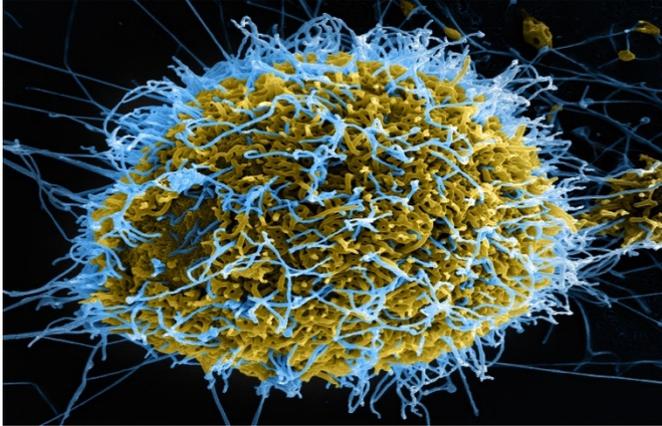# BREXIT AND CRISIS MANAGEMENT
Pandemics

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January 2019

This briefing provides an overview of the likely implications of Brexit for UK crisis management in the context of EU health security, namely for pandemic preparedness.

The governance of UK health security has become subject to European integration over the years and UK scientific expertise has played a key role in shaping EU crisis management arrangements in this area. Brexit introduces a number of uncertainties and complexities with regards to how Britain's withdrawal from the EU will impact on the processes of pandemic planning and response on future UK-EU networks of expertise.

These uncertainties need to be seen in the context of the fact that the UK will not be withdrawing from a multi-level crisis management system that can be regarded as in any way 'perfect' or without deficiencies. Although the EU promotes the policy position that several lessons were learned from the H1N1 ('swine flu') pandemic in 2009 (which caused at least 18,500 deaths worldwide[i]), pandemic planning has suffered from a degree of policy avoidance across the EU. This is because pandemics are not aligned to short-term political imperatives (i.e. they might not ever happen) so the motivation for long-term planning commitments has not always been shared across Member States. In fact, Member States know that health security is a sensitive and controversial area to openly discuss, even with each other, and moreover, getting public communications right about risk is a perennial challenge for policy-makers. In terms of cross-EU preparedness, there have been ongoing issues about a lack of consistency across Europe in terms of how vaccines are procured and different decisions being

Key points

- Despite the acute uncertainties that Brexit poses to the involvement of the UK in future EU health security arrangements, which ultimately have implications for human life, the issue has had very little prominence in the policy and public debate.

- The policy structures and processes of the negotiations have prevented health security issues being given the prominence they deserve. This is despite health protection and trade being inextricably linked (due to the trade of medicines, for instance).

- The Political Declaration on the UK's future relationship with the EU seeks more continuity over change when it comes to arrangements for health security governance but this is in no way guaranteed.

- The current distractions that Brexit poses to the work of agencies, including the European Medicines Agency, means that global health security risk prevention work (e.g. regarding anti-microbial resistance and the 'One Health' agenda) are being deprioritised. This poses risks for UK and EU health security. In short, Brexit is hampering progress towards more effective global health security.

- EU health networks are already changing, as is UK's engagement in EU policy affairs relating of life sciences, since the Brexit referendum.

- The UK has undoubtedly been a leader in shaping EU health security governance and pandemic planning, however the fact that they have already helped to develop capacities in other Member States means that the EU would cope without as much UK involvement in the future.

made about who should be vaccinated in the event of a pandemic, and issues of protectionism when it comes to sharing data and intelligence with EU counterparts. This was the case even before 'Brexit' was a word. What this indicates is that EU health security, in terms of risk minimisation is an area that requires ongoing

collaboration, consistency, and information-sharing. It is not clear how Brexit benefits such endeavours.

There has been much attention placed in the media and in the public debate about a number of Brexit 'high politics' areas (e.g. citizenship, the single market, immigration) but those policies which present risks to human life, such as pandemics, have seen far less attention. This is despite the fact that the UK Cabinet Office recognises that pandemic flu is the biggest risk to the health of population in the UK and an outbreak, if not managed effectively, would be a major civil emergency[ii]. In August 2018 the UK government published 'technical papers' (or contingency plans) that addressed the measures that the government would take in the event of a 'No Deal' Brexit, which included the supply medicines to the NHS. Nonetheless, the pharmaceutical industry genuinely believe that they need to be treated more like a special case, as opposed to other technical areas of public policy such as fisheries or aviation) because of the need for patients to have access medicines, no matter the Brexit scenario, in order to protect public health.

This research highlights that the need to prioritise health security is a view that is shared across UK and EU health agencies. The level of public debate pre- and post-Brexit referendum did not allow for the public to be informed about the fact that so much activity pertaining to the protection of public health relies on collaborations and networks between the UK and the EU. UK and EU policy stakeholders all agreed that, at best, health security has been 'overlooked' and, at worst, 'side-lined' in the Brexit negotiations.

From a UK governance perspective, one explanation for this is that the UK Cabinet have a sub-committee on EU exit and trade and, despite health protection and trade being inextricably linked (due to the trade of medicines, for instance), the UK Department for Health and Social Care (DHSC) is not represented on that committee, whereas all of the other key government departments are represented. The DHSC feeds into DEFRA and, therefore, has more of what can be considered to be 'proxy representation' on the Cabinet sub-committee. The governance arrangements for Brexit negotiations has somewhat sanitised the public health voice in the UK negotiations.

This policy brief draws together key points from interviews with relevant stakeholders on the issue of the implications of Brexit for UK health security. The stakeholder interviews include representatives from

Public Health England, the European Medicines Agency, the Centre on Global Health Security at Chatham House,

the European Federation of Pharmaceutical Industries and Associations, the UK Faculty of Public Health, and the NHS Confederation.[iii] The European Centre for Disease Control and the Health Threats Unit of the European Commission declined to be interviewed for this research.

How does the UK currently manage and prevent pandemics?

Given that disease outbreaks are transboundary, UK agencies such as Public Health England work with EU counterparts through the Commission's Health Security Committee and European Centre for Disease Control, as well as having close relationships World Health Organisation. Health security is affected by two main policy domains (veterinary health and public health). Both areas are of key importance for governing health security in the sense that the risks of pandemics often lie at the animal and human interface e.g. swine flu, avian influenza, Ebola (for instance).

It is important to note that when a crisis emerges on UK soil health security is first and foremost the role of national government and agencies to manage the crisis in cooperation with EU. Yet as part of crisis management processes the UK need to comply with the WHO International Health Regulations (IHRs). In order to minimise the likelihood of a global pandemic to emerge Public Health England is closely involved in advancing the UK's commitment as part of the G7 (to support IHR compliance globally). The UK Department of Health and Social Care fund this work to enable Public

Health England to cooperate within the WHO to build capacity of other countries. For example, there are programmes in Pakistan, Ethiopia, Nigeria, Myanmar, Sierra Leone, in an effort to evaluate global capacity for IHR compliance. This programme of work engages a number of other European member states as well the wider European Region.

Key UK-EU-global crisis management actors
The main crisis management actors for health security in the UK, and those who have a relationship with UK actors, are as follows:

National-level
- Public Health England
  An agency of the DHSC which is responsible for responding to public health threats and outbreaks, such as pandemic influenza. The agency cooperates with the devolved administrations – Public Health Wales; Health Protection Scotland – when required.

- Department for Health and Social Care (DHSC)
  The parent Ministerial department covering all aspects of health policy.

- Cabinet Office
  The main crisis coordination department across government in the event of a pandemic.

European-level
- European Medicines Agency (EMA)
  The EU agency responsible for the protection of public and animal health across the EU. This includes the scientific evaluation and supervision of medicines.

- Health Emergency Operations Facility (HEOF)
  The European Commission, through the Health Threats Unit, houses the HEOF which is responsible for taking a coordinated approach between EU countries for the public health management in emergency situations - similar to the UK Cabinet Office.

  Also within the Commission, the Health Security Committee is responsible for detection and communication. The Committee supports preparedness across sectors and internationally, supporting and promoting the International Health Regulations and aims to forge links between alert systems across Europe and more globally.

Stakeholder Insights on Brexit: Public Health England

- Public Health England's international engagement involves working directly with the WHO (including with the WHO European region). Brexit will not change the mechanisms that are available at the global level for ensuring global health security and PHE will continue to have access to the WHO European region.

- PHE is a significant contributor to the work of ECDC. PHE are committed to ensuring that information flows from the UK to the ECDC. It is in the interests of EU policy-makers to ensure that continues given that the UK are an 'net contributor' to the health intelligence of ECDC and provide significant expertise into those networks The protection of those relationships are in everybody's interest to maintain.

- The need for cooperation between the UK and the EU on pandemic preparedness is further reinforced due to the global threats outside of the EU i.e. international efforts are required to strengthen global health security (e.g. the need to focus collective attention on South East Asia, where pandemic influenza is most likely to emerge from).

- European Centre for Disease Control (ECDC)
  An independent agency that aims to identify, assess and disseminate information on current and emerging threats to human health posed by infectious diseases.

International-level
- World Health Organisation (WHO)
  The International Health Regulations (IHRs) 2005 are the overarching framework for global health security governance and are overseen by the WHO, of which the key contact is the WHO Europe in Copenhagen.

Although these are the key actors associated with health security there are clearly a range of other relevant actors who supply the resources that are crucial to contingencies and crisis management. The pharmaceutical industry being a key example. In Europe there are a number of industry organisations who represent different arms of the pharmaceutical industry however a key representative body for the trade of pharmaceuticals is the European Federation of

Stakeholder Insights on Brexit: European Medicines Agency

- The EMA considers their work on licencing medical products for public and animal health to be 'the poster child of EU integration'. The EMA reports that the UK Medicines and Healthcare products Regulatory Agency (MHRA), which works closely with the EMA on the regulation of medicines, were in a state of 'mutual shock, sort of, oh my God' following the referendum.

- Despite the sense of mutual shock, the UK has been fully committed across the existing committee structures since the referendum and the triggering of Article 50.

- The UK's contribution, in terms of expertise, to health security in the EU has made them a 'major player in the system; it's not just like one of 28'. UK nationals are embedded and have taken leadership positions right across the policy-making structure.

- The EMA regards UK expertise in the field of medicines regulation in terms of development, clinical trials, research, innovation, and post-authorisation, monitoring in the NHS as 'incontestable'.

- The UK's policy language is very similar to the EMA's in that the future should be about close alignment given that pharmaceutical regulation is largely global. The idea of having a type of sub-system evolution of arrangements in Europe is seen by the EMA as a 'retrograde step'.

Pharmaceutical Industries and Associations (EFPIA), of which the Association of British Industry is a member.

Will the UK be more at risk of a pandemic once it leaves the EU?

UK crisis governance structures are robust and the central executive territory of UK government has tried and tested coordination mechanisms. The Cabinet Office (via COBRA) would come into operation in the event of a pandemic to lead a governmental response to a crisis. If there was a localised outbreak of disease then the cascading mechanism would come into force. This means that the response would be coordinated by a Regional Hub. COBRA would be convened to monitor risk assessments and the spread of disease, which

would happen inevitably, but this would happen within a framework of national coordination. However, the challenge is not necessarily whether the internal UK response to threats would be sufficient, but what impact Brexit would have at the UK-EU interface and on the threat of a disease crossing UK borders.

Brexit poses key risks when it comes to the provision of medicines, which are key to supporting a pandemic response. A recent National Audit Office (NAO) Report expressed concerns that there is a high delivery risk attached to border programmes – '11 of 12 critical systems needing to be replaced or changed to manage the border were at risk of not being delivered on time and to acceptable quality'[iv]. Therefore, the assumptions upon which industry contingency plans are predicated would not be effective in the event of a 'No Deal' and the UK is not ready for such an outcome. In these circumstances, if medical suppliers import goods into the UK then the additional costs of doing so will be passed on to the NHS. In spite of this, the UK government has instructed NHS organisations, GPs, community pharmacies and patients to <u>not</u> stockpile medicines. In short, there is a need to address these problems to allow the import of medicines even in the event of a 'No Deal' outcome.

Even if No Deal is not the outcome, there remain uncertainties about the future relationship between the UK and the EMA, and the future supply of medicines. The Political Declaration on the future relationship between the UK and the EU includes vague references to the need for cooperation with EU health agencies, however the Prime Minister admitted when giving evidence to the Liaison Committee of the Westminster Parliament on 29th November 2018 that 'the EMA doesn't have examples of third country membership'[v] This means that a new policy model and relationship would need to be established as part of the negotiations after the end of March 2019. The future blueprint for this remains uncertain.

From an EU perspective, the EMA regards the current arrangements a 'family' in that there are interpersonal relationships across institutional structures. The EMA consider there to have been a 'psychological impact' amongst experts across the EU since the Brexit referendum. For example, there are seven main scientific committees that govern the licensing of

medical products with 60 or 70 working party sub-structures underneath these committees, all of which, according to a senior EMA official, 'the UK have been massively involved in'. The same official stated that the UK is 'a very active Member State, who have given a fantastic contribution historically'.

Challenges for the UK-EU relationship

The 'opportunity costs' of Brexit

One of the key themes to emerge from this research are the opportunity costs of Brexit when it comes to health security governance, more broadly. Interviews with the EMA indicates approximately 50 percent of the agency's work has been Brexit-related since the referendum and that productivity agency 'will dip significantly through 2019'. The divergence of policy attention, partly due to the costs of relocating the EMA from London to Amsterdam,[vi] has had implications for the attention given to other important aspects of global health security which affects the UK and many countries. For example, the EMA have scaled back their international collaboration activities in preventive work areas for threats such as antimicrobial resistance and the 'One Health' agenda. From a crisis management perspective this should be a cause for concern for the UK and the EU alike given that 'One Health' is about preventing of risks and the mitigation of effects of crises that originate at the interface between humans, animals and their environments. It is easy to forget that the devastating outbreak of Ebola in 2014 was due to

the breakdown of an effective One Health approach to health security governance. The level of seriousness of this re-prioritisation process for the risk of a pandemic emerging remains to be seen but it is fair to conclude that this is certainly not a positive development for global health security (and it can all be traced back to Brexit).

Another important aspect is in terms of the UK's role in capacity building with developing nations through the EU. For example, the EMA suggests that when EU enlargement took place, which brought in many former Eastern bloc countries to the EU, it was recognised by EU policy-makers that before and after enlargement the UK were very influential in 'syndicating their knowledge' with the health security agencies in other countries. Although UK influence in this regard has been important, with a senior official at PHE noting that, the UK has historically contributed 'well above its weight', including in terms of developing the ECDC, there is also a sense that the UK's dominance in the area of capacity building has waned given that other European countries have essentially 'caught up' with the UK in terms of the developing of their scientific policy structures, capacities and infrastructures in relation to health security. Interestingly, a representative from the UK Faculty of Public Health (who operates across EU policy networks) notes that a major current narrative to emerge across health networks in the EU, is that it is important to avoid 'overselling' the UK as the leader in health security as it can have the outcome of alienating the UK. In other words, 'promoting the idea of they

Stakeholder Insights on Brexit:
European Federation of Pharmaceutical Industries and Associations (EFPIA)

- Brexit brings *no opportunities* from the perspective of EU industry, only challenges.
- The main challenge is the supply of medicines. If the UK becomes a third country after March 2019, that will potentially lead to disruption to the supply of medicines.
- The UK has not thought through the implications of leaving the European network. One area that has not had much attention is what the absence of the UK's voice will be for innovation within the industry.
- The UK has been noticeably less active in the meetings of the Council of Ministers and the European Parliament in the pro-life sciences sector since the referendum.
- The EU27 will be able to continue without the UK given that they are already making up for the loss of the UK. They are hiring new staff to make sure that they have access to the expertise that they could previously rely on from the UK Medicines and Healthcare products Regulatory Agency (MHRA).

need us so much' is not well received by EU Brexit negotiators, and UK officials have been keen to adopt a more measured approach - i.e. one that recognises the UK's leadership by virtue of their role in facilitating existing networks, without overselling their historical status as a 'leader' in this area.

Changing policy networks and channels of influence
That being said, the UK Faculty of Public Health also acknowledges that a strong message to emerge is that if the UK's decision-making voice wanes over time then it is in the very nature of networks to adapt. In short, networks will continue even if the UK's influence is reduced. Brexit has already led to a recalibration of existing expert networks in the EU. A strong example of this was highlighted by a senior PHE official who noted that despite reassurances being given by the UK that an existing collaborative agreement with the EU to train epidemiologists in the UK will continue until the final outcomes of Brexit are agreed, the ECDC has not allowed candidates from other European countries to access this training because of ongoing uncertainties about the UK's future relationship with the EU. The

outcome of this decision by the ECDC will, in effect, be to impede professional interactions in a profession where this is crucial for the prevention and management of health security threats. In short, Brexit loosens what were tight networks in this area, and this will affect the UK's input to EU scientific meetings and interactions that occur under the auspices of the EU.

Although it remains to be seen whether the UK will maintain some type of affiliation with the ECDC, Professor David Heymann (Head of the Centre on Global Health Security at Chatham House and former senior official at the WHO) argues that the UK has underutilised the Commonwealth Framework and 'that partnering with the countries in the Commonwealth in strengthening their capacity would be a very positive strategy forward at the same time of working within Europe with the Regional Office of WHO'. In short, Brexit will lead to changed relationships with other organisations and other institutions, with WHO Europe being the one of the most likely institutions where more direct relations will likely be developed.

The industry (pharmaceutical) stakeholder network in the EU has also reported less 'positive engagement' from the UK in the policy meetings that affect the life sciences industry. The observation from those with a remit for market access in the EFPIA is that there has been a noticeable reduction in interest on the UK's side due to policy attention being focused on reaching a deal with the EU. The outcome of this is that more technocratic UK policy experts, who tend to be the type of policy actor involved in the life sciences, public health, and security areas, have been essentially prevented from continuing in EU policy dialogue with their counterparts within existing EU institutional channels.

A representative from the EFPIA also suggested that such changes in UK policy engagement has also led the EU to become cautious about interacting with stakeholders who are associated with the UK (not just academic researchers but also representative bodies of major health organisations in the UK). For example, a senior representative from NHS Confederation (a membership body that represents NHS services) noted that despite being Brussels-based (for the moment) they 'no longer have really close contacts with people in the European Commission' because the situation is 'delicate while the negotiations are going on'. This has led to a need for such UK stakeholders, who seek to influence from the outside of decision-makers

structures, are no longer able to 'directly lobby members of Michel Barnier's Article 50 taskforce'. The outcome of this has been a change in lobbying techniques towards a 'more subtle' approach which, in practice, means working laterally with EU-based organisations[vii] who are UK-based in order to indirectly lobby on health policy matters.

Conclusions

This brief provides key insights into the perspectives of major stakeholders that will be affected, in varying ways, by Brexit in the area of health security. It is clear is that the UK seek to maintain the status quo, or as near to it as possible, with the EU on health security. Such sentiments are included in the Political Declaration on the UK's future relationship with the EU, yet it is light on specific details. What we know is that since the Brexit referendum the lack attention that has been given to the crisis governance of health security, and public health more generally, has been problematic. This has masked what has been going on since the referendum, which is a change in the strength and composition of EU policy networks. Brexit has also led to a distraction away from global health security challenges. This, in the end, poses more risks for the UK, EU, and the world as compared to what would have been the case if the Brexit referendum never happened.

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[i] Connolly, J. (2014), 'Pandemic Influenza in the UK and EU Competence in Health Security Policy, *Eurohealth*, 20(4): 23-26

[ii] Cabinet Office (2017), National Risk Register of Civil Emergencies. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/644968/UK_National_Risk_Register_2017.pdf

[iii] The UK Faculty of Public Health and the NHS Confederation are both part of the 'Brexit Health Alliance'.

[iv] National Audit Office (2018), 'The UK border: preparedness for EU exit. Available at: https://www.nao.org.uk/press-release/the-uk-border-preparedness-for-eu-exit/)

[v] UK Parliament Liaison Committee (2018) 'Evidence from the Prime Minister: Brexit', Available at: https://www.parliamentlive.tv/Event/Index/6eaccb9b-e1a3-4298-b307-65356415d112

[vi] This will result in an initial reduction of 20 percent of the EMA's workforce, a substantial amount of which are scientists.

[vii] Examples include: European Federation of Neurological Association; the European Public Health Association; Science Europe; European Brain Council; European Association of Hospitals and Healthcare Providers; European Association for Rare Diseases; European Patients' Forum