Innovative Governance – or Just Muddling Through? Covid-19 Pandemic and Finland[1]

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Abstract: Most of the pandemic management measures in Finland were based on the Emergency Powers Act and the Act on Contagious Diseases, both of which entered into force in 2017. When the pandemic broke out, this up-to-date legislation was thought to provide a strong legal basis for managing the situation. However, it soon became clear that these Acts were neither comprehensive nor flexible enough to fulfil their tasks. Although the legislation covered formally pandemic types of emergencies, it did not take sufficient account of the specificities of such situations. In particular, the ambiguity of the roles and responsibilities of various players in the multi-level system of social and healthcare services, as well as exclusion of certain fields of action, such as restaurants, from the scope of legislation created a need for further regulation. Passing the new regulation was not without problems, which meant that delays arose in the adoption of the necessary measures. Despite this, it can be argued that, all in all, the Finnish public administration succeeded relatively well in dealing with the situation. Although the regulatory framework was deficient and the powers of the authorities were somewhat unclear, the national and regional authorities were able to develop policies enabling timely action.

I. Introduction

The Covid-19 pandemic arrived in Finland at the cusp of a major social and healthcare reform. At the beginning of 2023, the reform centralized the responsibility for organizing social and healthcare services to the well-being services counties that constitute a new level of self-governing regional administration.[2] The reform has modified the Finnish healthcare system in profound ways and has also affected the governance of public health security. It is now important to take stock of lessons learned regarding

1 This research has been funded by the Research Council of Finland (grant nos 340501 and 340503) and the Strategic Research Council (grant nos 345298 and 345300).

2 See more a detailed description of the new health system structure in European Observatory on Health Systems and Policies: Liina-Kaisa Tynkkynen and others, *Finland: Health system summary 2023* (World Health Organization 2023) <https://apps.who.int/iris/handle/10665/366710> accessed 17 March 2024.

governance of the Covid-19 pandemic in Finland because it is likely that the legacy of how the pandemic was governed will live on in the new structures of the Finnish healthcare system. That said, a major reform is also an opportunity for system transformation.[3] In view of this, in this chapter, we ask what we can learn from the past and what we should avoid in the future.

Governance of the pandemic was conducted in the 'old', highly decentralized healthcare structure. In this structure, some 300 municipalities bore primary responsibility for funding and organizing social and healthcare services and public health security. Specialized healthcare services were purchased by the municipalities from 20 hospital districts organized as joint municipal boards. The decision-making on pandemic governance measures was scattered across various levels of public administration, including municipalities, hospital districts, Regional State Administrative Agencies and the Ministry for Social Affairs and Health. Uncertainty as to the roles and powers of various players, as well as the inadequacy of the legal framework for governing the pandemic sometimes required improvisation and innovative solutions, which, in turn, could result in compromised adherence to the existing legal framework and the rule of law.

This chapter assesses the strengths and weaknesses of the Finnish system for pandemic governance during the initial years of Covid-19, especially focusing on the health system from the point of view of legislative instruments. It combines a legal analysis with interview data collected from key civil servants, health system leaders and politicians (n=53) who were responsible for pandemic governance at local, regional and national levels of the Finnish healthcare system. We have two main objectives: 1) to describe and analyse the legal basis of pandemic governance and its feasibility in Finland and 2) with empirical interview data, to explain how the available legal tools were used by key decision-makers and what kind of enablers and barriers were set by the legislation for the public administration and its innovativeness in Finland. In this chapter, we refer to the term 'innovative' as new and creative actions in public administration which, while perhaps being innovative, can also undermine the rule of law and compromise the protection of fundamental rights and freedoms.

3 Soila Karreinen and others, 'Pandemic preparedness and response regulations in Finland: Experiences and implications for post-Covid-19 reforms' (2023) 132 Health Policy no 104802 <https://doi.org/10.1016/j.healthpol.2023.104802> accessed 17 March 2024.

II. Assessing the crisis response

II.1. Overview of the administrative and legal framework

When the Covid-19 pandemic reached Finland in March 2020, legislation scattered the responsibilities for pandemic governance among several authorities functioning at various levels of the healthcare system and public administration.[4] At national level, the Ministry of Social Affairs and Health (MSAH) was responsible for supervising and steering the system, as well as for preparing new legislation. As a national research and expert organization, the Finnish Institute for Health and Welfare (THL) was responsible for collecting and producing information, as well as for national-level surveillance and monitoring of the pandemic. THL was also responsible for information steering and for providing guidance to both the MSAH and players in the local and regional healthcare system. However, THL did not have a mandate for giving binding orders. The Regional State Administrative Agencies (AVI) were responsible for deciding on restrictive measures (e.g. closing public premises) at regional level on the basis of expert statements provided by the hospital districts. The municipalities were the key players at local level, having the competence to decide on restrictive measures in their own area, as well as on the majority of mitigation measures, such as pandemic surveillance. Furthermore, in the municipalities, the physician in charge of communicable diseases was responsible, among other things, for decisions on quarantine and isolation, as well as for public outreach and public communication.

Most of the pandemic governance measures enacted in Finland were based on the Emergency Powers Act (1552/2011, *valmiuslaki*), which entered into force in 2012, and on the Communicable Diseases Act (1227/2016, *tartuntatautilaki*), which entered into force in 2017.[5] After the pandemic arrived in Finland, it soon became clear that these acts, despite being relatively recently adopted, were neither sufficiently comprehensive nor flexible enough to respond to the requirements arising from this large-scale, long-lasting societal crisis. The legislation covered pandemic types of emergencies, but it did not sufficiently take into account the special

4 For a description of the responsibilities and mandates of controlling communicable disease in the Finnish public health system from 2020 to 2022 see Karreinen and others, 'Pandemic preparedness' (n 3).

5 See also Karreinen and others, 'Pandemic preparedness' (n 3).

characteristics of such situations. The ambiguity regarding the roles and responsibilities of the competent players in the fragmented and multi-level system of healthcare administration, as well as the exclusion of certain fields of activity from the scope of the legislation, such as some private enterprises, created a need for further regulation that was adopted hastily and on an *ad hoc* basis. The problems with the Acts were further exacerbated by the fact that not all players were familiar with the procedures and measures provided for by the legislation.[6] Even when legal instruments were at their disposal, they were not always properly applied.[7] This lack of sufficient legal knowledge, together with the need for urgent action, resulted in serious problems in drafting laws. Consequently, the Constitutional Law Committee of the Parliament (Committee), which is the body responsible for the constitutional pre-review of Government bills, concluded that several legislative measures proposed by the Government are unconstitutional, among other things because they were excessive with respect to the needs actually arising from the situation. This was the case, for instance, with a bill that would have imposed a curfew in certain regions of Finland.[8] When reviewing the constitutionality of this bill, the Committee concluded that the restrictions that this law would have caused to the freedom of movement protected under section 9 of the Finnish Constitution were neither proportional nor acceptable for the gravity of the pandemic situation. The Committee's conclusion that the bill was unconstitutional resulted in the Government withdrawing the bill from Parliament.

II.2. The legal framework

The Finnish legal system has three different legislative frameworks which address health crises. The primary act regulating the governance of infectious diseases is the aforementioned Communicable Diseases Act. This Act contains general provisions on controlling contagious diseases, such as the

6 See also Laura Kihlström and others, '"Local cooperation has been the cornerstone": facilitators and barriers to resilience in a decentralized health system during Covid-19 in Finland' (2023) 37(1) Journal of Health Organization and Management 35–52 <https://doi.org/10.1108/JHOM-02-2022-0069> accessed 17 March 2024.

7 See also Laura Kihlström and others, 'Power and politics in a pandemic: Insights from Finnish health system leaders during Covid-19' (2023) 321 Social Science & Medicine no 115783 <https://doi.org/10.1016/j.socscimed.2023.115783> accessed 17 March 2024.

8 Government Bill 39/2021 for an Act on Restrictions upon Freedom of Movement and Interpersonal Contacts.

administration of vaccines, preconditions and procedures for mandatory medical examinations, quarantine and isolation, as well as the powers and tasks of the relevant authorities which are responsible for controlling and combating infectious diseases.

The second Act covering health emergencies is the Emergency Powers Act. This Act gives authorities a set of exceptional powers for emergency situations, such as an armed attack against Finland, especially serious accidents and highly widespread and dangerous infectious diseases. If the measures laid down in the general legislation, such as in the Communicable Diseases Act, are insufficient to govern a situation, the Emergency Powers Act can be invoked. This Act contains provisions on, for example, placing private healthcare and social welfare facilities under the control of public authorities, as well as provisions on the obligation of healthcare professionals to work.

Finally, section 23 of the Finnish Constitution allows, in the event of emergency, provisional exceptions to be made to the fundamental rights and freedoms protected under the Constitution. The precondition for applying this constitutional provision is that exceptions to fundamental rights and freedoms are necessary in the event of an armed attack against Finland or other comparable emergency situations posing a serious threat to the nation. This provision can only be applied if the competences and measures provided by the ordinary legislation are insufficient to govern the emergency. Furthermore, any exceptions made on this basis must be compatible with the international human rights obligations by which Finland is bound.

There is a hierarchy between these three legislative frameworks. The Communicable Diseases Act constitutes the primary legislative means for governing health crises. When the means and competences provided by this Act are insufficient to govern a situation, the Emergency Powers Act is invoked. The Emergency Powers Act provides additional competences to the respective authorities to combat a crisis. Lastly, if the competences and means provided by the Emergency Powers Act are insufficient, section 23 of the Constitution is applied as a last resort.

Besides these legislative means, public authorities can also use non-binding soft law instruments, such as administrative instructions and guidelines, to govern an emergency situation.[9] In fact, many of the containment measures adopted during the Covid-19 pandemic by the health authorities

9 See also Karreinen and others, 'Pandemic preparedness' (n 3).

were non-binding guidelines and instructions rather than legally binding measures.[10] There were, however, several incidents in which non-binding recommendations were formulated in such a way that gave the impression that they constituted a binding order. This created confusion among the players to whom the recommendations were addressed. Therefore, there were situations where restrictions of fundamental rights were based on non-binding recommendations and not on legislation, despite this being contrary to the requirements arising from the Constitution.[11]

When the Covid-19 pandemic reached Finland, it soon became clear that the measures provided for by the Communicable Diseases Act were insufficient to govern the situation in hand.[12] Therefore, the Finnish Government, in cooperation with the President of the Republic, declared a state of emergency under the Emergency Powers Act on 16 March 2020 and again on 1 March 2021, and the Government subsequently issued decrees on the use of the powers laid down in the Emergency Powers Act. Consequently, a wide scale of protective and restrictive measures was adopted under the Communicable Diseases Act, the Emergency Powers Act and section 23 of the Constitution. These regulatory interventions included, for example, temporary closures of school buildings and other educational institutions, as well as public cultural and recreational venues, a prohibition of public assembly, quarantine orders and additional border controls and travel restrictions. The immediate goal of these measures was to maintain the operational capacity of the healthcare system.[13] The haste with which

10 On the use of soft law to fight the pandemic in Finland, see Emilia Korkea-aho and Martin Scheinin, '"Could You, Would You, Should You?" Regulating Cross-Border Travel Through Covid-19 Soft Law in Finland' (2021) 12 European Journal of Risk Regulation 26–44.

11 See eg case EAOA/3232/2020 of the Deputy Ombudsman, Maija Sakslin, where bans on visits to homes for the elderly were based on soft law guidance by the Ministry of Social Affairs and Health. The Deputy Ombudsman emphasized that restrictions on fundamental rights (here: the right to privacy and family life) must also be based on binding legislation and not on sources of soft law.

12 For a more detailed timeline of the measures of pandemic governance, see Karreinen and others, 'Pandemic preparedness' (n 3).

13 On legislative interventions meant to control the spread of Covid-19, see eg Ittai Bar-Siman-Tov, 'Covid-19 meets politics: the novel coronavirus as a novel challenge for legislatures' (2020) 8 Theory and Practice of Legislation 11, 14; Antonios Kouroutakis, 'Abuse of Power and Self-entrenchment as a State Response to the Covid-19 Outbreak: The Role of Parliaments, Courts and the People' in Matthias C Kettemann and Konrad Lachmayer (eds), *Pandemocracy in Europe: Power, Parliaments, and People in Times of Covid-19* (Hart Publishing 2022) 33, 34.

the new legislation and other measures were adopted meant there was little assessment of their impacts.

II.2.1. Communicable Diseases Act

Most of the measures governing the Covid-19 pandemic were adopted under the Communicable Diseases Act. These measures included, for example, transitioning into remote teaching and the physical closure of many public buildings, such as libraries and museums.[14] However, it soon became clear that the scope of this Act was insufficiently extensive to meet the requirements arising from the pandemic. Several temporary amendments were made to the Act to address this shortcoming.[15] For instance, the Act contained provisions on closing educational institutions (section 58) but not restaurants. Therefore, the restrictions on the activities of restaurants and other catering establishments were implemented through temporary amendments to the Communicable Diseases Act (sections 58a and 58i).

While crisis management at national level was in the government's hands, the Communicable Diseases Act provided significant powers to the Regional State Administrative Agencies, the municipalities and the physicians in charge of communicable diseases. Issues such as mandatory health screenings, mandatory quarantine, contact tracing, physical closure of educational institutions and prohibition or restriction of public assembly all primarily pertain to the parallel jurisdiction of the respective municipality and Regional State Administrative Agencies, which led to confusion: it was not always clear which authority should take action in a given situation.

14 Government Bill 73/2021 for an Act on the amendment of section 58 d of the Infectious Diseases Act and on the temporary amendment of the Infectious Diseases Act. For more on this subject, see Martin Scheinin, 'Finland's success in combating Covid-19: Mastery, Miracle or Mirage?' in Joelle Grogan and Alice Donald (eds), *Routledge Handbook of Law and the Covid-19 Pandemic* (Routledge 2022) 130, 132.

15 See eg Government Bill 72/2020 for an Act on the temporary amendment of the Infectious Diseases Act. For more on this subject, see Mehrnoosh Farzamfar and Janne Salminen, 'The Supervision of Legality by the Finnish Parliamentary Ombudsman during the Covid-19 Pandemic' (2022) 99 Nordisk Administrativt Tidsskrift 1, 5.

II.2.2. Emergency Powers Act

According to established constitutional law doctrine, the threshold for applying emergency legislation is extremely high.[16] Ordinary legislation contains rules for handling health crises and other such serious situations, and only exceptionally grave catastrophes can trigger the application of emergency powers. When the threshold for applying emergency legislation is reached as a result of a grave civil or military crisis, the key legislative instrument for governing emergency situations is the Emergency Powers Act.[17]

This Act shifts legislative powers from Parliament to the Government and authorizes the Government to give emergency decrees to combat the crisis at hand. These decrees may concern subjects which, according to the Constitution, are normally stipulated by an act of parliament and not by a governmental decree, such as restrictions on basic rights. Importantly, the Constitutional Law Committee monitors the constitutionality and human rights conformity of both legislative bills and governmental decrees issued under the Emergency Powers Act.[18]

There is a specific procedure for activating the Emergency Powers Act. At first, the government, in cooperation with the Finnish President, declares a state of an emergency. After that, the government issues a decree defining which powers provided by the Emergency Powers Act are to be applied. This decree commissioning emergency powers (Finn. *käyttöönottoasetus*) must be submitted to parliament immediately and within a maximum of one week after the government adopts it (section 6(3) of the Emergency Powers Act). The parliament then decides whether the decree can enter into force and whether it can stay in force for the suggested period (the maximum period is six months). This commissioning decree creates the government's mandate to issue implementing decrees (Finn. *soveltamisasetus*) containing actual substantive provisions. If the parliament upholds the commissioning decree, it will review the subsequent implementing

16 See eg Anna Jonsson Cornell and Janne Salminen, 'Emergency Laws in Comparative Constitutional Law – the Case of Sweden and Finland' (2018) 19 German Law Journal 219, 244; Päivi Neuvonen, 'The Covid-19 policymaking under the auspices of parliamentary constitutional review: The case of Finland and its implications' (2020) 6 European Policy Analysis 226, 230.

17 Cornell and Salminen (n 16) 244; Neuvonen (n 16) 227.

18 See eg Neuvonen (n 16); Maija Dahlberg, 'Finland – Ex ante constitutionality review of laws relating to the Covid-19 pandemic' (2021) 4 Public Law 819.

decrees issued by the Government to use the emergency powers *ex post* (section 10 of the Emergency Powers Act). Importantly, the parliament can repeal the decrees issued under the Emergency Powers Act in full or in part, but it cannot modify their content. From the point of view of the supremacy and status of parliament as the state's highest authority, the government's competence to apply delegated emergency powers under the Emergency Powers Act is challenging.[19]

The application of the Emergency Powers Act did not proceed without problems. Before the Covid-10 pandemic, the Act had never previously been applied, and when it had to be activated, there was some lack of knowledge about the correct procedures for adopting both the decree commissioning emergency powers and the implementing decrees issued under these powers. This stumbling block caused some delays in adopting the measures that the pandemic situation called for.

The provisions of the Emergency Powers Act that were eventually triggered applied to healthcare and social services (sections 86–88), educational institutions (sections 109), derogations from employees' rights regarding annual leave, working hours and resignation (sections 93–94), enabling compulsory work for healthcare professionals (section 95f), and restrictions on the freedom of movement (section 118).[20] For example, the government issued a decree (127/2020) under section 88 of the Emergency Powers Act waiving deadlines for access to non-emergency healthcare under sections 51–53 of the Health Care Act. Furthermore, the Uusimaa region, which is the most densely populated area in Finland, was temporarily isolated from the other parts of the country by a decree (145/2020) under section 118 of the Emergency Powers Act.[21]

19 See eg Neuvonen (n 16) 228; Scheinin, 'Finland's success' (n 14) 131–132. For the constitutional tensions during the Covid-19 pandemic, see Tony Meacham, 'Covid-19 and constitutional tensions: Conflicts between the state and the governed' in Ben Stanford, Steve Foster and Carlos Espaliu Berdud (eds), *Global Pandemic, Security and Human Rights: Comparative Explorations of Covid-19 and the Law* (Routledge 2021) 15–34; Tom Ginsburg and Mila Versteeg, 'The bound executive: Emergency powers during the pandemic' (2021) 19 International Journal of Constitutional Law 1498.

20 See Farzamfar and Salminen, 'Supervision of Legality' (n 15) 4.

21 This was one of the most constitutionally controversial measures adopted under the Emergency Powers Act. The Constitutional Law Committee emphasized that the right to free movement constitutes part of individual self-determination; for more on this subject, see Reports by the Constitutional Law Committee (PeVM) 8/2020 vp and 9/2020 vp.

II.2.3. Section 23 of the Constitution

Section 23 of the Constitution is the ultimate legal basis for combating emergencies. This constitutional provision is the last resort, meaning that it can only be applied when competences and means provided in the Emergency Powers Act or in ordinary legislation, such as the Communicable Diseases Act, have proved to be inadequate to address a given situation.

The concept of emergency is defined in section 23 of the Constitution as 'an armed attack against Finland or other situations of emergency posing a serious threat to the nation.' According to this provision, the emphasis is therefore on armed conflicts, but the preparatory works of the Constitution clarify that the concept of emergency is to be understood in accordance with international treaties, specifically the European Convention on Human Rights and the International Covenant on Civil and Political Rights.[22] The Emergency Powers Act defines the concept of emergency in a more detailed manner, referring explicitly to large-scale pandemics as one type of emergency that can constitute a basis for applying this Act.[23]

Besides defining the constitutional limits for protective and restrictive policy interventions during crises, section 23 of the Constitution also establishes a legal basis for legislating temporary exceptions to fundamental rights in two ways. First, it gives the possibility of creating provisional exceptions to the fundamental rights and freedoms by an act of parliament. Second, this constitutional provision also recognizes the use of delegated emergency powers and, consequently, creates the ability to make exceptions to fundamental rights through government decrees.[24]

Section 23 of the Constitution was used as a legal basis, for instance, for an act that would have provided for restrictions on the freedom of move-

22 See Government proposal HE 60/2010 vp p 36.

23 Generally, state of emergency refers to war, while the Swedish constitution does not provide for a constitutional state of emergency in peacetime; for more on this subject, see Julia Dahlqvist and Jane Reichel, 'Swedish Constitutional Response to the Coronavirus Crisis: The Odd One Out?' in Kettemann and Lachmayer (n 13). In addition, some states (such as Germany and Switzerland) did not declare a state of emergency when the Covid-19 pandemic began. The constitutional possibilities were not considered practical or efficient with regard to the pandemic (see more Konrad Lachmayer, 'Austria: Rule of Law Lacking in Times of Crisis' (*Verfassungsblog*, 28 April 2020) <https://verfassungsblog.de/rule-of-law-lacking-in-times-of-crisis/> accessed 19 March 2024.

24 See eg Scheinin, 'Finland's success' (n 14) 133.

ment.[25] New Covid-19 strains started to emerge in Finland in January 2021. Consequently, the government, in co-operation with the Finnish President, again declared a state of emergency under the Emergency Powers Act on 1 March 2021. The new strains were believed to pose a significant risk to the capacity of the hospitals, and therefore the government issued a legislative bill based on the emergency clause in section 23 of the Constitution to restrict the freedom of movement of the population. Section 23 of the Constitution would have provided a direct legal basis for restrictions on derogations from fundamental rights and freedoms, mainly freedom of movement. However, the Constitutional Law Committee of the Finnish Parliament considered this decree to be excessive and, therefore, unconstitutional. This case has briefly been described in section II.1.[26]

In addition, restaurants were closed for two months, with the exception of take-out orders, through a separate Act of Parliament (153/2020) enacted under section 23 of the Constitution, as an exception to the fundamental rights of property and business freedom.[27] As neither the Emergency Powers Act nor the Communicable Diseases Act gives a legal basis for such a measure, a specific law based on section 23 of the Constitution had to be enacted on this.

II.3. Conclusions on the use of legal instruments governing the health crisis

Legal scholars have argued that both the Finnish Emergency Powers Act and the Communicable Diseases Act were not fit for purpose during the health crisis. Particularly, the Communicable Diseases Act needed to be continuously complemented by new powers that were better suited to Covid-19, but often crafted in haste and unprofessionally.[28]

From a legal techniques point of view, scholars have claimed that the use of section 23 of the Constitution would have been the best alternative to enact quickly tailor-made measures to combat various health crises. This is because the scope of the Emergency Powers Act is very limited and

25 Government Bill 39/2021 for an Act on Restrictions upon Freedom of Movement and Interpersonal Contacts.
26 See Dahlberg (n 18).
27 Government Bill 25/2020 for an Act on the temporary amendment of the Act on accommodation and catering.
28 See Scheinin, 'Finland's success' (n 14) 134.

therefore not very useful, while the Communicable Diseases Act proved to be highly inadequate when combating an airborne pathogen with a relatively high reproduction number, mortality rate and a long lifespan.[29]

Overall, some have claimed that Finland was unprepared and unprofessional in its response to the Covid-19 pandemic,[30] while others have claimed that Finland succeeded rather well in managing the crisis.[31] There are also evaluations which emphasize that both of these claims may be valid to some extent. While there were apparent regulatory and structural problems which challenged the governance of the pandemic in Finland, the key elements which can be linked to a successful pandemic response seemed to be in place. These included, for instance, sufficient state capacity, strong formal political institutions, social policies to support the compliance of citizens, as well as a high level of societal trust.[32]

III. Evaluating the crisis response

III.1. Study and data description

In this light, we shall now consider the empirical data collected from the Finnish health system leaders during the Covid-19 pandemic to shed light on how the regulation described above was actually implemented in the

29 Scheinin, 'Finland's success' (n 14) 141–142; Farzamfar and Salminen, 'Supervision of Legality' (n 15) 5.

30 See Scheinin, 'Finland's success' (n 14); Ossi Heino, Matias Heikkilä and Pauli Rautiainen, 'Caging identified threats – Exploring pitfalls of state preparedness imagination' (2022) 78 International Journal of Disaster Risk Reduction no 103121.

31 See Hanna Tiirinki and others, 'Covid-19 pandemic in Finland – Preliminary analysis on health system response and economic consequences' (2022) 9 Health Policy and Technology (2022) 649 <https://doi.org/10.1016/j.hlpt.2020.08.005> accessed 19 March 2024; Kaisa-Maria Kimmel, 'Right to Life and Right to Health in Priority Setting in the Covid-19 Prevention Strategies in Finland, Norway and Sweden' in Stefan Kirchner (ed), *Governing the Crisis: Law, Human Rights and Covid-19* (LIT Verlag 2021) 16, 30. From the insolvency law point of view, the legislative amendments during the Covid-19 pandemic were mainly successful, see Laura Ervo, 'Insolvency Law and Covid-19: The Finnish Example on Tackling the Pandemic' in Nadia Mansour and Lorenzo M Bujosa Vadell (eds), *Finance, Law, and the Crisis of Covid-19: An Interdisciplinary Perspective* (Springer 2022).

32 Karreinen and others, 'Pandemic preparedness' (n 3).

Finnish health system.[33] Health system leaders represented municipalities (local level), joint municipal authorities, hospital districts and Regional State Administrative Agencies (regional level), as well as representatives of the Ministry of Social Affairs and Health (MSAH), the Finnish Institute for Health and Welfare, the Finnish Parliament, the Finnish Medicines Agency, the National Emergency Supply Agency, the Finnish Border Guard and the National Supervisory Authority for Welfare and Health (national level). Interviews (n=53) with health system leaders were conducted between March–June 2021 and October 2021–February 2022, with the data collection period covering roughly the events of the first one and a half years of the pandemic.

The interviews were conducted using a flexible interview guide, which was structured around three key domains: preparedness for, governance and leadership of and learning from the pandemic. Two researchers conducted an iterative process to code the data. They initially thoroughly examined all 53 transcripts to distinguish 'big ideas' from the data. They then conducted a second round of analysis to identify emerging topics and themes. They used these findings to develop an initial codebook, which was reviewed and discussed by two researchers. Every proposed code was evaluated at this stage. The initial codebook was used by both researchers to code a sample transcript independently. After this, the researchers shared their insights to address any discrepancies, differences in interpretation, or potential additions or removals from the proposed codebook to ensure consistency. The researchers then prepared and used a final codebook to code the entire data set of 53 interviews in Atlas version 9.1.

Earlier research results published from this data focused especially on resilience in the health system during the Covid-19 pandemic, as well as on the processes and dynamics of power and politics in pandemic governance.[34] The data presented in this chapter is a summary of the reflections of the interviewees on legislative issues and challenges during the pandemic. The summary arises from segments of the data classified under the category 'legislative issues and framework', comprising a total of 63 segments. The summary of the empirical findings is presented, with key quotations included. The analysis was conducted in Finnish, while the

33 The data was gathered as part of the Academy of Finland funded research project, RECPHEALS (Resilience, Crisis Preparedness, and Security of Supply of the Finnish Health System), see more details in Kihlström and others, 'Local cooperation' (n 6).

34 See Kihlström and others, 'Power and politics' (n 7).

lead author of this research paper translated the quotes from Finnish into English. Every quote is accompanied by information about the participant's organization and their level of governance within the Finnish healthcare system. The participant's identity, consisting of a letter and a number, indicates the level of governance (N for national level participant, R for regional and L for local level participant) and the interview sequence number in the study.

Overall, the empirical findings suggest that legislation, especially the Emergency Powers Act and the Communicable Diseases Act, were not fit for purpose, specifically because they had not been made for a prolonged health crisis affecting all sectors of society. The findings shed light on a variety of challenges that came with the implementation of these acts, as well as on the perspectives of the health system leaders as to why and how these challenges arose.

III.2. Emergency Powers Act and the Communicable Diseases Act: Perspectives of the health system leaders

The empirical data contains differing views of different organizations and levels of the health system on the decision-making process which led to the exercise of the Emergency Powers Act during the Covid-19 pandemic in Finland. The process is said to have been preceded by a series of events which escalated in March 2020. These events contained a rising number of Covid-19 cases in Finland, as well as increased crisis awareness because of the 'images from Italy,' which showed how the operational capacity of the healthcare system had been compromised. The chronological order of these events is described in more detail in another article published from the same data set.[35] The escalation of events in March 2020 was described by some interviewees as somewhat surprising. One interviewee describes February as a month of 'mandate allergy' and an overall reluctance, particularly among political leaders, to prepare for and deal with a potential pandemic:

> *Political leaders wanted nothing to do with this at first. Rather, they said that they would like us to take charge of all communications and knowledge sharing regarding Covid-19. And yet, when we did take on some of this communication, they would tell us not to communicate like that.*

35 See Kihlström and others, 'Local cooperation' (n 6).

For example, if we published models or scenarios to the wider public, the political side got worried that people would be too scared.
– Interviewee, The Finnish Institute for Health and Welfare (Participant id: N7)

This notion is, however, contested by another interviewee representing the political side of decision-making:

The expert views of the Finnish Institute for Health and Welfare were very ambiguous. I have been present in many meetings, and the Finnish Institute for Health and Welfare has also taken the view that the World Health Organization overreacted, that we are not in an international emergency.
– Interviewee, Ministry of Social Affairs and Health (Participant id: N29)

The invocation of the Emergency Powers Act is described in the interviews by many as a political solution which received very little pushback once suggested. There were, however, discrepancies in the descriptions of the interviewees of the types of justifications provided for the invocation of the Act, with descriptions that included ensuring the availability of a critical health workforce during the pandemic, fears about the economic repercussions of the pandemic, including the potential for export bans in the European Union, and the influence of the Finnish President on the decision to invoke the Act. After the invocation of the Act, the practicalities of implementing the legislation were considered chaotic and messy. The following quotation from one interviewee summarizes this view:

The Emergency Powers Act has been a sort of 'ogre' in the operations of the Ministries for quite some time. The Ministry of Justice has generally been attributed with responsibility for its existence and content. And, in our more traditional areas of security, so have the Ministry of Domestic Affairs, the Ministry of Defence, and even we (MSAH); we did not have any expertise in this. It has been acknowledged that we have this sort of legislation, and we have some mandates, but when the first questions were asked at some point in the second half of February about what we should do if our country applied the Emergency Powers Act… or what the Act even contained…in practice, we had no one in this Ministry, no one besides myself, who would have known anything about the Emergency Powers Act, who would have been able to activate it. It wasn't just us, though. The Prime Minister's office, which formally bears the responsibility for leading and coordinating a situation like this, was not at all aware that they had

> *a role like this to play. It was a pretty general note in the parliament's instructions, which had been externalized… it was for a completely different kind of era, legislation for wartime. No one had prepared for an issue like this to be solved in any capacity.*
> *– Interviewee, Ministry of Social Affairs and Health (Participant id: N25)*

As the above statement suggests, most of the coordination and decision-making regarding Covid-19 was centralized to one sectoral ministry (the Ministry of Social Affairs and Health, MSAH) during the early months of 2020. This was done despite the MSAH being understaffed and under-resourced, particularly on matters regarding legislation and despite the fact that governance of the pandemic required the expertise of several other ministries. The interview data also suggests that the knowledge base for implementing the Emergency Powers Act was insufficient at other levels of the Finnish administration. For example, some municipalities made decisions on the basis of the Emergency Powers Act in the spring of 2020, before the law had officially been activated. Finally, the evidence base for the need for the Emergency Powers Act is also questioned in the empirical data. For example, one interviewee stated that one of the justifications used for activating the Emergency Powers Act was the need to ensure operational capacity, particularly the availability of a healthy workforce, during the pandemic. However, there is no national-level data on the availability of a healthy workforce in Finland on which such a decision could be based.

As for the Communicable Diseases Act, the interviewees described several challenges in its implementation. One interviewee described the legislation as being incomplete for a prolonged pandemic, and therefore political action was required to enforce more drastic measures:

> *The Communicable Diseases Act is designed for controlling a situation such as a rubella epidemic in schools. The law even has some provisions for large epidemics, but not for a pandemic faced by the whole nation. It just did not have enough provisions and tools to help control the spread of this disease, leaving the issues on this to be urgently dealt with at the level of the government. We thought that, legally, we did not have the power required to take the necessary action.*
> *– Interviewee, Prime Minister's Office (Participant id: N10).*

Others remarked that the legislation was not only unsuitable for a prolonged crisis, but that, during its planning stage, no one had anticipated that such a scenario as the Covid-19 pandemic could take place. Addition-

ally, the Communicable Diseases Act did not contain provisions on measures at country borders during an epidemic. These shortcomings meant there was a need to amend this act, and the amendments had to be made in a hurry. Interviewees described the sense of rush and lack of time as key challenges throughout the health system: statements on the legislation sometimes had to be provided overnight without much preparation or insight:

> *The government made tough calls. The Emergency Powers Act was activated, the Uusimaa region was closed off, restaurants were closed and so forth. These were tough decisions. The decisions were justified by the Emergency Powers Act. Legislative work has been slow, late and rushed since the deactivation of the Emergency Powers Act. For example, some decisions arrived for comment on Friday, and comments have to be ready by Monday. This was the rule, not the exception.*
> *– Interviewee, hospital district (Participant id: R16)*

The Communicable Diseases Act was described by one interviewee at local level as hard to comprehend 'even for an army of lawyers'. These challenges especially applied to section 58, which dealt with social gatherings, school closures and restrictions to business operations. The language in section 58 was described as ambiguous with concern about school closures, which, according to some interviewees, made it difficult to implement such closures at the local level.

The interview data also points to several challenges regarding parallel responsibilities and uncertainties in mandates. For example, the Communicable Diseases Act emphasizes local governance and decision-making. When the pandemic reached Finland, decisions-making was by and large centralized to the national authorities. Starting in the autumn of 2020, the hybrid strategy adopted in Finland shifted the emphasis in managing the pandemic from the national authorities to local and regional governance. Despite this shift, health system leaders at the local and regional levels refer to being micromanaged from the national level, even though the Communicable Diseases Act granted decision-making powers to the municipalities, joint municipal authorities and Regional State Administrative Agencies. Local and regional levels refer to being publicly chastised by political leaders for not being sufficiently proactive in their decision-making, while trying to make sure that their decisions would have a sound legislative basis. Civil servants at the regional level even said they were being personally pressured through phone calls from key policy-makers:

> *The Ministry of Social Affairs and Health tried to take power, which the law does not grant it. This happened several times. The minister tried to use such power by making phone calls about school closures and such matters. And the question was whether or not we would do what the minister wanted us to do. If they did not have authority to address the topic at hand, then we made our own decisions. But in terms of restrictions and non-pharmaceutical interventions, there were many unclear issues. For example, last spring, we decided – as did others – that no visits should be allowed in assisted living units. And then, during our summer holidays, we read the Ombudsman's statement that we could not prevent people from inviting others to their homes.*
> *– Interviewee, Joint authority for health and well-being (Participant id: R7)*

Civil servants also mentioned receiving anonymous death threats and other kinds of harassment, which further increased their anxiety in an already stressful situation.

The use of various soft-law measures also invited criticism from several of the civil servants interviewed, especially those at local and regional levels. Guidance from the national level (MSAH), which had no legislative mandate but 'was presented as such,' was described as 'not satisfying the criteria of good governance' and even being in conflict with existing legislation. Additionally, regional-level health system leaders expressed their confusion about the decision to keep restaurant closures under the government's jurisdiction when, according to the legislative framework, the correct entities for this would have been Regional State Administrative Agencies. Overall, these issues led to some describing the pandemic as being 'politicized,' and decision-making during the pandemic as being 'an expression of political will.'

III.3. Innovative management during Covid-19

The empirical data reveals some innovative solutions on how the pandemic was governed by the Finnish authorities. Finnish legal culture has strong roots in the principle of legalism and the rule of law and therefore it is quite surprising that national authorities (MSAH) were ready to ignore

provisions of the law and steer the authorities at the local level through non-binding guidance.[36]

Other elements showing innovation by the Finnish authorities is that, even though the ministries had no lawyers or legal expertise on the procedural steps and legal details regarding the implementation of the Emergency Powers Act, the implementation of the Act still succeeded – even though some steps were unlawful at both the national and local levels (e.g. some municipalities made decisions on the basis of the Emergency Powers Act in the spring of 2020 before the law had officially been activated). In this sense, a pragmatic approach to solving legal problems seems to be evident in the Covid-19 pandemic in Finland.[37]

The empirical data also points to factors which enhanced adaptation and resilience during Covid-19 in Finland. Local and regional players described cooperation as crucial for governing the pandemic and, during the first year of the pandemic, several new structures of collaboration were set up to identify solutions at local level. Such structures were set up organically at local level, as well as through the recommendations of the MSAH, which, during the autumn of 2020, directed the regions to set up regional Covid-19 coordination groups. Given that municipalities and regions bore the primary responsibility for health and social services during Covid-19 in Finland, these novel networks of cooperation brought many benefits, such as bringing together people who had not actively cooperated before the pandemic. This enabled resources to be shared and tensions to be resolved and, while these networks had no formal decision-making powers, they were largely considered valuable.[38]

36 More on this topic (in Finnish), see Moona Huhtakangas and others, '"Peruskehikko on olemassa, mutta sitä ei seurattu" – asiantuntijanäkemykset kansanterveysjärjestelmän toiminnasta ja ketterästä hallinnasta Covid-19-pandemiassa vuosina 2020–2021' (2023) 42 Hallinnon tutkimus 149–168.

37 Pragmatism is one basic feature of the Nordic legal culture, which means that legal decision-making is not bound so closely to the written statutory text but rather is free to seek more general argumentative bases for justification purposes; see eg Jaakko Husa, 'Panorama of World's Legal Systems – Focusing on Finland' in Kimmo Nuotio, Sakari Melander and Merita Huomo-Kettunen (eds), *Introduction to Finnish Law and Legal Culture* (Forum Iuris 2012) 5, 14.

38 Kihlström and others, 'Local cooperation' (n 6).

III.4. Summary of the empirical findings

The empirical findings present a snapshot of the perspectives of the health system leaders on issues regarding legislation during the Covid-19 pandemic in Finland. They reveal a lack of capacity and expertise to use certain legislative instruments, such as the Emergency Powers Act. This may arise from reduced human resources in the government administration, as well as the silo structures of the Finnish government. The lack of capacity and expertise can also partly explain why the use of soft law instruments, such as recommendations, were both communicated and interpreted as binding rather than non-binding recommendations.

Furthermore, the results reveal that the legislation (which was) in place for the governance of the pandemic was not fit for purpose with regard to a widespread epidemic with a long duration. This was reflected by both the lack of regulatory instruments to implement necessary non-pharmaceutical interventions and the ambiguous roles and responsibilities of the players at various levels of the system. While the unclear roles enabled the expansion of the mandates of certain players, it also became possible to avoid responsibility in situations where roles were not clearly stated.

Finally, the results highlight how politics was involved in the governing of the pandemic in a manner which undermined the separation of powers between the legislators and those with decision-making powers at the local and regional levels. The full extent to which civil servants were pressured by politicians during the Covid-19 pandemic cannot be fully captured by this study, but it can be stated that this phenomenon was real and, indeed, was reported by several interviewees.

IV. Conclusions

The Covid-19 pandemic revealed that, in Finland, the legal bases provided by the three core legislative frameworks intended to govern emergencies of a pandemic type were not very innovative in the sense that they did not take into account the variety, complexity and diversity of potential threats and crises arising from such situations, as well as their magnitude.[39] It seems that scenarios such as an armed conflict or even full-scale war, as well as nuclear disasters, were the core considerations when the emer-

39 Heino and others (n 30).

gency legislation was being drafted. However, in modern societies, with high levels of global connectivity and reliance on computerization, threats can take on a number of different forms. Finnish preparedness legislation should, therefore, be reformed to take better account of unexpected threats.

Although the regulatory framework for governing the pandemic was deficient and the roles and powers of the authorities were somewhat unclear, it can be argued that, all in all, the Finnish public administration succeeded relatively well in maintaining the capacity of the healthcare system. The national and regional authorities were able to develop innovative policies and modes of operation enabling the spread of the virus to be controlled and the capacity of the healthcare system to be maintained.[40]

At times, this innovativeness came at the cost of weakening the rule of law and the protection of fundamental rights. There are examples of various authorities overstepping their powers, as well as of the excessive use of restrictive measures. For instance, at times, the legal nature of the instructions and guidelines given by the authorities was not clear, as soft law instruments were formulated as if they were legally binding. There were incidents where fundamental rights were restricted on grounds of such non-binding instruments – which is strictly prohibited by the Finnish Constitution. In addition, there were cases where political guidance sought to override powers based on the law through personal calls to civil servants or through the media – a practice that is highly problematic in the light of the separation of powers.

On the other hand, at all levels of the Finnish administration, authorities were quickly able to develop new forms of cooperation. For example, regional coordination groups were an administrative solution proposed by the Ministry of Social Affairs and Health, and they brought together local and regional players starting in the autumn of 2020. This is an example of an administrative innovation, which several interviewees also mentioned in the empirical data as an administrative structure which it would be beneficial to continue with after the pandemic. Municipalities were able to move personnel flexibly from one task to another, thereby responding to needs as they arose. For instance, as libraries and museums were closed, employees from these sectors were able to play a role in testing and tracing, as well as delivering meals to older people who, at the time, were recommended to

40 Kihlström and others, 'Local cooperation' (n 6); Karreinen and others, 'Pandemic preparedness' (n 3).

stay at home. This was possible because every municipality constituted one employer organization within which the transfer of personnel was flexible. At the same time, private service providers, such as service housing units, were struggling because of the lack of staff caused by quarantines and sick leave of personnel. As a whole, the Finnish public administration proved to be rather flexible and agile; in order to serve the management of the crisis at hand, the organization of the administration could be modified in a matter of hours through the transfer of personnel and administrative structures. For instance, the municipalities and hospital districts also provided additional central government funds for governance of the pandemic, which made the flexibility of operations even greater.[41]

In conclusion, the key problems appeared to be limits of competence and scarcity of (human) resources for managing the pandemic. The crisis was managed in rather small units by a limited number of experts. The question can be raised of the extent to which, for example, overstepping of powers and other problems arose from the fact that the law was unclear or deficient or from the fact that the relevant players were unfamiliar with the legal rules and, consequently, unable to apply them correctly. The resources and the know-how in Finland's public administration need to be strengthened so as to better manage future crises. The reform of social welfare and healthcare in Finland would be a step in the right direction.

41 Ruth Waitzberg and others, 'Balancing financial incentives during Covid-19: a comparison of provider payment adjustments across 20 countries' (2022) 126 Health Policy 398 <https://doi.org/10.1016/j.healthpol.2021.09.015> accessed 19 March 2024.