the new structure takes shape. It also generates greater clarity and places the task of regulating the new structure on the agenda. The adaptability of the parties involved in the COVID-19 crisis is discussed below.

8.2 Governance in national crises

In the initial phase of the COVID-19 crisis, the structure of infectious disease control, the national crisis structure and the regional crisis structures of the safety regions were all put into action. For the policy makers and their advisors, the existing, prepared structures were not always appropriate to the scale, the broad impact and the long duration of the crisis. This mismatch was translated into adaptations to the crisis structure, achieved mainly by adding new elements to the structure.

If adaptations to a structure are not carefully considered or explicitly identified, there exists a risk of uncontrolled growth in structures and a lack of clarity about the nature of the adaptations. This aspect is further elaborated in the sections below with regard to various points. This clarifies that there is room for improvement in the interaction between structure and adaptability. This applies to the national crisis structure, the governance based on healthcare and the link between national and regional level. The consequences of changes to the structure for checks and balances is also discussed.

The national crisis structure

In a national crisis, it is essential that the relationship between the national crisis structure and the affected government department is clear. The aim of implementing the national crisis structure is that if national security is under threat, national government can deliver a coherent approach that includes the coordination of measures to be taken and the relevant decision-making processes. With a view to an integrated approach, it must be clear that as soon as the national crisis structure is scaled up, leadership over the crisis transfers from the Minister of a specific government department to the Ministerial Committee for Crisis Management (MCCb).

In the COVID-19 crisis, primacy was originally vested with the Minister for Medical Care and, after he stepped down, with the Minister of VWS. This responsibility arose from the nature of the crisis, and was based on the legal responsibility of the Minister in the face of a class-A infectious disease epidemic. When the national crisis structure was scaled up, there was no explicit transfer of the leading role from the Minister of VWS to the MCCb, under the chairmanship of the Prime Minister. As a consequence, there was no clear marking that a broader view was required for an integrated crisis approach. Within the national crisis structure, there was no shared vision on who was in charge of the crisis. In practice, the Minister of VWS retained a central role in the approach to the crisis. This was for example reflected in the fact that the OMT, an advisory body to the Minister of VWS, became and remains the chief advisor to the entire MCCb. These positions, occupied by the Minister of VWS and the OMT, were key contributing factors in ensuring that the Cabinet remained focused on the three central strategy points, namely: insight in the spread of the virus, sufficient healthcare capacity and protection of vulnerable individuals. Despite the fact that these three points were not actually realized and in the face of the ever broader spread of the crisis.

The broadening of the consequences of the crisis was also reflected in the growth in the number of participants in the crisis teams within the national crisis structure, which jeopardized rapid and effective decision making. In response, the Prime Minister decided to alter the national crisis structure by organizing the coordination process in a smaller assembly, in the informal consultation sessions in his official office in The Hague, which became known as *Torentjesoverleg* and informal consultation sessions at his official residence, which became known as *Catshuisoverleg*. As a consequence, management of the crisis was informally shifted to other bodies beside the MCCb. Even within these consultation bodies, the parties involved held different views on the relationship with decision making and the issuing of advice within the national crisis structure. This lack of unity is a clear signal of the absence of the explicit designation and marking of adaptation, as elements of adaptability.

Governance based on healthcare

Based on his legal responsibility to take charge of infectious disease control in the face of a class A infectious disease epidemic, the Minister of VWS is authorized to instruct the chairpersons of the safety region to organize regional disease control efforts. However, the Minister does not have that authority in relationship to parties in the healthcare field, despite the fact that being in charge of infectious disease control does require a managerial and coordinating role in respect of the healthcare field. The standard situation in the healthcare field is characterized by autonomous care institutions with their own responsibilities, and a structure of consultation between the healthcare field and the Ministry, in which sectoral and professional associations fulfil an important representative function. Neither the Ministry nor the umbrella organizations have any compelling power or other instruments to direct individual healthcare institutions. In addition, there has never been a national preparation process in which managers are trained in infectious disease control. The lack of elaboration of, experience with and preparation for a leading role for the Ministry of VWS resulted during the COVID-19 pandemic in a number of bottlenecks.

The fragmented structure of the (crisis) organization at VWS also played a role in the creation of these bottlenecks. Contact with the healthcare field was maintained via several separate directorates. No structure existed that combined all the information and developments on behalf of the department, despite the establishment of a new consultative body for the Ministers and the senior civil servants. As a consequence, the contribution from specific sectors, such as the nursing home sector, was not always directly considered in the decision-making process at national level. Contacts between representatives from the various disciplines at regional level were more easily established. For example, the existing Regional Network Healthcare Crisis Response (ROAZ) structure was extended in all regions to include representatives from non-acute care (crisis response) sectors. These discussions for example included the distribution of personal protective equipment among crisis and non-crisis care providers in the regions.

During the COVID-19 pandemic, bottlenecks emerged across the whole of the healthcare sector, due to rising numbers of patients, the measures introduced and the conflicting interests that emerged due to the shortages of personal protective equipment and test capacity, among others. None of these issues could be solved at individual healthcare institution level or even in collaboration in regions or in sectors, and as a consequence, the need grew for agreements and a governance structure that went beyond the level of individual institutions and sectors (at a national scale). In the efforts of VWS to identify ways to introduce management on a national scale, a variety of impromptu forms of governance emerged, which in turn led to more uncertainties about responsibilities and management within the healthcare sector.

The mutual coordination that was necessary to establish the national cooperation and make it work, was at the expense of the speed required in an acute phase of the crisis. This situation also meant that within VWS and among the advisory bodies, attention was initially above all focused on the bottlenecks in acute care. Based on its tasks and responsibilities, this sector is more commonly involved in healthcare crises.

Another contributing factor was the informal hierarchy within the healthcare sector where (teaching) hospitals are at the pinnacle, with other healthcare sectors (such as nursing homes) further towards the bottom.

The crisis revealed that the internal crisis structure at VWS and the linking structures with and between the healthcare providers were not sufficient. The new national coordination points, the changes to the departmental crisis structure, the appointment of different project groups within the Ministry, the use of regular consultation and decision-making processes and the combination of a departmental and a national crisis structure made the whole situation extremely complex and highly unpredictable for many of those involved.

Effective governance according to the needs of healthcare in a national crisis requires a completely different set of mechanisms than those needed in the regular situation. On the one hand, it calls for the creation of possibilities for centralized control and overruling powers and on the other the establishment of a national crisis structure, both within the healthcare field itself and in the interaction between VWS and the healthcare field. Even within this crisis structure, further space is needed for adaptation, including the capacity to integrate the various individual elements, so that any changes to the structure do not increase overall complexity and do not result in uncertainty or delays in decision making.

The link between national and regional level

In the approach to a national crisis, national and regional parties cannot operate independently of each other. Nonetheless, the link between the national crisis structure and regional parties such as the safety regions and GGD is not well safeguarded.

In the COVID-19 crisis, decisions were initially taken by the chairperson of the safety regions in the province of Noord-Brabant on measures aimed at limiting the spread of the virus. This subsequently transitioned into a national approach, also implemented by the safety regions. The chairpersons of the safety regions succeeded in unifying their actions via the Safety Council (*Veiligheidsberaad*). The missing link between the regions and national government was eventually established when the chairpersons of the safety regions achieved representation within the MCCb, the directors of the safety regions were represented in the ICCb, and through instructions from the Minister of VWS. The establishment of the National Operational Team - COVID-19 (LOT-C) also contributed to strengthening the links at national and regional level.

In the summer of 2020, the Cabinet opted to downscale the national crisis structure. From that moment onwards, the approach to infectious disease control was entrusted to the safety regions, while the approach to the (long-term) societal effects was dealt with at national level, in the new programme structure to be established. As a consequence of this downscaling of the national crisis structure, the Safety Council lost its seat on the MCCb and as such lost its direct link with national government, so that in the summer, when the number of positive test results started to rise, the process of taking the appropriate measures was delayed. The safety regions, which at that moment were still operating at a high level of upscaling, no longer had a point of contact via which they could coordinate the frameworks for a regional approach, with central government.

In the event of an epidemic involving a class-A disease, the Minister of VWS is able to formally direct the GGD via the chairpersons of the safety regions. In order to acquire a greater understanding and more control of the testing and tracing process, as a key element of the COVID-19 approach, the Minister found it increasingly important to be able to control the GGD directly. In practice, however, this proved difficult, also because cooperation and coordination between the GGD themselves was anything but smooth. Unlike the chairpersons of the safety regions, whose deliberate primary objective was to achieve uniformity, the directors of public health (the directors of the GGD) failed to arrive at a similar level of consensus. The initiatives aimed at appointing Public Health Directors (DPGs) to coordinate on specific themes, and to establish a system of representation via the GGD sector association GHOR Nederland (Medical Response Organization in the Region) offered no immediate solution.

During the first phase of the COVID-19 crisis, the Cabinet and safety regions decided to meet the demand for a link between the crisis organizations at national and regional level by making changes to the underlying structure. It may however be concluded that representation of the safety regions in the national crisis structure did not offer any structural safeguarding for that link; after all, as soon as the Cabinet downscaled the national crisis structure in the summer, the representation also evaporated. This shows the essential need for the parties involved to carefully consider and explicitly specify any changes to the structure, so that any reinforcement of the crisis structure remains in place despite any subsequent changes.

Balanced decision making and task focus

Within the crisis structure, checks and balances exist to arrive at traceable and balanced decision making. Given the numerous changes to the structure and the ad hoc manner in which many of them were arrived at, a number of these checks and balances were jeopardized and the balance was disrupted. Alongside the formal crisis structure, more and more parallel structures emerged, in which checks and balances were not safeguarded, and in which roles became intermingled. The lack of balance created space for dominances, whereby other perspectives became snowed under.

The dominance of the perspective of infectious disease control for example led in practice to the outcome that set against this perspective, the perspective of broad societal effects remained underexposed. In a similar way, the Minister of VWS occupied a dominant position within the national crisis structure. Within the 'medical column', the perspectives and interests of acute care and infectious disease control dominated over the interests of long-term care and broader healthcare problems such as the postponement of treatment and quality of life. Moreover, the focusing of efforts on action at source, acute problems and short-term solutions prevailed over efforts aimed at tackling the effects and longer-term problems. During the acute phase of the crisis, these areas of dominance were useful in reducing complexity and allowing a rapid response. The Ministers did not deliberately opt for this particular focus but responded to the ongoing situation. This made it difficult to deviate from the pre-set course with regard to the three strategy points (understanding disease spread, preventing the overburdening of the healthcare sector, protecting the vulnerable) and to reconsider the balance between the perspectives. The risk of tunnel vision was always present.

The advisory and decision-making route contained in the national crisis structure via the IAO-ICCb-MCCb had built-in checks and balances to ensure balanced and well-defined decisions during a crisis. As the crisis went on, and its impact broadened, the number of participants in the MCCb in particular also constantly increased, making the eventual decision making all the more complex. The desire of the Ministers of VWS, Justice and Security, the Minister for Medical Care and the Prime Minister to hold informal discussions in a smaller group, led to the establishment of the *Torentjesoverleg* sessions, which at the highpoint of the crisis were held practically daily. However, as time went by, these *Torentjesoverleg* sessions increasingly acquired the character of a (preparatory) decision making body, parallel to and taking precedence over the formal crisis structure. This in turn made the decision-making process less transparent. The same applied to the *Catshuisoverleg*. These informal consultation sessions at the Prime Minister's official residence (the Catshuis) were introduced in response to a need to reflect on the developments and to gather information from a variety of experts. However, these sessions too were soon also used to prepare for the decision-making process, in a smaller assembly, in advance of the MCCb meetings.

The creation of parallel decision-making structures in turn led to greater complexity within the decision-making process. Because the deviations from the structure were not explicitly specified and the tasks of the new bodies in relation to the existing bodies were unclear, the route via which the decisions were arrived at also became unclear. In addition, there was no interim evaluation of the decision making structures. In response, involved parties who as a result of the adjustments felt that they were losing their influence within the decision-making structure went in search of other means of representing their interests. This in turn further expanded the overall complexity, while at the same time reducing the transparency of the decision making process.

Because these altered structures were not made transparent, they also effectively increased the demand for information among Members of Parliament and the media, who wanted to know why national government was not sticking with the formal crisis structures and exactly where the real decisions were being taken. As well as raising numerous questions about the approach to the crisis, the many questions about the deviation from the formal structure created a new challenge for the crisis organization, since capacity had to be made available to answer these questions. Because VWS opted to have the questions answered in house by its own staff, as a sort of additional task over and above their work in dealing with the crisis, the result was huge pressure on the crisis organization.

In addition, unmarked changes to the advisory role of the OMT meant a weakening of the checks and balances. The task of the OMT is to offer advice and knowledge to the Minister of VWS from the point of view of infectious disease control. However, because the chairman of the OMT was also in attendance at practically every formal and informal crisis team meeting, the distance the team of (scientific) advisors should have maintained from the decision-making process (which was expected to consider a far broader scope than the theme of infectious diseases alone), was lost. Moreover, at certain moments, the role of the OMT (Outbreak Management Team) and BAO (Administrative Consultative Committee) became confused. The role of the BAO is to discuss the advice of the OMT before they are formally presented to the Minister of VWS.

Due to the speed with which the OMT advices were followed up and decisions were taken, the BAO lost its ability to thoroughly assess the viability of the advices. As a consequence, without it ever actually being made explicit, an important check in the advisory process was lost.

In its advices concerning the use of personal protective equipment, the OMT had already taken into account the scarcity of the resources, without ever explicitly stating that it had done so. In doing so, the OMT anticipated the feasibility of its advise on the use of personal protective equipment in practice, a decision that should not be made by the OMT, but by the BAO. Balanced decision-making demands clear and fixed roles and explicit communication about the assumptions made.

The important position acquired by the chairperson of the OMT also confirmed the picture that infectious disease control was more important than other interests. More distance ensures a more balanced weighing of interests. This also prevents the OMT from becoming responsible for policy in the eyes of the outside world, or finding itself in a position in which it is seduced to defend Cabinet policy. The strength of an advisory team lies in the fact that it must feel free to restrict itself to substantive advice based on its own specific area of expertise (in this case infectious diseases), and as such is not required to express any opinion on associated areas, nor is it expected to have to defend decisions by the Cabinet.

To maintain balance within the crisis decision-making process, it is necessary to take into account the impact of the crisis on areas besides healthcare. During the COVID-19 crisis, many organizations issued advice to the Cabinet about the effects of the measures on society. These parties include scientific councils and planning agencies but also bodies established on an ad hoc basis, such as the working group Halsema and the Red Team. However, none of these organizations had a formal position in the crisis structure, in addition to which the crisis structure itself proved incapable of establishing any structural form of cooperation in an improvised manner. As a consequence, in the considerations of the MCCb in reaching decisions, the advice on the effects of the measures on society were not given the same weight as the OMT's advices. The perspective of infectious disease control maintained its dominance. Signals and advices about the practical implementation of the decisions received insufficient attention in the decision making process. Although the Safety Council (*Veiligheidsberaad*) was represented on the MCCb, other organizations that were important in implementation of the decisions such as nursing homes and GGD were insufficiently involved. Due to the lack of a broad-based implementation assessment, several decisions were taken that resulted in problems in implementation.

Specifically during a protracted crisis, checks and balances are essential for a traceable and balanced decision-making process. The many ad hoc adjustments made to the crisis structure, that were subsequently not explicitly specified or evaluated, led to an imbalance in the decision-making process and less transparency. That is why it is necessary to carefully consider and mark any changes to the crisis structure, in anticipation of these potential risks. It is also vital that the roles and responsibilities of advisors and decision-makers be clearly separated, and that the decision-makers be offered a wide range of advice, to consider.

In this way, the balancing of advice and interests becomes both prominent and visible and as such can contribute to greater support for policy decisions.

8.3 Dealing with uncertainty

It is inherent in any crisis that in reaching decisions on the approach to be followed, crisis teams are faced with uncertainty about and unpredictability of information. The course of any crisis is after all uncertain and highly unpredictable. Also during the COVID-19 crisis, uncertainty and unpredictability became manifest at various different moments. At the start of the crisis, for example, there was uncertainty about the contagiousness and spread of the virus. In addition, the emergence of mutations with other characteristics influenced in the model of the impact of the virus in the Netherlands. This in turn led to uncertainty about the effectiveness of the advised measures and the decisions taken on the basis of those advices. With regard to the side effects of the measures, for example the social-societal impact, there was also clear uncertainty during the course of the crisis. Because uncertainty and unpredictability are not unique to the COVID-19 crisis, lessons should not be sought in the prevention of uncertainty, but in the way in which the parties involved deal with it.

It became clear during the investigated period that the advisors and decision-makers above all focused their efforts on reducing uncertainty. One of the ways of achieving certainty is by seeking solace in quantifiable infectious disease and hospital data such as intake capacity, the length of hospital stay, contamination figures and R-values. Besides the fact that these specific data supplied and maintained the dominant perspective of infectious disease control, just like all other data, these figures also have their limitations and may not be considered without interpretation. Rough infection figures, for example, give no indication of the seriousness of the consequences of an infection. This investigation reveals that with regard to both the advices given and the decision making, communication about the uncertainties and limitations of the data used was not always clear. This meant that a picture was able to emerge whereby the stakeholders appeared more certain about the effects and results of their advices and decisions, than was actually the case.

In the initial period of the COVID-19 pandemic, experts, including experts from the RIVM and the OMT, communicated with society about the (limited) potential risks of the virus for the Netherlands. They issued statements on contagiousness and transmissibility of the virus that were based on previous outbreaks of other viruses. The lack of knowledge of the characteristics of the new virus and hence the uncertainty about the possible cause of the outbreak received far less focus in the advices and public communication. This may have prevented unrest, but by failing to take account of the fact that the virus could behave differently than expected, the urgency perceived among policymakers and the general public remained low during the first months of 2020.

By focusing heavily on the data that *were* available, these data took on a dominant role so that other - non quantifiable - information was initially not included in the advice and decision making. As a consequence, signals concerning rising infection levels and deaths among residents of nursing homes in the early spring of 2020 were not clearly

communicated to advisors and decision-makers. There were no 'solid' figures available, in part because only limited testing was carried out in the nursing homes, and deaths were only included in the COVID-19 figures if the deceased had been positively tested for COVID-19. The approach to the pandemic was focused fully on the maximum capacity of intensive care departments. It was not until nursing homes started to quantify their infection rates and deaths that the urgency of the high infection rates in the sector became fully clear to the advisors and decision-makers.

Another way in which the various parties involved sought to reduce uncertainty was to initiate studies aimed at supporting and legitimizing the decisions taken. By actively going in search of figures and scientific arguments to support the advice issued and the decisions to be taken, uncertainty in that specific area could be reduced. However, this mode of operation engenders a certain risk. The specific data from the studies, which also had their own limitations, were given so much weight that other relevant information was lost from view. This created the risk of tunnel vision, with the selective use of the data available. From March 2020 onwards, signals started to be received from abroad suggesting that the elderly demonstrated atypical and asymptomatic characteristics in the event of COVID-19 infection. During the course of the spring, the initial signals were followed by similar indicators from Dutch practice. However, these signals were not considered sufficient grounds to adjust the case definition or to start issuing personal protective equipment to nursing home staff. It was not until August 2020, when additional studies had been completed, that the OMT recommended the preventive use of protective equipment in nursing homes.

As the COVID-19 crisis developed from an infectious disease outbreak to a social crisis, the calls for focusing greater attention on the social effects also grew. However, it proved no simple task to acquire real insight into effects as loneliness among the elderly, growing social unrest or concerns about the welfare of young people, let alone to quantify those effects. There was no structural attempt to gather signals concerning social-societal issues or in respect of ethics and welfare for the purposes of decision making, and they were not made an integral element of the formal crisis structure. Moreover, the qualitative data and signals that were available were not interpreted in a structured manner, in relation to the quantitative data for infectious disease control. As a consequence, despite all the advices and signals about the effects of the measures from parties outside the crisis structure, the qualitative information continued to occupy a subordinate position as compared with quantitative information. As such, quantitative data about infection rates, ic-occupation and R-values remained the dominant factor in the process of advice and decision making.

The COVID-19 crisis provided to be too extensive and too complex to allow many of the uncertainties to be removed by gathering information and conducting further studies. As such, a different approach to dealing with this unavoidable uncertainty in the face of a crisis of this scale is needed. On the one hand, advisors and decision-makers must be aware that in using data as a form of management information, they must take into account its limitations. These include the fact that the data available will always lag behind the actual situation, that data has limited predictive value and that data furthermore has limitations in terms of validity and completeness. Moreover, it is vital

that advisors and decision-makers remain clear in their advices decisions about the certainties and uncertainties that played a role in those advices and decisions.

On the other hand, advisors and decision-makers must continue to keep an eye on scenario's that are not directly supported by the available data, which can nevertheless be realistic. By taking observed data as the primary basis for advice and decision making, a (too) restricted picture of reality is created, backed up by an unjustified feeling of certainty. By placing other qualitative information on an equal footing as quantitative information, and by then interpreting that information, a greater variety of insight and sources is established. That variety contributes to a more complete picture of the situation and of the opportunities and risks involved in specific interventions. By also explicitly taking account of factors and scenarios that cannot be immediately expected on the basis of the data, it is possible to intervene earlier, and more flexibly, if an undesirable situation does arise.

8.4 Retaining support in a protracted crisis

In a protracted crisis in which the population has a contribution to make in bringing the situation under control, the success of the approach stands or falls with the level of support among the population. In the COVID-19 crisis, the support for the behavioural measures was of primary importance. After all, compliance with these measures was the key success factor in reducing the infection rate. Creating public support for government policy proved broadly successful during the period through to September 2020; many people understood and accepted the measures and attempted to comply with them. Nonetheless, after the initial months of the COVID-19 crisis, the government no longer succeeded in maintaining large-scale support for its measures. Support for the measures in March and April 2020 was relatively stable among the population, and around 70% of people felt that the government had taken the appropriate measures. Gradually, this percentage fell to around 50% in August. People started experiencing the measures as constricting and increasingly started to express doubts about the government policy during that period.

The explanation for the downturn in support lays in part in the performance of government itself. In their press conferences in March and April, the Prime Minister and the Minister of VWS had repeatedly referred to the personal responsibility of individuals. Such an appeal can be counterproductive because not only is it based on the involvement of each individual person, but it could also be interpreted as offering space for a personal assessment of the value and necessity of the measures and, if they so wished, to allow people to deviate from those measures. The failure to live up to firm promises and expectations based on uncertain assumptions also contributed to the erosion of support within society.

Due to the great importance of public support for government policy during a protracted crisis with considerable impact on the population, the Safety Board has considered what is necessary in order to create, to maintain and - if necessary - to reinforce public support. That goes beyond organising public campaigns in the right way to encourage the population to adopt appropriate behaviour. Creating, maintaining and reinforcing

support is also influenced by the practical implementability of decisions, the deployment of expertise and the sentiments present in society. Each of these three aspects is further elaborated below. It should be noted that none of these aspects can be entirely clearly demarcated. The experiences of the parties involved in implementation can for example also be part of the expertise in tackling the crisis, but at the same time are also an element of sentiments in society.

Implementability of the decisions taken

To create, to establish and - if necessary - reinforce support, it is essential that government has a clear vision on the implementability of the decisions taken. In that context, implementability can relate both to the implementation of decisions and to the perceived inconsistency of measures, and the extent to which people struggle to comply with the measures.

With regard to the implementation of decisions, public confidence in the approach to the crisis slumped whenever the connection between policy and implementation faltered and whenever promises and expectations expressed by government proved unachievable, in practice. Examples include the situations described earlier in this report in which the government contributed in the long term to the erosion of social support, by not always being able to live up to its own firm promises and expectations.

The inconsistencies in the policy perceived by individual citizens, or the feeling that government was applying two standards, also placed support under pressure. One example is that healthcare professionals working in home care and nursing homes, who according to the rules issued by the RIVM in urgent cases were permitted to continue work even in the event of mild symptoms, were in fact expected to show up to work in practice, in order to ensure the continuity of care. This was in stark contrast with the social standard of anyone with symptoms being required to stay at home. Inconsistencies of this kind meant that healthcare workers were concerned both about their own health and that of the residents whose care they provided, and their families. Other examples of perceived inconsistencies were the calls from government to work from home, while government representatives in many cases were seen to not be complying with this rule, or the legal distinction between groups and gathering, which meant that there were uncertainties within society about whether groups of more than three people in a public place were or were not permitted.

Finally, public support for government policy fails if (in principle well-meaning) citizens or professionals experience problems in implementing the measures within their specific private or professional context. Healthcare professionals in hospitals and nursing homes, for example, experienced problems in using personal protective equipment, the elderly and young people increasingly experienced a sense of loneliness, in nursing homes many people were unable to pay their last respects to their loved ones, and many people died in solitude.

The examples above show that in a protracted crisis, maintaining the link between policy and implementation is a major challenge, the keeping of promises and expectations is not always achievable, and in certain cases measures prove insufficient or are perceived as being such. All these elements undermine the trust of the population and of

professionals at operational level in the approach to the crisis, as a result of which compliance with the measures, in this crisis a key element of the implementation, comes under pressure. As discussed earlier, the implementability of decisions is not an element of the advice provided to decision-makers in the national crisis structure. In order to gain an insight into the implementability of decisions at the earliest possible stage, it is vital that decisions be assessed for their implementability as early as possible. In that process, the various groups responsible for implementing, complying with or enforcing those decisions must be heard and must have a voice in the appropriate consultation structures.

Use of expertise

In order to create, establish and - if necessary - reinforce support, it is also essential to determine how the available knowledge is interpreted and is used in crisis communication. In this context, knowledge refers both to knowledge of all relevant aspects of the causes of the crisis and of the way in which the crisis can best be tackled, as well as the effects and impact of the measures on society.

Scientific knowledge that was made available to the decision-makers via the OMT was reliant on 'solid' data from the RIVM, such as infection rates, hospital admission rates and age groups. More 'soft' data, such as that supplied by knowledge institutes and planning agencies like the SER, the CPB, the SCP, the WRR, RVS, the Education Board and the Behavioural Unit were discussed, but counted for less in the decision making process. This meant that the consequences of the measures on society were made subordinate to gaining control over the virus. During the press conference on 24 June 2020, the Minister of VWS announced that he had been guided by the signals from the dashboard, as discussed on a daily basis in the Infection Disease Assessment Meeting of the RIVM.[1] Partly as a consequence of this focus, the government had no suitable answer to the growing dissatisfaction about themes affecting society, such as growing learning deficits, the spread of loneliness, threats to fundamental rights, the postponement of healthcare and the declining quality of life in care institutions, all of which slowly but surely were starting to reduce levels of support. At the same time, ad hoc expert organizations that put forward solutions from within society, such as the Red Team and others, had little or no access to the crisis organization. Nonetheless, many of these solutions were shared in the broad social debate. There was no single comprehensive plan in which, on the basis of a broad inventory of experts, national government set a course, in consultation with the safety regions and municipalities, to enter into discussions about the social concerns that emerged from the initial phase of the COVID-19 crisis.

The knowledge shared by scientists in the social debate had an important task in establishing and reinforcing support for the measures. The way in which that knowledge was contributed, however, sometimes detracted from support. For example, a number of the experts associated with the OMT and behavioural scientists and specialists from other disciplines helped boost support by making their knowledge of the COVID-19 virus available to a broader public via interviews, in talk shows, podcasts and other forms of expression.

1 Press conference Prime Minister and Minister of VWS, 24 June 2020, https://www.rijksoverheid.nl/documenten/mediateksten/2020/06/24/letterlijke-tekst-persconferentie-minister-president-rutte-en-minister-de-jonge-na-afloop-van-crisisberaad-kabinet-24-6-2020

At the same time, the statements of scientists involved in the approach to the COVID-19 pandemic as advisors led to public confusion, which in turn led to a downturn in public confidence and support. The head of the National Coordination Centre for Patient Distribution (LCPS) and the Chairman of the Dutch Society of Intensive Care, for example, spoke at the end of April 2020 ahead of the decision making within the MCCb by referring to potential easing of the restrictions, which for advisors was an unusual move in the event of a crisis. A further complicating factor in these public performances was that it was not always clear to outsiders whether the experts were responding in their talk show performance as members of the OMT, as independent consultants with specific expertise or as representatives of their own sectoral or professional association. The fact that the chairman of the OMT emphasized the political nature of the choice to make the wearing of face masks compulsory in public transport (in May 2020) and in public areas (in August 2020) while he himself openly expressed doubts as to the value of the measure, in no way helped maintain support for the announced measures. As a result of these statements, government policy was effectively undermined by advisors to that same government.

The crisis reveals that despite all their best efforts, far from optimum use was made of the available knowledge, and that communication about the available knowledge left much to be desired. If expertise is to be put to the best possible use, it is essential that government offers the various knowledge parties access to the appropriate consultation structures systematically, transparently and at the earliest possible stage. On the one hand, the purpose of such an approach is to allow the relevant advice to be optimally used in the decision-making process and on the other it makes it possible to demonstrate to society that broad-based advice has been obtained, that the various arguments have been taken into account and that it remains important to continue to discuss the issues, as widely as possible. In this way, the use of expertise contributes both to an adequate approach to the crisis and helps establish, retain and reinforce support for the measures.

Understanding of sentiments in society

The final element of establishing, maintaining and - if necessary - reinforcing support is the importance of government keeping an up-to-date vision on the sentiments in society. It is important to be able to anticipate what will happen to support in the longer term, when people start to lose their sense of involvement in the crisis, with the resultant risk of 'crisis fatigue' with regard to the measures. To some extent, the Dutch government did anticipate this effect by constantly monitoring sentiment in society throughout the COVID-19 crisis, and repeatedly using the information thus gathered as the starting point at important consultation moments, such as the IAO, the *Catshuisoverleg*, the ICCb and the MCCb. However, the way in which the government used the information resulted in only a restricted understanding of the situation, in that information was primarily used as a 'snapshot' as opposed to being systematically deployed to support decision-making in anticipating the needs of society in the longer term.

The crisis and the measures aimed at managing that crisis had major consequences for many sectors. One example is the hospitality industry, which was severely hit from 15 March 2020 onwards. The interests were huge. After the hospitality sector association *Koninklijke Horeca Nederland* (once again) sounded the alarm bells on 15 May about the huge turnover losses suffered, and on 19 June announced its withdrawal from all

discussions with the Cabinet, on 16 July that same organization instituted legal proceedings against the State aimed at demanding an easing of the restrictions. Healthcare personnel were also hit hard by the crisis. As the healthcare sector increasingly struggled with high pressure of work, unsafe work situations and a staff exodus, healthcare professionals took action at the start of September and demanded better working conditions, less work pressure and greater autonomy. Other sectors, too, including the hairdressers, sports associations, cultural institutions and sex workers were also badly affected, and stood up for their interests.

Not all sectors were equally represented in the consultation structure, or indeed capable of organizing their media performance. As a consequence, certain groups were better able to represent their interests than others. For example, for a long time representatives of the nursing home sector felt that their voice was little heard, if at all, when it came to demands for a better distribution of personal protective equipment between acute healthcare and the long-term care sector. In the same way, other groups including children and young people, nursing staff and doctors who all expressed their concerns about the COVID-19 policy, and individuals who stood up in defence of their personal or economic freedoms felt that their voice had been unheard or poorly heard, and instead turned to the media to express their views. The result was a dynamic in which various involved parties opted to represent their interests outside the consultation structures, in which some parties were better represented than others.

To obtain a clear understanding of the sentiments in society, it is essential that government recognizes and actively maps out the social dynamics during any protracted crisis. This can help clarify the interests at stake for the various parties involved, and how, following careful assessment and consideration, the various interests can best be given a place in policy. This requires that a record be kept of developments in the social debate, the exposing of patterns in that debate, and the inclusion of those patterns in the approach to the crisis and crisis communication. An approach of this kind will boister the democratic process while at the same time sending a signal to the general public that government not only wants to inform, to convince and activate its citizens to comply with the measures, but that it also understands the impact of those measures on their personal and professional life.

Inform and include

Creating, maintaining and - if necessary – strengthening support in a protracted crisis is not only achieved by informing, convincing and activating individual citizens, but also by involving those affected by the crisis, and the measures taken to tackle that crisis. For that reason, it is important that in the event of a crisis, government gains an understanding as quickly as possible of the implementability of the decisions taken, makes optimum use of a broad range of expertise and, as far as possible, has an understanding of the sentiments in society. Although the government did deploy initiatives in respect of each of these aspects, this investigation has revealed that more attention was needed for the implementability of decisions, the use of knowledge and an understanding of the sentiments in society. To achieve these goals, it is important for all parties involved stakeholders - ranging from umbrella organizations, implementing bodies and planning agencies through to citizens, professionals, experts and representatives of specific target groups - to be heard and involved at an early stage of a crisis, so that their insights can

be better taken into account in the decision-making process, and the chosen approach to the crisis can be adequately accounted for in the crisis communication.

8.5 In conclusion

For Dutch terms, the COVID-19 pandemic was - and still is - a crisis of unprecedented scale. The tremendous efforts of many, which for those involved in the heart of the crisis organization still continues to this day, has not been able to prevent the crisis eventually affecting everyone. People were not only hit by the crisis itself, but also by the implemented measures.

It would be an illusion to believe that preconceived structures and working methods fully meet the needs that emerge in tackling a protracted crisis with national impact. This requires a systematic approach that starts with preparation, for example by training the parties involved in the preparation phase to improvise, and to implement changes according to a pre-set plan in crisis situations. This helps create adaptability so that in a crisis, any changes to the crisis organization can be carried out in a carefully considered and structured manner, instead of being left to chance.

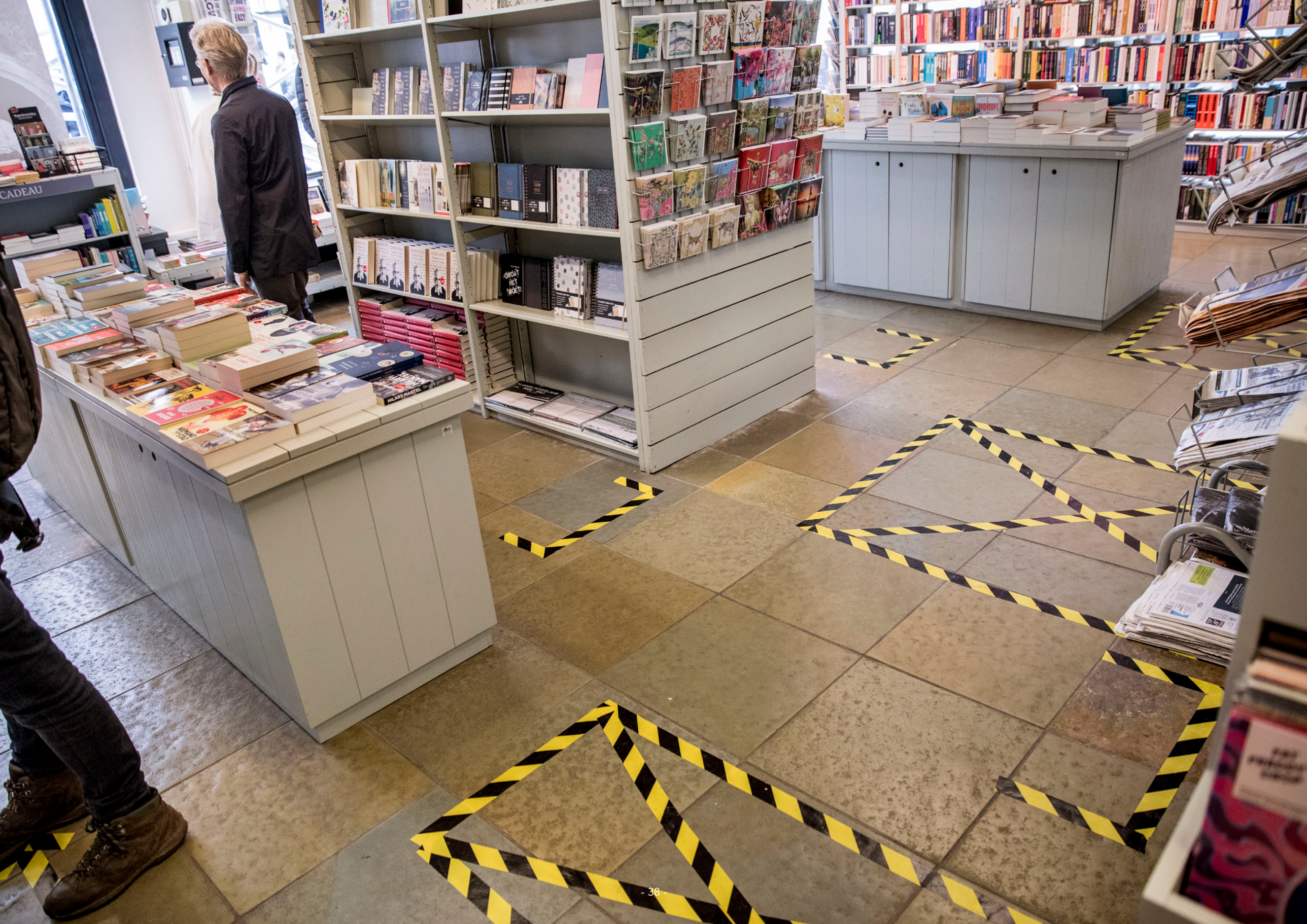
Adaptability also means that in the phase in which individual signals may possibly amount to a crisis, the parties involved succeed in recognizing and interpreting those signals, based on constant reflection about whether the facts and signals should in fact result in changes to the initially conceived approach. Specifically in the phase in which there is uncertainty about the direction the crisis will take, it is vital to think ahead on the basis of scenarios, and to establish a well thought-through structure accordingly. This prevents the parties involved from falling behind.

Even when the crisis is in full swing, it remains important for the parties involved in the crisis organization to regularly reconsider working methods and the implemented structure, with a view to assessing whether they are still appropriate, and to decide where changes need to be made. Although the adaptations made to the structure during the investigated period each meet a specific need, because the adaptations were insufficiently thought through and were then not reflected upon, the consequences of the changes remained underexposed. This in turn had consequences for the checks and balances. A degree of imbalance was established in the decision-making process, leading to a reduction of transparency. This had an effect on the support in society.

Reflection on the crisis structure is not the only essential element. Certainly in a crisis with uncertainties in many different areas, it is also important that decision-makers reflect on the management information on which they base their decisions, and that they regularly reconsider the implemented strategy. Whereas at the start of the COVID-19 crisis it was possible to explain why the available medical data were given priority, in the later stages, when the crisis developed from an infectious disease crisis to a social crisis with broader scope, this was less comprehensible. By clinging to specific management information obtained from a select group of advisors, the risk emerged of tunnel vision and a blurred understanding of the broad social impact of the consequences for vulnerable groups.

These shortcomings can be obviated by a process of reflection which also considers whether the gathered management information actually contributes to the broader scope and is appropriate as a basis for tackling the crisis. If the crisis control policy is based on a limited set of variables, there is a clear risk that support for the resultant measures will crumble. In that situation, people feel that they are no longer represented, if at all, in the approach to the crisis, and feel that their voice is insufficiently heard, if lower priority is given to the effects of the measures on society.

In a protracted national crisis, one thing is certain: even with sound preparation, the people responsible for tackling the crisis will face surprises. This makes it crucial that space for reflection is built in during the preparation for a crisis, in the phase of the run-up to the crisis and during the crisis itself. Wherever the need emerges to adjust structures and working methods, it is important that those changes be carefully considered and explicitly identified, including an open reference to any inconvenience that may be caused by changes. Under all circumstances, the reflection must focus on the question whether the existing structure is effective and where it needs adjusting, which management information and strategy should be followed as a basis for decisions, and whether everyone affected has been successfully reached. Without such moments of reflection, the adaptability so essential in a crisis of this scale will not be sufficiently achieved. This creates bottlenecks that reduce the effectiveness of the approach to the crisis.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CONCLUSIONS

This chapter contains the conclusions drawn from the investigation into the Dutch approach to the COVID-19 crisis in the period through to September 2020. It is important to consider the lessons with a view to improving the approach to pandemics, as well as other protractive crises with broad (inter)national impact, in the future. This has been translated into recommendations.

Preparation for a pandemic

The parties most closely involved in infectious disease control in the Netherlands were prepared for relatively small-scale and restricted outbreaks of infectious diseases, the consequences of which affected healthcare (only). There were scenarios that prepared for the advent of a socially disruptive pandemic, but the preparations for tackling an infectious disease outbreak were not aimed at a protracted crisis with broad national consequences. This can in part be explained by the fact that the parties involved used recent experiences with infectious disease crises as their reference point. Moreover, the priority for infectious disease control on the administrative and political agenda has fluctuated over the years. For the chosen approach to the COVID-19 crisis, this meant that the parties involved were forced to improvise in scaling up resources and capacity. The Ministry of Health, Welfare and Sports (VWS) plays a central role in managing this type of crisis. However, the manuals and scenarios contain no explicit explanation of the precise nature of the role of the Minister of VWS in managing the crisis in practice. This aspect was also not covered in the exercises.

Improvisation and adaptability

In their tackling of the crisis, many of the parties involved demonstrated considerable improvisational capacity and adaptability. This huge level of effort on their part proved essential. It was crucial in order to tackle the COVID-19 crisis, and resulted in the creation of coordination structures such as the National Coordination Centre for Patient Distribution, the National Consortium for Medical Devices and the National Coordination Structure Testing Capacity.

Dealing with uncertainties

This crisis was characterized by numerous uncertainties, for example with regard to the development of the virus and the effect of the measures. There were also differing opinions within the scientific community and studies were sometimes contradictory. Advisors and decision-makers attempted to reduce those uncertainties in this crisis as far as possible, in a variety of different manners. In using the data that were available, insufficient information was provided about the limitations of those data, such as the fact that data always lag behind the actual situation, have limited predictive value and/or have limitations in terms of validity and completeness. In the RIVM models, on which the Outbreak Management Teams' (OMT) advices were based, a margin of uncertainty was taken into account. In the decision making, the primary response was based directly on the OMT advices.

These advices, however, were issued with a greater level of certainty and conviction than could have been expected on the basis of the discussions within the OMT, and given the state of scientific knowledge. Moreover, the advices failed to present any alternative scenarios. Although they were often discussed in the technical briefings of the chairperson of the OMT, less positive scenarios were anticipated to a limited extent in the decision-making process.

Realization of strategic targets

The rapid development of the pandemic in a context of uncertainties meant that in the initial phase of the COVID-19 crisis, the strategy was shifted from containment to mitigation. In addition to these terms, the Cabinet used a whole raft of other terms for the approach, such as 'herd immunity', maximum control and 'flatten the curve'. In fact, the Cabinet strategy was threefold: monitoring the spread of the virus, controlling the demand placed on the healthcare sector and protecting the vulnerable. In practice, the approach was focused above all on managing the demands placed on hospital care.

Understanding the spread of the virus

The case definition employed by the government in February and March 2020 was too limited to acquire a full understanding of the spread of the virus in the Netherlands: people with symptoms were only considered potentially infected in very specific cases. In addition, until June, the Netherlands operated a very restrictive test policy, in which only a limited number of target groups could be tested. This also restricted the understanding of the spread of the virus. Another consequence was that less test material was allocated to the Netherlands than to countries with a more extensive testing policy. Moreover, the global shortage of test material meant that large-scale testing was not possible during the first months of the crisis. However, even within the context of shortages of materials and capacity, there were possibilities for more testing. The possibilities remained unused, which meant that the management of the virus was based on incomplete information about its spread.

Protecting the vulnerable

One of the three strategic objectives was to protect the vulnerable. This objective was visibly implemented in respect of vulnerable persons admitted to hospital. The protection of vulnerable elderly people within nursing homes, however, received little attention during the first wave. Due to the restrictive test policy, the understanding of the course of infections or the large number of victims in nursing homes was limited. Initially, the nursing home sector was not involved in the decision making, and for a long time was given a subordinate role in the distribution of the scarce resources.

Broader social effects

Logically enough, during the first few weeks of the COVID-19 crisis, infectious disease control was all-encompassing in the advice offered and the decision making. Economic effects, however, soon also received attention. The management efforts of the national crisis organization were based primarily on the figures available to it, such as infection rates, R-value and intensive care capacity. Throughout the entire investigated period, the perspectives and interests of acute care and infectious disease control remained dominant over those of long-term care and the broader healthcare problems.

'Soft' information about effects on society such as loneliness, consequences for mental health and learning deficits received little attention in the advice and decision making processes, also as a result of time pressure. This meant that long-term effects on society were only taken into account on a limited scale.

Separation between policy and implementation

The huge separation between policy and implementation meant that at national level there was little understanding of the practical aspects of implementation within organizations such as nursing homes, Municipal Health Services (GGD) and the safety regions. As a consequence, both in the advice offered by the BAO, IAO and ICCb in particular, and in the decisions taken within the MCCb, in many cases, the practical perspective remained absent, so that in formulating measures, insufficient account was taken of the needs of practice and practical implementability. This in turn led to bottlenecks, additional pressure and misunderstanding.

Communication and support

Communication with the public was a crucial instrument for the national government in tackling the COVID-19 crisis because all Dutch people were called upon to adhere to measures to prevent the spread of the virus. There was much and regular government communication to the public. Within its communication strategy, the government mainly instructed the public top-down to follow the behavioural measures, focusing in particular on the general public. This crisis communication approach meant that through to May 2020 at least, support for the measures remained high. However, this high level of support could not be maintained.

From around mid-May 2020 onwards, public resistance to the COVID-19 approach became increasingly visible. The crisis communication by national government matched poorly with the growing numbers of people with psychological, social and financial difficulties as a result of the crisis and the consequences of the measures. In addition, the support base was influenced by the limited feasibility of decisions, the limited use of broad advice on the effects on society, and the fact that groups of citizens and professionals did not feel heard. In addition, communication aimed at target groups such as those with functional illiteracy, people with minor mental disability, people with a migrant background and young people only started in May 2020, and to a limited extent.

Governance of the healthcare field during the crisis

Healthcare in the Netherlands is organized in a decentralized manner, with a high degree of autonomy for healthcare institutions and healthcare professionals. In periods of crisis, there is no formal crisis structure with coordination and management capabilities to rapidly and adequately deal with problems that go beyond the boundaries of individual institutions, healthcare sectors or regional collaborative organizations. This made it necessary to improvise in order to deal with a variety of problems including a balanced spread of patients between hospitals, and the shortage of medical equipment. Because the Ministry of Health, Welfare and Sports (VWS) itself did not have access to the necessary knowledge and expertise, it was heavily dependent on the healthcare field to implement an effective approach.

National crisis structure

When the national crisis structure was activated, there was no explicit transfer of the leading role of the Minister of VWS to the Ministerial Committee for Crisis Management (MCCb). In practice, the Minister of VWS retained a central role in crisis control, and it was not emphasized that a broader view of an integrated approach to the crisis was needed. Understandingly enough, due to the protracted nature and magnitude, the crisis structure was adapted. However, this increasingly led to the creation of a parallel structure alongside the formal crisis structure. In this parallel structure, checks and balances were less well secured, for example because the substantive discussions and decisions above all took place in the so-called *Catshuisoverleg* and *Torentjesoverleg*, rather than within the MCCb. At the same time, the roles of the parties involved became intermingled, for example the role of the OMT and the BAO. Because the chairperson of the OMT, responsible for epidemiological advice, was present in almost all crisis teams, the perspective of infectious disease control remained dominant. The dominance of this perspective made it more difficult for advisors and decision-makers to take a broader view beyond the theme of infectious diseases. The adaptations made to the crisis structure finally meant that no clear picture was presented to the parties involved with regard to the decision-making in the crisis organization.

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