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The effect of size and the Nordic states' responses to the COVID-19 pandemic: Reactive or proactive?

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Abstract: This paper examines whether the small size of the public administration of the seven Nordic countries affected the nature of their crisis responses, focusing on the mix between proactive and reactive strategies, during the early phases of the COVID-19 pandemic. Comparing across all seven cases, a key pattern emerges: the smaller the state – in terms of both population and administrative depth – the more likely it is to rely on reactive mechanisms at the outset. However, these same states also tend to be more flexible and socially cohesive, allowing for rapid adaptation. In contrast, larger Nordic states have broader institutional structures and more expert-based capacity; this promotes proactive planning but may be hampered by decentralization, bureaucratic silos, or institutional inertia. This study confirms that small states are more likely to begin with reactive responses due to limited resources; but their capacity for quick adaptation, voluntarism, and tight governance networks leads them to develop proactive measures over time. Thus, size alone does not determine effectiveness; it interacts with governance structures, administrative culture, and public trust. The crisis responses across the Nordic region demonstrate that proactive and reactive strategies coexist on a continuum; and that agility, learning, and institutional coordination are crucial to successful pandemic management, regardless of state size.

Keywords: crisis management, COVID-19, governance, Nordic states, pandemic, proactive, public administration, reactive, size, small states

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Introduction

One of the most common claims of the small state literature is that small states lack administrative, economic, military, diplomatic and human resources compared with large states. Small states need to prioritize their effort to skilfully implement policies at home and abroad. They find it easier to prioritize issues than large states due to their narrower range of economic and political interests (Thorhallsson, 2000). They focus on policy sectors or issues of great importance where direct benefits can be gained. They adopt prioritization strategies (Panke, 2010). For instance, Iceland, Greenland and the Faroe Islands have prioritized interests that benefit their fishing industries, Norway has prioritized its oil and gas industry, Sweden its manufacturing sector, Denmark its agrarian sector and Finland its forestry (Ingebritsen, 1998).

Accordingly, small states may compensate for their aggregate structural power disadvantage with greater issue-specific power (Habeeb, 1988; Tallberg, 2008). This enables small states, particularly those who have high-quality administrations and bureaucratic cultures, and have the experience in the given field, to adopt active strategies (Panke, 2010). On advantageous issues, small states are proactive and expend considerable resources (Thorhallsson, 2000; Panke, 2010). The seven Nordic countries are all proactive in securing and defending interests of the sectors mentioned above, domestically and internationally (Ingebritsen, 1998).

Due to their lack of resources, this also means that small states need to put certain policies/issues on the side. Small states are more reactive on policies/issues of less importance (Thorhallsson, 2000; Panke, 2010). For instance, Luxembourg has prioritized policies that relate to its significant financial sector, but sidelined the development of its higher educational sector, leaving it largely to its larger neighbouring states (e.g. the University of Luxembourg was not established until 2003) (Thorhallsson, 2015). Nevertheless, citizens of small states demand that their governments fulfil the same implicit obligations as governments of large states, such as those regarding health care, and primary and secondary education. Small state citizens are likely to make similar demands to a skilful management of crisis, such as the COVID-19 pandemic, as those of large states. Good and skilful governance is applicable to small and large states alike. Hence, small states must somehow compensate for the greater resources of large states to be competitive with these large states.

Bernhardsdóttir and Svedin (2004) argue that limited resources make crisis management systems in small states much more prone to be reactive than proactive in identifying and managing crises. We understand their claim to focus on how great public participation and little professional staff to organize and manage crises within a country – as is prominent in small states systems – cause them to be more reactive than proactive in their crisis management.

Decision-making in the Nordic states follows the subsidiarity principle and takes place as closely as possible to citizens (de la Porte et al., 2022). Local governments have authority in a range of sectors and are not only responsible for implementing policies determined by central authorities. Hence, the Nordic states' governance structures are highly decentralized, especially in the welfare-state sector, even though they are relatively small.

Also, great public participation in the Nordic countries is shaped by authorities' reliance on volunteers in emergency response. In 1967, a report by the Nordic states on civil defence emphasised that responsible for rescue and humanitarian work to protect inhabitants should be civic but recognized by the state (Jörundsson, 2010). Iceland has by far the most public participation in its risk reduction and response compared with the other Nordic states. Voluntarism was a prerequisite for the formation of the civil protection system and associated policies. Scholars

have argued that, in certain aspects of emergency response, the Icelandic Red Cross and its volunteers have an even larger role than the formal social services such as in mass care and psychosocial support (Eydal et al., 2016; Van Well et. al., 2018; Rapaeli et al., 2018). In general, the success behind the civil protection policies and the operation of the systems in the Nordic countries is built on a long-term maintenance and development of collaboration between authorities and volunteer organizations (Bernhardsdóttir & Hrafnsdóttir, 2022).

Accordingly, this paper examines the hypothesis that limited resources and 'lay characteristics' – that is, broad public participation and little professional staff to organize and manage crises – prominent in small states crisis management systems. make them more prone to be reactive than proactive in identifying and managing crises. We will also consider how these expectations become more apparent the smaller the population. We expect that responses become more reactive with diminishing country size. We will assess the effects of size of public administrations on the responses in the respective Nordic countries and compare their crisis responses while considering their size.

We distinguish between proactive and reactive crisis management to assess how the Nordic states responded to the COVID-19 pandemic, particularly during its early phases. Drawing from organizational behaviour literature, proactive behaviour is defined as the act of anticipating future challenges and taking initiative in advance of unfolding events. It involves forward-looking planning, early intervention, and shaping outcomes before they materialize. In contrast, reactive behaviour is triggered by external events; it is characterized by responding to crises as they occur, often under conditions of pressure, uncertainty, and time constraints (Bateman & Crant, 1993).

In essence, proactive management seeks to prevent problems, develop systems, and plan for long-term success, while reactive management focuses on solving problems as they arise, troubleshooting issues, and maintaining short-term stability (Bateman & Crant, 1993). These approaches may be viewed as two ends of a continuum: mutually exclusive in theory, but often coexistent in practice. Governments may adopt proactive strategies in some areas while relying on reactive responses in others, particularly during complex and evolving crises such as a pandemic.

Each mode has its strengths and weaknesses. Proactive strategies are advantageous in risk mitigation, long-term resilience, and fostering accountability, but they require foresight, planning, and often greater investment of time and resources upfront. Reactive approaches, on the other hand, offer agility and are effective in managing sudden threats or unexpected developments. However, they tend to be less strategic and more susceptible to inefficiencies or poorly coordinated responses.

Applying this framework to the COVID-19 pandemic, we note that all Nordic countries exhibited elements of both proactive and reactive crisis management. Prior to the pandemic, they had developed some level of preparedness, including epidemic legislation, health surveillance systems, and emergency management frameworks. These pre-existing structures and plans – rooted in past epidemic experiences – can be classified as proactive measures. They reflect a forward-looking approach aimed at minimizing health risks and ensuring governmental readiness (Christensen & Lægreid, 2020).

However, COVID-19 differed fundamentally from earlier health emergencies in scale, transmissibility, and societal impact. No country was fully prepared operationally or logistically. A comparative study of health system responses to COVID-19 highlighted how Nordic countries share similar welfare models; but their crisis responses varied significantly (Saunes et al., 2022). Testing and treatment capacities had to be ramped up swiftly, coordination mechanisms had to be adapted in real-time, and health systems were pressured to improvise. These responses, by

definition, were reactive: initiated in response to an unfolding crisis. Nonetheless, even reactive measures often built on proactively accumulated knowledge, illustrating the fluid boundary between the two modes (Christensen & Lægreid, 2020).

For analytical clarity, we define the key attributes of each approach as follows:

Proactive crisis management includes:

- Anticipation of risks and development of contingency plans before the crisis materializes.
- Active data collection and health threat surveillance in advance of critical developments.
- Activation of emergency management structures, including inter-sectoral coordination mechanisms and vertical integration between central and local authorities.
- Legal and institutional preparedness to act decisively under emergency conditions.
- Willingness to act under uncertainty, using pre-existing frameworks and knowledge to mitigate risk.

Reactive crisis management includes:

- Delayed engagement, often adopting a "wait and see" posture in early stages.
- Limited pre-crisis resource mobilization, with institutions scrambling to match capabilities to needs as the crisis unfolds.
- Fragmented or ad hoc responses, including difficulties in implementing prevention measures such as testing, tracing, and isolation.
- Uncertain or inconsistent emergency measures, often dictated by rapidly changing circumstances rather than pre-planned strategies.

Despite their analytical distinctiveness, proactive and reactive responses often coexisted during the first wave of the pandemic. The distinction became especially blurred in real-time decision-making, as governments moved between anticipation and reaction based on the evolving threat landscape. In this paper, we focus on the period from January to summer 2020 and analyse the early pandemic responses of the seven Nordic countries. Our analysis considers how country size, administrative capacity, and governance structures influenced the balance between proactive and reactive crisis management. Special attention is paid to whether smaller states – with more limited bureaucratic resources and greater reliance on civic voluntarism – were more prone to reactive responses than their larger Nordic neighbours.

Norway: 'Wait and see' reactive approach followed by more proactive approaches

Norway's initial response to COVID-19 was largely reactive, reflecting a lack of preparedness and a weak analytical capacity (NOU, 2021:6, p.23; Christensen & Lægreid, 2023a). Throughout January and February 2020, the government's response was minimal and focused on observation, reflecting a cautious "*wait and see*" approach (Christensen & Lægreid, 2020, p. 776). This cautious stance was likely influenced by the country's unfamiliarity with managing a global pandemic and the fact that COVID-19 was not detected in Norway before 26th February, 2020 (NOU, 2021:6, p. 34).

Despite Norway's predominantly reactive approach to the pandemic during this period, the government did take proactive steps to gather more information about the emerging virus. One example involved engaging in close dialogues with several countries to inform the state's future strategies. Among these, Norway's dialogue with the Italian government – Europe's first country severely affected by COVID-19 – proved particularly impactful in shaping Norway's early crisis management efforts. Despite Norway's comparatively distinct geographical composition – a relatively low population density spread across a broad geographical area – Italy's personal experiences offered insights into the pandemic's potential trajectory. The international initiative to share knowledge from the Lombardy region provided Norway with much needed insight. Italy's struggles with the pandemic highlighted to the world that even a well-equipped western nation could find itself overwhelmed by an infection wave of the SARS-CoV-2 virus (NOU, 2021:6, pp. 127, 139). These dialogues, along with analytical reports like those from Imperial College, London, likely played a critical role in guiding the Norwegian government to make more informed decisions, and adopt a more decisive and suppressive approach to managing the COVID-19 crisis (NOU, 2021:6, p. 148). Also, Norway's cooperation with the World Health Organization (WHO) and the European Centre for Disease Prevention and Control (ECDC) helped shape the country's response through critical guidance and recommendation (NOU, 2021:6, pp. 140, 185, 191; NOU, 2022:5).

The above highlights that, while Norway's response to the COVID-19 pandemic was largely passive and reactive during the first two months, the government actively engaged in proactive efforts to improve its understanding of the newborn virus.

During the first quarter of March, the Norwegian government response remained somewhat minimal. However, on March 12th 2020, this shifted dramatically as the government implemented a lockdown, travel restrictions, closure of schools and non-essential businesses: its strictest measures since wartime (NOU, 2021:6, p. 22; NOU, 2022:5; Christensen & Lægreid, 2023b, pp. 293-294). Rather than being driven by a preventive/proactive strategy, these measures were implemented in reaction to the escalating crisis (NOU, 2021:6, p. 63). During this time, Norway experienced a rapid surge in cases, registering its first 1,000 infections within just seven days of identifying its first case. This rapid escalation stood as a huge contrast to the Norwegian Institute of Public Health's (FHI's) initial projection, which anticipated reaching this count in 100 days (Ministry of Justice and Public Security, 2020; NOU, 2021:6, p. 15). There were no plans for a lockdown and the government had to improvise urgently to find measures to fight the pandemic (Askim & Christensen, 2025), partly inspired by the lock down in Denmark a couple of days before. As a result, Norway's response during this period was reactive rather than proactive.

Understanding the underlying reasons for Norway's reactive approach requires considerations of the characteristics of small states like Norway. Despite its well-funded government, Norway's crisis management was complicated by the country's vast territory and widely dispersed population. These geographical and demographic characteristics made it difficult to sustain a fully centralized crisis management system. In practice, a small population spread across a large area poses significant challenges for ensuring an effective and coordinated response nationwide (NOU, 2021:6, pp. 404-405; NOU, 2022:5, p. 443; Bernhardsdóttir & Svedin, 2004). As a result, the crisis management system was a combination of strong top-down control from the government and significant responsibilities entrusted to local municipalities (Christensen & Lægreid, 2022, p. 298) particularly when it came to testing, isolation, infection tracing and quarantine (TISK) as well as vaccination. Over time, municipalities were also allowed to adjust measures according to local infection rates, which limited the capacity for a uniform and proactive

strategy across the entire nation. This crisis management system, while promoting local empowerment and quick reactive responses, often relied on improvisation rather than systematic and proactive planning. Especially in the later phases of the pandemic, local municipalities' involvement in decision-making would bring about local solutions tailored to specific community needs which boosted public engagement and participation (Christensen & Lægreid, 2022; Baldersheim et al., 2024).

The nation's cultural framework promotes a crisis management in which significant levels of public involvement and participation are invested: a key component to Norway's efforts to curb the virus's spread. As a result, citizens adhered to guidelines, complied with lockdowns, and participated in testing and vaccination (NOU, 2021:6, pp. 17, 176; NOU, 2022:5, p. 362). This public involvement would continue throughout the pandemic, but as time passed citizens' engagement somewhat diminished (NOU, 2021:6).

Norway's initial response highlights both the strengths and limitations of a system that relies on public participation, whilst potentially lacking professional expertise to anticipate and prepare for crises on a proactive basis. However, Norway's ability to adapt and learn from its experience enabled it to improve its crisis management. In particular, the Norway's Corona Commission reports served an important role in translating early shortcomings into actionable insights, offering critical assessments that later informed the development of more proactive strategies (NOU, 2021:6; NOU, 2022:5; NOU, 2023:16). The implementation of the traffic-light model for school closures and the TISK system serve as key examples of proactive strategies that Norway later adopted (NOU, 2021:6, pp. 171, 238).

Sweden: a response that was 'too little, too late'

In the case of Sweden, the hypothesis that limited resources yield a reactive management gives two separate answers depending on the focus area and level of analysis. The main public inquiry ("Coronakommissionen") states that the government acted too weakly and too late as far as implementing public health measures to prevent the spread of the disease; but acted quickly as far as implementing economic measures to soften the blow of the pandemic (SOU, 2022:10, p. 638).

Looking at the operational end of healthcare, and at how the municipalities and counties took on the task, the hypothesis is largely confirmed. The general pattern observed in both the commission report and in subsequent reviews shows that larger counties could operate more freely and proactively, safe in the knowledge that economic, cognitive and personnel resources had sufficient buffers to forge ahead; whereas smaller ones felt a need to wait until resource allocation on a national level had been sorted out (SOU, 2022:10, pp. 403ff).

In this, the care for the elderly stands out as a special case. On the one hand, this was a core component of the early spread and the large number of COVID-19-related deaths (SOU, 2020:80, pp. 242ff); but size and resources are at best indirect mechanisms that can only vaguely be correlated with issues such as degree of privatisation and inconsistencies in how public health measures were adopted in the elder-care facilities.

In general, Swedish crisis management is heavily decentralised and is meant to operate on an upscaling principle: primarily, crisis management is a local concern and one of the many responsibilities of municipal authorities. Formally, the smallest Swedish municipality, at just over 2,300 inhabitants, is tasked with having the same preparedness and capabilities as the largest municipality with a population of just under 990,000. Banding together in crisis management clusters and having structures for quick upscaling are common means for smaller local agencies

to allow for mutual support and reach a critical mass in staffing and competence to meet this formal requirement. This solution works reasonably well in every-day emergencies and smaller crises. But the COVID-19 pandemic quickly illustrated the limits of such structures where there was no longer any mutual support to be had: everyone was hit, badly. Consequently, larger regions and municipalities had a reserve to dig into by virtue of their size and thus could act more decisively and independently; whereas the pandemic directly affected and under-cut the very structures that were supposed to offer similar capabilities to smaller areas.

Finland: non- or limited response

At the top political level in Finland, the response was non-existent until the registered infections started to rise in early March. However, some of the government institutions, e.g. the hospital system, together with Finnish Institute for Health and Welfare (THL), responded proactively, setting up a testing scheme, which allowed one of the world's most comprehensive testing-tracking-isolation approaches, and which became the basis for all COVID-19 governance until early 2022. Prior to the pandemic, Finland had drafted a national influenza preparedness plan (Ministry of Social Affairs and Health 2012), National Security Strategy (The Security Committee 2017) and a National Risk Assessment (Ministry of the Interior, 2018) which all included the possibility of a worldwide pandemic. Most of them were updated only a few years before the covid-pandemic started. However, despite multiple estimates, national preparedness proved to be insufficient. Hence, the political system was mostly reactive in the beginning but became smarter and more proactive as time went by, to the extent that developments allowed for proactivity.

Although Finnish authorities, including the THL, were aware of the virus as early as January 2020, the gravity of the situation was not fully registered until the WHO declared a public health emergency of international concern (PHEIC) on 30th January 2020. Some proactive administrative measures were taken: a corona coordination group in the Ministry of Social Affairs and Health was set up (Ministry of Social Affairs and Health, 2020); COVID-19 was included into the Communicable Disease Act; and Regional State Agencies acted proactively, according to the Communicable Diseases Act (Tiirinki et al., 2020). However, Finland's overall response to the onset of the virus was largely reactive in its early stages.

In late February 2020, the first infections in Finland started to appear, and the situation quickly worsened in Italy. Finland's government chose to take more decisive action. This included lockdown measures and bans on gathering, following actions carried out in Denmark and Norway. In addition, the government implemented proactive prevention measures, such as closing the Uusimaa region, including the capital city of Helsinki, to prevent the spread of the virus to other parts of the country (Safety Investigation Authority, 2020).

Before the activation of legal measures (the Emergency Powers Act) in mid-March, THL experts had close contact and a coordinated view of dealing with the corona virus with their Swedish counterparts (*Folkhälsomyndigheten*). Interestingly, this cooperation was not realized on a higher political level. No references were made to Nordic arrangements, including the Nordic Public Health Preparedness Agreement, even though the Nordic Health Preparedness Group (the Svalbard Group) held frequent online meetings to discuss the healthcare and anti-covid measures situation during the crisis (International collaboration, 2023).

One reason that has been mentioned for Finland's delay in response and its reactive stance was the reduction in THL's expert activities due to financial constraints. THL staff had been reduced from 1231 to 962 between 2011 and 2019 (THL, 2013; 2019; Safety Investigation

Authority, 2020). This reduction led to a loss of experienced personnel, which impacted the effectiveness of the COVID-19 response. The Finnish government relied heavily on THL's expertise, which depended on global health authorities like WHO and ECDC for guidance.

The reactive measures culminated in the Finnish National Emergency Supply Agency's (HVK) procurement of PPE. In late March 2020, when it became evident that PPE reserve stockpiles were insufficient, the government ordered the HVK to acquire the masks from the open market. Under immense pressure from political leaders, Tomi Lounema and other HVK leaders bypassed formal procurement procedures, which led to some unsuccessful deals. Because of these failures, Lounema and his colleagues were forced to resign and were suspected of abusing a position of trust. However, in the end, the prosecutor decided to not press charges against three HVK leaders regarding the procurement of protective equipment, and the Chancellor of Justice concluded that HVK was placed in an exceptionally demanding situation, requiring it to take on new procurement tasks outside its normal operations. (YLE, 2021; Chancellor of Justice, 2020).

Denmark: from vigilant "wait and see" to flexible proactiveness

The initial response in Denmark was based on administrative routines and contingency plans developed from the experiences of H1N1 and swine flu in 2006 and 2013. As in the other Nordic countries, the Danish Health Authority initially considered it rather unlikely that COVID-19 would become a severe threat. The response in January was to increase disease surveillance and solicit information from international networks and organisations such as the ECDC and WHO. This initial phase of active "wait and see" lasted during January and February. Two major proactive measures were taken in late January. First, the Prime Minister's office stepped in and mandated that the Ministry of Health should provide regular updates and risk assessments to the Government. This was a first step towards the very active and strong role of the Government leadership that was to become the norm during the rest of the pandemic. The second step was that the National Health Authority issued an order to the five Danish regions that they should test their health crisis management plans which had been developed within the framework of the overall national crisis management plan. The plans were built on the principle of early detection, isolation and tracing of contacts if COVID-19 cases would emerge in Denmark. These two proactive measures were part of a general intensification of COVID-19 preparation work in the Danish Ministries at the time (Christensen, 2022, p. 5).

The vigilant "wait and see" phase lasted until 27th February when the first case of COVID-19 was detected in Denmark. At the same time, there were reports about the critical situation with overburdened hospitals in Northern Italian towns including Bergamo. The response from the Government was to switch from the traditional sector-based approach, where the main responsibility was located with the health authorities (Sundhedsministeriet, Sundhedsstyrelsen og Statens Serum Institut), to a much more centralized and politically driven process, with the Prime Minister and her cabinet in a leading role, and with the activation of special government crisis coordination structures (Christensen, 2022, p. 8; Folketinget, 2022). This phase was initiated at a meeting of the Government Security Council on 27th January. From then on, the overall strategic coordination rested with the Prime Minister and her office and government coordination meetings with key ministers. The operational coordination was handled by the Ministry of Justice, and two important administrative coordination networks – the AC Group of leading bureaucrats in the ministries, and the NOST and NOST+ networks – which were headed by the chief of police and included key crisis management agencies. The AC Group communicated demands and orders from

the Government apex and collected and coordinated responses across the ministries; NOST+ coordinated operative practices and supplies (test, tracing and isolation measures) and liaised between the state ministries and the broader set of operative crisis management actors (police, defence, civil defence, health, etc) (Folketinget, 2021, p. 135).

Notably, the Ministry of Justice was placed in a key position as coordinator of operational crisis management. This enhanced the capacity of the central administration significantly and it strengthened the capacity of the Prime Minister's office (which is rather small) and augmented the specialist competencies of the Ministry of Health with significant generalist capacity to coordinate and steer the many legislative and operational initiatives that were processed quickly from 27th January to the partial lock down on 11th March and the following gradual reopening from April 2020 (Christensen, 2022, pp. 12-13). The key role of the Ministry of Justice is also clear in the decision to place the newly established (August 2020) Danish Critical Supply Agency within this sector ministry.

While the Government apex and the Ministry of Justice had key political and administrative roles regarding general and covid related issues, the Ministry of Business and Industry was placed in a key coordinating role regarding the extensive economic aid packages which were announced stepwise on 6th, 10th and 11th March 2020 (Folketinget, 2021, p. 343). The development of aid packages followed a corporatist tradition with the involvement of industry and civic society organizations. Vertical integration with regions and municipalities were handled through the relevant sector ministries, particularly the Ministry for Health and Elderly, and ongoing coordination meetings with the NOST/NOST+.

The politicization and centralization reflected a realization of the complex nature of the crisis, which demanded leadership and political deliberations about many different objectives and policy options (Christensen, 2022). The crisis was not just a health issue, but also concerned business and the economy, foreign affairs, religious practice, education and the wellbeing of every citizen. The rapid centralisation and invocation of coordination also enabled an impressive number of parallel activities in the relatively short period from late February to the partial lockdown on 11th March and the following stepwise re-opening.

Danish authorities were unable to foresee the global pandemic of COVID-19. It therefore started with a vigilant "wait and see" approach, with proactive collection of international health data and gradually intensified preparation for the unknown potential crisis. This was followed by a proactive activation of crisis networks and reorganisation of administrative structures to significantly strengthen the capacity of the bureaucracy to engage in coordination and parallel processing of the many legislative and organisational initiatives during the crisis (including a revision of the Epidemic Law on 12th March and subsequent adjustments) (Christensen, 2022; Vrangbæk, 2023).

The organizational and legislative changes enabled a relatively early pro-active lockdown from 12th March, border closure from 13th March, and the gradual re-opening from April. It also enabled extensive aid-packages to be put in place at an early stage. The early lockdown and closing of borders were based on a political framing by the Prime Minister of a "precautionary principle" (Statsministeriet, 2020), which essentially is a discursive articulation of the intention to be proactive, also in situations of significant uncertainty. This framing was largely accepted by the population which displayed a high degree of trust in the Government's crisis handling, and hence a high level of compliance during most of the crisis (Kallemose et al., 2022; Nielsen, 2022; Petersen, 2021). The government received ongoing information from a national survey about population reactions to policies (The Hope-project: https://hope-project.dk/#/; Jørgensen et al.,

2021; Sundheds- og Ældreministeriet, 2020). This can be viewed as a pro-active measure to enable political adjustments based on (almost live) population survey data.

The extremely high speed of new legislation and other initiatives in circumstances of uncertainty during 2020 has been criticized for occasional breaches in normal consultation procedures and quality of legislation (Christensen, 2022, pp. 17-19; Christoffersen et al., 2020). The most prominent example involves the pro-active decision on 3rd November 2020 to exterminate all fur mink due to the risk of Cluster 5 mutations that could render the vaccines ineffective. The decision was fast, and the implementation was flawed. Yet, the decision exemplifies the need to make decisions under significant time pressure and uncertainty, and it demonstrates the willingness to act. The criticism prompted several institutional changes to enable better parliamentary control over government in future health crisis management scenarios (Christensen, 2022).

Iceland: Proactive and Flexible

Well before the onset of COVID-19, Icelandic authorities had been proactive in the development of a national contingency plan for a probable pandemic. This effort was more proactive than had been seen in previous Icelandic crises (demonstrating to large extent the small state's reactiveness) (Bernhardsdóttir & Kristinsson, 2013; Bernhardsdóttir & Svedin, 2004) and established a solid foundation and organizational structure for Iceland's response to the COVID-19 crisis. Within the framework of the plan, the details of the execution of the plan were largely reactive and relied heavily on the flexibility, adaptability and creativity of the stakeholders to overcome the unforeseeable challenges of an unprecedented pandemic. Iceland's success in its response to the pandemic can be attributed to the pragmatic combination of proactive planning and reactive execution in the face of evolving knowledge and multiple logistical challenges in the execution of its response.

During January and February 2020, Icelandic authorities focused on information gathering and processing. The Directorate of Health issued a statement about infections in China caused by a new virus on 13th January, citing information from the WHO and the European Centre for Disease Prevention and Control (ECDC). Thus, the government was conscious about the threat and followed updates from those institutions regarding the development of the infections in China. At the end of February, the National Police declared a state of alert and in mid-March the government implemented the first preventative measures: a ban of social gatherings of more than 100 people and closure of universities and high schools. While the authorities were alert and proactive in following events in the rest of the world, the lack of resources became obstacles in the response. An example is the challenge to follow WHO's guidance on identification, testing, and response to potential infections when lacking the necessary supplies and facilities adequate to the challenge. Another example is how a probable European Union export ban on medical devices and protective clothing threatened Iceland's response and created great uncertainty amongst the decision-makers; so much so that the Iceland Prime Minister felt it necessary to have a phone call with the President of the European Commission and seek her support.

Cooperation between the Department of Civil Protection and Emergency Management (National Police Commissioner) and the Chief Epidemiologist (The Directorate of Health), established well before COVID-19 outbreak, was an important factor in the first response. The cooperation began in 2005, with the aim of creating a contingency plan for a probable pandemic which led to the development of a national plan in 2008. At the same time, new legislation took

effect, sealing this cooperation and coordination behind preventive and preparedness measures. This plan was updated in 2016 and, although it had to be updated to better suit the nature of COVID-19 (5th March 2020), the years of coordinated planning resulted in a valuable learning process that was vital during the COVID-19 response. Personnel that knew each other well and had worked together to build the knowledge base, oversaw coordination of the response (Bernhardsdóttir et al., 2022, p. 484).

The civil defence system in Iceland is built on strong public participation where volunteers play a key role. Frequent responses to disasters caused by natural hazards have given responders extensive experience; they have shouldered significant responsibility that has earned them the trust of the authorities and the public. The COVID-19 pandemic was certainly a crisis that tested solidarity, where the challenge is to achieve mass consensus on responses to a crisis that threatens the lives of some more than others. Hence, the importance and the impact of using the system lay not only in providing channels to fight the pandemic but also in supporting general solidarity in society which is a prerequisite for the willingness of people to respect and support the government's measures.

In addition to the personnel working for the civil defence system, out of concern for the health and well-being of their fellow citizens, private companies and individuals stepped in and searched for solutions. The government secured an agreement with a private company regarding patient diagnostics, virus sequencing, and community screening and with other companies for the storage and distribution of vaccines and for the development of software solutions. Rear-guard units of medical personnel and welfare services were established and experienced volunteers provided psychological support. This wide public participation fostered creativity and flexibility in the response.

The reliance on experts in the decision-making process deviated from previous Icelandic crises, wherein expertise was more often opposed, resulting in reactive responses due to, for example, a delay in information sharing (Bernhardsdóttir & Svedin, 2004). However, the response to COVID-19 cannot be characterized by increased centralization but, as discussed above, by activating the civil defence system, the government emphasized that decentralization should be maintained (Bernhardsdóttir et al., 2022).

While the national plan had been developed prior to COVID-19, on the local level most authorities were poorly prepared, with few having confirmed contingency plans and even fewer having evaluated their resilience as required by law. Thus, while local responses were reactive, in most important issues such as in matters of schools and health institutions, local responses followed Reykjavik's lead. Considering that approximately two thirds of Iceland's population live in the capital area, it is understandable that smaller communities around the country looked to Reykjavik for guidance. Flexibility also became salient in the Reykjavik authorities' responses, not least in favour of those who needed welfare services (Bernhardsdóttir et al., 2022).

As discussed above, obtaining resources to fight COVID-19 was a constant challenge for the government which had to depend on other countries for critical supplies such as medical devices and protective clothing. Scientists worked diligently and provided statistical information about the pandemic, but Icelanders had to depend on other countries for analytical capacity that was used to update governmental measures. For instance, the Epidemiological Authorities benefited from COVID-19 research results sent to them from Norwegian institutions. An Icelandic epidemiologist who believed at the beginning of the pandemic that the use of masks was of little value changed his mind when new Norwegian research showed that they were effective; governmental measures

were updated to include them (Bernhardsdóttir et al., 2022). Such openness to new information and flexibility in policy could often been witnessed in the response.

The Faroe Islands: Unprepared but quick response

The small size of the Faroese public administration played an important role in managing the pandemic, particularly in its ability to take swift action and mobilize societal resources, such as trust and compliance. However, the size factor also posed challenges, such as burn-out in several sectors and a relative deterioration of public services.

In early January, the Faroe Islands were not at all prepared for COVID-19. However, in the following months, the Faroes managed to quickly adapt existing resources (people, funds and skills) to the COVID-19 pandemic. The reason for this is likely a combination of social cohesion (high trust), quite sensible decision-making, an integrated public sector: that is, trust between different organisations as a byproduct of having a small political system. In other words, the distance from citizens to those in charge was small, and the distance between those in top positions, directors, experts and so on, was also very small. As a result, the crisis team already knew who was best at performing what, and that person was always a quick phone-call away.

After the initial March infection wave, the Faroe Islands were completely free of infection on 9th May 2020. The initial measures by the government had worked well. Nevertheless, they are best characterized as a blend of proactive and reactive measures, since the authorities were constantly standing by to observe whether initial measures were working. This approach of maintaining a state of readiness was also embedded within public messaging, allowing for rapid shifts in strategy. The adaptability of this approach was facilitated by the fact that the Faroe Islands relied exclusively on soft law as the primary regulatory mechanism for managing the COVID-19 pandemic.

The response to the second wave in July was similar, but more proactive. Testing, tracing and isolation co-ordination had been streamlined, and testing capacity had been significantly scaled up by licencing private laboratories for COVID-19 testing. Another proactive decision during this period was the establishment of the COVID-19 advisory, which acted as a link between confused citizens and those issuing recommendations. This temporary institution became essential throughout the pandemic for interpreting soft laws on behalf of organizations and individuals.

Closely tied to enhancing adaptability between management and staff during the pandemic, formal and informal communication and meeting activities significantly increased at most workplaces, especially in the public sector. This escalation became necessary in the light of unknown and fast-changing circumstances. The need for more frequent and comprehensive dialogue enhanced collaborative efforts among government organizations, municipalities, and private companies, leading to more effective operations during COVID-19 compared to normal circumstances. On multiple occasions, collaborations emerged among organizations, departments, units, and individuals that had never collaborated before; and, on other occasions, existing collaborations were intensified because of the pandemic. Almost all respondents in the official government evaluation (Olavson, 2023a, 2023b) emphasized their commitment to collaborations with other parties during the crisis.

Despite epidemics (and pandemics) being a Danish jurisdiction in 2020, Danish involvement was almost non-existent in the Faroes, apart from co-ordinating vaccine delivery within the kingdom. Justinussen and Olavson (2024) point out that the Faroe Islands carried out a practical takeover of the epidemic jurisdiction in 2020, which was then formalized on 1st January 2024.

The agility within the Faroese system is aptly expressed in its response to the evaluation survey from the Ministry of the Environment and Industry (Olavson, 2023b, pp. 36–37):

> The Faroes had a very flexible (agile) system, meaning that it adapted quickly to the circumstances, and the formal bureaucratic boundaries were less limiting compared to larger systems abroad. … With an informal management approach that we have in the Faroes, it was nevertheless important that significant decisions were rooted [in available knowledge], and those responsible had to constantly communicate with each other.

As the quote highlights, the Faroes had an agile and flexible system that facilitated expedient decision-making and begs the question: would a comprehensive planning process have been as effective, since the pandemic was fraught with uncertainties anyway?

The Faroe Islands' experience during the COVID-19 pandemic highlights both the benefits and challenges of a small public administration. On the one hand, the administration's small size allowed for rapid decision-making, flexible responses, and a high level of social cohesion, which facilitated compliance with government directives. On the other hand, the limited size of the workforce put pressure on key sectors, such as healthcare and education, making it difficult to sustain quality governance and public services over a prolonged crisis. Despite these setbacks, the Faroese governance system managed to outperform many others in key areas such as low fatalities, infection control, societal openness and citizen satisfaction (Olavson, 2023a; 2024).

The key takeaway for administrations in other small jurisdictions is that, while the Faroe Islands demonstrated that small size can be an asset in terms of flexibility, especially early in the pandemic, it also revealed vulnerabilities in terms of resource availability and the risk of overburdening key personnel, particularly in the later stages of the pandemic. This is a common lesson in systems which lack capacity in absolute terms, but which may possess a high degree of relative capacity (Aldrich & Meyer, 2015). The experience underscores the necessity for such administrations to invest not only in adaptable governance frameworks but also in bolstering critical infrastructure and human resource resilience to withstand prolonged crises.

Greenland: from 'wait and see' to proactive measures

Initially, the Government of Greenland was having a reactive 'wait and see' approach, since the perspective was that Greenland was a peripheral area, isolated and islanded, with a sparse population, with 74 isolated communities with no road connections between them. This separation between towns and settlements means that travelling might become more challenging, since you must travel by air or by boat to reach your destination (Kristensen & Nathansen, 2020, p. 27). This might both be an advantage and disadvantage. The Government can easily close a town or settlement or the whole country and therefore isolate potential spread or hinder the spread of the disease; on the other hand, it might be difficult to reach out with medical support or health care in isolated towns or settlements for those in need. Greenland is very dependent on essential healthcare staff flying into the country, since there is not enough capacity available at the hospitals and healthcare centres. This was also what happened during the COVID-19 pandemic. Even though travel bans were in place, essential healthcare staff (doctors and nurses) and other essential staff could travel.

In January 2020, Greenland was following what was happening in Denmark and beyond: the Government was collecting data and news from WHO and ECDC. In February and March,

Greenland came into a more proactive phase while the first cases of COVID-19 appeared also in the country (Ackrén, 2024). By 9th March 2020, suspected cases had already occurred in Greenland, but it was later confirmed that these cases were not caused by COVID-19 (Interview with Chief Medical Officer, 10th March 2023). However, a week later, on 16th March 2020, the first case of COVID-19 was detected on an incoming resident. The late arrival of COVID-19 meant that Greenland became more prepared, since the disease was now better known and other countries had already established some preventative measures. Greenland implemented strict quarantines that included outright travel bans, self-isolation, and closures between February and July 2020 following crisis recognition (Petrov et al., 2020; Grydehøj et al., 2020). This was the more proactive phase in Greenland's crisis management.

Greenland has had a general national preparedness strategy for pandemic flu since 2006. The Greenlandic action plan was developed based on the Danish action plan of preparedness for a flu pandemic, similar to action plans for Alaska (USA) and the Northwest Territories (Canada), and WHO's May 2005 phase division plan (*Beredskab for pandemisk influenza*, November 2006). This meant that the Greenlandic government had some procedures already in place from earlier experiences with bird flu.

An Epidemics Commission in Nuuk was implemented, with the Chief Medical Officer (*Landslæge*) and Chief of Police as the leading figures. This is now a permanent commission for crisis management. During the pandemic, the Epidemics Commission was in close contact with the Greenlandic Department of Health and in sporadic contact with its Danish counterparts. An executive order on 12th November 2021 established an Epidemics Commission composed of the Chief of Police, the Chief Medical Officer, the leading veterinarian, the director of the tax administration board (because of customs), and three additional members (two appointed by the Naalakkersuisut [the government of Greenland] and one from the municipalities [or one member from each municipality]. The Chief of Police is the chair of the Epidemics Commission, and the commission manages the whole country (*Selvstyrets bekendtgørelse nr. 13 af 12. November 2021 af Intatsisartut om civile foranstaltninger mod smitsomme sygdomme*). All initiatives taken were discussed in the Epidemic Commission, but the final decision on major issues was always made by Naalakkersuisut (the Government of Greenland). The adoption of a nationwide strategy and the public's trust in expert advice, the restrictions, and other policy measures have been a successful way of keeping the spread of COVID-19 in check.

During the pandemic, institutions had to adapt to the new situation. Schools, early childcare services, and elderly homes followed the directives from the central government. Municipalities followed national guidelines and even imposed restrictions in relation to their own staff, including quarantine regulations and remote working. It was also not possible to visit elderly homes, the hospital, or other institutions when the disease was in its most contagious phase (Ackrén, 2024).

The COVID-19 pandemic was initially not seen as a problem: Greenlandic authorities thought that Greenland was unlikely to be affected and that isolating the country would be enough. But when the first person tested positive, the tone changed. The authorities realized that the pandemic was impossible to keep at bay and therefore adopted another strategy using PCR testing, quarantining, handwashing, a travel ban, as well as a national lockdown (Ackrén, 2024).

Discussion

This paper set out to examine whether the size of a state – in particular its administrative capacity and population – affects the nature of its crisis response, focusing on the balance between proactive and reactive strategies during the early phases of the COVID-19 pandemic in the Nordic countries. By applying a framework that conceptualizes proactive behaviour as anticipatory, coordinated, and informed by preparedness plans, and reactive behaviour as responses triggered by unfolding developments, the analysis confirms that, while all Nordic states engaged in both types of crisis management, their balance and form varied significantly across countries and over time.

One of the clearest findings is that smaller Nordic polities – namely, the Faroe Islands, Greenland, and Iceland – faced distinct constraints due to their limited bureaucratic specialization and resources. These constraints manifested in several areas, including health system logistics, expert availability, and the scope of testing and surveillance infrastructure. Despite these limitations, their responses were not uniformly reactive. Indeed, these countries compensated for structural limitations with adaptive advantages derived from social cohesion, civic engagement, informal communication networks, and flexible governance systems.

Iceland exemplifies this dual dynamic. While its national contingency planning before the pandemic was markedly proactive, many local authorities were unprepared and reactive. Still, Iceland's high levels of public participation, the embedded cooperation between the civil protection and health authorities, and flexible collaboration with private actors enabled a coordinated and largely effective response. These patterns suggest that a hybrid model – proactive planning combined with flexible reactive execution – can be a pragmatic crisis strategy for small states.

The Faroe Islands further illuminate how small size can function both as a liability and an asset. With no formal preparedness structures in place before the pandemic, the initial response was clearly reactive. However, the Faroese governance system swiftly transitioned into proactive mode by scaling up testing, establishing advisory bodies, and activating informal management approaches. The country's compact administrative landscape enabled quick decision-making, while high levels of interpersonal trust and societal compliance compensated for capacity shortfalls. As the pandemic progressed, the Faroe Islands demonstrated that agility and informality can deliver rapid, proactive measures; even in the absence of deep structural preparedness.

Greenland's case follows a similar trajectory. The government initially took a reactive "wait and see" approach, underestimating the potential spread of COVID-19 due to the territory's geographic isolation. Yet, once infections appeared, the authorities rapidly transitioned into a proactive stance, enforcing quarantines, implementing a travel ban, and activating an Epidemics Commission. The pre-existing pandemic plan – adapted from Danish and international models – provided a valuable framework; but it was Greenland's willingness to act decisively under uncertainty that ultimately determined the efficacy of the response.

In contrast, the larger Nordic states exhibited more structured preparedness but did not always translate this into proactive early action. Norway's initial response was reactive, shaped by uncertainty and an underestimation of the pandemic's pace. Nevertheless, it quickly shifted to a more proactive posture following the influence of international data and neighbouring experiences, particularly Italy's situation. Norway's later implementation of the traffic light model, centralized communication, and targeted lockdowns reflected a capacity to learn and evolve from reactive beginnings into a more proactive stance.

Sweden represents a distinct model in the Nordic context. Its decentralized approach and reliance on individual responsibility led to a response that was largely reactive in terms of public health, though relatively proactive in deploying economic support measures. The decentralized health system placed significant burdens on municipalities, many of which lacked the scale and resources to act decisively. This duality within Sweden underscores that subnational variation – especially tied to administrative size – also shaped the reactive-proactive continuum.

Denmark stands out as a case of early and coordinated proactivity. While the government initially followed a cautious 'wait and see' approach, it rapidly escalated to a centralized and politically driven response. Early activation of emergency management structures, strong political framing of the precautionary principle, and real-time monitoring of public sentiment allowed Denmark to act swiftly and decisively. However, the speed of legislative responses also led to questions about transparency and consultation, revealing some of the trade-offs associated with highly proactive crisis governance.

Finland's case lies between the smaller and the other larger Nordic states. Although it had developed pandemic plans and risk assessments prior to COVID-19, these were not fully translated into early political action. The initial government response was reactive, with decisive measures only taken in March 2020. However, technical agencies like the THL began proactive preparations earlier, and Finland's policy gradually shifted towards more anticipatory approaches. This reflects a broader lesson: preparedness plans must be coupled with timely political engagement and sufficient institutional resourcing to enable truly proactive governance.

Comparing across all seven Nordic states, a key pattern emerges: the smaller the state – in terms of both population and administrative depth – the more likely it is to rely on reactive mechanisms at the outset. However, these same states also tend to be more flexible and socially cohesive, allowing for rapid adaptation. In contrast, larger Nordic states have broader institutional structures and more expert-based capacity, which can enable proactive planning but may also be hampered by decentralization, bureaucratic silos, or institutional inertia.

Conclusion

This study confirms that, when faced with major crisis situations, small states are more likely to begin with reactive responses due to limited resources, but their capacity for quick adaptation, voluntarism, and tight governance networks enables them to develop proactive measures over time. Thus, size alone does not determine effectiveness; it interacts with governance structures, administrative culture, and public trust. The crisis responses across the Nordic region demonstrate that proactive and reactive strategies are not binary but coexist on a continuum; agility, learning, and institutional coordination are crucial to successful pandemic management, regardless of state size.

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