MODULE 2C QUESTIONNAIRE TO INDEPENDENT SAGE MEMBERS

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Date: 25 July 2023

1.	**Please provide some information as to:** **a. Your professional background and expertise; and** **b. A brief explanation as to:** **i. Any roles which you held during the pandemic;** **ii. How you came to be part of Independent SAGE; and** **iii. What your involvement with Independent SAGE entailed.**
	Response: My qualifications are as follows: MB BCh BAO Queen's University of Belfast 1979; MRCP (UK) 1982; MSc in Community Medicine, University of London 1986; MFPH 1988; Specialist accreditation in community medicine May 1989; MD 1990; DSc 2006 In terms of career history, my main post is that of Professor of European Public Health at the London School of Hygiene and Tropical Medicine (LSHTM) (which I have held since 1997). I was previously senior lecturer and later reader at LSHTM 1990-1997, and hedl training posts in internal and public health medicine prior to that. My other current roles are Honorary consultant, University College London Hospital NHS Trust; Medical Director LSHTM; Research Director European Observatory on Health Systems and Policies (a partnership posted by WHO); Member, EU Expert Panel on Effective Ways of Investing in Health; President, British Medical Association (until July 2023). In terms of professional expertise, I trained in internal medicine and then public health medicine. Since 1990 I have led a major programme of work on the health impact of large scale social, economic, and political change. This began with the collapse of communism in Europe and continued with the 2008 global financial crisis and then the COVID-19 pandemic. I have also made major contributions in the area of health systems research, including (with Ellen Nolte) developing the measure of avoidable mortality used by the Global Burden of Disease study, OECD, and the Commonwealth Fund in the US, among others. As I am researching complex topics, my work is transdisciplinary, integrating different perspectives and using multiple methods. I have published over 1,400 papers in peer-reviewed journals and am in the top 1% of scientists worldwide measured by citations (Clarviate). My contributions have been recognised by, among others, seven honorary doctorates and election to the UK Academy of Medical Sciences, Academia Europaea, and the US National Academy of Medicine. During the pandemic. I was a member of Independent SAGE (see below) and, in my role as a member of the EU Expert Panel on Effective Ways of Investing

	in Health, have contributed to a series of reports for the European Commission. These include reports on resilience of health systems, protecting mental health of health workers during the pandemic, and public procurement (which included a major section on procurement during the pandemic), on which I was the co-rapporteur. In my role as Research Director of the European Observatory, I was responsible for the COVID-19 Health System Response Monitor (https://eurohealthobservatory.who.int/monitors/hsrm/) , a resource that has collated information on national responses to COVID-19, run in partnership with WHO and the European Commission. As health adviser to the WHO Regional Director for Europe, I was invited to be a member of the Pan-European Commission on Health and Sustainable Development in the Light of the Pandemic, chaired by Professor Mario Monti, in which role I led the drafting of the report and wrote the evidence review that underpinned it. This work is being taken forward by WHO, where I continue to play a major role.See: https://www.who.int/europe/groups/pan-european-commission-on-health-and-sustainable-development In relation to this statement, I should add that I was born in Northern Ireland and lived there until I was 30. I retain links with the academic community there, for example as chair of the Scientific Advisory Committee of a local charity, the NI Chest, Heart, and Stroke Association, and appeared frequently on Radio Ulster and Radio Foyle during the pandemic. My publications include a selection of papers on COVID-19 include: 1. Douglas M, Katikireddi SV, Taulbut M, McKee M, McCartney G. How can we protect against the wider health impacts of the COVID-19 pandemic response? Social distancing may cause significant adverse effects on health inequalities. BMJ 2020; 369: m1557 2. Rajan S, Cylus J, McKee M. What do countries need to do to implement effective 'find, test, trace, isolate, support' systems? J Roy Soc Med 2020; 113: 245–250 3. Clark A, Jit M, Warren-Gash C, Guthrie B, Wang HHX, Mercer SW, Sanderson C, McKee M, Troeger C, Ong KI, Checchi F, Perel P, Joseph S, Gibbs HP, Banerjee A, Eggo RM, CMMID COVID-19 working group. Global, regional, and national estimates of the population at increased risk of severe COVID-19 due to underlying health conditions in 2020: a modelling study. Lancet Global Health 2020; 8: E1003-E1017 4. Roberts CM, Levi M, McKee M, Schilling R, Lim WS, Grocott M. COVID-19: a complex multi-system disease Br J Anaesthesia 2020; 125: 238-242 5. Vanoni M, McKee M, Bonell C, Semenza J, Stuckler D. Using volunteered geographic information to assess mobility in the COVID-19 pandemic context: cross-city time series analysis of 41 cities in 22 6. Rajan S, Comas-Herrera A, McKee M. Did the UK government really throw a protective ring around care homes in the COVID-19 pandemic? J Long-Term Care 2020; 2020: 185-195. 7. Han E, Tan MMJ, Turk E, Sridhar D, Leung GM, Shibuya K, Asgari N, Oh J, García-Basteiro AL, Hanefeld J, Cook AR, Hsu LY, Teo YY, Heymann D, Clark H, McKee M, Legido-Quigley H. Lessons learnt from easing COVID-19 restrictions: an analysis of countries in Asia Pacific and Europe. Lancet 2020: 396: 1525-1534

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2.	**The Independent SAGE Report of 12 May 2020 ("Recommendations for government based on an open and transparent examination of the scientific evidence") ("the May 2020 Report") states at page 21:**

	"One of the main criticisms of the response by the UK government so far has been the highly centralised approach that it has taken, in some cases excluding the governments of the devolved administrations from key decisions. The elected administrations in Scotland, Wales and Northern Ireland have the powers to determine their own policies in many aspects of the response to the coronavirus pandemic. While the general position has been to adhere to the decisions made in Whitehall, each administration has the opportunity to determine the distinctive measures needed to safeguard the well-being of the population for which it is responsible. The pattern of infection with the virus appears to vary markedly across the UK and the devolved administrations should take the opportunity, where possible, to engage fully in the introduction of our strongly recommended approach of case finding, testing, tracing, and isolation. This should be a cornerstone of their approach. Northern Ireland is a particular case, having a land border with the Republic of Ireland. We urge the Northern Ireland Assembly Executive to seek to harmonise their policies with those of the Republic of Ireland in keeping with the commendable Memorandum of Understanding that has been agreed between the two jurisdictions in relation to the coronavirus crisis." **Did you have a personal view as to the importance of the devolved administrations developing their own responses to the pandemic?**
	Response: My personal view is that the responses by the devolved administrations should be informed by a consensus about the science, as far as is possible given the state of knowledge at any time, and its implications. Then, the principle that should be applied is that the elements of the response should be determined at the level at which they can be implemented. Thus, it is necessary for elements that involve reserved matters, such as border checks, to be decided at Westminster. Other elements, relating to devolved matters, are best made by the devolved administrations. Similarly, decisions that must be implemented at lower levels, such as local authorities, should be made at those levels. Here, I might note the evidence given by Matt Hancock to the Inquiry, where he made much of the mismatch between his nominal responsibility for social care and his lack of levers to deliver on it. I also note the evidence given to the inquiry by politicians and officials from Northern Ireland about the challenges involved in cross-border collaboration on the island of Ireland. However, this requires absolute clarity on who is responsible for what and, as the Inquiry has heard, this was at times confused. Here I am thinking of the evidence presented by Dame Jenny Harries which seemed to suggest a lack of clarity about the role of Public Health England. In general, there are strong arguments for responses to be consistent across the tiers of government, as indeed there are between national governments

	(in particular on the island of Ireland), for two reasons. First, the science should be the same, although we must recognise that there will always be some uncertainty and different scientists, including those from different disciplines, may place greater weight on some pieces of evidence than others, and second, those promoting disinformation or otherwise seeking to undermine responses will exploit any differences. However, there are differences that may legitimately occur and lower tiers of government will often have information that is not known by those higher up. Thus, the logistic challenges of providing support in inner London are very different from, for example, the island of Barra. There may also be different constraints, for example in terms of resources, that may have to be considered. I might add that, where differences occur, advantage should be taken of the opportunity to learn from them. An example is a study we undertook that exploited small differences in the easing of lockdowns in England and Scotland that allowed us to see the impact on mental health of groups within the population: Serrano-Alarcón M, Kentikelenis A, McKee M, Stuckler D. Impact of COVID-19 lockdowns on mental health: Evidence from a quasi-natural experiment in England and Scotland. Health Econ 2022; 31: 284–296. Abstract: *The COVID-19 pandemic has been associated with worsening mental health but it is unclear whether this is a direct consequence of containment measures, like "Stay at Home" orders, or due to other considerations, such as fear and uncertainty about becoming infected. It is also unclear how responsive mental health is to a changing situation. Exploiting the different policy responses to COVID-19 in England and Scotland and using a difference-in-difference analysis, we show that easing lockdown measures rapidly improves mental health. The results were driven by individuals with lower socioeconomic position, in terms of education or financial situation, who benefited more from the end of the strict lockdown, whereas they suffered a larger decline in mental health where the lockdown was extended. Overall, mental health appears to be more sensitive to the imposition of containment policies than to the evolution of the pandemic itself. As lockdown measures may continue to be necessary in the future, further efforts (both financial and mental health support) are required to minimize the consequences of COVID-19 containment policies for mental health.*
3.	**Why did the authors of the May 2020 Report attach such significance (in particular) to each nation pursuing its own strategy as regards test, trace and isolate? Did you regard that as being of particular importance to Northern Ireland?**
	Response: I refer to my statement above. I believe that decisions should be made at the level where they can, most appropriately, be implemented, and where those making the decisions have knowledge of the context. Again, I note that I would anticipate that areas such as the Scottish islands would face particular challenges, but also opportunities. One issue that I believed was relevant was the differing structure of the NHS and public health in the four nations. Thus, the Inquiry has already heard concerns about the separation between the

	NHS and public health in England but this is not the case in the other three nations. In thinking particularly about Northern Ireland, I believe that the basic principle of taking decisions at the best level applies but with the additional consideration that Northern Ireland has a land boundary with another country. Here, I would note that the same considerations apply to Gibraltar and the Sovereign Base Areas in Cyprus but I have not studied these cases.
4.	**It is noted that in your evidence to the Northern Ireland Assembly Health Committee (on 14 May 2020), you stated:** ***"The island of Ireland is already treated as one for animal health, so it seems odd that it is not treated as one for human health. Islands always have an advantage. We see it in New Zealand, for example, where they have been able to impose certain restrictions and keep their death rate down to double figures or very, very low numbers. There is a clear argument for having consistency of policy."*** **Did you have a personal view as to the importance of Northern Ireland seeking to harmonise its approach with that of the Republic of Ireland?**
	Response: As has been noted throughout the discourse on Brexit, a large number of people cross the Irish border each day, with an estimated 30,000 moving for work. This fact has previously contributed to the creation of a number of cross border mechanisms to collaborate in health, for example Cooperation and Working Together, although in that case health was seen as a means of promoting Peace and Reconciliation rather than a goal in its own right. See, for example, chapter in the book Patient Mobility in the European Union, which I co-edited: https://apps.who.int/iris/handle/10665/330350 These arrangements provided a sound basis for enhanced collaboration in my view should it be desired. In my view the case for collaboration arises because people were crossing the border in large numbers and, even if this diminished during the pandemic, this would facilitate the transmission of infection. It would seem important to ensure that there is free flow of information, for example to facilitate surveillance, as well as consistency of rules, to the extent possible, to avoid confusion. Again, there is a risk that when two jurisdictions adopt differing policies there is scope to exploit the difference by those seeking to portray authorities as not knowing what they are doing.
5.	**Reference has also been made in commentary to the North-South cooperation on agriculture as effectively enabling the island of Ireland to be treated in policy and operational terms as a single epidemiological unit for the purposes of animal health and welfare (in support of an argument that Northern Ireland and the Republic of Ireland ought to have been regarded as a single epidemiological unit for the purposes of Covid - 19). Can you explain whether you considered that the animal**

	health model was an appropriate or sound comparator in this context? It would be helpful if you could explain any reasons for your views.
	Response: In the report and evidence review for the Pan European Commission on Health and Sustainable Development (see earlier) we made a strong argument for a OneHealth approach, aligning policies on health of humans, animals, and the natural environment. This is now being taken forward by WHO and other UN agencies such as FAO. It simply seemed logical that, as the island of Ireland already operated a single animal health approach, it made sense to do the same for human health. Many of the issues involved are, from a scientific perspective, very similar, although I concede that politicians concerned with the concept of sovereignty may disagree.
6.	**Did you consider that there was a proper or reasonable basis to compare Northern Ireland with other island nations (such as New Zealand) in relation to the pandemic? Can you explain, in epidemiological terms, what advantages Northern Ireland might have had by reason of its geography or physical location?**
	Response: This raises the question of border controls. Their role in a pandemic is highly contested. In general, advice has been against them but, in my view, this is largely because the interests of trade have been prioritised over health. Given how many other factors need to be taken into account, a clear answer to the question "do they work?" is probably impossible. Such factors include when, in the course of a pandemic, they are introduced, how easy they are to enforce, geography (the small Pacific Island states such Samoa, Tuvalu, and Kiribati were extremely successful at keeping infection out but their geography is quite specific – they were of course also influenced by the memory of earlier devastating importations as in 1918 in Samoa when influenza killed an estimated 20% of the population, the scale and nature of collateral damage. However, in a systematic review that we undertook, we concluded that they did have a role: Chung SC, Marlow S, Tobias N, Alogna A, Alogna I, You S-L, Khunti K, McKee M, Michie S, Pillay D. Lessons from countries implementing find, test, trace, isolation and support policies in the rapid response of the COVID-19 pandemic: a systematic review. BMJ Open 2021;11:e047832. Both Ireland and New Zealand are islands, with existing checks on entry and exit. It was possible, in continental Europe, to close borders as the Schengen Agreement contains provisions to do so in an emergency, but this is obviously more difficult when people can cross in locations away from checkpoints. I also note that regional authorities in Italy sought to control movement with checks on motorways but, again, this is difficult. Consequently, if it is considered desirable to restrict movement, it is inherently easier to do so on an island. That said, I fully concede that the normal volume of movement across the Irish Sea is greater than that between New Zealand and other countries, so it would be more difficult.
7.	**If you were in favour of, or advocated for, an approach based upon**

	harmonisation: **a. Can you explain what you considered might be achieved by it (from an epidemiological perspective)?** **b. What did you envisage might be harmonised?** **c. What benefits (again from an epidemiological perspective) did you consider might accrue from having a commonality of approach (rather than duality of approach)?**
	Response: A priori, when two jurisdictions are separated by a land border across which large numbers of people move regularly and, as in this case, there are practical and political barriers to imposing health checks at the border, it seems obvious that close collaboration will be necessary. I would envisage that this will facilitate a more granular understanding of the course of the pandemic I did not look in detail at what might be harmonised as this as it would have required a more detailed knowledge of existing collaborations than what I was privy to.
8.	**The May 2020 Report referred to the Memorandum of Understanding. It recites as part of its preamble:** ***"Everything possible will be done in coordination and cooperation between the Irish government and the Northern Ireland Executive and with the active involvement of the health administrations in both jurisdictions to tackle the outbreak. Protection of the lives and welfare of everyone on the island is paramount, and no effort will be spared in that regard".*** **Did you do any further work or research after May 2020 as to the extent to which there was co-operation in the fields set out in the Memorandum in response to Covid-19?**
	Response: No.
9.	**Do you have any opinion as to the following:** **a. Whether Northern Ireland and the Republic of Ireland ought to have pursued opportunities for cooperation set out in the Memorandum (because they may have improved the response to Covid -19 in either or both territories)?** **b. Whether there were particular areas or types of work which lent themselves to co-operation?** **c. The extent to which there was cooperation between Northern Ireland and the Republic of Ireland.**

	d. Whether Northern Ireland and the Republic of Ireland took advantage of these opportunities for cooperation (in pursuit of the common aim of tackling Covid - 19)?
.	**Response:** **a. Whether Northern Ireland and the Republic of Ireland ought to have pursued opportunities for cooperation set out in the Memorandum (because they may have improved the response to Covid -19 in either or both territories)?** I do not have detailed knowledge of what was done, although I have listened with care to the evidence given to the Inquiry by politicians and officials from Northern Ireland, which I interpret as showing that there were many weaknesses. For the reasons stated above, I believe that it would have been a good idea. **b. Whether there were particular areas or types of work which lent themselves to co-operation?** Again, I have been unaware of what was being done, except for what I have learnt from evidence given to the Inquiry, but I would include exchange of epidemiological data, in particular communication of more granular data than the national information available on platforms such as GISAID, cooperation between laboratories to maximise capacity, collaboration by healthcare providers to increase the flexibly of scarce resources, exploring means to achieve interoperability of contact tracing apps (as was done within the EU). As others have noted, early in the pandemic the highest rates of infection in Ireland were in border counties. https://sluggerotoole.com/2020/05/12/establishment-of-biosecurity-zones-could-allow-different-regions-of-ireland-to-safely-emerge-from-lockdown-at-different-speeds/ **c. The extent to which there was cooperation between Northern Ireland and the Republic of Ireland?** I am unable to answer this question beyond the evidence already given to the Inquiry. **d. Whether Northern Ireland and the Republic of Ireland took advantage of these opportunities for cooperation (in pursuit of the common aim of tackling Covid -19)?** I had no first hand knowledge of what happened but I have listened with care to the evidence given to the Inquiry which, in my interpretation, raises serious concerns.
10	**If you are of the view that opportunities for cooperation were missed or not pursued, do you have any views as to what barriers to obtaining cooperation may have existed?**

	Response: I have only limited knowledge of the information that would be needed to answer this question. However, issues that I am aware of include: a) The seeming illogicality of the situation whereby, when the UK moved out of the first lockdown, it decided that it would not apply quarantine requirements on travellers entering the UK on direct flights from Ireland. Meanwhile, Ireland maintained a 14-day quarantine restrictions on travellers on flights from the UK. This was further complicated by the ability of people to enter Ireland via Northern Ireland and, although this should have been reported, it was difficult to see how this could be enforced. b) The situation where cross-border workers living in Northern Ireland but working and paying taxes in Ireland were only able to claim less generous benefits in the former. c) The fact that the NI Executive is funded, through the Barnett formula, to provide the same level of services as in the rest of the UK through a block grant. Consequently, had it wished to go beyond that to align with Ireland it would have had to raise additional funds.