HOUSE OF COMMONS

Foreign Affairs Committee

Oral evidence: Coronavirus: FCO response, HC 239

Tuesday 17 March 2020

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Watch the meeting

Members present: Tom Tugendhat (Chair); Chris Bryant; Chris Elmore; Alicia Kearns; Henry Smith; Royston Smith; Graham Stringer.

Questions 1-50

Witnesses

I: Professor David R Harper CBE, Senior Consulting Fellow, Global Health Programme, Chatham House; Managing Director, Harper Public Health Consulting Limited.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Professor Harper.

Q1 **Chair:** Welcome to this afternoon's session of the Foreign Affairs Committee. Professor, will you introduce yourself for the record?

Professor Harper: Thank you for the invitation to appear today. I am Professor David Harper, a senior fellow at Chatham House, where I work on the global health programme.

Q2 **Chair:** Can you say a little bit about your background as well?

Professor Harper: For a large part of my career, I worked at the Department of Health and managed a number of emergencies. I was the director general for health improvement and protection. Perhaps particularly relevant to today's discussions, I managed the Department's response to the H1N1 flu pandemic in 2009 and 2010. Then I went to the World Health Organisation as a special adviser on secondment from the Department of Health. I left and set up my own one-man company, and much of my time is now spent with Chatham House.

Q3 **Chris Bryant:** I remember you from 2009. There is a strong perception, fairly or unfairly, that Britain was some way behind other countries when it came to repatriating people from China. First, is that fair? Secondly, why do you think that might be the case?

Professor Harper: If I may, I will preface what I am going to say by making it very clear that I do not have any particular informed insights about the situation in China and some of the other areas that I am sure you would like to discuss this afternoon. So what I will say is largely based on what I have heard through the media and through my own networks.

I think the repatriation was incredibly challenging. The risks that need to be balanced I would expect to include risks to the individuals and to the country that people will be leaving, and of course risks to the receiving country as well. That is a complex set of risks to get to grips with. My assumption is that in taking the right advice—public health advice and advice from experts—the decisions were made at the appropriate time. But I really do not have any more information on whether it was slower than it could have been or should have been, or whether it was very much in line with other countries.

Q4 **Chris Bryant:** It was slower than the United States and Japan, for instance.

Professor Harper: It was, and that was reported. I do not know the basis for the decision, so I cannot comment much more on why the timing was as it was.

Q5 **Chris Bryant:** You said that there would be challenges; perhaps you would like to say a bit more about what those challenges might be, apart

from the simple question of whether we wanted people to come back to the UK.

Professor Harper: From a public health perspective, balancing the risks that I mentioned presents a huge challenge because if the issues are not very carefully considered, decisions and actions can be taken that have unintended consequences. That is not to say that decisions should not be taken—on a precautionary basis they often are. I think taking the advice that is necessary to inform those decisions is a vital part of that. Logistically, just moving people from one place to another, one might say particularly from that part of the world, can present particular challenges in itself.

Q6 **Chris Bryant:** But if you look at the present situation, most MPs have some constituents somewhere in the world who are in a place that either is highly affected, such as Italy or Spain, or is in some version of lockdown, where perhaps the hotel they are staying in is throwing them out on the street because it is closing. What choice do the British Government have other than to repatriate in such circumstances?

Professor Harper: That is a very good question. It is hard to see, with the responsibility and duty of care for British nationals overseas, what else could be done. Saying it is one thing, achieving it—I know from travelling the world myself—is very difficult. Everything that can be done needs to be done, but that does not necessarily mean that would give the outcome that everyone would like. What I have heard not just through media reports but through contacts that I have, is that communication is probably the one area that could be improved markedly. At least some of the people in those difficult situations—we have social media where people are interviewed in situ—say that they seem not to get the information that might help them, so they feel quite isolated. That is something I would expect, without knowing how that might work. That could be addressed as a priority, at least to let people know that they are not alone, to reduce some of the anxiety and stress. That is looking at it from a public health perspective.

Q7 **Chris Bryant:** Let us say there are 500 Brits stuck in Madrid, many of whom have either medical conditions or need to get back to the UK to be with the elderly or to support family members, and they have no finances to be able to stay on in a hotel, which may be closing. What is to stop the Government hiring one of the many hundreds of airplanes sitting at Heathrow at the moment, flying to Madrid and picking them up?

Professor Harper: That is not my area of expertise, I am afraid. I cannot say why that cannot happen. Intuitively, one would think that would be a way of approaching it. I assume that if it is not happening, there are either logistical reasons or reasons from the Madrid or the UK perspective. I agree, it sounds easy to get a flight to go and pick people up, but the fact that it is not happening makes me think that it is not quite that straightforward. I am only commenting as a member of the public.

Chris Bryant: Okay.

Q8 **Chair:** The handling of the cases on the various cruise ships offers slightly different questions. Many of the people on the cruise ships either have gone down with the virus or have been very closely connected to people who may have the virus. The age demographic on cruise ships tends to be older than the average people who go on holiday. Can you comment at all on the handling of those cases, given your experience of H1N1, when the response among older people was different?

Professor Harper: I am bound to say, again, that I can comment on what I have seen and heard from a public health perspective. Keeping people quarantined is a tried and tested principle in public health terms. It has been done many times before with a successful outcome. If we go back to the Yokohama cruise ship, it seemed very clearly—even as the situation evolved at the time—that the quarantine conditions were not being observed. It is hard to know quite what went wrong, but transmission occurred where it should not have done. I know that this will be looked at in great detail, but of course people are rather preoccupied with other things at the moment.

Once we see the results of a detailed analysis of what went wrong, it will help us to know for the future. Although we are in the midst of this current situation, it is never too early to start learning the lessons. We said that back in 2009 and 2010. We put things in place then—research that was necessary during the outbreaks themselves—ideally to inform future responses. I think this is a situation where that might well be the case. We will learn a lot from the cruise ship situation.

Q9 **Chair:** Can I ask a question based on your personal experiences in 2009 and 2010 of the H1N1 viruses? What did you get wrong at the beginning that you improved on during the process, and how do you look at those incidents today?

Professor Harper: We were fortunate, if I can use that word, inasmuch as we had been preparing for an influenza pandemic, because of the situation with avian influenza—H5N1. There was a lot of effort because of those concerns, and the risks that were perceived at the time and still. There were many discussions, not just nationally—far from it—and not just national multi-sectoral discussions, although those were very important, with a whole of Government and eventually whole of society approach; we also worked internationally. We worked very closely with our G7 partners, the European Union, the United Nations and particularly the World Health Organisation. We had a great opportunity and lead-in time so that when it actually happened, we were as well prepared as we could reasonably expect to be.

But there were issues. Communication is always a big issue. It is sometimes hard to say, until you have the benefit of hindsight, how that could have been improved. We tried very hard, from previous experience, to identify a trusted spokesperson to be very visible, even when there was not a great deal to say—for example, when the situation in the early days was not changing. Sometimes it is important for somebody just to say

that, and not to wait until there are a raft of measures to introduce that of themselves can cause great confusion.

Q10 **Chair:** Forgive me—I am not trying to criticise the early responses to H1N1. I am just trying to understand what lessons were learnt. You made a point about communication in global pandemics. I wish to focus not on the UK's response, but on the global response. There has been a remarkable—and perhaps expected—unwillingness by the WHO to call out nations that are doing better or nations that are doing worse. Is that just the nature of the WHO, or is it something that it could do better?

Professor Harper: First, I should make it clear that the WHO is made up of different parts, but is largely a member country-based organisation, so the countries have a very powerful voice, and rightly so. The secretariat, which people sometimes see as being the World Health Organisation—Dr Tedros and the people in Geneva, or in the regional offices or country offices—are there to provide the administrative support and expertise that goes into running the organisation, and to provide the guidance and operations that are necessary. The reason that I am saying it like this is that it is very difficult for the WHO to be particularly critical of an individual country, because it recognises the sovereignty of countries and states to take their own action.

Q11 **Chair:** May I then ask the question differently? Have I misunderstood the role of the WHO? Perhaps the answer is yes, and the correct thing to do is recognise that there are cases such as Ebola where the WHO responded extremely slowly in calling out the various different national failures. Is there an argument to say that actually we should not be waiting for the WHO at all, and we should be looking for alternative ways of co-ordinating, if the WHO, as you rightly say, is a member-led organisation and is very unlikely, quite obviously, to criticise those who are paying, or those who are shaping the policy within it?

Professor Harper: I think, personally, the way to improve the situation would be to work with the World Health Organisation, maybe in peacetime, to address the sort of issues that you are alluding to. Because it is the leading UN agency, it should be in a position to be able to do the sort of thing that you are describing.

Q12 **Chair:** Yet it doesn't.

Professor Harper: I think at times it would feel constrained, not just financially but in the sense that we are just discussing—that it is a member country-based organisation. It is very hard. It does happen and the international health regulations provide a framework for the WHO secretariat to do a large part of what it does; but the world is dependent, very much, on the World Health Organisation for its risk assessments, for bringing in information from countries. It is the organ, if you like, as well as the organisation, that receives all of the information at a very early stage, and then, as a situation like this develops, it is collating—assessing the numbers that it gets, and providing information to the countries, on which they should be able to base their actions and their decisions; but countries are very able, and encouraged, to make their own risk

assessments and to take actions on the basis of local risk assessments. This is the way the organic nature, if you like, works.

Q13 **Royston Smith:** About lessons learned and about global response, my inbox is full of lots of people giving me advice on what I should be saying to Government or what Government should be doing, and they frequently reference 1918 but they almost never reference 2009. I remember 2009 because I was but a humble leader of a modest-sized council, and we had our pandemic planning, and all the other things that went with it; but people seem to have forgotten that. It almost looks like Governments have too, in a way, because there are different approaches to what is happening. There seems to be panic, sometimes—almost as though this is new. This virus is new, of course, but 2003, 2009—that is not new. It was not even that long ago; but it is almost like there is a collective amnesia about it. I might be being unfair, but it feels a bit like that. It does from my constituents, and it looks a bit like that with Governments and perhaps the WHO. Is that an unreasonable thing to say?

Professor Harper: I do not believe the WHO have forgotten 2009, the H1N1 pandemic, or SARS, or MERS or Ebola. They are very conscious of these situations and they do their best to learn the lessons. In fact, they have their committees and many other analyses that are done post-event, which inform the WHO's learning. I think it is probably fair to say that Governments, if by Governments you are talking in the collective sense, are not preoccupied by the H1N1 pandemic; and, in a sense, why should they be? Different Governments around the world have their own immediate priorities and often different people are in government from the people that lived through those episodes. It does not mean that there is not a record. The officials, the experts, the public health community in that sense—part of the Government machinery—they will all be working very hard looking at what happened, looking at what they can do better and preparing for the situation that we are facing now; but it is for the public health professionals, the scientists, the researchers and, ideally, Governments providing resource to fund research, etc., to work together. It is not entirely surprising, I think, that Governments in the sense of Ministers and the elected individuals have their own priorities and so are not thinking back to SARS or MERS, until it becomes necessary; but they have people who should be doing that.

Q14 **Henry Smith:** Obviously, we have seen over recent weeks the closing down of travelling, and different advice being given by different countries, as the pandemic has affected them. In the House of Commons earlier today, we heard the Foreign Secretary advising UK citizens against all but essential travel abroad. Clearly, a huge economic impact results from the advice against travel and outright bans. How much do you think economic factors and the economic impact of travel bans should be taken into account, beyond the pure health advice?

Professor Harper: Again, that is an excellent question and, in a way, the perennial question. If I go back a little to an earlier stage in my career, I was very much involved with risk assessment and risk management. To

the purists, I will say that it is good practice for the assessment to be separate from the management.

Governments are there as the top risk managers, to take decisions that take account of all the different factors they need to take account of. The people who are doing the assessment—the modellers, for example, and the public health professionals—should be separate, up to a point, and, from a health perspective, as you mentioned, should not be tainted by other issues.

However, the reality is different. Many people are in a position where they wear different hats. It is not unreasonable to suppose that a senior public health professional would give attention to social disruption, economic effects and so on, but ultimately the advice that is coming from different quarters should be factored in for what it is. The public health advice, the modelling and the real health side of it is going to help inform Ministers and the people sitting around the table in Cobra, who are the risk managers in this case.

Q15 **Henry Smith:** Just a brief supplementary on that. In terms of consistency of travel advice, how much do you think there should be an attempt at international consistency, given that different jurisdictions and regions are affected in different phases?

Professor Harper: It comes back largely to the sovereign nature of countries, states and territories. The situation will vary, as you just said, country to country, society to society, culture to culture, but also in terms of the epidemic spread. It is good to have a framework in which to make decisions and to have the information on which to base those decisions. I think trying to have a blanket approach doesn't work, from a public health perspective.

That, in a sense, is one reason that the guidance from the World Health Organisation that was used in the 2009-10 influenza pandemic was revised, in order to try to unlink the political decisions—the decisions from Geneva about declaring a public health emergency of international concern or declaring a pandemic, and all the discussion about the use of that word—as that served as a distraction in the current situation, in my view. These were important points of process and procedure back in 2009 and 2010. It was recognised that it was a constraint, even within countries, because of the heterogenous nature of the spread of a disease such as influenza or covid-19. It was necessary to unlink it so that people could make their own decisions according to the prevailing conditions at that time.

Henry Smith: Thank you.

Q16 **Chair:** You spoke a little about the words—whether it is a public health emergency of international consequence or whether it is a pandemic. Is any consideration given to any factor other than the medical and scientific data? Is the WHO influenced by any other considerations when it makes that decision?

Professor Harper: It has an emergency committee of experts that provides advice to the director general, if we are talking about a public health emergency of international concern under the international health regulations. The experts that come together are essentially health experts. They will take into account, as much as they can, the impact of what they are doing and of their discussions on travel and trade, where that impacts on public health, but I would not expect them to take into account the sort of financial pressures that may be at the back of the question.

Q17 **Chair:** The reason I am trying to be clear is that they would not, for example, be considering a particular market, geography or industry, such as insurance, and the implications of that; they will take it purely on a factual basis.

Professor Harper: They are looking very often at a new situation—the spread of a disease or something that will cross borders. It could be a chemical, radiation or, as in this case, an infectious agent. That is what they are focused on.

Q18 **Graham Stringer:** You explained to the Chair the structural problems in the World Health Organisation in dealing with problems. After the Zika and Ebola outbreaks in 2014 and 2016, there was a lot of criticism of the World Health Organisation, both on the grounds of dysfunctionality and in terms of its practical delivery on the ground. What improvements have been made since then?

Professor Harper: I left the World Health Organisation in 2013, but even in the time that I was there we had begun to consider MERS coronavirus, and what was then and still is a concern, another influenza-type, H7N9, which had emerged in China. On a progressive basis, in the area of preparedness, the guidance and discussions that are facilitated by the World Health Organisation—the secretariat—have been taking place to try to help in advance of the next emergency. In addition, the setting up of an emergency programme and a reorganisation within the secretariat to bring together people from different disciplines in a different way has been done, essentially, to address the sort of criticism that you allude to.

Q19 **Graham Stringer:** Can you explain to the Committee how the Ross Fund has been used over that period?

Professor Harper: I am sorry—I cannot really comment.

Q20 **Graham Stringer:** Because you are not aware of it, or because you do not know the details?

Professor Harper: I do not know the details.

Q21 **Graham Stringer:** When you have such situations as appeared at the start of this outbreak, where China was treating the disease politically and appeared to be not being completely transparent with the figures, and was locking up clinicians who were trying to alert the Chinese public and the world to what was going on, what do you think the response of the international community should be if the World Health Organisation cannot deal with the situation?

Professor Harper: This is a really tough issue for me to comment on because, again, from a public health perspective, the key objective is to have information as quickly as possible, and ideally as high-quality information as can be achieved. Anything that can be done to improve that situation is absolutely the right thing to do. That is not about the global community in some way reacting to what you describe as the Chinese situation. I know that the WHO was encouraging the information from China, to get as much as they conceivably could under the international health regulations, to be able to begin to do the risk assessments that we have talked about a bit this afternoon. How the global community might react is outside my field of expertise. I am sorry.

Q22 **Graham Stringer:** Let me ask it in a softer way. Given the structural problems of the World Health Organisation, do you think that there is a role for the G7, G20 or any other international body to step into that vacuum?

Professor Harper: I don't know about structural problems, as you describe them, within WHO. What they have now is a structure that has evolved—actually, that is not the right word to use; it has changed quite remarkably over the past few years to be able to perform its functions, as member countries have agreed, far more effectively and efficiently. It has changed the way it works and is a far more nimble organisation. But it has its challenges—the ones we talked about a little earlier. In the time that I was in the Department of Health, there were meetings, which only started when I was there, of Health Ministers from what was then G8. I recall a number of very good discussions where like-minded Ministers came together, but working with the World Health Organisation. It was not a substitute for it; it was there to complement what the World Health Organisation was doing, as the UN agency responsible.

There are things that only G7 or G20 could do, and that is right and proper, but if we are talking about a public health response or public health preparedness, there is an infrastructure. If it is not working as member countries think it should, that is the thing to address, as I said earlier. But it is likely to cost money, and we have seen recently a country taking a decision to reduce funding. From a public health perspective, it is a tough one.

Q23 **Chair:** The United States?

Professor Harper: Yes, the US. It is well documented, and right now it is brought into sharp focus. Here we have an organisation that has tried to adapt and to move, and that has gone quite a long way towards doing that. There are always improvements to be made, without a shadow of a doubt, but to do some of what is required, it needs resourcing. Sometimes that is a tension that is not always recognised.

Q24 **Graham Stringer:** Is there anything more that the Foreign Office can do to increase the effectiveness—short of providing cash, which always helps—of the World Health Organisation?

Professor Harper: In the diplomatic circles that are the bailiwick of the Foreign and Commonwealth Office, there are occasionally things that can be done in-country that will help the functioning of the World Health Organisation quite considerably. There are sometimes national issues that can be addressed, I am sure, through embassies and consulates, if people were to become engaged in the right way. That is certainly one thing that could be done to help to facilitate conversations that are sometimes necessary and that are not happening in other countries at the local level. That is one way that the Foreign and Commonwealth Office could help things.

Q25 **Graham Stringer:** A final question—you may not be able to answer this; it might be, as you said in answer to some of the other questions, beyond your immediate expertise. Do you think that the US ban on travel from the EU, and now the EU plus the UK, is a measure of the failure of international relations, or is it just the arbitrary nature of some of the decisions coming out of the President's office?

Professor Harper: I beg your pardon, coming out of—

Q26 **Graham Stringer:** President Trump's office.

Professor Harper: I don't know the basis for the decision, of course, but I can speculate. From a public health perspective, the sort of travel bans that were implemented at the very early stages of the outbreaks might have some impact on slowing the spread of the disease, if the travel bans—if I can call them that—were used in the context of other measures as well. It is not enough just to ban travel; there needs to be case finding, contact tracing, quarantining and isolation, as a package. There is evidence to show that travel bans can have some impact, but once there is community transmission, the impact is very low, if any, in public health terms, so one would speculate that there are either political reasons—most likely—or other reasons that are outwith the public health world.

Graham Stringer: Thank you.

Q27 **Chris Bryant:** Forgive me for this question. You might have spotted that, in Russia, a scientist and Russian television have said that coronavirus was started by the British and that it was developed at Porton Down or at the Pirbright, with the deliberate intention to mask Brexit. Just as we smeared the door in Salisbury with Novichok, so we smeared Wuhan with coronavirus. What is the polite way to say that none of this is true?

Professor Harper: I think I would probably say it is far-fetched. The impact of the current situation is so remarkable—the potential impact is even more remarkable—that it is unthinkable for me as a public health professional.

Q28 **Chris Bryant:** It is unthinkable, but I worry. My anxiety is partly about misinformation as well.

Professor Harper: Ah yes.

Q29 **Chris Bryant:** Misinformation in this field can cost lives, can't it?

Professor Harper: You are absolutely right. I could not agree more. The current situation—what the WHO are calling the "infodemic"—has become a major issue in terms of the impact on public health. It would cost lives. People need to get to grips with how social media can be used and abused. There are lots of tools out there that could be used for good, but the risks are huge indeed. I couldn't agree more.

Q30 **Chair:** Can I jump in off the back of that? The Chinese Government's spokesperson has been blaming the United States. Given that there is not any great discussion about where the epidemic started, could you make it clear that that claim is as laughable as the accusation of any other group? It strikes many of us as particularly bizarre, given that the silence and fear brought about by Beijing's tyrants exposed China and the world to this terrible disease.

Professor Harper: I can really only repeat what I have said. Myth-busting will probably become a discipline in itself. You have used some words there that I, as a public health professional, would not comment on, but it is very important to get as much information for the people who are the trusted communicators—I mentioned them earlier—to be able to use.

Q31 **Chair:** How likely do you think it is that this disease emerged from anything other than the wet markets of Wuhan city in Hubei province?

Professor Harper: Everything points towards that being the source of the outbreaks at the moment. In scientific and public health terms, a lot more needs to be done to elucidate pathways of transmission, source, reservoir and so on. That will be done. It has been done successfully in the past with other diseases that we have been talking about today. That will become clearer and clearer with more and more information, but there is no reason to suppose for a moment that the allegations that are being made have any basis in reality.

Q32 **Chair:** Given your experience in public health emergencies, you must have known about previous covid viruses, as they have existed. What likelihood is there that any country, Government or system could have manufactured this coronavirus?

Professor Harper: Wow. These are very good questions. The first thing to say is that there is no need to manufacture a coronavirus. There are coronaviruses in nature that can be changed, if need be. They can be adapted quite naturally. With the technology that we have, it is now possible to create or recreate organisms such as viruses. Hypothetically, there is the technology to be able to do that sort of thing, but there is no driver or reason. From my point of view as a public health professional, what we are seeing in the current situation is clear. It would have to be something quite remarkable that has gone on to create a situation of the sort you are describing.

Q33 **Chair:** So you would say it would be better if Governments focused on dealing with the real emergency, rather than creating science fiction in order to justify their own failures.

Professor Harper: That is an excellent way of putting it. Those are the words that I would have liked to have come out of my mouth.

Chair: I give them to you.

Professor Harper: Thank you.

Q34 **Royston Smith:** Can we go back to travel bans? I do not want to make criticisms of anyone particularly, but I think people would suggest that the US was slow in reacting. Some people in the Administration thought it was not as important as it is, and then they overreacted or reacted with a complete travel ban, followed by the EU now and followed by us. Are those travel bans the right thing to do to contain this? Is there a right time to introduce those or is everyone now just playing catch-up with the one that decided to go first?

Professor Harper: If I can, again, talk from a public health perspective, which is really the only perspective I can reasonably talk from on this one, there are different types of travel ban. What I was talking about earlier was intended, if done early enough, to slow the spread of the disease. In terms of the countries we are now seeing—the UK today, and you mentioned the Foreign Secretary announcing a travel ban earlier—to me, that is done for very different reasons from a public health perspective and is an extension of the measures announced yesterday in terms of social distancing, trying to reduce social contact and unnecessary travel, and to protect vulnerable populations. In part, that is the public health part, but I would also expect there to be considerations that go beyond that, which would be, "How do you get people back?" People know, or should be aware of, and look to the FCO to advise them on risks. People would expect to have as much information as they can get from the FCO and others. All of that is part of the decision from the UK perspective.

I am sure that there are a lot of other things that I wouldn't know about as well. On whether there is a right time, there might be a right time for an individual country—that is what we are seeing today—but there is not a blanket time to do that. It is not really playing catch-up in the sense you may have meant. People have been saying that the measures the UK has introduced are slow and that they are behind what has happened in other European countries. The experts, the people here in the UK who are informing the policy decisions, are some of the best experts in the world, and they are saying, "Yes, but the epidemic is in a different place here. We are now taking the decision for the UK at the right time, and we did not need to take it three or four weeks ago or whenever other countries were doing that." That is a reasonable point of view.

Q35 **Chair:** You touched on the G7—or G8, in your time—beginning the Health Ministers' dialogue. In your experience, do you think there are forums other than the WHO in which groups could be brought together to respond quicker or more assertively? As you said, the WHO acts more as a secretariat. What about the G20?

Professor Harper: I have to be a little bit careful in the way things are interpreted. I said that the WHO is a composite organisation of member

countries and the secretariat. The secretariat is doing what member countries have asked it to do. That is a way the organisation has developed. It was not intended as a criticism in this context.

Q36 **Chair:** Forgive me, I am not intending it as one. I am just saying that, given that we are looking for a response mechanism and not just a co-ordination mechanism.

Professor Harper: The response mechanism exists through the World Health Organisation. We have seen it most recently in DRC and even more recently with the WHO staff who went to Wuhan to see what the situation was and to verify, validate and collect information. That is all right and proper for the World Health Organisation to do. There is an infrastructure and a framework in which response, information and so on can be facilitated. It depends on what countries are looking for. That is the key question. If the WHO is not doing what countries are looking for, then sort out the WHO first and foremost.

But there are other things. There is a group that I was involved with that still exists that was called the Global Health Security Initiative—like-minded health ministers from G7 countries plus Mexico who came together quite a number of years ago, and worked very, very well. People at director general level, the official group shadowing the ministerial group, met frequently and they created a trusted network. In 2009 and 2010 there was value, from a personal perspective, in being able to pick the phone up and talk to my opposite number in Paris, Berlin or Washington; to say, "How much Tamiflu are you buying?" and to have that sort of confidential discussion which, unusually, is off-the-record. That made my life so much easier, and it helped the response. That grew because there was a need. It was not there to replace the WHO in any way, it had a specific function. In a policy sense and in terms of informing the risk management decisions that we have been talking about, I found that very valuable indeed. There are other mechanisms that can be created if there is a need to supplement or complement that big international global response machine that is the WHO.

Q37 **Chair:** Would you say that, at this stage, it would be worth reaching out to many of these organisations to see what they can offer in terms of co-ordination, or is there a risk of over-co-ordinating, as it were, and of having too many bodies?

Professor Harper: Yes, because I was not talking about co-ordination. I was talking about a particular need that was addressed by a particular group. That is a sensible way to look at this. If there is a need, say, for not harmonisation but an exchange of information or research, then that is a function of the WHO. Co-ordination is an interesting concept because there are sovereign countries doing their own thing. It would be great for member countries at the World Health Assembly to say, "This didn't work in the way that we wanted it to work, as member countries of the WHO. What do we really want? What do we think was lacking? Can the WHO deliver it?" If not, there is a basis for thinking about a possible alternative.

It is hard to see an alternative outside the WHO framework at the moment, other than the sort of situation I just described to you.

Q38 **Chair:** If you were to be empowered by the Foreign Secretary to attend the next World Health Assembly, what would you be asking for?

Professor Harper: Particularly after the analysis that will be carried out by the international health regulations review committee that will say, "This worked really well, that didn't work really well," I would look at that and say, "Some of these things were said back in 2009 and 2010. The committee that looked at that H1N1 pandemic said, 'You need to do this.' It has not happened. Why not?" Same thing with Ebola in 2014. There was a review committee that asked why these things had not already been implemented. There will be reasons for that. If I was at the World Health Assembly I would be asking the question, "Why haven't these things been done?" If it comes down to finances, or to other things, then at least there is an opportunity to improve the situation.

Q39 **Graham Stringer:** A final question: this kind of infectious outbreak of a disease has been top of the Cabinet Office risk register for some time. Given a perfect scenario of international collaboration—which we have not got—in which a vaccine is made which would deal with it tomorrow, or maybe today, we have no capacity to manufacture it in this country. Do you think that that a serious failing, both of the international response—the lack of worldwide capacity—and of our national capacity?

Professor Harper: There are ways of addressing national capacity where national capacity is not available. It is not just the UK. If we look at the international scene that you have just touched on, many countries around the world do not have vaccine-manufacturing capability. The World Health Organisation recognised that with influenza, and it set up a framework where the industry contributed financially to improve the capacity and the access to the vaccine, particularly for those countries that would find it most difficult. There are different ways of managing the sort of situation that you have just described.

For the vulnerable countries, those less able to respond than some of those we have focused on this afternoon, it is very important to have the benefit-sharing that people talk about. For example, with viruses emerging in some parts of the world where the global community needs access to the viruses to make vaccines but the country from which the virus originated cannot afford the vaccine—that was the thinking behind setting up that mechanism and framework on influenza quite a number of years ago. It would make complete sense to me to have a much broader framework to cover other viruses. Why would it apply only to influenza?

Q40 **Graham Stringer:** The point I am making about the United Kingdom is that we do not really have manufacturing capacity. I suppose the answer that I was looking for was that we should, if we really are to reduce the risks to the people in this country.

Professor Harper: I am sorry for not being clear. My response is that it is not necessary to have national vaccine manufacturing capacity if there are ways of achieving the same end through agreements.

Q41 **Graham Stringer:** Surely that depends on the actual quantum, the size of it. Is it real-world politics to think that China or Italy will sell us vaccines while their own populations are dying?

Professor Harper: There are undeniably those sorts of issues. I can only go back to 2009 and 2010. At that point, a lot of effort went in. There was not a flu vaccine for the H1N1 strain that emerged, but a lot of work had been done internationally, including in the European Union, to facilitate the process, the licensing and all of that sort of thing. What the UK did was to have contracts in place—commercial contracts and advance purchase agreements with vaccine manufacturers—so that we were near the head of the queue whenever it was that we needed vaccine. Those agreements were triggered when the pandemic was declared.

You can look back and say that we ended up with a lot of vaccine that we didn't need, because of the way the pandemic proceeded, but you cannot plan for that. Our insurance policy, from my point of view as a public health professional, is along the lines that I have just described. There are ways of addressing the issue. It would be fantastic, wouldn't it, if countries had more vaccine-manufacturing capacity, but that comes down to the economics, the commercial situation, and so on and so forth.

Q42 **Graham Stringer:** A final question, if I may. To go back to one of your previous answers, you said that, basically, we were three weeks behind other countries in terms of their response, because they have the more intense impacts of the disease at the present time. There is one area where we seem to differ internationally, not just in timeline but in our understanding of the science, and that is in the closure of schools. Do you think that we have got that right?

Professor Harper: I would go with the advice from the best experts that we have, who are saying—as people know, because it has been reported widely—that at the moment it does not seem to be the right time to go for school closures, but it is absolutely on the table. The only comment I want to add is that one reason that I would absolutely go with the experts I have just referred to is because I have been in that world and I can say, with some assurance—I am hoping the situation has not changed markedly—that we did our very best to get the best expertise.

What could be done, which is being discussed currently, is making the basis for the decisions absolutely open and available to other people to have a look at, because if they can't look at it, they will criticise it, and then you get conflicting information. But I am not questioning the decision. It might well be that in the next period, there will be school closures, with all of the ramifications that school closures will bring.

Q43 **Chris Elmore:** On school closures, I am not advocating not listening to the medical advice, but there is confusion. We share a land border with the Republic of Ireland. Northern Ireland does not have any school

closures and the Republic does, and that is causing some anxiousness, particularly in Northern Ireland. There is conflicting advice from within what the EU is doing, almost as a collective of states. It has been reported this week that the Health Secretary has either not been invited or has not taken part in discussions with EU Health Ministers. So, there is a confliction with one of our land borders, and we also don't appear to be engaging with near neighbours. This is not about Brexit; I am not having a dig about Brexit. You have said through quite a lot of answers that we should be sharing information and engaging on an international basis, but it seems as if we are not doing that on the basis that we maybe should be.

Professor Harper: I think you have described the situation. I can only say again that the information should be available on which there can be some scrutiny by a wider field of experts than the ones that are directly involved in the assessments and the informing policy decisions.

It really is not possible for me to comment on whether it is the right or the wrong decision for Ireland to close schools, or for other countries to close schools. They might well have different considerations and different social structures. From the UK perspective, which I know some more about, there are what I would call the fairly obvious knock-on effects of school closures when, from a public health perspective, we are trying to protect vulnerable people. As we know, it is not uncommon in the UK for children to spend time, if they are out of school, with grandparents for childminding duties—for grandparents to look after their grandchildren. That flies in the face of trying to protect the most vulnerable population. That stacks up from a public health point of view, in my opinion, but there might well be very good reasons—I am sure there are—for other countries to take the view that they need to close schools.

Q44 **Chair:** I certainly know of one school that cares for kids with various disabilities, where all that has happened is that the parents have had to take on the responsibility that the school once had, except now they are doing it in a less safe environment. I don't just mean that in terms of sharing potential pathogens, but also because the home that is being used is simply not geared up for that kind of care. Actually, all you have done is shift risk and increase it, rather than diminish it.

Professor Harper: I think these are very good points. I expect some of them, or many of them, will have been taken into account in the unintended consequences, because we have sort of been here before, with influenza of course—a different situation with children being affected in a way that doesn't seem to be the case with covid-19.

I should have said earlier that it is entirely reasonable for a school to close of its own volition, taking advice from public health professionals, but a blanket closure of schools at the moment, informed by the science, does not seem to be the appropriate thing to do. But who knows what will happen next week.

Q45 **Alicia Kearns:** My apologies for having missed so much of your evidence.

I was in a DL Committee passing a statutory instrument, so apologies. I have two very different questions. My first one is about how we balance behavioural science and the field of actual medicine and science. Obviously, we have to be driven by the science, but we recognise that unless you look at behavioural science and behaviours and psychology, it doesn't matter how good the medical advice is—people won't follow it. Do you think we are getting that balance right yet in the UK? How would you improve it? Is there anything particularly innovative that you think we should be doing that behavioural science will tell us that we are not?

Professor Harper: I can't say for sure what the current situation is, but I can say what we did back in the influenza pandemic. We made it very clear that we needed high-level, high-quality social science input from social psychologists and behavioural specialists involved very much in the assessment process. So, one of the committees that I chaired for the Department of Health, as it was, included somebody who I just saw on TV this morning from the University of London, who is a social psychologist.

Obviously, you have limited opportunity to get people sitting around a table; you can't necessarily take everybody. But you take people who are opinion leaders and expert, and who have their own networks to be able to then take discussions elsewhere if they need to, and come back to the main committee.

So we tried very hard to do that sort of thing. In many ways, the policy decisions of the time and even the communication—or particularly the communication; when to roll out pre-prepared phases of communication—were informed not just by the communications experts but by the social scientists in a much broader way.

Q46 **Alicia Kearns:** My second question is very specific, so bear with me; it is about mass gatherings and how we tackle them. A big concern for me, as I represent Rutland and Melton, is our cattle market, which is absolutely vital to our economy; cattle markets across the country are vital. They make most of their money in the month of April; the rest of the year they pretty much run at a loss. So for all cattle markets across the country, April is really pivotal. We are looking at—I'm working very hard with Departments—how we ensure, in some way, that farmers can still bring their livestock to market or sell them in some way.

If we find ourselves in a place where we have to hold some form of market, is there anything in particular, in terms of mass gatherings, that you would advise, or that you learned from previous experience, or is it literally just a case of, "There is nothing you can do—mass gatherings are a bad idea"? Essentially, is there any advice for the cattle markets if we are able to keep them open?

Chair: Not quite the area that we are looking at as a Committee, but—

Alicia Kearns: I'm sorry—of course. I'm so sorry. I had a moment where I just went into coronavirus mode. I'm so sorry; I'm happy to withdraw the question if that is helpful. I'm so sorry; I was in full coronavirus mode.

Chair: If you have a desperate desire to answer it, Professor, you are very welcome to.

Professor Harper: We could maybe talk later.

Chair: That would be maybe a bit more appropriate. Forgive us.

Alicia Kearns: It's like Bob asking about separating the Isle of Wight earlier.

Q47 **Chair:** We are extremely grateful for your time, particularly today. Can I just summarise one of the most important points that you made right at the beginning, which was about information, even if you have nothing to say—that confidence in a reliable and trusted source of information was your prime lesson from H1N1? Is that correct?

Professor Harper: That was a very important point and I think it applies absolutely to the current situation.

Q48 **Chair:** Is there any other sort of key generic learning that you would take?

Professor Harper: That I would like to see happen now? I think it is probably along these lines: it's never too early to learn the lessons and to try to implement as you go. It's a moving field. And in this case, it's rapidly moving. I think that's what should be happening; I hope that it is what is happening. But it's important to set up the framework to learn those lessons during the outbreak; it's not always something that can be done retrospectively, because the chance might have gone. Very important to set up—

Q49 **Chair:** And you would do that with partners around the world, not just in the UK?

Professor Harper: I would, as far as I could, but bearing in mind that people are very focused on dealing with the immediate issue. It's not something—prioritisation has to apply. I would be looking internally—nationally—but absolutely working with my international partners.

Q50 **Chair:** Perhaps one of the instructions you might give, were you to be Foreign Secretary, would be to ask the embassies—not immediately now, but as they are reopening—to engage with whichever nation they are in as quickly as possible, to draw the lessons, so that at least they are ahead of the curve for next time?

Professor Harper: For sure, and also to work with a country office of the World Health Organisation, where there is one, because they will have seen things in sharp focus.

Chair: Okay. Professor Harper, thank you very much indeed for being very understanding of our questions, including about cattle markets in Rutland. I am extremely grateful.