HOUSE OF COMMONS

Foreign Affairs Committee

Oral evidence: Global health security, HC 897

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Watch the meeting

Members present: Tom Tugendhat (Chair); Chris Bryant; Stewart Malcolm McDonald; Henry Smith; Royston Smith; Graham Stringer.

Questions 1-42

Witnesses

I: Dr Clare Wenham, Assistant Professor of Global Health Policy, London School of Economics, and Professor Colin McInnes, Pro Vice-Chancellor (Research, Knowledge Exchange and Innovation), Aberystwyth University.

Examination of witnesses

Witnesses: Dr Clare Wenham and Professor Colin McInnes.

Q1 **Chair:** Welcome to this afternoon's session of the Foreign Affairs Committee. We are lucky to have two witnesses as part of our global health inquiry this afternoon. I will ask them to introduce themselves. Dr Wenham, will you start?

Dr Wenham: Hi, I'm Clare Wenham, assistant professor of global health policy at LSE. My research is into the politics of pandemic preparedness and health emergencies.

Professor McInnes: Hi, I'm Colin McInnes. I hold a personal chair in international politics at Aberystwyth University. For the past two to three years I have been working with the World Health Organisation on military interventions in health crises.

Q2 **Chair:** Thank you very much indeed. We are lucky to have you both with us today. As you know, we are the Foreign Affairs Committee, so we are not looking at the science of covid; we are looking at the international effect, the co-operation, and how it can be improved. Clearly, some of this inquiry will have to look at what has happened over the covid challenges that the world has faced over the last year, but we are really trying to look forward to the areas of co-operation that could be built on, changed or removed in order to improve the outcome for any potential future pandemic.

Having said we are looking forward, perhaps I can start by looking backward and asking what has the covid-19 pandemic taught us about the importance of international collaboration in securing preparedness and resilience against biosecurity threats? Dr Wenham first.

Dr Wenham: I think, for me at least, what the coronavirus pandemic has shown us is that international collaboration is vital to the success of this and to getting out of the situation that we are in. We live in a multi-stakeholder framework of global health. There is a mix of Governments, WHO, international organisations, the private sector and NGOs—the list goes on. We really need to be able to all work together and each bring our strategic advantages and areas of expertise and strength.

However, I think the problem that covid has exposed is that there has been a lot of talk about global governance working and us all working together at a time of crisis, but what we have seen is that it has not worked as effectively as it could have done. We have seen particularly nation states pulling back and retrenching to nationalist approaches, rather than working collectively, and the cosmopolitan ideals that underline a lot of global health activity have not necessarily come through. Any future work on this inquiry and more broadly in this space needs to really understand why that happened. Why have we got to the point where

Governments do not want to collaborate in the global system during a pandemic?

Q3 **Chair:** Can we talk about that in slightly different ways, in two ways? The first is the obvious World Health Organisation challenge that many people have cited in recent months and years and their ability to oversee and then investigate the origins of this virus in Wuhan, China. Then, if I may, I would like to ask about the European Union's response. I don't wish to make this a European Union type of argument, but this is an organisation that has co-operated incredibly closely over more than 40 years on trade and many other aspects of public health, yet here at a moment of great stress it first of all had the challenge of PPE-sharing between nation states, and then it later had a challenge over vaccines. Are there lessons to draw out of both of those?

Dr Wenham: Sure. Starting with the first one about WHO, I think the WHO has actually done quite well during this pandemic for the capacity it has to do so. We cannot underestimate how little funding the WHO has. The annual budget of the WHO is about the same as six days of NHS care, so it is hardly anything. Not only does it not have much money to do anything; it also has had waning political power. Governments are not looking to it as the focus. They are using it for technical guidance, but then they are deciding whether to engage with that guidance. I think that, going forward, we have to have the WHO at the centre, or we will just invent something that looks very similar to the WHO and we will waste a lot of time and effort in doing that. We need to work out why Governments do not want to work more closely with the WHO and do not want to follow the temporary recommendations that they issued, such as under the international health regulations. We need to try and understand how we can better build trust in the institution and in the processes and protocols that the WHO put out. Maybe that is a series of better exercises, practices and simulations, or whatever it might be, at a time of crisis.

In response to the EU point, I think that that is a really interesting question. The EU level analysis is difficult because there are multiple competing frameworks and institutions. You have WHO/Europe, the European Union, and the ECDC, and you have individual member states working bilaterally in the Union as well. The EU has not been able to respond as effectively as it might have in other areas because this is not something that it has faced before, and I think it speaks to a broader exceptionalism of, to date, epidemics occurring in lower middle income countries, somewhere not here, and so we have not looked to build capacity in the same way, or never thought it would be a problem in the same way, so I don't necessarily think there is operational readiness in the institution.

Q4 **Chair:** Thank you very much. Professor McInnes, may I ask your thoughts on those issues? Do you broadly agree?

Professor McInnes: Yes, I think I do. It was slightly depressing, if not surprising, that as soon as this rhetoric of international collaboration encountered a stress test, we reverted back to the norm of national

responses and national measures. There were suspicions of industrial espionage by nation states, suspicions of China hiding the origins of this, and we moved away from the ideals that started to emerge two decades ago that we were in a different world. We are back into a world of nation states protecting their interests, which is not wholly surprising, perhaps, but at the same time is a little bit worrying given the globalised nature of this pandemic.

You've got to recognise the limits of the World Health Organisation itself. Clare mentioned its budget. It is an organisation of member states, numbering close to 200 now, and getting them all to agree on something will be incredibly difficult. It has a very powerful devolved regional structure, so Geneva doesn't rule the roost. The regional offices are very powerful indeed. It has an internal bureaucracy which, at best, is less than optimal, and at worst is dysfunctional, so in its ability to actually respond to these crises, the fact that it does as well as it does is sometimes little short of a marvel, I think. But there is no escaping the fact that it is not a leadership organisation in the sense of being proactive and able to marshal massive resources. It has a convening ability, for sure, but its real authority lies in its moral authority and its technical authority. When you have states such as the United States publicly undermining its moral authority, is very difficult to expect the World Health Organisation to maintain a leadership role.

On the European Union—Clare is absolutely right that all sorts of competing actors are involved, not just the European Union, which European states are party to, and it is interesting to see how the stress test of covid has revealed major fractures within the European Union. That was slightly more unexpected. I think we would have expected a much more concerted, co-ordinated, coherent response from the European Union, so that was one thing that took me a little bit by surprise.

Q5 **Chair:** You suggested that these different barriers are both administrative and political, in both circumstances. We are going to be looking at different ways in which we can try to overcome these barriers and different ways in which we can improve co-operation. What do you see as the role of the Foreign Affairs Ministries in public health and co-operation in these areas, particularly during pandemics, but, perhaps even more importantly, before pandemics?

Professor McInnes: I think there is a really large role for Foreign Ministries to play here. We can start with global health diplomacy. One of the great success stories of global health in the past two decades has been the framework convention on tobacco control.

Tobacco still kills very large numbers of people each year, either directly or indirectly, and the framework convention, which was a negotiated settlement, relies not simply on the technical expertise of public health officials, but on the diplomatic expertise of Foreign Ministries. That sort of thing can be really helpful.

It is easy to fall back on the trope of security, whether direct security or the indirect risk of state instability, but on things such as health as a human right, the promotion of human rights, and the right to health, Foreign Ministries can play a really important part in advocating for them.

I am trying to explore this beyond the threat of pandemic disease and think about non-communicable disease as well. I don't think we should be myopic in our focus on epidemics and pandemics. We should think about endemic diseases as well, and the roles that they have in human health.

Q6 **Chair:** This is a particularly interesting and topical issue at the moment, because people are talking about different forms of vaccine passporting and so on. We already have yellow fever passports, or certificates rather. What we are really talking about here is—as you touched on, Professor—finding different ways of co-operating in other areas of public health that may not necessarily directly affect another country. This pandemic has clear links to foreign policy, but you are suggesting that there could be other areas in which co-operation could be helpful. Where do you think the line is drawn? Do you think that health should become part of foreign and security policy? Do you think it should be seen in that bracket? Or should it be seen as just global public health and therefore part of aid? How do you see it?

Professor McInnes: I think it very clearly has a foreign policy component to it, not simply because you are negotiating these things internationally, but because national security and national interests are at stake. Also, to be blunt, there are those who would argue that health is a form of soft power and that we can use health interventions to advance the profile and interests of the state. I am not saying I am necessarily one of those, but it is clearly the case that you have seen a number of Administrations explicitly using health interventions to promote their particular national interests. There are a whole range of ways in which health and foreign policy can and often do intersect. It is not a hard and fast thing, but you draw a line—this is foreign and security policy, and that is international development policy—and the line between the two is very fudged. The merger of the two Departments poses interesting opportunities and challenges in this very respect. I don't think it will be an intrinsic question of this is development, this is foreign policy. It is going to be much more a case of working, hopefully, together, but potentially at loggerheads with each other over whether you promote the interests of the state or poverty alleviation.

Q7 **Chair:** Dr Wenham, the professor has left us at an interesting point. The question of foreign aid or health as foreign policy is something that we have seen over the past year, most notably with China's use of PPE and now with different forms of vaccine diplomacy. Where do you see that being successful? Where do you see that working? Do you see that as a kind of soft power that we should try? Should we be like Russia in supplying different vaccines to Hungary, or should we think about this more cautiously?

Dr Wenham: I agree with Colin. You cannot separate health policy from foreign policy. You cannot just talk about it in the abstract of public health. Foreign diplomacy has been at the core ever since the start of this epidemic when we were looking at trade embargoes—the old trade limitations—being put on China as early as January 2020. We see it through the way we have been talking about COVAX and vaccine distribution and all these things. We need to establish whether we want to play those games, or, rather, if we want to openly play those games. I imagine those games are being played more informally, anyway. We are the second largest bilateral donor in health. We are huge funders of WHO, CEPI and COVAX. So we are using that and we do use bilateral efforts in health and building capacity for pandemic preparedness elsewhere in the world. That does feature as part of UK foreign policy. Whether it is self-interest or altruism is neither here nor there, because I think it is happening, anyway.

Chair: Thank you. Graham, you wanted to come in on this.

Graham Stringer: I would like to follow up on the comments to see if I understood properly what our witnesses were saying—*[Interruption.]*

Chair: I'm sorry, Graham, but the line is very poor.

Graham Stringer: I will get a little closer to the screen. Is that better?

Chair: Seems to be.

Q8 **Graham Stringer:** In terms of the European Union, I might be disagreeing with both you and the witnesses, and I am interested in their comments. This was surely not the time for the EU to move beyond its legal competence—it does not have a health competence—as it showed its practical competence. That was not the time.

On the points made about co-operation, I want to see if I understand the points. I am quite happy to vote for money for COVAX and for foreign aid. I think that is both a moral and a self-interested thing to do. What this epidemic has shown is more reliance on the nation state. I want to ensure that this country has its own capacity to manufacture vaccines, and I want to vote for the people I represent to have vaccines as soon as possible. Is that in contradiction to what you are saying?

Professor McInnes: I do not think it is necessarily in contradiction, but certainly in terms of vaccine development and production, we are dealing with a highly globalised pharmaceutical market, so having a national provider is very difficult. When you look at many of these vaccines, they are a product, either directly or indirectly, of international collaboration. When you look at some of the major drug developments that are being undertaken at this moment in time, they are so enormously expensive that it has to be the sizable multinational companies that engage in these. If we are looking for the next generation of antibiotics, for example, which is a major issue—arguably, it requires major international co-operation to reduce our dependency on antibiotics—that has already cost billions, and we are not close to it yet.

In terms of looking for the UK to develop and produce its own vaccines, sometimes that might be lucky and it might be straightforward. As I understand it, the Oxford team had a bit of a head start because they had already been contracted to do some research on a different form of coronavirus, MERS. However, sometimes you are going to have to collaborate internationally simply because of the complexity of the technical challenges. I must apologise: this is stretching the boundaries of my competence, in terms of understanding the biology involved, but certainly the politics are very clear that, in terms of drug discovery, you are looking very much at international collaboration or major global pharmaceutical players.

Turning to the European Union, you are, of course, absolutely right: in strict terms, this was beyond their formal competence areas. However, you would have hoped that after the decades of co-operation and collaboration together, they would have got their act together a little bit more effectively, at least from what I have seen. I must confess that this is not an area I have looked at particularly closely, other than watching the usual news sources, but it did seem to me slightly surprising that they were not operating in a more concerted manner.

Q9 **Graham Stringer:** Can I just follow that up, because I do want to understand this issue? I understood that when you were talking about co-operation, you were not talking about the scientific co-operation that is necessary in the world to develop these very complicated vaccines with very complicated science behind them. I thought—this is what I wanted to clarify—you might be saying that we should be handing over vaccines at the same rate we are handing them over to our electorate, in the case of MPs, or to the British population. The point I was making is that there always has to be a priority in that, and my priority is, by whatever methods, to get as much security and safety as possible for the people I represent.

Professor McInnes: Sorry, I misunderstood your initial question. No, I was not arguing that we should hand over vaccines before large numbers of the British population, but there is a judgment here, isn't there? The judgment is one about human rights, and it is also one about the national interest. As a country that has a very robust public health infrastructure and a very strong national health service, we can deal with a pandemic such as covid in a much more advanced—to use a terrible word—or, let us say, sophisticated manner, with much greater capacity than other countries. You could argue that we have a moral obligation to help those who cannot necessarily help themselves, particularly if the risk to us is much lower. There is a judgment call there, and I am not just talking about covid: it could be about other pandemics, such as swine flu, where we were much less affected.

There is that argument, but there is also the interest argument, that in a globalised economy and in a world where soft power is widely seen as being important, if you are seen as putting up barriers to other countries—that you do not want to help other countries, or that it is UK first—I am not sure that necessarily does a lot for your reputation internationally. In

that sense, I think there may be a national interest argument in play as well, but in both, it is a judgment call, isn't it? I am not going to hold an extreme position on those at all. It is about where you do the balancing in the middle, and it is a very difficult judgment call between them.

For example, I heard just before this meeting that I am due to have my vaccination next week, and I am very pleased about that. If my family were not vaccinated but we saw very large numbers of vaccine going elsewhere in the world that did not have the prevalence levels that we have, I would have to think hard about that, because prevalence rates in the UK are very high. On the other hand, if it is a pandemic where the risk to the UK is much lower but there are countries elsewhere that are suffering disproportionately, maybe we would have a moral duty there. It is very context-specific and I do not like the idea of a hard and fast rule whereby once 80% of the UK population is vaccinated for any pandemic, we will move on to elsewhere. It has to be more nuanced than that. My apologies if my original answer was unclear.

Graham Stringer: That has clarified it. Thank you very much.

Q10 **Henry Smith:** I thank our witnesses for attending today. How co-ordinated do they think the UK's approach to global health security is? Is there enough collaboration, for example, between the relevant Government Departments? Dr Wenham, would you like to kick off on that?

Dr Wenham: In all honesty, I think it is well co-ordinated. It seems that we have—well, you will know better than me—quite a good working relationship between the Foreign, Commonwealth and Development Office and the Department of Health. Public Health England have a large international team who are doing a lot of implementation and support work elsewhere in the world. Through those mechanisms, it is possible to see the power of the UK in the global health space.

These things can always be improved. We would have to think about extending it into other Departments, as we recognise that pandemics and health issues are not just in those two areas of health and foreign policy. You could see it being extended into all areas—education and so on.

The question is: how, then, does the UK play on the global stage? That is a slightly different question, and one that might be more interesting. We see a lot of financial commitment to the UK. We see them trying to support normative goals of health security, global health and health equity, using a lot of the language and being a leading force in this space of global health over the past couple of decades. But my concern at this stage with the way we have handled the pandemic domestically is: will that affect our reputation on the international stage? How will the fact that we have been departing from WHO guidance, for example, affect our relationship with the WHO and other bilateral relationships that we have in the global health space?

Q11 **Henry Smith:** Thank you very much. Before I come to Professor McInnes,

that leads on to a related question. Do you feel that the merger last year between the Foreign and Commonwealth Office and the Department for International Development has changed the UK's approach to health diplomacy? You started to touch on that. I would be grateful for some further thoughts.

Dr Wenham: I will put my hands up and say that I think it is slightly beyond my level of comfort and expertise to be able to understand this. I would say that my main concern is less the merger and more the cut to the 0.7% commitment of GDP to aid, because that is going to have a significant impact across health budgets—both those that are more foreign policy-related and more development-related. As Colin said, those things are so highly related that strengthening global health from the everyday health issues rather than the emergency ones affects, in turn, a country's ability to be able to respond to a pandemic.

Q12 **Henry Smith:** Dr Wenham, thank you very much. Professor McInnes, I would be interested in your perspective.

Professor McInnes: What is interesting is that, as a country, we have a very strong record of policies and procedures for national emergencies. There is the gold command system and so on, and we have a pandemic preparedness plan, all of which is based on a multisectoral response. There is quite a lot in place. It is not perfect, but then again you sometimes do not want it to cover every contingency, because Murphy's law is that you will have four or five types of emergency and the one you actually encounter is the sixth one, which you were not thinking about. That is the way of the world. I am never a fan of overly prescriptive plans, but internally we do have quite a strong system. I am not convinced that we have the same sort of multisectoral response externally.

Obviously, with the merger of the two Departments, they are still in shakedown mode, and my understanding is that internally, not all the structures are in place and not all the people are in place. So, I am going to do a cop out. It is too early to say, but clearly people are looking, quite rightly, to see which way the cookie is going to crumble on aid issues. Is aid going to be much more targeted towards areas of influence or is it going to be about poverty alleviation, which is what DFID was established to do? Going back to the 1990s, when this was part of the Foreign Office before, one of the reasons for establishing DFID was that it was seen that poverty alleviation was a separate and worthy goal in and of its own right. So, this is what I think many people are going to be looking at. Clearly, the reduction in ODA—understandable though it is, given the economic situation—has nevertheless been seen as a signal of the way in which this might be going.

In terms of global health security, I would suggest that a much more coherent approach globally is necessary. We do not quite have that—we are much more reactive. When you think about the west African Ebola crisis, we did not really have plans in place; we reacted to that. As it turned out, we reacted fairly well—one or two areas could have been better, but by and large we did it pretty well, and it took a while but we

got there. So, we are active in the global emergency response to health crises, but it tends to be much more reactive and we do not always have the plans in place to allow us to do that or the close integration of the military with the foreign and development arms of state as well.

Q13 **Henry Smith:** Are there lessons to be learned from large donor countries like Australia that have merged their foreign affairs and development assistance Departments? Do they deliver their global health security and diplomacy well in that context?

Dr Wenham: Australia took a lead in this. Going back 10, 15 years, Australia and Canada were seen as two of the leading countries, but they were very different: Australia was driven much more by national interest and integrating this into the national interest, whereas Canada was driven by a sense of moral responsibility, so you had two very different approaches to this. I am not going to say which one was right and which one was wrong—if I dare be so presumptuous, that is up to you as politicians—but I can analyse this and say that there are two different models and the Canadians got a lot of soft power benefits from their approach, but whether that actually translated into any tangible benefit is a completely different question.

Cards on the table: I am a little bit of a sceptic on soft power sometimes, because it is hard to see the tangible benefits. I understand it in the inchoate manner that if people feel positively inclined towards you, they might give you the benefit of the doubt on certain things, but when you actually look hard and say, "What are the tangible benefits from it?" or if you have KPIs for it, it is quite difficult to see. The Canadians got a lot of good publicity out of it; I am not sure about the tangible benefits.

Chair: Graham, did you want to come back or are you content? Okay. Stewart? I have lost you, Stewart.

Q14 **Stewart Malcolm McDonald:** No, I am here, Chair. Don't worry, you've not lost me just yet. We might have touched on this earlier. Professor McInnes, you mentioned non-communicable diseases. Could you talk through the threat that they pose to global health security?

Professor McInnes: It is not a direct threat in the way in which we would see covid or even something like HIV and AIDS, but its effect is particularly in macroeconomic growth. If you have a country with a high burden of endemic non-communicable diseases, their growth potential is limited. If you buy into the argument that we are in a globalised economy, where you are looking for markets to grow, if a state isn't performing in terms of its economy, that affects us in terms of potential markets, potential supplies and so on. It is the economic risk, and I would nail my colours to the mast and say that human rights are also involved.

For human rights, some of these diseases have quite high burdens. I will pick one, which may not fully fit with the NCDs—infant diarrhoeal disease. Half a million children die a year unnecessarily of diarrhoeal disease. You see lots of celebrities and others talk about HIV, which was a particular interest of mine. You see prostate cancer badges. I have never seen a

badge for diarrhoeal disease. I hate to think what one might look like, but nevertheless this is an enormous burden for many countries, particularly in Africa, and one that we almost wholly ignore, even though addressing it is not particularly expensive.

I think we have a moral obligation. I do not want to be solely tied to the economic case. I think there is a moral case there that when you can do something, at not an enormous cost, maybe you should.

If you are looking at the more interest-focused arguments, they would certainly be about macroeconomic growth. You could possibly link that, as some have, to state instability and terrorism. Certainly, there were concerns in years gone by that if states had a verified burden of disease, the state might start to fail and that would lead to instability and the potential for terrorism and so on—all those sorts of things are bound up with the whole state instability.

As it happens, I don't think I am convinced by that. There is not the evidence that states have collapsed. You looked at HIV and AIDS, for example, where this is a long-wave event and, prior to more recent treatments, you would be living and dying with HIV over a very long period of time, becoming increasingly a burden on your family and on the state, posing huge burdens. There was a very real fear that states could collapse as a consequence of that, particularly because HIV was not limited in terms of its impact. Quite often, to use International Crisis Group's terms, it was the glue that stuck society together. It was teachers and police who were suffering from it, and there was a fear that states would collapse. We didn't see that, despite horrendous prevalence rates in southern Africa.

So, the argument that you would see state instability has yet to be demonstrated. The argument is there, but there is no empirical proof for it. Nevertheless, you will find people who argue that if the burden of disease grows too high, the state might fail and that might open up the way for instability and potential terrorism.

Q15 **Stewart Malcolm McDonald:** Dr Wenham, do you have anything to add to that? Would you say that because of the focus on covid-19, other health threats have been overlooked for the past 12 months?

Dr Wenham: I will just jump in on that non-communicable disease issue and whether we should consider that as a health security issue. I think we have to be careful. When we consider something a security issue or securitise a disease, it produces a particular policy pathway, which is, "We need to combat this at all other costs." As we have seen with covid, we have let cancer waiting lists grow, risks to maternal safety and all sorts. We have to not securitise everything and keep that area just for the big ones that emerge.

Beyond the macroeconomic that Colin talked about, we know that in covid, for example, non-communicable diseases are a direct risk factor for how you are going to be able to cope with the disease. We have seen a

particularly high prevalence of severe outcomes among people who are obese or who have other underlying health conditions, so we have to think about those things as part of a whole and not separate from it.

The last thing I would add would be that these non-communicable diseases and neglected diseases, such as the diarrhoeal diseases that Colin was talking about, are also diseases of inequality. They disproportionately affect the poorest and most marginalised in a society. I think there is a tension between wanting to create health security policy—which has been widely criticised, at least in the academic literature, for being western-centric and focused on the status quo—and then reaching out with the same policy space to areas of inequality. I would argue that it is really important because we need to make sure that everybody enjoys the best health possible, but there is a conflict between those two areas in that space.

Stewart Malcolm McDonald: That's all from me for now.

Q16 **Royston Smith:** Thanks to both our witnesses for giving up their time. The 21st century has seen several global disease outbreaks, including Ebola, SARS, MERS and H1N1. How well do you think the WHO responded to those outbreaks?

Dr Wenham: I think the WHO have done a pretty good job in this last decade of global pandemics.

Starting with SARS, the WHO's efforts were relatively unprecedented. That was a time before the international health regulations, and the WHO went beyond their legal or policy framework to be able to try and bring about the end of the pandemic. Many Governments criticised the WHO at the time because they put in travel restrictions that they were not legally able to do. But they did manage the pandemic pretty well in a relatively short timescale, and with relatively few deaths globally.

Then we fast-forward to H1N1: we have the WHO again acting quite decisively. That was the first time we saw a declaration of a public health emergency of international concern. They raised the global alert, and that is something that is happening here. Governments started to prepare, and they listened to the WHO. We see that this was the pandemic that never was. The problem with these public health interventions is that we do not see the ones that are really successful, such as the H1N1 situation. The WHO have to be given credit for sounding the alarm.

Ebola was slightly different. The WHO are quite a dynamic organisation in the way they respond to health emergencies. They were criticised for acting too soon and for crying wolf with H1N1, so when Ebola came along they delayed action for a certain amount of time. They misread the signals for a bit, and did not understand the risk of a second wave and all the competing social factors around micro-populations and porous borders. But when the WHO did move, they managed to actually do quite a good job of coordinating the response to the epidemic with the budget they had.

What Ebola showed us about the WHO, though, is that there is a mismatch between what the WHO are mandated to do—to be the technical organisation and the normative body—and what the world expects them to do. The world wanted boots on the ground and wanted the WHO to deploy a force of people to manage the pandemic. The WHO did not have that capacity but, again, they did learn from that.

In the wake of Ebola, we saw the WHO creating the Health Emergencies Programme, which was trying to operationalise some of their activity in responding to the need and demand of member states. On the dynamic journey, again, we saw the WHO act very quickly with Zika before we had evidence, to learn from Ebola and show that they were on top of their game and able to manage the situation. The WHO were almost overly precautious, but that is a good public health approach to take.

In the coronavirus pandemic, the WHO have—again—done a pretty good job, given the amount of money and power available to them. They declared a public health emergency within less than a month of the first cases being detected, which is pretty quick.

The problems faced by the WHO have not been in producing guidance or in an inability to move; they have been in Governments not listening to them. That is not necessarily the fault of the WHO, although the WHO could obviously do more to win that trust back. The WHO are still the leading institution in that space to manage outbreaks, and they do a good job.

Q17 **Royston Smith:** You have touched on much of this already, but what are the lessons to be learned internationally by Governments? You know more about this than I do, but people will criticise the WHO on some of their announcements and handling of this pandemic. You suggest that the WHO have done a pretty good job under the circumstances, so what lessons should be learned from this by Governments, if not the WHO?

Dr Wenham: I think we need to understand why Governments are not listening to the WHO, and we need to rebuild that trust. A key lesson for Governments is that if the WHO are giving advice, it is the best technical guidance out there.

The WHO have wide convening power, excellent expertise, and committees of all kinds compiling all the best information. That is the global best practice guidance. Governments should try to follow that. The WHO do not put out temporary recommendations in response to a pandemic just for fun; it is because this is the best evidence that we have at that moment. We need to get Governments recommitted to following those guidelines. That is not an easy process.

There is a tension between, "We need to act now; this is the best practice," and Governments delaying and focusing on different areas of pressure. I am very aware that the WHO are putting out only public health guidance for the best public health approach and, obviously, Governments have to consider everything else that might affect them.

Somehow we need to get Governments to give the WHO that power and to follow it. That is not just more money, although we obviously need more money in the WHO, but trying to work out how we get Governments to follow these rules. It is not just for us in the UK. We want everyone to play by the rules, so that we can get the best information.

If everyone is sharing data and epidemiological information, we'll know about pathogens sooner. We will be able to launch a global response sooner. We all have to play by the rules and all commit to an organisation such as the WHO to be able to manage future pandemics.

Q18 **Royston Smith:** I suppose the challenge is the question Graham Stringer asked about vaccines and the answer that Professor McInnes gave in a roundabout way. The WHO suggested that we should have been sharing our vaccines with other parts of the world earlier. There is that tension about what countries do, in spite of the advice they might be getting from the WHO, isn't there?

Dr Wenham: It is a difficult one. The WHO have proposed two different things on vaccine sharing. They obviously have the COVAX scheme, which is a donation mechanism, whereby we will give a certain percentage, either of money to buy vaccines and/or share our vaccine supply, for example, as we are seeing in Norway.

The other mechanism they are now pushing is the waiver of intellectual property and meaningful tech transfer, so that low and middle-income country production facilities can start to produce the vaccine for distribution elsewhere in the world.

That is obviously a loaded issue, full of concerns about trade and the future of IP. I am sure that pharmaceutical companies don't want that to happen, for obvious reasons. As a form of developing capacity for future pandemics, developing research capacity to be able to develop the vaccines, to be developing manufacturing capacity for all drugs and pharmaceuticals is a strong model—building capacity elsewhere in the world, rather than being reliant only on similar locations.

That is why the WHO, with a member state body of 194 member states, think that is the best approach. They want to try to break down some of the reliance on donor states. That might be different from the UK's position, but the WHO is a global body, trying to think of the best global solutions.

Q19 **Royston Smith:** Professor McInnes, would you like to add anything to that?

Professor McInnes: I would. I very strongly agree with what Clare has just said. It is quite easy to take pot shots at the World Health Organisation when it fails. In the 1990s, its failure on HIV led to the establishment of UNAIDS. Its failure to eradicate polio led to Rotary International stepping in and doing that. Its failures during the early stages of Ebola were clear.

Its successes tend to be hidden. We think about the early stages of Ebola; we don't think about the later stages, when the WHO was central to the speeding up of developing vaccines for Ebola. There are certain things it can be good at. It is a bit of curate's egg, I'm afraid.

One thing that strikes me is that this is part of a UN system and, therefore, we think about UN reform, improving transparency and accountability. Maybe we should start applying those, too, to the WHO. Having dealt with it directly, you do get very frustrated sometimes about the lack of transparency and accountability in certain parts of the WHO.

That is completely offset when you see some others literally putting their lives on the line, in going to places where there are disease outbreaks of a new and potentially fatal disease. They have a terrific convening power of getting some of the best scientific minds together and the moral authority that they can sometimes mobilise.

It is an incredibly frustrating organisation to deal with, but I think that, overall, we need to ensure that it can provide the leadership in a transparent and accountable manner. That is where it has failed sometimes: in ensuring its capacity for leadership, its transparency, and its accountability. When it fails to do that, we start seeing the difficulties.

Q20 **Chair:** On building up that credibility, there are three areas of gap, if you like. One is that the co-operation with China has been criticised; the second is the pick-up rate of some of the major industrialised countries that could have listened to its advice but did not; and the third is the ability of the WHO to fill the gap as a public health expert for countries that do not have public health expertise of their own. If I am right, those are the three areas of criticism.

May I very briefly touch on that, Professor McInnes? First, the China question is a problem of power within the UN organisation, I would suggest, rather than a WHO-specific one, although you could raise some comments about the director-general's willingness to push back. Or do you think I am being unfair?

Professor McInnes: I think the director-general has been in an invidious position—particularly during the Trump Administration, when the United States were explicitly about to pull out of the World Health Organisation, causing major funding difficulties. The next most powerful state in the world is China—are you seriously going to push back very hard against China?

The director-general was placed in a very difficult position, but that is when you want your leaders to stand up and say, "Well, actually, I am not beholden to one particular country, whether it's the United States, China, Russia or the UK. I am the director-general of the World Health Organisation, and the answers China has given us are not satisfactory, and the access it has given us is not satisfactory. I am pushing back on that." That, I think, was a failure of leadership. I would stick to my guns here and say leadership, transparency and accountability. That was a

leadership issue on which the World Health Organisation did not cover itself in glory.

Chair: Okay, thank you very much. Chris?

Q21 **Chris Bryant:** May I ask about the international health regulations? As some of your written evidence suggests, they are a slightly fraught area and, bearing in mind all the other things you have said, I wonder whether you think they were up to scratch. Is their proper reform deliverable?

Professor McInnes: I think that, for all their weaknesses and faults, we are better with them than without, and renegotiating them might prove horrendously difficult. It took multiple years of effort to negotiate the revisions in 2005. What we have could be workable if states had the capacity to actually deliver on them.

There are two areas of weakness I would focus on. The first is the issue of disease surveillance, which is what most people focus on with the international health regulations, and the way in which it tried to open that up a little bit so that states could hide what was going on. Clearly, that is not working as well as we would hope. There are ways in which we could improve that, but it is always going to run up against the issues of state sovereignty. The World Health Organisation is a member-state organisation, and the states are the high-contracting parties, so you are always going to have that problem there.

The second area is national capability. Eight core capacities are outlined in the international health regulations, including things such as preparedness, response, laboratory capacity, communication during the risk, and so on. The World Health Organisation does this joint evaluation on a periodic basis. That shows that the overwhelming majority of states are failing to meet their eight core capacities. Oftentimes, it is due not to a lack of willingness, but simply to the costs. Provision of laboratories, of preparedness and of plans—all those things come down to capacity issues.

Before we scrap the international health regulations, we should look at what we can do as a global community—I am thinking about the G7 that is coming up—to implement them more equitably and make sure that states who are at the moment unable to implement them are given support so that they can. At the end of the day, it could be in our interests directly to do that if diseases emerge in these states and start to develop momentum such that they affect us eventually quite dramatically, as has happened with covid.

The IHRs need to be worked on in terms of trying to make them work. I don't want to scrap them, but I do think that the aspirations on the surveillance side are going to be hugely problematic for the foreseeable future because of the issues of state sovereignty.

Q22 **Chris Bryant:** I presume you accept that, for instance, the US ban on China failed to comply with the IHR.

Professor McInnes: Yes—I think. I would not want to be absolutely certain on that, but I think it did, yes.

Q23 **Chris Bryant:** Have we complied with them throughout?

Professor McInnes: The international health regulations? It is not a binary, so you don't either comply or not comply. It is the degree of capacity that you have to meet the core capacities. We are pretty close on most of them.

Dr Wenham: Can I jump in and add something?

Chris Bryant: Yes—go on.

Dr Wenham: Like Colin, I think the IHR work for the most part, and I don't think we should scrap them at all. But if you break them down into the three different components of an outbreak—preparedness, detection and response—you see different levels of ability.

On the preparedness efforts, which is what Colin talked about—the core capacities and how ready are countries to be able to respond to a pandemic—most countries have tried as much as possible to meet those core competencies, as Colin has highlighted. We see that most high-income countries have met them, or almost met them. It is countries with less capacity that have struggled, but we do see, as per article 43 of the IHR, support from high-income to low-income countries to try and build some of these capacities. I think that bit is working. It just takes time to work.

The detection part is also working. We pick up diseases pretty quickly. We are able to then use, as Colin mentioned, different surveillance mechanisms, both state-based and non-state-based technological solutions, to identify outbreaks and then share that information through other Governments.

What has been exposed by covid is that there is not enough on a response part in the international health regulations. They are designed to never get to the stage of a major pandemic; they are designed to prevent a pandemic. We don't necessarily have that legal framework, or normative framework, for how Governments should respond at the point of crisis. The WHO puts out temporary recommendations, but I don't think that bit has been thought through enough.

Again, opening up the IHR is a risk. You might lose more than you have, but there are other models. You could use the RevCon model that we see at the biological weapons convention, where states meet biannually to reinterpret what the regulations mean and to create new normative standards around that.

Linked to this whole IHR conversation is that these are technical instruments. This is technical guidance that has political overtones. I would argue that the regulations work as a technical instrument; it is the political commitment following them that is missing.

Linked to this conversation is what happens next with the pandemic treaty. The pandemic treaty, which was proposed first by the EU and now by the WHO—and more recently by Boris Johnson as part of the UK presidency of the G7—might be a way to bring in political commitment to the IHR, but it should be done in collaboration. You should not replace, but simply add on that political arm.

Professor McInnes: Can I follow up on that a little bit? This is a good example of where the World Health Organisation can act. It identified the problem in developing the core capacities and in identifying the fact that large numbers of states lacked the ability to respond. What the World Health Organisation has been trying to do is produce a framework so that militaries can be mobilised during a health emergency and work within a public health infrastructure in states to support them, much as we see the British military doing to a certain extent in the UK at the moment. For a number of states, there just is not that history, that structure for the militaries to assist, but there is the capacity within militaries, ranging from embedded medics within the military, through to the ability to construct infrastructure.

This is one of the areas where the World Health Organisation is actually trying to make the IHRs work, by looking at the inability of some states to respond effectively and saying, "Actually, if you used your militaries here—and we can help you understand how they can be used—then you can address some of the deficiencies in your ability to respond."

Chair: Thank you very much. Henry, you wanted to come in on the G7, and then I am going to come to you, Stewart.

Q24 **Henry Smith:** Mention was made just now of the G7 presidency, which the UK holds at the moment. I want to get both of our witnesses' views as to whether the UK should be using this as a moment to pioneer a new approach to global health security. If so, what should the priorities of the UK Government be when it comes to health during the presidency?

Professor McInnes: I am going to start with a negative: one of the things that we should not do is simply rest at a declaration. I am sure there will be a declaration. There usually—there was one after Gleneagles. I think back to 2006 and the Oslo declaration on global health security, which had a lot of fanfare but did not actually translate into an awful lot of action. If we are going to do something, it has to be tied into some credible action that can be done.

There are two areas that strike me. One is the governance deficit. We are seeing a very crowded marketplace in terms of all global health organisations. It is no longer just the case that it is the World Health Organisation. There are a very large number of international organisations, charitable organisations and even individuals, such as Bill and Melinda Gates and their foundation—very powerful players. This is a very crowded marketplace and it is very diffuse and lacking any sense of coherence. If some sort of framework can come out of that and we pull it all together and say, "Look, these are the key principles that we are all

going to work towards," that is a hugely ambitious target but one worth trying for.

The second is perhaps less ambitious, and that is to think about what we can establish that will support the World Health Organisation in terms of emergency response—if you do have a health crisis, whether it is Ebola in the DRC, SARS in Hong Kong or wherever, that there is some sort of capacity to respond very quickly to that. The WHO has been trying to develop this and it now has a much larger budget for it, but getting the weight of the G7 behind that, given the variety of membership of the G7, might be something we could look into doing—some sort of emergency assistance, emergency programme, co-ordinated between the G7.

My Hail Mary, if you like, is to have some sort of framework for global governance to address this inchoate mess that we have at the moment. My less ambitious goal is trying to think through how the G7 can work with the WHO and support it—conceivably, possibly even independent of it—so that it can react to a global health emergency when it emerges, and react very promptly.

Q25 **Henry Smith:** Dr Wenham, do you have any comments on that?

Dr Wenham: The only thing I would add—and I think that the pandemic treaty is going to be the thing that the G7 is going to look to—is that, for me, the key thing that the G7, or anyone reviewing global health security now, should be doing is looking to address the actual problems we have, rather than trying to create policy solutions for problems that I do not think are so important. The big one is political commitment. If the G7 can get political commitment, somehow, in a treaty linked to the WHO and to the IHR, that would be a great success.

However, the other thing that the G7 could do is really think through financing for pandemics—that is a key gap. For example, how do we finance not only building capacity around the world to be able to prevent pandemics? At the point of a disease emerging, when we have requirements to report, under the IHR, to the WHO and that information is then shared, there is no money available to then do the next step. We really have to think through sustainable financing mechanisms linked to a public health emergency of international concern declaration. Not only would that incentivise reporting—if you know that if you report, there will be money there that you can then draw down—but it would also mean that we are able to move much quicker.

The World Bank tried to do this in the wake of Ebola, with the pandemic emergency financing facility, which has simply failed because the criteria for the deployment of this money were too stringent, which meant that it did not pay out until May 2020, by which point it had obviously turned into a pandemic.

We need to think through other ways of drawing down money from an emergency fund in the IMF, or creating an emergency budget line at the WHO as an insurance mechanism that Governments can pull down, or user

insurance for those who are most likely to lose out in a pandemic. Could we take 1% of all business continuity insurance and put it into a pandemic insurance fund at the WHO, for example? Thinking through all these different ways of finding meaningful ways of being able to respond to a pandemic is something which the G7 with its clout—financially and in a public health space—could really do.

Q26 **Stewart Malcolm McDonald:** Can I talk about the early warning systems? If we go back to the Prime Minister's speech last year at the UN General Assembly—it has been referenced already—he said at the time that he wanted to design a new global pandemic early warning system. Can you talk me through the early warning systems as they exist now? Do they need to be reformed at all?

Dr Wenham: I can jump in, Colin, unless you want to start.

Professor McInnes: Yes, I am happy for you to start and then I will follow up.

Dr Wenham: I think this is one of those things I mentioned before, which is trying to find a policy solution for a problem that doesn't really exist. I think we have good functioning early warning systems for disease control. We have the EWAR system, which is the member state system through to the WHO, where Governments have to report diseases. It is not full proof. This is where we get state sovereignty interfering, but for the most part it is well used, we get a lot of noise from it, and the WHO is informed about a lot of outbreaks from it. Supplementing that, we have GOARN, which is another WHO initiative—the global outbreak alert and response network—which has a horizon-scanning approach, reading media sources and all sorts.

Then we have online systems like HealthMap and ProMED-mail, which are online mechanisms. ProMED-mail is a clinicians' forum, for want of a better word, where you can type, "Someone came to see me today who had these symptoms," and that is able to detect clusters through IP addresses. HealthMap scans media sources—social media, Google searches—to identify clusters. HealthMap and ProMED have detected coronavirus ahead of Government. They detected Ebola ahead of Government. We know about these things.

Again, I feel a bit like a broken record in this: the problem is that we have this early information, but what do you do with that information when you get it? Fundamentally, if we had known about coronavirus a week before we did, I don't think it would have led to a different outcome. I don't think we would have suddenly changed the response that much. The gain of a couple of days, compared with actually addressing the main problem, which is, "Why don't Governments do more in the early stages of a pandemic to respond?" is a really big question.

The other part that could be improved is that we know that a lot of pandemic events or epidemic events start out as zoonoses. We know through the OIE and FAO that there are number of early warning systems

in the animal health community. There needs to be slightly more joined-upness between those systems. There is the GF-TADs and GLEWS, which I am not an expert in, but I understand that they detect animal health emergencies. How do we feed that information? I am sure that it is happening, but greater awareness of that link might be one way to improve it. But ultimately, I don't think we need a new institution.

Professor McInnes: We are a world away from 2002, when the Chinese could almost hide the outbreak of SARS for a number of weeks, if not months, before it went international in Hong Kong. It is much more difficult now for states to hide it, but it still does happen, and it still slows the response.

With covid, it probably wouldn't have made much of a difference—Clare's right there—but with some other diseases, pandemic influenza for example, it might make a really significant difference. If you leave it by one or two weeks, a highly transmissible disease is all of a sudden international and is being transmitted very quickly. Sometimes, a small amount of time can make a really big difference. We are in a much better situation than we were before, but there are still problems.

The other major improvement are the algorithms for using social media. A few years ago, there was Google Flu Trends. The idea was that by spotting and geotagging people searching for flu symptoms on the internet, you could spot clusters. It didn't work for all sorts of reasons and was described as an "epic failure". We are a lot better now. The algorithms are a lot more sophisticated and we can use social media and other online sources to start to understand what is going on. That sort of technology has come on in leaps and bounds. Our ability to use social media sources and those sorts of things is now much better than 10 years ago.

There are potentials there, but there is a limit to what we can do. It's not like improving some sort of surveillance technology—some sort of radar or lidar or something like that. There are real limits to do with the number of clinicians and laboratories you've got and so on. If a disease emerges somewhere and you don't have the clinicians and the laboratory technicians to analyse it and say, "This is actually something different and it is causing a lot of deaths," rather than something else causing those deaths, you are stuck. That's not the fault of surveillance, in the sense of looking in. It is the fault of the public health infrastructure not being able to spot and diagnose these things quickly enough.

Q27 **Stewart Malcolm McDonald:** Okay. Let's go back, then. The Prime Minister wants to reform the early warning systems. Presumably that is still his policy as we sit here now. What challenges is he going to face in trying to reform early warning systems, in your view? I don't want to use the term "fool's errand", but is it worth doing at all, in your view? I can't pick up from either of your answers whether this is a worthy pursuit that the Prime Minister wants to undertake.

Professor McInnes: I think there might be marginal gains, but whether it's worth the effort to be expended is questionable. As Clare said, we've

got a number of surveillance systems already up and running. It's not as though we've got nothing there. We've learned the lessons of SARS in 2002-3. We're in a much better position and I think we are getting to the limits of what we can do, given political restrictions and given the sometimes lack of laboratory capacity in states around the world.

With flu, one thing you have are the WHO co-ordinating centres. New samples for flu are sent to the central centres, which compare them to databases and so on. That is a very well-established system. Of course, sending samples takes time and so on. For a new disease, sometimes you are not aware that it is a new disease, a new zoonotic disease or whatever. You just assume that it's something else and miss the fact that it's a new variant or a wholly new disease sometimes. That's where you get the really difficult problems in surveillance: when it is something that is wholly new, but it looks initially as though it might be a familiar disease. Ebola wasn't quite that, but they misdiagnosed the first few cases of Ebola, for example. They didn't recognise it as Ebola; it was misdiagnosed as some other diseases.

It is that in-country laboratory infrastructure that is going to be hugely costly to do. That is why, unless you actually can do that, which I doubt we would be able to do, the gains are going to be pretty marginal. Sorry to be a bit sceptical on that, but that is my view.

Q28 **Stewart Malcolm McDonald:** No, you are the expert, and we are here to pick your brains on these matters. If the Prime Minister wants to go ahead with this new early warning system, is he likely to get much buy-in from other members of the WHO, for example, do you reckon? Do have any views on that, Dr Wenham?

Dr Wenham: I agree with Colin, but probably would be more extreme and say that I don't think it is a good idea. I think it will not make much difference in the big picture, and there could be better use of that money in the global health security space. For example, when we find out about these outbreaks through the early warning systems that we already have, do we need a mechanism under the IHR or elsewhere whereby Governments do a risk assessment? How would that play out in my healthcare system? It is those things that we need to have, rather than the means of detecting an outbreak sooner. We need to think about the IHR and the response mechanisms, and having a workforce who are able to respond. I think the money would be much better spent elsewhere, than actually doing as proposed. I don't know whether other member states would agree, but I think there would definitely be pushback from the WHO, because they would say we have this in-house and online. Why not increase pay for healthcare workers, or increase the number of healthcare workers who are able to respond?

Q29 **Stewart Malcolm McDonald:** Perhaps I am not being uncharitable by saying that it's a fool's errand.

Dr Wenham: I don't think it's the best use of money.

Q30 **Stewart Malcolm McDonald:** Anything else to add on that, Professor?

Professor McInnes: No, I think you have summed it up quite nicely as a fool's errand. I think there are better things to put political capital and finances into than this idea.

Q31 **Stewart Malcolm McDonald:** I accept what you have said, and agree in large part, but if we are to have the introduction of, say, an intermediate regional public health alert system, is that worth pursuing? Perhaps something at a European level, forgetting the fact that we are not in the European Union. Or, from what you have just said, Dr Wenham, and as you said, professor, you are actually better in investing in your own lab capability and healthcare capability? Is that just the better thing to do, rather than worrying about a problem in terms of early warning systems, regional or beyond, that doesn't really exist?

Dr Wenham: Are you getting at this question of an intermediate tier of a public health emergency?

Stewart Malcolm McDonald: Yes.

Dr Wenham: We have done quite a lot of work on this, and I don't think that this intermediate level or regional public health emergency declaration will actually work. If you think about what the problems are with the fake mechanism—and there are plenty—the director general and the emergency committee that advises the director general on the declaration of a public health emergency sometimes don't want to overreact and overpanic, and they perceive that there might be knock-on economic and trade effects, so they try to avoid declaring. They have states pressuring them not to declare, which we saw during Ebola and again during coronavirus when states said, "Please don't declare, because we are worried about what might happen." We then have Governments who ignore that information when it comes out.

Introducing a tier system does not get at any of those problems. If you look at other policy mechanisms that have tier systems—for example, the integrated food security classification for famine, which has one to five tiers, or the US national terrorism alert, which has tiers, and the UN humanitarian emergencies tiered system—basically nothing happens until it gets to the top tier anyway. It just creates an arbitrary, technical level, which does not inspire action.

I fear that if you brought such a mechanism into a public health emergency, you would have technical indicators that wouldn't really mean anything, and no one would do anything and no Government would respond until it got to red alert anyway. That would lose the normative power of the tool to call Governments to account. I think we would see it politically stuck at amber a lot. The immediate response would always be to declare something at amber, because the WHO would want to err on the side of public health caution, and member states would want to push away from that alert being red because of the risk of travel restrictions. That would just dilute the power further.

If you think about a regional public health emergency, you risk the balkanisation of a response, which is that you have Governments globally

that support each other in responding to epidemics, as we saw in the Ebola outbreak, when the UK supported Sierra Leone. We support lots of Governments around the world in emerging infections. The risk of a regional one would be that you would not support something that was not in your region, for example. In the political economy of how epidemics are financed, or the response to financing, that is a real concern. If they also take in the reality of globalisation, which is that pathogens spread globally—it was not that covid went from China to its regional neighbours; it went from China to Iran to Italy—I think we have to recognise that that is not going to work.

While there are problems with the PHEIC mechanism and getting Governments to do anything, the intermediate tier is not going to change that. If anything, we need to strengthen it, because the WHO declared a public health emergency on 30 January 2020 for covid and that did not do enough. That made the WHO then declare a pandemic on 12 March. The pandemic does not have any legal status, it is not part of the IHR, but the idea was that this was not having enough of an effect, so we needed to do more and use stronger language. I do not see how diluting the language is going to help.

Q32 **Stewart Malcolm McDonald:** Professor, do you have anything else to add?

Professor McInnes: Yes. My understanding is that the World Health Organisation does have a number of levels of response underneath the public health emergency of international concern—the PHEIC—but nobody pays any attention to them. Everybody in the field understands the PHEIC, but there are four other levels, if memory serves, and they do not really do an awful lot. They could. We all know that tiered responses can lead to resources being opened up, the establishment of gold command structures, all that sort of thing; you could do it in that way. However, the way in which it is working out is that does not happen and I suspect that it is because of the politics involved. You really do not want to start pressing an alarm button because of the damage that might do to your tourism, to your economy and to various other things. So people are very cautious about pressing emergency buttons. That is why I think this is not a very satisfactory way of going about it.

On the regional thing, I agree with Clare completely. Viruses spread globally very quickly. International travel will spread them. Air travel in particular will spread them very quickly indeed. I do not think that you can contain diseases to particular parts of the world unless they are very particular forms of disease where the transmissibility is quite difficult. Ebola, for example, is quite difficult to catch in comparison to covid and certainly compared to flu. There may be some of those—haemorrhagic fevers and so on—where you can try and localise the spread. However, most of the diseases that the UK is going to be most concerned about are going to be very quickly transmitted and a regional approach is not going to be particularly effective.

Stewart Malcolm McDonald: Thank you, both. Thank you, Chair.

Q33 **Graham Stringer:** Before this pandemic, the country stood pretty well on the Global Health Security Index. Where do we stand now when you look at international comparisons of infection rates and death rates? Although they are not exact, we have not done so well. If we have gone down the list, does it really matter?

Professor McInnes: It probably matters to some people, but it does not matter to me particularly because these lists are always subject to what you are actually measuring, and different measures will give you different results and could be equally legitimate. I am not overly worried about that. I do think that the UK's response to covid threw us into sharp relief. There was a certain complacency prior to covid that we had a very advanced public health infrastructure, we had advanced medical facilities, particularly in hospitals, and we could probably deal with these things. The reality, of course, has been shown up—we actually lacked large areas, particularly in terms of ICUs and so on. It actually revealed some of the deficiencies and some of the complacency, perhaps, that we originally had.

As for our international standing on health provision and so on, I do not think has been particularly badly hit. Clearly, the United States has suffered more, through a combination of its clear mishandling of covid and the Trump Administration's overall attitude towards a global crisis, which seemed wholly lacking in any form of leadership whatever. If the United States were seen as the leading nation prior to covid, it certainly is not in that position now; we are nothing like that.

The British system has worked up to a point, but there are clear stresses there. We assumed that we would not have very large numbers of cases if there was a pandemic; we were wrong. We assumed that we had an integrated system; devolution has shown that sometimes different parts of the country go off in different directions and, as someone living in Wales, I am very aware of the differences between the Welsh and Westminster responses.

We have been shown up as not as quite as good in our response as we would have liked to have been seen, but I do not think that our standing has been particularly damaged. The Oxford vaccine and the way in which we have tried to deal with this through lockdowns, in comparison with some of the states in the United States of America, have shown that we are pretty serious about these things. I am not too worried about international standing, I must say.

Q34 **Graham Stringer:** May I take Dr Wenham back to an answer she gave some questions ago? She said that the best expertise was with the World Health Organisation. That assumes that there are technical answers to all these questions and that all scientists, all clinicians, agree on what the response is. If we look at social distancing or the wearing of masks, there are very limited amounts of research and very different recommendations from serious scientists. Are you suggesting that we should listen to the World Health Organisation if it recommends different things from our own scientific and medical advisers?

Dr Wenham: I don't necessarily think that those things are separate. The epistemic community of scientists is both national and international, and UK scientists and scientific advisers also advise the WHO, so we should not separate them entirely. What the WHO does is not only to get data from states directly, but to synthesise all the evidence out there to make its conclusion. That then puts it in a position to be able to take in all the different expertise and opinions to formulate its opinion.

Where we see criticism of the WHO is of its early guidance on face masks. That was because, in the absence of evidence, it did not recommend them. That does not mean it has not now changed its opinion, just as the UK Government have. We have to recognise that this is a learning process, as is all science, and we have to make the best decision on the evidence that we have at any one time. Personally, I believe that that often comes from WHO, but we have to remember that it is putting out public health guidance and is therefore limited in its ability to integrate that alongside the political, social and economic costs that are left to Governments to weigh up—the science alongside all those other factors.

Q35 **Graham Stringer:** Thanks. It is a question of authority—because the science is not exact and is developing as we learn more about this disease, there are judgments to be made. One of the other things you mentioned was the transferring of intellectual property rights. I do not know this: is it the World Health Organisation's view that intellectual property should be made free, that patents should be made free, to developing countries?

Dr Wenham: The IP agreements under WTO regulations have an exception to be waived in times of a public health emergency or public health crisis. We have seen this only once before, which was during the HIV epidemic in South Africa, where it was waived to allow South Africa to buy generic production antiretroviral drugs at much-reduced cost, to be able to do it. The WHO's position on this currently is that this is obviously a public health emergency and, therefore, we should waive the IP regulations. But because of the difference of production between making antiretroviral treatment and vaccines, it needs to come alongside meaningful tech transfer, whereby we build capacity and expertise in production facilities elsewhere in the world. That will not only allow us to rapidly scale up how much vaccine we can make now; we will also have that pipeline there for future emergencies and future research and development, and it might lead to new treatments and new products in future as well.

Q36 **Graham Stringer:** I understand the situation in South Africa. Isn't the development of vaccines different? If you are transferring production, don't you hit a regulatory barrier whereby each unit of production has to get new regulatory approval, which actually slows the dispersal of the virus to other countries?

Dr Wenham: I am not in a position to answer that question. I would not know the detail of that, but I know it is something that the WHO are

seriously exploring and pushing for. I don't think they would be doing that if there were going to be further barriers.

Graham Stringer: Can I put it on the record that Professor Sarah Gilbert, who developed the Oxford/AstraZeneca vaccine, said it would really be very damaging if intellectual property was spread in that way? But I accept that it is not your expertise. Thank you.

Q37 **Chair:** There are just two very brief final questions before we wrap up. The first is looking ahead. Do you think covid-19 will make public health a higher priority in terms of foreign policy? Professor McInnes, perhaps you could answer. I hope the answer to this is yes.

Professor McInnes: In the short term, for sure. In the short term, definitely, but you have to be a little bit sceptical that when the next international crisis comes along, attention will shift on to more traditional forms of diplomacy and more traditional areas for foreign policy. I am a short-term optimist and long-term pessimist on that.

Chair: Dr Wenham, do you agree with that?

Dr Wenham: I do, although I would say the slight difference is that we have not seen a pandemic of this scale in our lifetimes, and I think that will build slightly more longevity into it. I cannot see any Government in the next 20 or 30 years ever saying they should not be investing in pandemic preparedness, but we need to develop ways to ensure this and make sure it is continued. We can think about either ring-fencing budgets or pandemic preparedness efforts. I know that Jonathan Ashworth this morning was suggesting having a requirement to report on pandemic preparedness by the Secretary of State for Health every year as a way of trying to maintain capacity in the UK, so that we do not become complacent on how ready we are to do it. More simple efforts like that could be brought in to safeguard against future apathy on pandemic preparedness, but I would like to think that while we will see an immediate investment and then gradual decline, it hopefully will not be quite at the same rate that we saw post Ebola, just because of the magnitude of the issue.

Q38 **Chair:** It's the old banker's line, isn't it? Those who remember the last recession are the only ones who prepare for it, although this time I think it is a bit different. I can tell you my six-year-old son will remember this for his entire life, and maybe even my four-year-old daughter will. It is likely to mark not just an entire working-age generation, but literally everybody who has been born over the last few years.

Dr Wenham: I think that is important, though, because it means that voters are going to remember this. In previous outbreaks, it has been the public health community that remembers Zika and Ebola. I know I as a voter want to make sure that our Government and future Governments do not forget this. Because it has affected every part of people's life and society, hopefully that is something that will last.

Professor McInnes: Can I intervene? Over the past 10 years pandemic influenza has been the most likely, most dangerous item on the UK risk register, other than more traditional defence and security threats, and very few people registered its presence there. I think that is going to change now.

Q39 **Chair:** I think you are absolutely right. May I go on to one last brief question? By what metrics should we judge the effectiveness of the Government's approach to health security? The metrics could be either the rise of various potential pandemics in other countries that are stamped down on, or they could be the effect on the UK directly. How would you see it, Professor McInnes?

Professor McInnes: I think this is an incredibly difficult one because there are so many variables in play to determine success, ranging from the mortality and morbidity rates of the disease, through to how you know that something didn't happen because of your policies.

I am a fan of KPIs in certain areas where you can actively measure things, but I don't think this is something that you can measure in such a precise manner, so I think it is much more of an intuitive judgement rather than a more traditional audit, perhaps. I do not think this is something where you can measure it, but it is something that you can analyse afterwards and have a sense of whether it has been successful or not, but I would not really want to put a KPI against it.

Q40 **Chair:** Okay. Do you have any last points on that, Dr Wenham, before I invite Stewart to ask his last question?

Dr Wenham: I think you would have to bring in a range of different things. I don't think they would necessarily be fully comprehensive, as Colin has suggested. I think you could make sure that there are risk assessments done at every outbreak that emerges, see how the Government is scoring and put those on public record. We can make sure that the budget lines are contained, and that table-top pandemic exercises continue, so we know what we are dealing with.

We can make sure that we are compliant with the IHR and other regulations that might come in in the future, but those are all part of the story. As Colin said, there is not going to be one answer; a bit of everything is always going to be good. Keeping track of what we are doing and spending, and making sure that continues, is vital.

Q41 **Stewart Malcolm McDonald:** Thanks to you both. I think you have given fascinating evidence this afternoon. You will know, I am sure, that next week we are expecting the integrated review to be published. It will be announced by the Prime Minister, no less, next Wednesday, on security, defence and foreign policy. If there were to be one or two big headline things in the review that would make you think, "Oh wow, this is potentially game-changing for the better," what would they be? I don't want to open up a whole new 25-minute discussion—I am sure that my fellow Committee members would kill me—but could you briefly say if there were some properly game-changing things in there, what would

they be, in your view?

Dr Wenham: There is one thing that strikes me immediately. It might sound a bit left field, but if you are asking for game changing, I guess this would be my answer. Covid has exposed something that has happened in all previous pandemics: it is the most marginalised who are affected. We see increased rates of infection among lower socio-economic groups and among black, Asian and minority ethnic groups. We are seeing disproportionate effects, not of the disease but of the impacts of the policies associated with them, among women, single parents and, again, lower socio-economic groups.

Something that would be amazing would be recognition of that—recognition in our security policy of the differential effects of health emergencies, and efforts to really mitigate them. It is one thing to say, "This is a problem. You're more likely to lose your job if you're a woman. You're more likely to get infected and die if you're a black man." Actually trying to bring something in that changes that, and that tries to move away from a very neutral way of thinking about security policy, and reflecting the society in which policies are implemented would be a real game changer, and would be world leading in that respect, because we have not seen that coming out of other policies around the world at this stage.

Q42 **Stewart Malcolm McDonald:** A greater emphasis on human wellbeing security, as much as tanks, drones and all the rest of it. Professor, anything from you?

Professor McInnes: I am going to pick on one very specific but very important issue: the mobility of health professionals. We are very lucky in this country that a number of health professionals come from elsewhere, many of whom may be trained here, and stay here and work in our national health service, but sometimes that is to the cost of other countries that have a much lower percentage of health professionals per head of population. That is one of the things that we really need to address somehow—how we increase the percentage of health professionals in other parts of the world, so that they are better prepared to manage these epidemics and pandemics when they emerge. That is one of the things that I really would be pleased to see, and surprised to see.

Stewart Malcolm McDonald: Both of you said things that are music to my ears. Chair, thank you for allowing me the final question.

Chair: May I do something slightly odd, please, which I should have done right at the beginning of the session? I have to declare an interest that is unconnected to this session: I have received a donation to support an extra member of staff supporting my work as Chair of the Foreign Affairs Committee. It has been registered in the Register of Members' Financial Interests; I am just putting it formally on the record. Thank you very much, and forgive me for doing that at a slightly odd juncture before I say thank you very much to our fantastic witnesses, Dr Clare Wenham and Professor Colin McInnes.

This has been a really excellent, informative and open session. Lauren, who is the Clerk responsible, has done a fantastic job in making sure that this inquiry into global health security is well prepared. There are some really important questions here that you have helped us to consider, including not least how we co-operate internationally, what it means to be prepared, what exactly we can reasonably ask others to do, and how we can really look into the details of that co-operation, and consider it not just as security, which could taint the way in which we address it, but as a challenge that affects the British people in all manner of ways, both at home and abroad, and look at how it affects our commercial and, indeed, personal interests. On that note, may I say thank you very much indeed to both of you? You have been fantastic witnesses. Thank you very much to everybody.