The problems of commissioned oral history: the swine flu 'crisis' of 2009

by Virginia Berridge and Suzanne Taylor

Abstract: An oral history of the response of the UK Health Protection Agency (HPA) to swine flu in 2009 revealed how, even after extensive pre-planning, the turn of events took health agencies by surprise. The HPA, rather than the NHS, initially ran the on-the-ground response, and tensions occurred at the local level where health agencies operated uneasily in relation to each other. At the national level, politicians were unwilling to drop a crisis response and were divided about the nature of risk communication to the public. This oral history exercise, which ran into trouble with its funders, throws light on both the problems of commissioned, government-funded oral history and the issues for such history at a time of crisis.

Keywords: swine flu; crisis; commissioned oral history; health policy

Introduction

Since the millennium there has been discussion in the oral history field of 'crisis oral history', with work on the aftermath of Hurricane Katrina, the Haitian earthquake, the Deepwater Horizon oil spill and other crisis events.[1] Recent discussion of oral history and crisis has its precursor in research on a health crisis and methodological discussions in the 1980s and 1990s about the use of oral history among other sources for research on the history of the HIV/AIDS crisis, in which I (Berridge) was involved, along with historians in the US.[2] Another ongoing discussion, not specifically tied to oral history, has been about the problems that can arise in carrying out government-commissioned and government-funded research. For example, in 2016 Sense about Science published *Missing Evidence: An Inquiry into the Delayed Publication of Government Commissioned Research*, led by a former Lord Justice of Appeal, the Rt Hon Sir Stephen Sedley. It argued that 'delayed publication can be as damaging as indefinite suppression because it deprives parliamentarians, the media, NGOs and others of the timely access they need in order to be able to engage with policy formation in the light of contemporaneous evidence'.[3]

The purpose of the current article is twofold: to discuss the result – the policy-relevant issues – that came out of an oral history project dealing with what had been perceived at the time as a health emergency, but also, in the context of debates on government-funded research, to reflect on the difficulties inherent in the relationship that this project entailed. In this case the funding source, ethical permission and the timing of project publication caused major problems for the research. This paper is presenting results for the first time, some years after the events.

The project: swine flu 2009 and the role of the Health Protection Agency

Swine flu hit the UK in April 2009. The Health Protection Agency (HPA) was one of the central government agencies at the forefront of the response and was proud of its role. One of its senior staff, who

had an honorary appointment at the London School of Hygiene and Tropical Medicine (LSHTM) and an interest in history, approached me to see if I would be interested in conducting an oral history study. The aims were to document how responses had evolved in order to gain insight into organisational links that had operated, and to provide a resource for future pandemic planning and future research into the history of public health. The outputs were to include a web booklet on the HPA website and other publications as well as the archiving of the interviews. I was attracted to the project through my own research interests in public health and the relationship of history to policy. I had a wide portfolio of publications in the contemporary history of health and had used oral history in policy-making circles, a very different focus from the history-from-below oral history which had been part of my earlier work on opium.[4] I had also reflected on the oral history of elites and the different issues it presented in several publications.[5] My institution, the LSHTM, is a global centre for public health research and provides useful ongoing contacts for the Centre for History in Public Health, a group of professional historians of which I was director at the time. Our location in the midst of epidemiologists, health economists and other health disciplines was unusual for the historical profession. The project was also opportune in the present-day academic world in providing employment for Dr Suzanne Taylor, who had been working for me as a researcher and who was coming to the end of her contract.

A staff member in the LSHTM research grants section warned me that the contract was a standard government one, which gave the funding department ownership of the research and hence could prevent publication. However, this caveat was not seen at the time as a reason for not going ahead.

The background: the HPA, swine flu

First, some context is in order. What was the HPA? It was an arm's-length organisation, a Special Health Authority originally formed in 2003 from an amalgamation of several government agencies. The impetus for its establishment came from the post-millennium concern about the threat presented both by infectious disease and by exposure to chemical and radiological hazards, possibly through deliberate release by a terrorist organisation. The new organisation brought together several existing government health and surveillance agencies, including the Public Health Laboratory Service (PHLS) and the Communicable Disease Surveillance Centre (CDSC). The aim, articulated in an influential report from the government's Chief Medical Officer (CMO), *Getting Ahead of the Curve*, was to ensure that health protection and emergency planning operated effectively from the national to the local level.[6] In 2005 the HPA incorporated the National Radiological Protection Board (NRPB) and was reconstituted as a non-departmental public body: this meant it was at arm's length from government. As well as its constituent bodies, it had a regional and local organisational dimension with parts of the agency operating at those levels. The HPA, prior to swine flu, gained considerable experience in dealing with a range of serious threats to public health, including SARS (severe acute respiratory syndrome) in 2003, polonium poisoning with the Litvinenko case in 2006, the Buncefield explosion in 2005 and the London terrorist bombings in the same year. Its brief included: providing independent advice to government; support for the NHS and other organisations; the monitoring and response to new threats to public health; and improvement of knowledge through research and training.

Pandemic planning was very much to the fore after the millennium. The new avian influenza virus (H5N1), shown as passing from birds to humans in 1997, had sparked global interest. Official investigations took place at both national and international level. The House of Lords Science and Technology Committee published its report *Fighting Infection* in 2003.[7] The World Health Organization had set out guidelines for preparedness in 2005 and the European Union and member states also developed plans after 2005. In Britain contingency plans were published by the Department of Health at the same time.[8] The House of Lords Science and Technology Committee published a report, *Pandemic Influenza*, soon after this, which raised concerns about the existing plans.[9] The Royal Society and the Academy of Medical Sciences also published a report on the role of science in planning, recommending some changes to the structures for planning and response.[10] The Department of Health and the Cabinet Office then published *Pandemic Flu: A National Framework for Responding to a Pandemic* in November 2007.[11] This document formed the basis for the response to the 2009 swine flu outbreak. The plans were tested with several planning exercises, among them one codenamed 'Winter Willow', held in early 2007, which identified a number of issues that subsequently proved problematic in 2009. Nevertheless, the HPA's role was clearly set out, with levels of response and a clear reporting structure.[12] The National Health Service was to be the operational lead, running a national service dealing with an outbreak or epidemic, while the HPA would play a subsidiary but vital role providing information and surveillance for decision making. A follow-up inquiry by the House of Lords was underway when the pandemic struck in April 2009, providing a real-time test. It should be noted that the shorthand popular term 'swine flu' was used (just as 'bird flu' was used at the turn of the century to characterise avian flu) because the flu virus was similar to one that also affected pigs. The outbreak began in Mexico in April 2009 and spread worldwide due to the absence of immunity to the new virus, among young people in particular.

The first two confirmed cases were on 27 April 2009: a couple who had returned to Scotland from

Mexico. Over the next seventeen months, the UK saw two waves of infection. Responses moved from the initial policy of containment of spread, to a strategy of treatment only, and then to a vaccination programme. An extensive H1N1 (the official swine flu virus name) information campaign was mounted across all media. The vaccination programme, which began in October 2009, focussed on specific risk groups: young people, immune-compromised patients and pregnant women. In the end, most people affected experienced a relatively mild illness and numbers were nowhere near as high as projected. The number known to have died by March 2010 was 457. In August 2010, WHO declared the end of the pandemic. The episode had really been a crisis that never was.

Oral history interviews

Our research focussed on oral history interviews. A brief literature review examined the historiography of past epidemics, among which the 1918 influenza epidemic loomed large – a past pandemic which became of particular interest to policy makers.[13] We also looked at reviews of the 2009 response, including a recently published report by the Welsh CMO, Dame Deidre Hine.[14] But most of our attention focussed on twenty-five informal interviews with HPA staff, which we carried out in 2010. The HPA provided an initial list of possible interviewees and this was modified as we developed the research and formed ideas about who we wanted to talk to. The aim was to talk to a cross-section of the organisation as well as staff from different levels. There was no restriction on either who we spoke to or the topics and content of the interviews. They were carried out in different locations: some in the workplace, some at the LSHTM. We also responded to suggestions from interviewees about who they thought it was important to interview. Some interviews were carried out by Suzanne Taylor, some by me and some we conducted together. This was helpful in terms of developing interpretation. The interviews were recorded and ethical permission was obtained from the LSHTM ethics committee. Interviewees saw an information sheet and signed a consent form that allowed for a choice of anonymity, use of attributed quotes and/or approval of quotes prior to publication. We kept to our brief, which was to interview HPA staff rather than other 'players' in the response. We were not given access to internal HPA documents. There is a danger of an 'official view' or 'received line' in the origins of an official project, but this was less the case as the research progressed. The immediate aftermath of perceived crisis proved to be a good time to interview as memories were fresh and concerns (which surfaced later) about policy acceptability were not apparent. The issue of timing was to recur in a less positive way when we moved to publication.

Findings from the interviews

In this section we will present some of the striking findings from our interviews, which could have been useful in the policy context but, in the event, were not. The 2009 pandemic has been discussed extensively, in particular in relation to the over-provision of vaccines, purchased in large quantities by government for an epidemic that never really happened.[15] But the response also raised other important issues that are still of relevance. We are not setting out a full historical analysis of the course of the epidemic here and our aim is not to criticise or blame. We rather highlight some issues that have received less discussion but which are nonetheless significant. In our draft report, we identified three phases of the response to swine flu. From April to June 2009 there was a period of containment, with the focus on limiting spread; the purpose was to slow the spread of the virus as much as possible. Another phase came from June to July when containment ended and treatment began, with WHO declaring the pandemic was at stage 6; the NHS National Pandemic Flu Service went live at the end of July. The first wave of infection peaked in July and the second in October. Finally, August to October was a time when the vaccination programme began, after discussion. Cases diminished between December 2009 and April 2010 and the NHS National Pandemic Flu Service ceased operation in February 2010.

We present the key issues that came from our interviews:

- Initial shock and unplanned responses: flu response centres
- Local responses: confusion between agencies
- National responses: expert advice and political decision making
- Risk communication
- Moving to the new public health service.

Initial shock and unplanned responses: flu centres

Despite the extensive planning for a pandemic, a feeling of shock and also excitement came over in the interviews. The first news of the outbreak in Mexico came through a casual comment.

> At the very end of March, we had a telephone conference between the G7 countries and Mexico, as part of the global heath security initiative […] at the end […] Mexico came up and said that our flu is carrying on a bit longer than normal […] That was two o'clock in the morning for me […] and they asked a question, what was the situation in other countries? We said our flu finished early March or at the end of February and we have only seen one or two cases a week […] and they said, oh, we are still seeing quite a lot of flu.[16]

The expected slow start did not occur.

> I should certainly have not been surprised that a pandemic would arrive, nevertheless I secretly harboured a view that the pandemic wouldn't arrive until after I retired […] When it arrived the natural first reaction

> to the first bit of news was, oh, that's of no significance, after all incidents involving flu in animals quite often spread into humans and cause small problems and then disappear. My first poor call [the interviewee means misjudgement] was that it was unlikely that we would need to set up an incident room. That was a wrong call within about twelve hours. That would have been on 27 April. But then it built from there. The next expectation having recognised that actually this was a real issue was nevertheless that it would take quite a bit of time for it to arrive properly in the UK […] there too I was completely wrong and it arrived within a couple of days and it started building up pretty much straight away.[17]

This initial period was one of containment as far as possible. Individual cases were investigated, surveillance projects launched, schools closed, contacts traced and anti-viral drugs recommended for early treatment of all cases and for prophylaxis of close contacts. The aim was to slow spread as far as possible. Despite the extensive pre-planning, matters did not go according to plan. The blueprint envisaged that the NHS would set up and run a National Pandemic Flu Service (NPFS). But this was not ready in April 2009. The government decided on a policy of containment while the organisation became operational, and the HPA was asked to step in to provide these services. The HPA was thrust to the forefront of the response, which was not the role envisaged for it in the previous planning exercises.

This period was the one that was remembered most vividly by our interviewees. The agency unexpectedly took on the role that had been intended for the NHS, identifying cases, tracing contacts and providing anti-viral medication. This was done through what were called flu response centres, organisations that had not figured in any pre-planning. In May 2009, these were established in the ten Strategic Health Authority areas of England. Their provision stretched HPA staff and resources to the limit. Due to the lack of pre-planning, it was necessary to design and develop procedures, and to find new premises, people and software. The logistics of the delivery of anti-virals proved a major problem. This new role for the HPA also produced problems in relationships with other health organisations. For example, the NHS still needed to be convinced that the HPA had a lead role to play during this phase. Such issues surfaced at the local level in particular and are discussed below.

One interviewee among several remembered the unusual nature of the response.

> We were in the lead. So part of what we had to do then because this was not in anybody's plan, it wasn't in the Health Protection Agency's plan, it was in the department's national flu plan, we had to design mechanisms to allow us to identify cases quickly, to make sure they were treated quickly, to trace the contacts of those cases, so that they could receive anti-viral drugs on a prophylactic basis and so on and so forth. We had to put our proposals for doing that into the Civil Contingencies Committee (CCC), it wasn't just go away and do it, you know actually there was a very detailed control of the response at the ministerial committee, really very detailed […] We developed the idea of the regional response centres […] that were entirely novel and we set them up and got them working in a very short space of time, it might have been two weeks […] including with new IT, new software system, premises, hardware, people and with some difficulty persuading local NHS on the ground that they should give us the support that we felt we needed.[18]

Local responses: confusion between agencies

The local level was crucial to the response, but here agencies jostled in an uncoordinated way. The NHS, HPA and local government structures operated uneasily in relation to each other. The local level raised very starkly the problems of coordination and liaison with the NHS and local authorities but also of who was seen and accepted by all parties as being in charge. The closure of schools and treatment demonstrated these issues. In the containment phase confirmation of cases in a school led to closure for seven days. It was a controversial response, disruptive and more drastic than that taken by other countries. Those who were ill were offered treatment with the anti-viral Oseltamivir and were allowed to return to school when symptom free. Contacts were offered prophylaxis and if large numbers of cases meant contacts could not be identified then the year group or whole school was offered prophylaxis.

This caused particular problems in areas that were flu hotspots such as Birmingham in the West Midlands. HPA staff were in charge of an operational response that had not been planned for or anticipated. The planned response had been for the HPA to have an advisory and support role to the NHS. Issues came thick and fast at the local level and the speed of outbreaks soon made containment unrealistic. Ramping up the response caused problems in finding and training staff, and in providing call centre services capable of handling thousands of calls. School closures caused particular problems. By early June it was clear that containment was no longer practicable. Postcode areas in Birmingham were declared hotspots, then on 25 June the whole city was declared a hotspot. A local HPA staff member commented:

> You might have thought that the pandemic flu plans as they were might have led to some confusion on the day but they were quite clear I think that the NHS would be in charge, in coordinating and leading and commanding and the HPA would be providing support. Then of course on the day it wasn't like that![19]

The definition of flu changed from day to day and the team was criticised for missing a school outbreak when the algorithm used at the time emphasised travel-related cases.

> Usually about four or five o'clock something would happen, we'd get a new algorithm or we'd get a new outbreak and we'd get a new problem in terms of the partners and their anxieties […] So by about six o'clock we were always sort of flat on our backs paddling very, very hard and it would take us until perhaps eleven o'clock at night, to actually get back into a position where we felt we could go home.[20]

This interviewee summed up:

> So the combination of an endless stream of untrained people, new algorithms, collecting and all this criticism. As I say it was probably the hairiest thing I've ever dealt with in my whole professional career. So I suppose the big issues for me really were that we were never meant to be in charge, nobody really told the NHS that we were in charge, nobody explained really what it was we were trying to do and we tried to run a service that we are not geared up to run.[21]

Staff had to run a service they had not planned for and for which resources were lacking. This local situation raised very starkly problems of coordination and liaison with the NHS and local authorities. Lack of clear management structures and the issue of who was in charge were never resolved.

National responses: expert advice and political decision making

The difficulties of the situation at the local and operational level in part derived from the nature of national policy making and the structures in place for planning. The HPA's role in providing information and advice to central government was significant but also problematic. In the UK during such an emergency, responses are coordinated through a set of official committees made up of civil servants and national politicians. At the time of the swine flu outbreak, the central committee was called the Civil Contingencies Committee (CCC) located in the Cabinet Office and sometimes also called COBRA, from the Cabinet Office Briefing Room where it met. This was the central policy and political decision-making body. Scientific advice was provided through expert committees, primarily the Scientific Advisory Group for Emergencies (SAGE) and also the Joint Committee on Vaccination and Immunisation (JCVI). The CMO, the central public health official within government, also provided advice. The HPA's role was to provide a situation report, or SitREP, to these meetings. Its production was an intensive process: drawing information from across the agency in order to brief the committees on the number of new cases, number of consultations, school problems and international comparisons.

The HPA's role as an advisory one at the national level meant that it was in a subordinate role to other interests. It was represented on SAGE but our interviewees felt that the committee should have incorporated more public health expertise, perhaps even doctors operating at the coal face, at the local level. It was difficult to emphasise the difficulties of the containment response at the local level.

They felt advice should have been more open to the public with papers, minutes of the committee and advice published. The HPA had been able to present an agreed view from the organisation to the CCC thanks to its incident centre, which collated information from across the agency. This unified view was contrasted sharply with a lack of consensus building in the committee as a whole, with other members having their debates in front of officials or ministers rather than prior to the meeting.

This indirect influence had meant that it was difficult to secure politicians' support when it became the HPA's opinion that the containment phase was serving no useful purpose anymore and the balance of benefit and risk began to change. It began to emerge that for most people the flu was a mild self-limiting infection and the effects of anti-virals on children began to cause concern. However, the government response did not change easily.

> Ultimately politicians are looking to the public, that's how […] they see themselves being judged. Therefore they don't want to be seen as changing their mind all the time, they don't want to be seen as not being you know determined, decisive, so therefore something that says oh we're going to change what we did in the West Midlands […] their worry was that […] is the way they would be perceived.[22]

Another interviewee made the same point.

> The people on the committee wanted the containment phase to continue because it, public confidence, was high in the government's response, people did feel the right things were being done, public confidence was high and to a politician, if you are doing something and the public are with you, why on earth would you stop doing it […] So that's why it took several weeks to convince them that we actually needed to change.[23]

So making the case at the national policy level to end containment took some while. Finally, in late June the new Minister of Health, Andy Burnham, came to Birmingham and saw the situation for himself. The move to a new approach followed soon after.

The government was subsequently criticised for over-ordering vast stocks of vaccine, which were not used. The comments from HPA staff on this showed acceptance of the political and logistical constraints of

decision making. The higher profile of pandemic flu on the public health agendas of governments had given a fillip to vaccine production. One interviewee commented on timing.

> The reality is that if you are going to make a decision about vaccine, it takes three to four months and then you don't have the benefit of the facts available to you in July, in April when you have to make the decision […] The vaccine arrived on schedule […] The problem was that in terms of slowing the spread it was too late. If you were going to do that, you had to hit it early and you had to probably look at the part of the population that was spreading it, which would have been children. And at the point we had sufficient stocks of vaccine, the priority then became the risk groups because you had missed the chance to slow it. If we were going to slow it we should have done it in July/August time, the vaccine wasn't ready until September at which point it was a case of targeting the vulnerable groups.[24]

Surveillance and research were important parts of dealing with the outbreak and provided crucial evidence for policy making. The outbreak placed this system under strain but also highlighted areas of development and some forms of research, such as modelling, which were over-relied upon. Surveillance measures included hospital surveillance, collection and analysis of data from confirmed cases of H1N1 from laboratory testing, and contact tracing. Research focussed on the clinical, epidemiological and virological features of the virus. A key mechanism was the FF100 or the First Few Hundred (cases), which had to expand rapidly as the outbreak developed. This provided epidemiological analysis to determine the virological and clinical characteristics of the virus, its potential for spread, and impact and risk factors. Staff commented on how the centralised NHS data systems on which the HPA relied and its laboratory services gave the health protection services an enviable advantage over other countries with more fragmented services. However, looking back, they felt there were gaps in the data, such as the number of hospitalisations.

In addition, modelling had had great influence and had used the 1918 flu epidemic as a perhaps surprising starting point. Some of the interviewees argued that serological data would have given a very different picture of the problem and a better understanding of the epidemic (and also of its resurgence in 2010). A subsequent outbreak of swine flu in 2010-2011 as part of seasonal flu took people by surprise. This later epidemic evoked quite a different government response, with a limited policy of vaccination and no national advertising campaign.

Risk communication

Media interest had proved intense during the first outbreak and the role of risk communication proved challenging. Staff felt that the HPA had managed its media relationships well. Initially, the HPA sent flu experts to front its media interviews, but they were soon overwhelmed by the demand and other senior staff were brought in. This involved a fast learning curve, in particular in relation to the media's insatiable demand for up-to-the-minute information and hard numbers.

> Every afternoon at three pm the government announced the new numbers of cases, this only happened for a few weeks but when the cases were going up at a significant level. We knew the number of cases because it was from our Situation Report, that had been presented in the morning […] But then you'd sometimes get odd situations where in that window, that time between seven in the morning and three in the afternoon, either new cases would emerge and that was OK, we would just talk about them the following day, but what would happen if the media found out about some of the new cases […] and I had an interview in that period before the new cases had been announced and that happened once or twice. I remember it being slightly uncomfortable and having in my mind the number of cases I'm supposed to talk about […] So for instance there might have been no cases in Newcastle […] that morning, but we knew that there were a couple in Newcastle.[25]

Staff were supportive of the lead role of the CMO in dealing with the media but there were differences of opinion about how to explain the data to the public. The CMO, Sir Liam Donaldson, had good relationships with members of the media. He held daily briefings, which led to the reporting of the possibility of 60,000 expected deaths. HPA staff were doubtful about this approach which came to over-focus on what was called 'worst-case scenarios'.

> You know risk communication is a very difficult thing to do […] I think it's a very bad policy to give any estimates because you just don't know and you give a range and people will take the highest range […] what's more important is to convey the message that there are precautionary measures that need to be done and these measures are really an insurance policy in case things get worse. And that is the way you sell something like this, you sell the stockpile, you sell everything that way to the public […] you don't say there might be a hundred million deaths, that is the wrong way to go. So anybody who uses figures is putting themselves into a very vulnerable position because modelling is only as good as what goes into a model […] I would not use figures […] the press rightfully so is waiting for figures and when they get a figure they take it and sometimes it's portrayed out of context […] I think they took maximum figures. I don't think they listened closely to what Sir Liam was saying.[26]

So rolling twenty-four-hour news created problems as did the focus on 'real numbers'. The ways in which numbers were taken up often focussed on worst-case scenarios.

The HPA also ended up providing information at the local level, to schools for example, on how to communicate with parents, not a role that had been planned for. In general, risk communication exposed divisions between different parts of the public health service at the national level, with the HPA much more inclined to circumspection about potential numbers than the CMO.

Moving to the new public health service

At the time we carried out our interviews, major changes were being planned in public health and health services in England and Wales. At the local level, the public health function (personnel and action), which had been located within the NHS since the early 1970s, was moving back into local government and local authority control. At the national level, a new national service now called Public Health England was to bring together all agencies into a consolidated public health department. There were mixed feelings among our interviewees about this. Consolidation could be advantageous but it did raise the issue of loss of independence for decision making, which was seen as crucial for the expert advice given during the swine flu outbreak.

> What is coming is probably a very good move, to consolidate a public health department instead of just having a Department of Health because the tensions that naturally exist between arm's-length bodies and the government will disappear. But then it's a responsibility to be sure that the independence is maintained in decision making and that is the hard part.[27]

There were concerns that the type of independent advice given by an arm's-length agency would not be possible in the new situation where the new agency would be much closer to government and political decision making. Ultimately, these fears impacted on the use of our research.

Crisis oral history and implications for policy

In terms of the oral history of decision making, our research had been productive and relatively open in the way in which interviewees interacted with interviewers. The agency felt that it had done a good job in difficult circumstances; the crisis had not in the end happened as had been initially expected. There was less need to present an 'official history', at least at the time we conducted the interviews. Interviewees talked with relative openness about the alternative service they had had to set up, about problems in managing the media and in managing politicians through the central government committees. The research took place during a 'window of opportunity' for recollection before more official concerns set in. This also made it valuable as crisis oral history. It drew on the 'confessional relationship' noted in other oral history interviewing.[28] The fact that we were funded by the employing body mattered relatively little because the institutional *esprit de corps* and pride in what had been achieved in difficult circumstances was to the fore. Some of the urgency and emotion of responding to a pending emergency came across, in particular in the interviews dealing with the local response, one of which was highly emotional. Alongside emotion, there was also excitement and a positive sense of the waiting being over and public health staff swinging into a role for which they had been trained. The unexpected also came into this: staff ended up running services for which they had not been trained at all.

However, our swine flu interviews and their funding also raised problems. Our research had raised significant relevant issues about public health structures and officials at both local and national levels: how they operated in coordination or not; the structure of pandemic planning at the local level; the relationship between local and national planning; the nature of expertise drawn upon; the political input into a pandemic response; relationships with the media during the outbreak; and risk communication to the public. Overall, they had shown that however much planning had been done, the unexpected can happen and that, too, should be built into planning in future. As someone who had also researched HIV/AIDS policy making, I recognised some familiar themes, including: the worldview of politicians about epidemics and the politics of epidemic response; the nature of risk communication, which could be unnecessarily apocalyptic; and the over-reliance on modelling as a form of research. These were not new issues, but they did not seem to have been recognised or addressed in the interim (twenty years) since the advent of HIV/AIDS. Could the results from oral histories about the 'crisis' of swine flu feed into better policy understanding of how to respond to a health crisis?

When we moved to finalise our report to the HPA we encountered problems. Many interviewees did not provide the necessary permission to use the quotes from their interviews. Time had passed and they felt it was inappropriate to draw attention to some of the issues given the pending changes to public health and the HPA at the national level. A number of interviewees had clearly been upset by events, especially in the early stages of unplanned response and the confusion at the local level. One interviewee had broken down in tears during the interview and it had to be resumed later. It had made for difficult interviews and later concerns about allowing the researchers to use the material. Time had passed and the openness of the early interviews had been replaced by greater wariness and a feeling that some comments might have been unwise.

There was delay while the responses and permissions from interviewees came in. Ultimately, we were told that our HPA contact would manage the process

in-house along with the publication. Time passed with no publication. As we had no control over what was written, I asked for our names to be removed from any publication produced without our consent. Then a fellow historian mentioned in passing that the HPA had meanwhile held a witness seminar to mark its short history and demise as a separate organisation. This had been published on its website. Swine flu received a brief mention, but none of the issues our research had raised were acknowledged, and our research was not mentioned. The chair of the board of the new successor organisation, Public Health England, was an honorary professor at the LSHTM. I wrote to him proposing that we be allowed to write an academic article from the research, with all interviews anonymised in such a way that respondents could not be identified. This was agreed and the present article has now been written, some years after the events.

At the time we were carrying out our interviews, one official report had drawn conclusions. This was the independent review carried out by the Welsh CMO, Dame Deidre Hine, into the 2009 influenza pandemic, published in 2010. Its careful civil servant language makes for instructive reading. Dame Deidre found that the response had been 'proportionate and effective' but singled out some issues for comment such as: the tendency to talk of 'worst-case scenarios', which she saw as unhelpful; the over-reliance on modelling; and the need for population-based surveillance such as serology. She also favoured the public availability of scientific advice and forecasts. Her brief comments on the containment phase were clearly carefully phrased.

> I recognise the hard work of health services and health protection staff across the UK in delivering this part of the response. Many contributors to this Review believe that the steps taken during this period had some impact in slowing the initial spread, although this cannot be demonstrated definitively.[29]

Subsequently, in 2011, the House of Lords Science and Technology Committee published a report on scientific advice and evidence in emergencies, which also picked up on some of the same points, in particular how language and terminology are used during outbreaks. For example, 'worst-case scenario' was seen as unhelpful but often put to use by the need to support appropriate levels of expenditure.[30]

Our research raised significant issues about the nature of the response to a health emergency, which could have been drawn upon in assessing that response and in better planning for the future. Some of these dimensions were later discussed in academic output, in particular the confusion over the local response and the unnecessarily apocalyptic media coverage.[31] What issues did the research raise for the twin themes on which we focussed at the outset? In terms of the official funding of research, and in this case oral history, it matters greatly who controls the processes of funding and publication. Official funding was a positive factor at the outset as it gave us interview access quickly and there was little if no restriction on who we spoke to. But later it was a severe drawback not only on publication and dissemination, but also on drawing out the policy implications of the research, which could have been useful. On a practical note, the standard ethics permission required now in a medical or public health institution places power in the hands of the interviewee. Such a format is intended for a clinical study and for patient participation, rather than for this type of oral history, which is not 'history from below'. A previous study of AIDS policy making, where interviews with policy makers were also important, was not constrained in the same way because ethics committees and standard permissions did not exist then. Interviews were anonymised from the start unless the interviewee wanted to be identified.[32]

In terms of crisis oral history, the research raised issues that had been discussed in the 1980s and 1990s in relation to HIV/AIDS and oral histories, again at a time of crisis. Oral history as a methodology was at the fore because of the immediacy of the health crisis in the 1980s. Its legitimacy was discussed and US researchers termed the process of doing historical interviews 'slow journalism'.[33] Interviewees had also communicated a sense of excitement and crisis response – in a sense, 'the first draft of history'. This is a continuing and valuable function of crisis oral history undertaken at or near the time of crisis. Interviews undertaken later lack immediacy and of course 'the official line' on events emerges as stories are told and retold. The ongoing policy issues surrounding the response to HIV/AIDS over a period of years had meant that some interviewees had tried to present 'official history' while others were wary about their interviews being openly attributed.[34] In the research on swine flu, time was also of the essence in recording the interviews, in part because it made funding for them available and interviewees keen to speak about their experience. However, later, time worked against us on both counts as the policy situation changed.

Our experience with swine flu shows the potential power of oral history, but also, paradoxically, that some forms of history can be overused or be the 'wrong sort of history'. The impact of the 1918 influenza epidemic was notable in 2009, not least in the way in which its mortality figures were built into pandemic modelling and led to unwarranted apocalyptic projections of mortality then taken up by the media. Historians, including one of the authors of this article, have recently spent much time arguing that history should be brought into closer relationship with policy as evidence.[35] Our experience in this case showed that elite oral history and the recollections in our interviews would have been a better form of historical input on which to base future planning for a health crisis. In the event, swine flu as a health 'crisis' died away and the virus is now a normal part of the range of viruses experienced by the population. The issues raised for oral history and for official funding, however, remain.

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