Joint Committee on the National Security Strategy

Corrected oral evidence: Biosecurity and National Security

Monday 28 September 2020

4 pm

Watch the meeting

Members present: Margaret Beckett (The Chair); Lord Brennan; Lord Campbell of Pittenweem; Sarah Champion; Richard Graham; Lord Harris of Haringey; Baroness Healy of Primrose Hill; Baroness Henig; Baroness Hodgson of Abinger; Lord King of Bridgwater; Baroness Lane-Fox of Soho; Angus Brendan MacNeil; Baroness Neville-Jones; Lord Powell of Bayswater; Bob Stewart.

Evidence Session No. 2 Virtual Proceeding Questions 17 - 32

Witnesses

I: Professor Frederic Bouder, Professor of Risk Management, University of Stavanger, Norway; Professor Sophie Harman, Professor of International Politics, Queen Marys University London; Professor Colin McInnes, Pro Vice Chancellor, and Professor, Department of International Politics, Aberystwyth University.

Examination of witnesses

Professor Frederic Bouder, Professor Sophie Harman and Professor Colin McInnes.

Q17 **The Chair:** Welcome to this meeting of the Joint Committee. We are extremely grateful to our witnesses for their attendance. I begin by reminding everybody that, in terms of what we are here to look at as a Committee, we scrutinise the national security strategy and, along with that, the national risk register drawn up by the Government.

In this inquiry, we are particularly interested in the Covid-19 outbreak, not as a health issue in itself but because it features on the national risk register, which is drawn up with consideration of what risks are the most likely and would have a major impact if they occurred. It features in the

national risk register as a tier 1 security risk. On this Committee, we are looking into the handling of the outbreak as an example of what happens when a tier 1 risk occurs and what that means for the way in which the apparatus of the national security strategy and the National Security Council responds to it. That is why we have asked the three of you to come here today. Thank you very much indeed for your attendance.

There is a suggestion that the biological risks facing the UK are in fact changing as a consequence of the occurrence of Covid-19. Could I ask each of you to say what you see as the major future biological risk to our security and to identify what you see as the factors driving the risk?

Professor Sophie Harman: Good afternoon. Covid-19 has exposed the main risk, which I would always have as pandemic flu. That will continue to be a risk going forward. It is how we, therefore, mitigate that risk. The second risk, which is also reflected in the national security strategy, would be antimicrobial resistance—AMR. While those have been flagged in the existing strategies, they have lacked investment and co-ordination within the wider security framework in the UK. Those are the priorities going forward, and why this Committee is meeting.

Professor Frederic Bouder: I agree with the previous witness. In a world where we have a higher population density and a lot of movement, the kind of disease that we are seeing now and pandemic flu are the types that are most likely to hit us hard for that reason, so I would put that on top of the list. Antimicrobial resistance is also a key issue that has preoccupied the area of risk assessment and management a great deal in the past few years.

Professor Colin McInnes: I am afraid you are going to find unanimity here. We have known for a very long time that infectious disease is a major cause of concern. Going back 20 years or so, it was first identified as a major potential security risk. That has only increased over the past few years, so it did not come as much as a surprise to any of us that we had a pandemic. The surprise was that it was a Covid rather than influenza-type pandemic. Antimicrobial resistance has, again, been on the agenda for a while but at a fairly low-profile level, with disconcertingly little action about it. There have been various attempts by international organisations, up to and including the United Nations, to come up with ideas but so far we have seen too little action to address this. I am afraid you are going to find unanimity here among us on that.

The Chair: Please correct me—one of you or, if you like, all of you—if I am mistaken, but am I right in thinking that you are identifying antimicrobial resistance not only as an issue in itself but perhaps as a potential driver for other pandemics, or is that a mistake on my part?

Professor Colin McInnes: We have seen an increased resistance to not only bacteriological but virological diseases. If the vaccines and antibiotics that we have are much less effective than they have been in the past, our vulnerability to these sorts of outbreaks is going to increase quite dramatically. That is the concern for this particular area of interest

for the security dimension, although there are clearly major health implications as well, such that routine operations in the future might become much more problematic and much less safe. There is a risk that infectious diseases such as Covid and influenza, if we get greater immunity to the antivirals and antibiotics that we have, will be much more dangerous in the future.

Professor Sophie Harman: I concur with Professor McInnes. AMR is a comprehensive threat in that way. It is looking not only at pandemics but everyday routine surgeries that will have knock-on effects on, for example, maternal mortality as well as some of the existing priorities of the sustainable development goals agenda. It cuts across everything in that respect.

Professor Frederic Bouder: I would like to stress the underlying factors, which are more population, climate change and interconnected societies. Unfortunately, these patterns also increase the risk of running out of antibiotics or treatments that work, for instance.

The Chair: As I recall, the Government specifically identified globalisation as one of the driving factors. I assume that none of you would disagree with that.

Professor Colin McInnes: I absolutely agree with it. It is seen as one of the key drivers of this. I will throw in a couple of other issues that we have not mentioned, which are perhaps not of the same order of magnitude but nevertheless are concerns. One is bioterrorism. Thankfully, we have seen very few instances of that since the Amerithrax in 2001. There is also lab safety and security: the work that is going on in laboratories—academic or industrial—and the security surrounding those is of some concern. Those are not in the same league as AMR and infectious disease, but they are, nevertheless, concerns that are worthy of some attention.

The Chair: They are not so much drivers as risks in themselves. That takes us neatly on to the next question.

Q18 **Sarah Champion:** I would like to start global and then reduce it back to the UK. My first questions are to Professor Harman and Professor McInnes. Has the UK effectively used its position in multilateral organisations to promote international collaboration in response to Covid-19 and the global health security agenda? If so, can you give us examples of how that has happened?

Professor Sophie Harman: Before Covid-19, I would have said yes, absolutely, because the UK Government have a very prominent role in global health institutions, from the WHO to the Global Fund, the World Bank, et cetera. We also have a very active epistemic community in the UK. It is not just the Government but the publications, the academics and the research institutes that we have previously exported to other countries in response to outbreaks.

The UK Government's record on promoting collaboration on Covid-19 has been a bit mixed. In the initial six months, you did not see very outspoken support for the WHO, particularly around the World Health Assembly. You would have hoped to have seen that a bit more, particularly around President Trump's comments about the WHO. However, this was picked up over the weekend at the General Assembly, with the Prime Minister's statement and commitment of support to the WHO. We can also see it with the UK leading on COVAX—the joint vaccine initiative between the WHO, CEPI and Gavi. I am sorry; global health is a world of acronyms, so I am happy to clarify what all these mean. CEPI is the Coalition for Epidemic Preparedness Innovations.

We are seeing the UK Government taking quite a lead role in that now, so we are starting to see a galvanising of support, but in the previous six months there was definitely a separation. Diplomacy at the UK Government level has been quite quiet—this has picked up recently—but it has been quite vocal when you look at the wider epistemic community around global health security.

Professor Colin McInnes: A large number of us were quite disappointed in the initial reaction of the British Government. They were not at the forefront of trying to see this as requiring a multilateral response. They were not throwing the full weight of their still very considerable influence, particularly in international organisations, behind trying to get a concerted and co-ordinated international response. I am not thinking here just about the World Health Organization, although we tend to assume that that is the most important body; there are other bodies that are involved in the Covid response, ranging from the World Bank through to UNESCO.

Since the first few months, we have seen increased engagement but it is still quite patchy engagement. In certain areas, we are beginning to act and, arguably, to act more effectively. Sophie has articulated a couple of things that I would have drawn attention to as well. In other areas, we are perhaps much less successful and have not really been at the forefront of international efforts to try to promote a multilateral response. Key in this is the response to the US comments about the World Health Organization and the imminent withdrawal of US funding from it, which would be little short of disastrous for the effective running of the WHO.

Sarah Champion: Professor McInnes, could I ask you to speculate on why we have had some reluctance on the world stage? Could you also give specific examples of what we could have done in the last six months?

Professor Colin McInnes: I can speculate quite wildly about this. It is to do with all sorts of things. I am little more than an informed citizen, but clearly relations with the United States post Brexit are looming very large and one does not want to upset the President of the United States. We have previously been natural multilateralists; perhaps there has been a shift in tone, so that multilateralism has to make a case for itself. We are not intuitive multilateralists at this moment in time; the Government

are not intuitively multilateralists, so the case had to be made and to be accepted in a way in which it perhaps previously had not been.

On the areas in which we could have done it, we have fantastic co-ordinating capacity. We have world-leading scientific resources. We have a very high international reputation. In the work that we could have done in bringing together not just the World Health Organization but other international organisations both within and outside the UN system, there were real opportunities for global leadership, which were not fully taken.

Sarah Champion: Professor Harman, I know you wanted to come in but could I add an additional question before you do? You made a submission to this Committee that highlighted several elements of the UK's role in global governance in a very positive way, but you also said, "The UK … has not made full use of its leadership position in global health security in the domestic response to Covid-19". I wonder if you could speak a little bit more about that in relation to its domestic response.

Professor Sophie Harman: Yes, absolutely. I was also going to mention the UN Security Council as well. The UK could have been more active in securing a Security Council resolution. I know some people in global health security now say, "We did not need it anyway", but it would have been a good diplomatic moment for the UK Government. There is also a wider question that is building now around trust and the UK Government regarding Brexit, the withdrawal agreement and international law. Perhaps that is something we could pick up a little later.

In regard to your question on domestic, yes, you would think that this position in global health governance positions the UK quite well. We have all these networks and we believe in the system by paying into it, so why did that not translate into the domestic response? It is very interesting how the UK Government followed the WHO's guidelines, particularly around orders and travel restrictions, but not so much when it came to find, test, trace, isolate and support. That is where we fell down and that is a very important disconnect, because it would seem that, for all the expertise that we had, for some reason that did not happen, even when you saw experts questioning this very vocally to try to understand it.

It was a bit of a halfway. We said, "Yes, we agree and align ourselves with these strategies", but a wider issue is that the UK was looking the other way. We have always thought of global health security as something that happens in other countries: the UK itself is not a problem; we have the NHS and everything is going to be fine. The UK was looking at other countries and seeing global health security as something that you protect the UK from, from an outside actor, whereas, in many respects, the threat, which might be too strong a term, was internal to the UK.

Sarah Champion: What could we have learned and implemented from the work that we have done internationally?

Professor Sophie Harman: Lots of things. First, protect your health workers. That is the first line, whatever you do. Secondly, you have to see where the virus is, so test, trace, isolate and support. The other issue that is often missed is the wider socioeconomic impact. I do a lot of work on gender and the gendered implications of outbreaks, and we have always seen that outbreaks have a huge impact on women in terms of their personal safety, their economic situation and the change to their careers, and their domestic burden, all of which intersect in very interesting ways. We know this from past outbreaks, and that was not implemented. It was very much the health aspect, and there were issues there, but the wider socioeconomic context was completely lost. That is still not being fully integrated when we see this movement, with cases going up in this second wave.

Q19 **Lord King of Bridgwater:** Professor Harman and Professor McInnes, you both referred to the role of the military and the part that it can play in this. I ought to declare a personal interest. I am a director of ExCeL and I saw at first hand, when people had rather been dithering around about how to convert ExCeL into the largest Nightingale Hospital, the impact of the military when they came in and did the whole thing in a week. Would you like to comment on what its role should be?

Professor Sophie Harman: In a way, you hit the nail on the head. What is quite impressive about the military response is how you have that logistical capacity to arrive and construct these hospitals. I was in Sierra Leone during the Ebola outbreak, doing research on civil-military co-operation, which was very interesting. It was very controversial when you saw the head of Médecins Sans Frontières saying, "We need the army", when what they were expecting was the logistics and infrastructure.

In the UK context, I would be very nervous in some respects. The UK population is used to logistics and infrastructure, and we see that in emergencies; however, there should be some caution around enforcement. If the military is to become involved in enforcement mechanisms of, say, isolation or quarantine restrictions, that can potentially undermine public health messaging, so I would be slightly sensitive around that.

Lord King of Bridgwater: You mentioned Ebola. The military usually bring good communications with them, particularly in territories where they may not naturally be established. Is that right?

Professor Sophie Harman: Yes and no. In Sierra Leone with the Ebola outbreak, command and control was really important. Lots of those frameworks were set up by RSLAF, the Sierra Leone military, before the UK military arrived. The UK military was also, as you will recall, working under DfID, so DfID was actually leading that operation. That is normally when you have an environment not of chaos but of no order. It is the kind of blunt instrument to impose that kind of order, so you are quite right in that sense.

Professor Colin McInnes: If I could explain a little about where I am coming from with this, I have done a piece of work with the World Health Organization, which has been very concerned about the inability of many countries across the world to respond to disease outbreaks and was interested in whether it could leverage the capacity of militaries to help in disease outbreaks. This work started in 2018, prior to Covid. I am coming from that perspective rather than a UK perspective, but many of the points are equally applicable to the UK. It is not just the engineering or the ability to build Nightingale Hospitals. Comms might be an option but it is about ensuring that the military comms work with civilian comms. Sometimes it is not just the technology but the procedures, which can be a bit problematic, so I am less convinced about that.

The military can be deployed and moved very quickly, so they have certain capacities there. In the early stages of the UK response to a Covid outbreak, we saw the mobilisation of retired health professionals and civilian contractors. Do not forget that we have military medics, who can be used very effectively. There are a whole variety of capabilities that the military possess.

What is quite interesting is the way in which, historically, we have used the military in emergency situations and responses such as floods and similar natural disasters. This is one of the few occasions where it has been a health issue that the military have been used for in the UK, and a number of us are a little worried about this because of the traditional antipathy in certain areas of the health sector towards the military. What has been quite impressive is how, as a country, we have accepted how the military can be incorporated into a civilian health response. The issue now is not whether we should do it; as I said in my paper, it is how we do it.

Lord King of Bridgwater: I do not know if you have seen General Shaw's evidence. I have just a note to say that we published it only an hour ago, but he draws particularly on the foot-and-mouth experience. One of the things that happened there was that the whole strength of an army brigade HQ was put into MAFF—the Ministry of Agriculture—to really start making things happen. You will recall that that was when there were certain problems. You referred in your evidence—and you have just said it again—to how the military can jar a bit with the health professionals. The other thought that comes is that, in some of these circumstances—we can see it possibly arising in this country—some of the policies and proposals of the health professionals can be publicly pretty unpopular and lead to quite serious disturbances, which is another aspect of whether you need the military in support of the civil power.

Professor Colin McInnes: I sincerely hope that we will never be in that position and look to the Blue Helmets to be able to respond. If the worst comes to the worst, that might be something which is required. Also, of course—I may be wrong about this, so please correct me if I am—I understand that, if it is a bioterrorist incident, the military takes control. Even though it is clearly a health issue that a biological agent has been

used, nevertheless the military is in charge of responding to that. There are certain situations in the UK where the military will take over in a health response, if I understand this correctly.

Lord King of Bridgwater: I am not sure that that happened with Novichok in Salisbury. In the initial stages, I think the police were in charge.

Professor Colin McInnes: That is the case but it was such a small incident there. I am thinking much more along the lines of a deliberate release of smallpox or something like that, with mass infection in a reasonably short period of time.

Q20 **Lord Campbell of Pittenweem:** I hope that our two excellent witnesses will not think it presumptuous of me to say that there is, of course, an international organisation that has performed very substantially in this area, and that, of course, is NATO. It is a military organisation composed of 28 members, and I can tell you from my own understanding—you may think it worth exploring this further—that it provides strategic airlift, member to member. Apparently, more than 100 field hospitals have been built at various stages by NATO countries for others. Medical personnel, to which you have referred as being deployed internally, were deployed internationally. In a rather interesting twist to this, aircraft carrying essential supplies are allowed to use the NATO callsign, which accelerates their passage through air traffic control. I am suggesting to you that, if we look outside the United Kingdom, there are some illustrations where the military, without getting into any problem of enforcement, are none the less available as not just a UK but an alliance asset.

Professor Colin McInnes: Yes, I am aware of a number of European countries that have done quite extensive exercises with the military and civilian health authorities on the assumption that, if a pandemic or a major epidemic did occur, this might be required. Clearly, some of the lessons from those might be applied, as well as some of the capabilities, if necessary, so thank you, Lord Campbell.

Professor Sophie Harman: Interestingly, I also thought about NATO when preparing my comments, but then thought that, again, global health tends to be organised around collective security rather than collective defence. NATO might be shifting some of those priorities as it moves forward. The interesting point is around alliances: NATO alliances and Commonwealth alliances, and how you see militaries working together in that respect. Alliances are very important when we look at the role of the military in global health.

Q21 **Baroness Healy of Primrose Hill:** Professor Bouder, what changes have you seen in the UK Government's public messages around risk at different stages of the Covid-19 pandemic? How has the approach to communicating risk evolved over time? One example that I would just like to put to you is that the Prime Minister said on 10 July that people who could go back to work should go back to work, and now, on 22 September, he is warning people again to work from home.

Professor Frederic Bouder: Thank you very much for the question. I also have a remark about the former question, which I will bring in later on. In terms of the UK, I am not in the UK, although I am often there, but I am speaking now as a foreign observer from a university based outside the UK. I have seen quite a substantial change in the approach throughout the pandemic. There is an excellent article by Professor Freedman, emeritus professor at King's College London, who looked into the variations and the problems of changing course.

I would like to put that into perspective with other countries. Other countries have chosen quite different approaches, and this is not an easy area. The countries that have managed best to keep the population onboard are those that have stuck to one approach. Countries such as Sweden never went into lockdown, and there have been discussions internationally. On the whole, because the strategy has been coherent throughout, support for the policy has been high in the country. There has been a clearly identified strategy; in the UK, unfortunately there have been some changes and they have not necessarily always been very clearly or explicitly framed as such. Sometimes you can change policy but you very much have to explain how you frame it.

Again, as an outside observer of the situation, it seems that there have been many voices, and the core message has sometimes been a bit blurred. Again, in risk communication, which is my background, it is very important that you keep quite a clear message about what the problem is and what you are doing about it. That would be my observation.

If I may add a footnote to the discussion about the military, I just wanted to say that, in different countries, militaries have been involved; for example, in France, the firefighters in Paris are a branch of the military. Also, the positive view of nuclear energy in France is partly linked to the fact that the nuclear military operations are seen as a warrant of national sovereignty and has been perceived as positive for that reason for many decades. You have to take that aspect in the context of how societies see their military. There is no right or wrong answer but you have to contextualise it. Coming back to how operations, risk communication and risk mitigation can be perceived, often trust in the various actors within a society matters enormously.

Q22 **Bob Stewart:** Some 28 years ago, when I was involved in Bosnia, the military were viewed with huge suspicion by some agencies. In fact, the local representative of one UN agency said to me that the reason the British Army was on the ground was to kill people. I rang Geneva immediately and that person was removed from her post as a consequence of that. Things have changed remarkably since those days and are very different.

The first part of my question is about the opportunities and risks of using defence and security assets; for example, using military forces and also involving the Security Council in helping global health situations. Professor McInnes, perhaps you could address that.

Professor Colin McInnes: There is clearly a legacy issue in the UN system, which goes back to the 1990s, which I know you were personally involved in.

Bob Stewart: I was trained by your university. I went to your university in Aberystwyth.

Professor Colin McInnes: I know you did.

Bob Stewart: A great university of the country, along with Oxford and Cambridge.

Professor Colin McInnes: Thank you very much. The international advisory guidelines at the moment are still very much that the military should be used as a last resort. This reflects very much the experience that you had in Bosnia in the 1990s, and elsewhere in the late 1990s and early years of this millennium, where militaries were viewed as undermining the humanitarian principle. If you go in as an international community on humanitarian grounds, the military sits ill with that. In particular, if you go in to support health activities, the military does not look to be promoting health; it is very often the risk in communities to health. We have seen this in the DRC, with the Ebola outbreak there. There is that predisposition against the military in some areas, versus two major factors.

The military can often provide protection for health professionals. That is a really difficult issue for a lot of health agencies: whether or not to accept military assistance, to provide them with the protection so that they can deliver the aid. Sometimes, a government-funded military is seen as the problem, not the solution, in many areas, and so health becomes politicised rather than being outside of a political discourse—health for health's sake. There is that whole package of issues, which is increasingly complicated and pertinent.

The other series of issues is around who controls this. If you are sending in an international military, who is in control? Is it going to be the national Government, because they are requesting the international aid? Is it going to be the international militaries themselves under some sort of UN banner? How do you manage the command and control, particularly if the government-sponsored military, as we have seen on a number of occasions, is the problem, not the solution?

There are number of things going on that suggest that the current UN guidelines and the sorts of things we have been operating under for the past 20 years or so look in fairly serious need of revision. If, as seems to be the case, most countries in the world have failed to meet their obligations under the international health regulations to have the necessary capacity to respond to disease outbreaks, you have to ask yourself where the help is going to come from.

If we have another Ebola outbreak in west Africa and there is a need for support there, where is it going to come from? Some, for sure, will come

from the aid agencies—MSF, ICRC, et cetera—but at some point in time, you are going to require the rapid deployment of the very considerable capabilities of the military, if the situation gets beyond control. That is where we really need to focus some thought as a community: how and when we should use militaries to respond to an outbreak elsewhere.

There is a changed zeitgeist in the air. You see it in the World Health Organization, which has traditionally been very reluctant to endorse the role of militaries in health outbreaks, unless it really is the last resort. It is now thinking much more seriously that maybe this is going to be integral to a response rather than the last resort.

Professor Sophie Harman: I agree with most of that. There has been some queasiness and unease around the military in global health, but not in some domestic health systems, where we know that domestic militaries have always been involved in healthcare, whether it is running hospitals or responding to emergencies. However, it is about how we shift the language around last resort to the point at which it should be relevant that the military becomes involved. That is an ongoing discussion.

The big issue, which you pointed out with the Bosnia case, is the one of neutrality. The neutrality problem is going to be there for a long time. In Sierra Leone, someone from the British military showed me a picture, saying, "Look at this picture? Isn't it great?" It was of the military working alongside the Sierra Leone health professionals and NGOs, but where that picture is taken and seen out of context can really threaten public health workers, who are meant to be neutral and not work with militaries. Those issues are going to be ongoing for a period, and I would welcome seeing what happens with Colin's research for the WHO and how that goes forward.

Coming back to your question about the UN Security Council, that is a very interesting one with Covid-19. We had the Security Council resolution in July around Covid-19, which some would say was a bit of a delay; some would say it does not really matter because, really, in global health, you push for the Security Council resolution to get public attention for an issue to try to trigger more money and more attention and make it an exceptional issue. That has been the case with HIV/AIDS and with Ebola. At the time, you wanted more political support and attention, whereas, with Covid-19, arguably, it already had, by July, the attention of the world. It is important that we have the resolution. It is an important statement of intent but the question is whether you need it and whether it is as important as it was with both Ebola resolutions—the west Africa one and the one pertaining to the DRC.

Bob Stewart: I want to raise so-called securitisation in pandemic risks. What are the pros and cons? Sophie, you start on the pros. Colin, perhaps you could give the cons.

Professor Sophie Harman: The pros include that you get international attention. Lots of people understand the idea of securitisation as introducing security actors into an issue that is not normally securitised,

but actually it is about taking an issue out of the usual politics; it is exceptional. I could say that malaria is a threat to international security but people have to believe it. That is the key to securitisation: not the actors but something about exceptionality and people believing in that. The pros in global health are about getting political attention and, with political attention, triggering financial commitment to that issue. That is what you saw with Ebola and with HIV. I will just quickly—

Bob Stewart: You are stealing Colin's thunder.

Professor Colin McInnes: I was quite interested to hear what Sophie was about to say. The downside is very simple and very straightforward: it distorts the agenda. If you have a health crisis that you securitise, instead of treating it as a health crisis you treat it as a security crisis. You have changed the nature of the beast, and that is not always appropriate. Indeed, the originators of this theory were not in favour of securitisation. They developed the theory so that we could find a way to de-securitise, because they saw it as warping policy agendas in sometimes quite dangerous manners. That is the main risk.

I would distinguish between securitisation, which is taking a policy issue and making it into a security issue, and militarisation, which is when it stays a health issue but the military becomes much more integrally involved with it. It becomes a military operation. That is a different set of issues, and it goes to issues of character response and whether, if you can rely on the military, you bother to fund civilian agencies sufficiently. There are a different series of agendas here and one of the risks, if we are looking to the British and other militaries to play a much greater role in future health crises, which generally is something that I support, is that we can step back and ask, "Do we therefore need to resource emergency health responses to this? Can we not just rely on the military to do it for us?" That is the risk of militarisation, which is a slightly different thing from securitisation.

The Chair: That sounds like a very big risk to me.

Q23 **Lord Harris of Haringey:** I want to go back to risk communication, so this is primarily for Professor Bouder. The Government have given evidence to us that accurate, clear and timely messaging is essential in driving positive behavioural change at times of threat, so as to "save thousands of lives". In your view, how effective has the UK Government's public communication of risk information been during the Covid-19 pandemic, including for specific groups with additional risks?

Professor Frederic Bouder: That is a difficult question in the sense that it would require a full analysis rather than an off the top of my head kind of answer, which could be misleading. Nevertheless, I can give an answer. One issue that we know from psychological research is that behavioural change is very difficult to achieve. People tend to do the things that they think are the right things to do, rather than just following some kind of nudging. We know that there is sometimes too much optimism on the part of the decision-makers about what they will achieve

in terms of changing people's behaviour. There have been some quite clear messages about staying home and doing certain things, which have been taken up by part of the population but not so much by other parts of the population.

Here I come to what is key to risk communication. Coming back to basics, we first need to assemble the evidence. We also need to acknowledge public perspectives, which may be quite different, again in different segments of the population. We then need to analyse options about how we can communicate and then bring about change in a way that is diversified and targeted to the audience. You do not communicate to different audiences in a one-size-fits-all manner. I realise that, in the current context, it is very difficult to achieve proper risk communication and, therefore, I will not be the one blaming Governments for struggling with the situation. However, coming back to the core question and the idea that it is very easy to change people's behaviour, it is quite difficult.

We also know from risk communication that, in addition to understanding perceptions and working with those, we need to understand channels of trust. Who speaks is very important. Being a trusted third party, for example, can have more impact than being a Government; we have seen that in a number of cases. I keep coming back to this but I find the example of Sweden quite interesting because the management of the pandemic has been in the hands of an organisation that is perceived as a neutral, independent agency. Whatever decisions have been taken, that is a big boost on the side of trust. It is different for Governments, who always have to deal with the political ramifications.

Lord Harris of Haringey: That is very helpful. You talked about some clear messages, but you could argue that the messages have gone backwards and forwards. First it was, "Stay at home", then it was, "Go to work", and now it is, "Stay at home" again, and so on. How should the Government adapt their communication approach as the situation changes or perhaps as the science becomes better known?

Professor Frederic Bouder: You need to be very clear about the responsibility and the decision-making. As you say, you have to be quite up front about the fact that you interpret the evidence in front of you in different ways in terms of what needs to change.

I like to focus on that as well. You interpret and you make a decision as a decision-maker. You are not simply following the science. I am not a big fan of that expression. What does it mean exactly? Science is not something that gives you an answer once and for all. There are different contributions from different disciplines into making a sound decision.

We know from various examples of risk communication that it has worked fairly well when decision-makers have been humble and said, "Okay, we are looking at the evidence and we are changing what we are advising you to do". That is not necessarily a big problem.

Professor Colin McInnes: I have two very quick points. Of course, what we failed to do as the UK was to have a UK message, and understandably so because each of the four nations had their own distinctive responses, often driven by slightly different patterns within their countries. There has been a lack of co-ordination between the four nations. Whether that is inevitable or not, I am not sure, but, as somebody who lives in Wales, it has been very clear to me.

We live in an age where social media is an important vehicle for communication, and the Government are not very good at it. Just before coming online, I looked at the Department of Health and Social Care's Twitter account. Their last 10 tweets about Covid averaged 43 retweets and 30 likes. In contrast, when Bill Gates tweeted on 26 September about the UK vaccine—this is an American tweeting about the British response to offering a vaccine funding—he had 1,000 retweets and 4,800 likes. That is an order of magnitude difference.

We are not very good at social media, I am afraid. We saw this during swine flu, which was very early days for social media, but we also saw it during Ebola, when we had the nurse, Pauline Cafferkey, positive with Ebola, landing in London and then catching a flight up to Glasgow. This pattern is being repeated now. We are just not very agile or adept at using social media, which is the way in which increasing numbers of our citizens are accessing the news.

Lord Harris of Haringey: Those are both very interesting points, which we are about to come on to, so we will park those.

Four years ago we exercised in this country for a pandemic, Exercise Cygnus. Arising from this, the Government talked about pandemic communications needing to offer "the necessary reassurance and adequate levels of information". I would be fascinated to hear what Professor Bouder might tell us about how honest, in dealing with emerging health risks, the Government should be with the public about what is and is not known.

Professor Frederic Bouder: My view, as a risk communication person, is that you should be honest, but there are different ways to present. There are ways to present things which amplify the risks and there are other communication methods that may put things in perspective.

Of course, if being honest means just amplifying the negatives and not putting things in perspective, it does not do a good job in terms of risk communication, but trying to suppress some evidence or trying to misrepresent things will not help, because in the end there will tend to be a backlash.

Again, from a risk perspective, what we like to look at in our field is, in a wider context, the risks and the benefits. If we come back to the current pandemic, I find that sometimes there has been a very narrow discussion about the issues. We have not sufficiently opened the discussions on the various repercussions, including on the measures. We have been very

focused on transmission, but we have not been sufficiently balanced in our communication and looking at different streams of evidence.

Professor Sophie Harman: Professor Christian Enemark from the University of Southampton did some work on this and called it the biosecurity dilemma: to what degree do you inform the public without [1]ca using mass hysteria? Quite similar to what Professor Bouder said, that is actually just honesty and being transparent. It will have an impact on your response further down the line if the public do not trust you or if they think there has been a cover-up.

I was also looking at a report from Will Jennings, who has been doing some research on trust and the UK population. He is seeing that trust is starting to wane, particularly as the public start to think that the Government are going to use Covid-19 as a cover-up for the economic fallout from Brexit. This is actually among leavers; this is not among remainers in the population. There is some interesting work there, which I would be happy to send to the Committee as a note in follow-up.

Lord Harris of Haringey: That sounds fascinating. Presumably, you also need to be open with the public if you do not know. "We simply do not know" is a valid thing for Governments to be saying. You are both nodding. I have one final question for Professor Bouder. Are there particular ways that Governments should make best use of particular channels to reach specific sections of the population, for instance some of the at-risk groups?

Professor Frederic Bouder: First of all, on the previous point, it is fine to say that you do not know, but it is not fine to say that you are not doing anything to get more evidence. You also have to map out what the process would be to gain more knowledge and say that you will come back with answers. That is how you would typically deal with uncertainty in communication. You do not just leave people with, "We do not know".

The second question is a very important point, because we know from research we conducted with colleagues from the UK, from King's College, that the typical government channels are not really well known, and people do not necessarily go to Governments for information. We conducted a survey. For instance, in the Netherlands only 2% of the population were aware of the existence of the regulatory agency for pharmaceuticals. In the UK, MHRA was often confused with MRSA; people thought it was a nasty bug and not the pharmaceutical agency.

Therefore, working through known channels is extremely important. We have worked on specific diseases and specific patient groups in some areas. HIV/AIDS is an example where you have a robust infrastructure of organisations where patients have interactions, so it would be very important to work through them to get the message out. Of course, when

[1] Note by witness: 'Trust, COVID19, and Brexit' https://ukandeu.ac.uk/wp-content/uploads/2020/09/Will-getting-Brexit-done-restore-political-trust.pdf

it is more of an all-population concern, you then have to look at different sub-groups.

In the case of Covid, we know that some patients are more at risk than others. For example, we know that obesity seems to be a factor. We have some organisations that we can work through there rather than just doing campaigns. We also know that the elderly are more at risk, so we need to work through the channels there. Often the third-party trusted channels will be more listened to, as opposed to government institutions. Again, trust is very important when considering who you communicate through.

When I say "communicate through", it is not just that top-down messaging is supposed to be picked up by those organisations. It is about developing a two-way exchange so that they take ownership of the message, because otherwise they will just say, "We are not quite sure", and they will not do that role.

Q24 **Baroness Neville-Jones:** Professor McInnes has come on to the topic I wanted to explore a little, which is the question of the multimedia world and the different channels that are open not only to government but of course to a lot of other people to communicate through. He said that Government are not very good at social media. Are there obvious ways in which the Government could improve their performance?

Secondly, looking at who else might be using social media—particular interest groups that press theses, some of them loony, some of them alarming—how should the Government try to deal with the anti-vaxxers and the extreme groups that, over time, begin to penetrate national debates of this kind and who can quite distort what people think and believe and what they may indeed fear?

Professor Colin McInnes: On your first point, we need to be quite agile in responding to what is happening on social media. Social media is an incredibly fast-moving world. Unless you have prior authorisation to respond in a particular way, if you get something coming out of left field and you have to find somebody to authorise your response as a government media specialist, you have just lost the narrative completely.

I will give you one example, which is perhaps light-hearted or perhaps not. Pauline Cafferkey was diagnosed with Ebola around Christmas-time. The then Chief Medical Officer, Dame Sally Davies, tweeted to try to reassure the British population. It was a fairly well received tweet, but within about five or six iterations of this, as the conversation developed on social media it became a conversation about whether we should therefore build a wall between England and Scotland to prevent Ebola coming across. That is an indication of how quickly these conversations develop a momentum of their own and go off on all sorts of weird and wonderful tangents. That was clearly quite a light-hearted aspect of it.

To your other point, if people come in and say, "The way to treat Covid is to use this"—some entirely unproven method—if the Government are not

agile enough to respond to that, you lose control of the narrative. All of a sudden, a government string becomes distorted and something that is entirely unsupported by the science. That is a problem. We have to be really quite agile and fast in our response, and that means you cannot rely on the traditional media departments. You need social media specialists, people who are very used to dealing with social media, who do not think like your traditional media people but think in terms of social media and the social media community.

I am afraid to say that there is almost no way in which a Government will be massively popular on social media, because it is a social site. On a social site, you look for the latest boyband or Premier League footballer and you follow them. You will not follow the Government. A few of us do, but according to my daughter that makes me a rather sad individual. She follows others instead. You need to find out who the key influencers are in public debates on social media and make sure that they are aware that if the Department of Health and Social Care produces a tweet on Covid they will be watching the Department of Health and Social Care Twitter account, will pick up on that and will retweet it in a positive manner. It is about working with them.

There has been some work on how you might do this, but we cannot afford to be in the same situation as has happened in the past. I did some work with the Norwegians on this following the Utøya island terrorist incident, and that was all over Facebook before the police even realised something was happening. You had the desperate situation of young adults on the island of Utøya using Facebook to say that the gunman was coming around the corner and they thought they were about to die. They were asking where the police were. This was all over Facebook before the Government had actually responded.

This gives you an indication of how quickly social media can be picked up and be used. It is a much faster pace than perhaps government is always comfortable with, and you want to check that the message going out is the approved government message.

I hope that gives some answers to your questions.

Baroness Neville-Jones: Are you aware at all of whether the Government have tried to get help from people who are adept at this?

Professor Colin McInnes: I am afraid I cannot talk about the London Government, but I can talk about Public Health Wales. I know that it has been trying to do that with some success. It has been trying to think about social media strategies as a completely different media form from traditional media strategies, and not only trying to find influencers but use geotagging to identify particular communities. If you have a localised outbreak of Covid and you know that a group of people have been tweeting from that area, you can target them using geotagging. There are things you can do, and this is a fast-moving area.

Baroness Neville-Jones: What about the loonies who get hold of the

debates? Is there any particular technique that can be used? It is quite serious when the anti-vaxxers start being quite loud. That can seriously distort the nature of the debate.

Professor Colin McInnes: You are absolutely right. Going back to what Frederic said earlier, that is why building up trust in advance is so vital, because once you get involved in a debate you will not win it. It is a classic conspiracy theory; any argument can be undermined by people who start from that position. It is about building up the trust in advance. You will not win it by engaging in an argument there and then. You will win it by being trusted more. That is where the battleground is. It is not over science and it is not over facts; it is over who is trusted.

Professor Frederic Bouder: That is a crucial point. In countries like Norway, where there are very high levels of uptake of vaccines and quite a lot of support for vaccination, there are the same arguments. We live in a global society. In Norway, people all speak English, so they have access to the entire anti-vax argument, but because the level of trust in the public health system is high, people still think, "They're loonies". Of course, the overall level of education of the population is also important, as is the communication to the population about issues such as vaccination.

There was a very interesting initiative in the Netherlands some years back. A humourist, who was very renowned and well known, had a programme about vaccination in which he had some fun. He opened umbrellas, and if only a few umbrellas were not open he would not get wet, showing that herd immunity is built up, but if too many were open he would get soaked. That had a very positive impact on the public's understanding of the mechanism of vaccination. We also need these sorts of programmes.

Coming back to the issue of social media, I have been collaborating with the European Medicines Agency and the medical agencies in different countries, and what is striking is how few staff they have dealing with communication. They have even less capacity to deal with new media, whereas anti-vaxxers are sometimes quite well staffed. They are always behind the curve, so it is very important to have more people and more resources. Communication in our world is becoming a force with major impact. We need to have more people in these agencies who are properly trained, including in risk communication and not just PR, because simply reinforcing messages does not necessarily lead to a positive outcome.

We also need to organise debates in society. That is very important. It comes back to trust, and those debates have to align with what we would call trusted third parties—people who are perceived as trusted. These people are the Attenboroughs of vaccination, if I may call them that, who can help to mediate the discussions in society. They can keep the debate alive on the positive side, so that again it counterbalances what you called the loonies when they start ranting on the internet.

Baroness Neville-Jones: That argues, does it not, for more voices than

just government debating these issues and occupying some of the space?

Professor Frederic Bouder: Yes, it does.

Q25 **Baroness Lane-Fox of Soho:** I am going to touch on the previous question. I should declare an interest, because I am on the board of directors of Twitter, so I am very interested in your perspectives, particularly you, Professor McInnes. You mentioned technology solutions to some of the challenges that I see in particular, as one of the directors, with such a mass of misinformation not just from loonies but from organised national Governments.

I am interested in your perspectives on countering some of this. We have Baroness Neville-Jones's loonies, but we also have the arguably much more pernicious and organised state or semi-state actors. Does anybody have any opinions about where the responsibilities lie and how to get over some of those bits of misinformation in communications?

Professor Frederic Bouder: Again, it is very important to have a more inclusive debate with more actors who are involved. If it becomes Twitter against some actors, that is potentially a very antagonistic relationship, and I am not sure that the outcome is very productive. Again, we need to contextualise more. If we are talking about vaccines or another subject, we need to go back to more third parties, more scientists, organisations of patients—people who have a positive say in that context. Bringing them on board is very important, whatever the platform.

Professor Colin McInnes: I am, frankly, sceptical about the value of experts in these debates. We have seen consistently over the past decade, if not longer, that experts have not been given the credence or deference that they once were.

Baroness Lane-Fox of Soho: That is not the case on this Committee, I hope you will find.

Professor Colin McInnes: In a democracy, it is healthy that there is scepticism about people in authority. That is what democracy should be about. The concern is when that scepticism turns to an outright refusal to believe anything they say.

My past has involved working on HIV/AIDS. What has been really impressive is the role of civil society organisations in demystifying a lot of issues surrounding the disease both in a UK context and in an international context. Rather than looking for experts, I would look to respected civil society organisations and building up strong civil society networks to try to offset these sorts of wackier—for want of a better phrase—outliers, who nevertheless seem to attract very large numbers of very active individuals who are susceptible to all sorts of interesting, weird, wonderful and outright dangerous things from time to time.

Q26 **Baroness Lane-Fox of Soho:** Yes, and they are all very well organised in the background. Thank you for those comments. Can I move to another question that is related but somewhat different? It is about the nature of public health information being communicated differently across

the different regions of the UK, from mask-wearing through to the latest social-distancing rules. I wondered whether you had a view about the strengths or weaknesses of a centralised versus a regional approach.

Professor Frederic Bouder: We know from risk communication analysis that it often damages trust when you have different authorities on a topic clearly giving very different messages. We have seen that in a number of cases, from oil spill issues to medical problems.

I understand that there are also some constitutional reasons for that, so I am not sure that it will help to get into a mode of it being just central government needing to communicate, because it can become very politicised. Having some form of closer co-ordination to define the key messaging would definitely help to bring trust across the board. Again, that is a very typical issue that we have run into in many areas of risk. This happens in organisations as well. When you have a chief scientist saying different things to a Minister or a CEO, that always drives trust down.

Professor Sophie Harman: In a way, a plurality of responses across the four nations can be helpful if they are learning from each other. If you are taking steps based on what has worked and what has not worked, that can be helpful. There is obviously the cliché of, "Where Scotland leads, England follows". I am not sure that is entirely accurate, but it can be on certain issues.

There is the risk of it being more widely politicised, and that is how the public sees it too. They think, "Why is England not doing what Scotland is doing? Is it about independence for Scotland?" There is some scepticism, which comes back to Professor Bouder's point about trust.

To pick up on your previous point about social media, plurality is also good there. If you look at the relationship between SAGE and Independent SAGE, I would argue that Independent SAGE is much better at social media, and much better not just at responding quickly but at galvanising key influencers on social media to get that message across. If you want to look at a contrasting perspective, that is quite interesting as well.

Professor Colin McInnes: We have seen quite clearly the weakness of a four-nations system. It just has not worked, and it has been incredibly confusing, particularly for people who cross borders on a regular basis. What guidelines should they follow when those guidelines seem to change on such a regular basis? The system is not working, and one of the things that is disappointing is that, if we knew that pandemic influenza or some other infectious disease was a very high risk for every country in the UK, why were the systems not better prior to Covid? This may well be one of those things where we tried our best and the reality just proved much more complicated than anybody could have imagined. These things do happen.

Clearly, there has been some politicising going on, and there has to be a degree of clear blue water between what London says and what Edinburgh and Cardiff say. There is a degree of politicisation there, but sometimes that obscures the very real sense that these are different countries where different responses might be appropriate. Certainly, it is not just nationally, but regionally in these countries. We are seeing this already with the Government's response.

Within the context of an overall message, we need to be able to have a more nuanced approach that is applicable to regions and countries in the UK. We should not be looking at the devolution settlement or anything like that; we need to have a frank and honest discussion about how we make it work better when there is a UK crisis in areas that are devolved. That has patently failed at this moment in time.

Q27 **Baroness Henig:** Can I expand this discussion into England? In England, increasingly, as the pandemic has gone on, the local government voice has been louder, particularly in London but also across the country. Professor Bouder, you spoke earlier about the importance of keeping a clear message, which we understand. When local government has developed a responsibility for delivery to its local community, as it has increasingly, has that helped or hindered people's understanding of risk? Might it have set up tensions between central and local messaging?

Professor Frederic Bouder: I would like to come back to the political background of this. We see the same issues around Europe right now. We are moving from the logic of lockdown to a logic of local restrictions and local lockdowns, which may even increase as the pandemic seems to be developing further.

We see these tensions. From a risk communication perspective, it is very important that there is a sense of respect for local politicians and local authorities. We saw that in previous cases, which do not necessarily have to do with pandemics. I am thinking about Buncefield in the UK, for instance, where respecting local politicians and articulating the local and the central was essential in maintaining a rather productive outcome as opposed to a very destructive environment. You cannot always be top-down, and in these cases that is very important. That would be my suggestion from my risk communication research.

Professor Sophie Harman: I am really pleased that you have brought up this issue, because local authorities have been completely missed out of any planning in relation to biosecurity and national security strategies, when they are the authorities that will deliver on social care, provision of supplies, food networks in a crisis and all those kinds of issues. At the outset of the response they were missing and were rapidly mobilised in some respects.

Also, there have been communication problems from the centre to the local authorities. That happened in the first round; it was, "Okay, now you're doing care packages", and, "Now you're building hospitals". Those

communications have been quite delayed or announced on Twitter, so the authorities picked them up at a later stage.

This disregard for local authorities has been really problematic in the UK response, especially after the years of austerity and cuts to local authority budgets. The other issue is that they were promised money. Did that money come? Communication and factoring in local authorities as those who provide many aspects of pandemic responses is very important.

Professor Colin McInnes: I would rather not comment on England, but I can comment a little bit on Wales. Certainly, the county councils in Wales did things differently. Ceredigion operated very differently from Powys and other councils, and we saw differential R rates as a consequence. Local authorities in Wales had a little bit more flexibility from quite an early stage in how they responded to the pandemic. Certainly in my part of the world, that worked very well. It was a locally tailored response that fitted a very rural community, which probably would not have worked if it had been in Cardiff or Neath Port Talbot. It is quite important to have that sensitivity to local dynamics. It is not just the demographics but the character of the regions and the local authorities you are dealing with.

Q28 **Baroness Henig:** Thank you for that. It is quite important to clarify this and to put central and local government into some kind of harmony without making it difficult for people to get messages from both that may not be exactly the same.

Can I move on to the Government's risk assessment system? Over a long period of time, this has been couched in terms of "worst-case scenarios". That terminology seeped into the media reporting early in the Covid pandemic, with talk of hundreds of thousands of deaths expected.

My first question is how this worst-case scenario was arrived at, and whether there should have been wider input from a more diverse group of experts into what the worst-case scenario was. Secondly, could the Government have done anything to present the figures in a way that people could understand more clearly?

Professor Frederic Bouder: As a risk-analysis person, I would definitely say that it is always very important for risk assessment—it is one of the basics of risk assessment theory—that you draw on a sufficiently large pool of expertise. If you empower modellers of diseases too much, for example, then of course you will get a certain result. You really need to separate the assessment from the management. In order to make a sound management decision, you need to draw on a sufficient variety of inputs so that your assessment is more robust. Without commenting necessarily on the UK assessment as such, I would say that that is always the way to go.

There are two points to make about communication. There is the communication of numbers and whether numbers are the key thing to

communicate. There are some techniques to communicate numbers better, and there has been some work on this in the UK. Professor Spiegelhalter and others have been focusing a lot on that aspect.

At the same time, we have some cognitive problems. All of us, as humans, tend to understand certain numbers more than others. We know from the work of people such as Daniel Kahneman, who won the Nobel Prize, that we understand, for example, base rates and numbers like 50% and 75% much better than more complex numbers. This means that sometimes it is not about just using numbers; it is also about finding other ways to communicate about risk and not being so obsessed by numbers. We know that there are these cognitive impairments.

Professor Sophie Harman: I do not have expertise on incidence and mortality estimates, but a global phenomenon is a lack of awareness of the secondary impacts from outbreaks. Particularly, again, from my research on gender and outbreaks, that is always missing. That is not just in the UK context; that is a global problem. If you broaden the expertise and have not just health experts, biomedical experts or statisticians but gender experts and experts on race and inequality, they can flag some of the issues you could expect. You would expect to see rises in domestic abuse in periods of lockdown or quarantine. We saw this before. You can put measures in place, for example. It is the same with safeguarding against women's professional careers and time spent in the home.

That is just one example, but when we look at these worst-case scenarios, we always think about the numbers around the response to the outbreak itself. If we also want to understand these scenarios more broadly, a diverse pool of experts would be very welcome.

Professor Colin McInnes: Worst-case estimates have a "wow" factor, do they not? In the west African Ebola outbreak, around early November, the Centers for Disease Control and Prevention in the US produced an estimate of a possible 1.4 million deaths in west Africa by January or February unless there was global action. That helped to galvanise the international community into action.

Sometimes the worst-case estimates can be politically useful in creating momentum: "Gosh, yes, we really must do something about this". This is not dissimilar to the way in which the UN system was galvanised at the turn of the millennium on HIV/AIDS. There was a sudden realisation when Richard Holbrooke went to Africa and saw what was happening there. He came back and got a Security Council resolution. People were going, "Wow, this is really serious".

Worst-case estimates can be politically useful, but generally speaking one should emphasise the median or the most likely estimate, because otherwise there is a downside to worst-case estimates that is pretty clear: people overreact and get overly concerned. All sorts of secondary problems emerge: you get shortages in supermarkets and all sorts of things, which we saw in the UK. By and large, I would try to avoid

worst-case estimates, but occasionally, if you want to change behaviour, they can be quite useful.

Q29 **Angus Brendan MacNeil:** I have heard mention of Scottish independence from some of the witnesses, which is music to my ears. I want to move out a bit further into the world and a bit more expansively internationally; my questioning is not just about Scottish independence.

Maybe the Nordics are a good example. I have been watching the Faroe Islands in particular for a few months. The Faroe Islands have twice banished Covid. In their second outbreak, they did so by testing about 8% of the population, which would be the equivalent of the UK managing to test something like 5.2 million people in a day, which is a phenomenal achievement altogether.

I notice now that the numbers are going up a little in Denmark and a little in Iceland. Finland and Norway are still pretty flat, and Sweden is somewhere in between. Is there much going on between those countries? For the current nations of the UK, is there much learning that we should be more aware of outside the UK? There is a lot of talk about how Wales may be doing something a little differently from Scotland, but maybe the bigger lesson to draw on is to look further out, to the Nordics.

Professor Frederic Bouder: I guess that is a question for me.

Angus Brendan MacNeil: I hope others have also been paying attention, but, yes, it is definitely a question for our Norwegian witness first.

Professor Frederic Bouder: First of all, of course you cannot always compare situations. Sometimes it has been portrayed that there are very different policies across the Nordic countries. The gap is not necessarily that big between Sweden, which did not impose a lockdown, and Norway, which did. In Norway, for instance, the lockdown was much more relaxed than in other countries. You could go outside and exercise. You have never had to wear masks; we are still not in the world of masks.

These features also have to do with the low density of population and the very good medical infrastructure. In Sweden, some of the reasoning behind its policy was driven by the fact that it knew that it would cope even if there was a surge.

Angus Brendan MacNeil: In fairness to Sweden, it has plateaued a lot in the last two months.

Professor Frederic Bouder: It has gone down. It went very high and then down. Of course, it is difficult. The Swedish authorities are not bragging at all. They are saying, "We will see over time".

There are also problems. It is not all perfect. Especially in Sweden, there were some high levels of infections in care homes that cost a lot of lives. On the whole, what I find interesting is the fairly steady commitment over time. There have not been peaks—"You should do this, and now you

should do that, and now you should do that"—compared with other countries across Europe. It has been fairly consistent.

Sweden has not tried to overdo it either, compared to other countries. The risk amplification has been lower, but this also has to do not just with the government response but with the society. In these societies, the tabloid press, for example, is not as developed.

Angus Brendan MacNeil: You are very lucky.

Professor Frederic Bouder: As we discussed before, there is high trust in Governments, so they have less conflictual environments. That also leads to a more relaxed approach to communication. It is a luxury, in a way, which you do not necessarily have everywhere. On the whole, that is the key feature that I would highlight.

Professor Sophie Harman: First, I would like to stress that we are at the end of the beginning of Covid-19. I know no one wants to hear that, but it is true. There is divergence on three issues: lockdowns, borders, and test and trace. Borders can be a bit of a distraction, so I will leave that there, but we can come back to it.

With lockdowns, it is interesting. We are not seeing many lessons learned between countries. There is a focus on what is going wrong when people do not lock down soon enough or strongly enough.

What is interesting is the research on test and trace. Joshua Moon[2] and his colleagues at the University of Sussex have just done a comparison study on this. All countries can learn, even South Korea. Everyone said, "Be more like South Korea", but there are gaps in that system. You can see some learning happening around test and trace. I can supply you the information about that study afterwards. They looked at a comparison between all states. The main thing is that no one state is doing everything well; we can all learn from each other.

This comes back to your question about the extent to which people are actually doing that. At the start, this was not happening so much, but we are at the six-month turning point. I always tend to think that Governments panic a little bit in the first outbreak and then there is a process of saying, "Okay, what has gone wrong? What can we do better?" I am hopeful that this is starting to happen in some countries, especially with the research that coming out. The research that I am quoting has been funded through UKRI. That is starting to filter through. Hopefully, there can be some feedback on that, too.

Professor Colin McInnes: The Government have been looking quite carefully at the data, particularly from other countries. We hear

[2] Note by witness: 'Lessons learned from different Find, Test, Trace, Isolate and Support' file:///Users/harman/Downloads/SSRN-id3694441%20(1).pdfhttps://papers.ssrn.com/sol3/papers.cfm?abstract_id=3694441.

Government Ministers referring almost daily to the data from elsewhere and how that might be applied to where we are at with the pandemic in the UK. There has been a degree of looking elsewhere.

Whether that has extended to looking at how effective responses have been is a slightly different question. My caveat would be that we are dealing sometimes with very different societies. What might work in China might not work in the United States. In such different societies, can you expect the same sort of societal response and the same sort of acceptance of what Governments are saying, or the following of government rules and regulations in different countries?

That is why your example of the Nordics is quite interesting, because they are fairly similar. Yes, you and I know that there are major differences between them in some areas, but there is a similarity between them in many respects. The transfer of lessons from Norway to Sweden might be much more straightforward in those sorts of respects. A little bit of context needs to be put into this. What might work very well in some areas might not work quite so well in others. You have to be a little sensitive to that.

Generally speaking, the disease is so new that we need to build up a body of knowledge about it, how it is transmitted and how we can mitigate the effect of it. It is these sorts of things. Learning from others, it strikes me, is extraordinarily important, even given the caveat I just gave.

Angus Brendan MacNeil: There was mention earlier of the difficulties in the UK in understanding what was going on from various borders to various borders. Was this because people are not used to getting specified messages for their localities or their particular nations? Is it an issue with the media, which is very London-centric, not itself fully appreciating the differences of the UK and just thinking that the UK is an extension of London? Was something like that behind it?

Professor Colin McInnes: Clearly, the latter is very evident. The way in which the UK is conflated with England in a lot of the London-based media is very evident. People get their information from multiple sources. They will get it perhaps from the BBC news, but they will read a local newspaper or look at a local Facebook site. It is these sorts of things. People tend to get a mix of UK-wide and more local or national sources of information. That is where the confusion can sometimes come in: if they are seeing a message from the BBC or one of the London-based newspapers saying one thing but they are being told by their local council to do something else. People get their sources of information from multiple different areas, and they cross the borders of the UK.

Professor Frederic Bouder: I have been able to compare the UK and Norway a bit. In Stavanger in Norway, for example, the communication on Covid-19 is driven very much by the local community and the local authority. It is really clear that the message is coming from there. You have a lot of signposting, et cetera. It is a very local type of

communication. I am not sure that is so striking in the UK, where there is more of a mix of communication.

Q30 **Lord Brennan:** The phrase "individual resilience" has become quite fashionable in talk about national security risk. What do you think about that phrase when we apply it to a pandemic? We can see social resilience or community resilience, where there was so much appreciation for what the health service has been doing in recent months, but individually it does not help somebody physically if the Government tell you not to touch other people and not to talk to them. How does this concept of resilience play with you people in the context of the pandemic?

Professor Sophie Harman: The context of the term "resilience", particularly in the UK context, came in after a period of austerity, and there was a question as to how the citizens of the UK would cope and provide certain social functions or public goods that were previously provided by the state or that the state has been cutting back on.

I understand the term in that context. As you quite rightly point out, it normally puts the onus on the individual to cope or deal somehow with a situation, so it is actually quite unhelpful. It also manifests distrust in the public, because the public are aware of what it means; it means that you are on your own, to an extent. It is quite unhelpful, and people working in global health increasingly know that there is this push towards the individual.

Talking about the individual more broadly in global health, aid and development, you see that more in individual choice, in the need for the individual to take responsibility, in the idea that the state does not provide, and even institutions such as the World Bank that are quite positive about these responses are themselves arguing that you need to have strong state infrastructure, not just for public health emergencies and outbreaks but for building functioning, effective health systems.

Professor Frederic Bouder: I will add something about the Norwegian context. Norway has a smaller population and is a more closely knit country in a way, but there has been a lot of emphasis precisely on keeping social links and there have been fewer severe measures such as telling people not to meet people from outside the family, et cetera.

The emphasis has been much less on that for reasons that have been quite explicitly stated: the country wants to have a more community-based response. They do not want individuals to feel isolated. There are different approaches in that respect, and maybe there is more emphasis on not leaving the individual feeling too isolated. They are also providing support to employers, et cetera. These mechanisms have also been taking place, which is not so surprising, coming from a society that traditionally has a more socialised approach.

Professor Colin McInnes: We have understood for some time that an emergency or a crisis cannot simply be pigeonholed as a health crisis, a security crisis or an economic crisis. It brings in lots of different things.

What we have seen with Covid is clearly a health crisis, but it is clearly also an economic and a social crisis. It is about how communities work together and how individuals survive when they do not have a community, which they are used to, to network with, relate to and so forth.

One of the things I found quite interesting is that there has been a long-running almost acceptance in sociology about the nature of risk. Risk is no longer seen as risk to a society but as a risk to an individual. The thinking is, "If something happens to me, how badly will it affect me?", rather than, "There's extremely low prevalence in the community. I'm not likely to get it. I should not be too worried about it".

We are seeing this play out a little bit here, but we are also seeing some individuals apparently thinking that because they are of a certain demographic they are less likely to be severely affected by Covid and therefore that some of the restrictions should be less applicable to them perhaps than to others. You are seeing this individuation of risk rather than a sense of community risk versus an equally strong narrative that there is a community here and we need to protect the vulnerable in the community.

This is playing out on a daily basis in the UK. It is playing out in the town in which I live, as I speak to you now. In my university, we have a small outbreak because of a number of irresponsible individuals. We are seeing a very interesting pattern within society. On the one hand, people are really coming together as a community and saying, "We are all in this together", whether it is banging the drums, clapping for the NHS or whatever—that was a very strong community response that was utterly astonishing; I had not seen anything like this for a long time—versus people saying, "The risk to me is not that great. I am not going to follow these regulations and rules that have been imposed on us and that curtail our liberties".

This tension between an individuation of risk and a greater sense of community that has been apparent at times is quite interesting.

Q31 **Lord Powell of Bayswater:** We have three absolutely outstanding witnesses. You have been extremely clear and jargon-free on a subject that attracts a great deal of jargon.

I will try to compress my questions into two in the interests of time. The first regards horizon-scanning and surveillance for approaching risks in the area of infectious diseases. Is the WHO quick enough on this? Is it too cautious? Is it too cautious in declaring a public health emergency? Could we do better by relying on our own resources? One could say that we ourselves were too slow in responding to the public health emergency, when declared. That is one area of questioning.

The second question is about the role of SAGE. Is its membership diverse enough? Does it have no only expert scientists but people who have a much wider range of experience, on delivery particularly? What about the role of politicians on SAGE? Do they defer too much to the scientists?

After all, many of the subjects are properly for politicians, not for scientists. It sometimes seems that they look to the scientists to be responsible for answering almost every question.

Professor Colin McInnes: There is this idea of the World Health Organization as a huge body with lots of resources and lots of information coming into it. That is far from the case. The budget for the World Health Organization is roughly that of a large city hospital. Much of that budget is ring-fenced for specific projects decided by states. The scope which the secretariat has to respond to things is quite constrained.

The second element of the defence of the World Health Organization is that it is an inter-state organisation. It is largely still dependent on the information that states provide it with. It has provision, under the revision of the international health regulations in 2005, to get information from third parties, from civil society organisations, et cetera, but by and large it is still heavily dependent on what states tell it. If states do not tell it the truth, it cannot do much about it. It has some other sources of information, but it is still heavily dependent upon states. Those are the arguments in defence of the World Health Organization.

The argument against it is that this is an organisation that has a history of being constrained by its own bureaucracy and is not particularly agile in responding to emergencies because of that. There are parts of the World Health Organization that are good at that. Some of its emergency response teams are very good, but as an organisation it is slow, beset by bureaucratic issues and not particularly effective at what it does. I am not making an argument here for getting rid of the World Health Organization. All I am saying is that it could and probably should be better run.

I do not know enough about SAGE and whether you should expand it to include other people. If you accept the fact that Covid is a social and economic crisis, the advice you need needs to be on the social and economic effects of possible policies and developments as well as the medical effects. You will be more aware than I am that advisers advise and politicians decide. Politicians are our elected representatives, and it is their responsibility to decide how our country responds to things like this.

Having said that, with something like Covid, you will get so many different pieces of opinion about what is going on and what the best response will be, particularly in the early stages, when it is very difficult to see a concerted and coherent scientific response. When you get that, that is great, but quite often you are dealing with margins of uncertainty, and that is where politicians using their judgment have to make the decisions. I am all in favour of advisers advising, but at the end of the day the politicians are the ones who are elected to make the decisions for us.

Lord Powell of Bayswater: Did Germany benefit from having a scientifically qualified Head of Government?

Professor Colin McInnes: Can I pass on that? I do not know. I suspect that politicians would be sufficiently adept at taking advice as to not require them to be experts in that particular area. I do not think that necessarily follows, but I would not want to go firmly on that.

The Chair: I have long held the prejudiced view that having a scientific background enables you to distinguish between evidence and opinion, which is not always evident elsewhere.

Professor Frederic Bouder: On the first point, I do not work so closely with the WHO. In a previous life, I worked for the OECD before I became an academic. I recognise some of the tensions between the positives of bringing people together that an international organisation has and the issues of bureaucracy at the international level.

In the future there should perhaps be some thinking about mechanisms to link countries with organisations better in such cases. That may be something to think about. I do not have the answers. That is just a question.

In terms of science and politics, I have quite strong views about there being sins on both sides. Some scientists are happy to have their moment of fame, because they get an article in the *Guardian* or somewhere else or because they are co-opted to a committee. That is a problem, because they need to keep their feet on the ground and say, "That is what we know and what we do not know. What we know could be revised, because that is the process of science". The politicians can hide behind the scientists and say, "I'm just following the science". That is their mortal sin as well.

Scientists, within the limits of their knowledge, which of course is segmented, need to provide advice honestly, but they should not get too far into advising. They should provide some advice but not do the deciding or being co-deciders. The politicians need to have the guts to say, "I've looked at different streams of evidence, which might be revised, and I'm making a decision". I understand that it is tough sometimes, but that is their role. That is what they are elected for.

That brings me to SAGE. It is important to keep that in consideration. Politicians need to have a mechanism that is sufficiently broad. The architecture is up to them to define, and not so much for me to comment on, but you need dialogue about the medical aspects, the epidemiological aspects, the economic impact, and the societal impacts that we discussed earlier to do with families and so on. You need these bodies of evidence to be put together somehow to help the politicians make the decisions. This is very important to articulate.

Professor Sophie Harman: I absolutely agree with Colin's comments about the WHO. As we know, it is underfunded. It is sometimes its own worst enemy. It can be cautious. What is interesting is that all the opinion pieces and op-eds that have come out basically argue for the WHO. They say, "We need these mechanisms". The Prime Minister made

comments to the General Assembly about setting up a zoonotic research centre, but that exists within the WHO. It is about investing in these mechanisms that already exist.

The architecture of global health governance has often seen splits and the creation of new institutions. That can lead to overlap and confusion. I would very much caution against that. You can sometimes accuse the WHO of trying to protect the institution itself and going into defence mechanism mode, but that is unsurprising given some of the criticism the WHO has had consistently over the last 20 or 30 years and the erosion of its funds. You can see why it has got to that point. Like Colin, I am very much arguing not for less WHO but for more WHO, and not creating new institutions outside that.

With SAGE, as a professor of international politics interested in global health, obviously I think that it should have us there. Sometimes, diversity can dilute what it is concentrating on. You could have standing members who came and contributed and then reached out to committees such as this one to say, "Can you contribute?" I do not want you to recoil, but an all-of-government approach is handy in these kinds of circumstances.

Absolutely, politicians decide. On the politicians point, in the UK there is a concern that the politicians will start deferring to the scientists when they start to blame people for what is happening in the response. Ultimately, these decisions are for politicians, and we should see more of that.

On the Merkel question, it is not because she is a scientist. She is an exceptional leader, and you have seen that throughout her chancellorship. In respect of whether scientists make better politicians, that is not necessarily the case. It could be unhelpful, because they could be a scientist in another area of expertise. They may work in a systematic way like a scientist, but they may also have certain judgments and confirmation biases of their own.

Q32 **The Chair:** I want to raise one final point with all of you. As we have talked, what has come through very clearly is that there have been certain circumstances—I heard this from Professor McInnes in particular—in which having different national responses within the United Kingdom when we are facing the same public health risks has been unhelpful and has perhaps run the risk of confusing the public. Overall, do you think that that verdict is generally right? No doubt there have been bits and pieces where the different constituent bodies in the UK could learn from each other, but on balance do you all feel that the differences have been unhelpful?

Professor Colin McInnes: It has been unhelpful. People in Wales listen to what the Prime Minister says and then they hear a different story from the First Minister, and that is not always very helpful. On the other hand, I would defend devolution as a democratic thing. I am not criticising that. Please do not misunderstand me; otherwise my colleagues will be most displeased with me when they hear.

Chair: I was not trying to infer that.

Professor Colin McInnes: As somebody who lives in one of the devolved regions, this has clearly been problematic. My daughter is at university in England, and at various times we have to try to understand whether we can actually go and see her because of different travel rules. It is not straightforward, and that is even more the case for people who live on one side of the border and work on the other side. It is not helpful at all, but perhaps this is an inevitable consequence of trying to have local responses to what is a global crisis.

Professor Sophie Harman: I agree. It is problematic for public understanding and for public trust. Again, it comes back to our earlier discussion about context—how you have that messaging and who or what is communicating it.

Professor Frederic Bouder: It is very important to keep the channel of communication very open between the various authorities. It does not help when there is bickering and competition in such circumstances. It is not so much the fact that there are different nations organised within a constitutional arrangement but that, within that system, there needs to be some clear co-operation and a fairly united front.

It might be interesting to look at some foreign examples. We have a project looking at Germany and Switzerland, for instance, which have a long history of federal systems. That is not the UK system precisely, but it is quite interesting when it comes to balancing the diversity of the constitutional arrangements with co-operation when there are issues like this.

The Chair: I echo Lord Powell's words: it has been an extremely good session. Thank you very much indeed to all of you, and thank you to members of the Committee.