BMA

BREXIT BRIEFING

Health improvement
maintaining a focus on prevention
after the UK leaves the EU

Key points

— Health improvement describes measures to improve the health and wellbeing of individuals or communities through enabling and encouraging healthy lifestyle choices and addressing health inequalities.

— The EU influences health improvement activities in three key areas:
  — developing policy and legislation to promote public health;
  — facilitating evidence-based decision making; and
  — supporting investment in economically disadvantaged areas.

— The potential consequences of the UK's exit from the EU for health improvement are:
  — the UK needing to develop new health improvement policies and legislation;
  — weakening or duplicating approaches to evidence-based decision making; and
  — widening health inequalities in the UK.

— To maintain a focus on preventing ill-health, the UK and EU should:
  — recognise the mutual benefits of collaboration and maintain a robust and evidence-based focus on prevention;
  — negotiate a commitment to continue to share evidence, including through specific agreements with agencies such as the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction).

— To maintain a focus on prevention, the UK should:
  — ensure any measures in the EU Withdrawal Bill do not widen health inequalities or increase pressure on the NHS;
  — consult widely with public health stakeholders and ensure proper parliamentary scrutiny to develop robust prevention and health improvement measures; and
  — replace the EU's regional development funding and support an increased focus on addressing regional health inequalities.

— For the UK, this approach would:
  — maintain measures currently in EU legislation that benefit public health, with the opportunity to go further in promoting prevention after March 2019;
  — support measures to improve the social determinants of health in the UK; and
  — guarantee the UK maintains its reputation and influence internationally in the UK's approach to prevention, and has access to the best available evidence.

— For the EU, this approach would:
  — ensure a consistent approach to issues such as the marketing, labelling and content of products which cross borders and contribute to the burden of long-term disease;
  — maintain access to UK expertise and influence in taking forward the EC's (European Commission) public health goals.

— Should there be no deal then this would create uncertainty and barriers to collaboratively tackling cross-border prevention challenges. It would also limit the exchange of evidence between the UK and EU, and in turn lead to duplication. After March 2019, the UK may have an opportunity to go further than the EU in our approach to prevention, and should engage with stakeholders to develop a robust approach to improving health.

Background

Despite continuous improvements in overall mortality rates and life expectancy at birth over recent decades,[1] the UK still faces substantial health challenges. The UK also has some of the highest levels of income and health inequality in the developed world.[2,3] Health inequalities are strongly linked to a range of lifestyle factors such as smoking, alcohol use, physical inactivity and unhealthy nutrition, which contribute to the development of long-term health conditions. In the UK, 17.2% of all adults smoke,[4,5] 7.8 million 'binge' (in excess of 14 units) on alcohol on their heaviest drinking day of the week[6] and 27% of adults are obese, while a further 36% are overweight.[7]

These patterns are not unique to the UK. Lifestyle factors have significant implications for health outcomes across the EU, and inequalities in outcomes continue to be shaped by the social determinants of health – the environment in which people are born, grow, live, work and age. The term 'health improvement' describes measures that the state takes to tackle health inequalities and the harm caused by lifestyle factors, in order to improve the health and wellbeing of individuals or communities. This briefing sets out the EU's role in prevention and health improvement and the impact it has had in the UK. It then outlines the impact the UK's exit from the EU may have on health improvement. Finally, it sets out the ways in which the UK and EU can maintain a focus on prevention moving forward, and the benefits for both of doing so.

Please note: while this briefing covers the key issues for health improvement, there are other related areas where the UK leaving the EU may have an impact on population health. These include, for example, UK and EU collaboration to support safe and effective medicines and medical devices as well as a range of health protection measures, which are covered by separate briefings in the BMA's Brexit series.

The EU's role in health improvement and prevention

The EU works with member states to improve public health, prevent illness and eliminate sources of danger to physical and mental health. Compared to other areas of public health, the EU's role in health improvement and prevention is more limited. Article 168 clarifies that it is the responsibility of member states to define, organise and deliver healthcare.[a] Nevertheless, the EU has developed specific legislation aimed at promoting public health and plays a key role in providing a strategy for ensuring good health and healthcare. This is underpinned by a specific objective to promote health, prevent disease and foster healthy lifestyles through a 'health in all policies'[b] approach.[8] This is set out in the EU Health Programme (see box 1).

Box 1: The EU Health Programme

The programme outlines the EU's strategy for ensuring good health and healthcare. It provides funding to support cooperation among EU countries and to underpin and develop EU health activities. The third health programme (2014-2020) serves four specific objectives:

1. to promote health, prevent disease and foster healthy lifestyles through a health in all policies approach;
2. to protect EU citizens from serious cross-border health threats;
3. to contribute to innovative, efficient and sustainable health systems; and
4. to facilitate access to high quality, safe healthcare for EU citizens.

The objectives are implemented through an annual work programme, agreed with countries on a number of defined policy actions, and criteria for funding actions. All EU countries, as well as Iceland, Norway, Serbia, Moldova and Bosnia and Herzegovina are signed up to the health programme and are eligible to participate in funding calls. Other countries can participate but funding cannot be awarded.

The programme also underpins the EU's work to tackle health inequalities and its commitment to establishing a focus on equity in health as a fundamental value of EU policymaking.[9] The UK has taken a lead role in the EU's work, for example through the IHE (Institute of Health Equity), by providing evidence and proposals to influence policy making and advising on best practice. The IHE sits on the EC expert group on the social determinants and health inequalities, and supports monitoring and evaluation of progress on tackling inequalities in the EU.

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a   Article 168 stipulates that "Union action shall respect the responsibilities of Member States for the definition of their health policy and for the organisation and delivery of health services and medical care".
b   A health in all policies approach requires governments to undertake an assessment of the impact of all new public policies and policy changes on health systems, the determinants of health and well-being.

How the EU has influenced health improvement activities in the UK

The UK and EU interact in a number of important, specific ways to tackle preventable conditions and address health inequalities in the UK:

— **Developing policy and legislation to promote public health**
The majority of measures designed to tackle lifestyle factors in the UK are introduced in Westminster or the devolved nations. However, a number of specific EU regulations, directives, principles, objectives, declarations and resolutions influence UK policy for prevention in targeted areas. For example, the EC Directorate General for Health and Food Safety works with member states to implement key tobacco control measures such as the Tobacco Advertising Directive, Tobacco Tax Directive and Tobacco Products Directive. These directives have provided the basis for the UK to develop its own domestic policy, and in many cases the UK has gone further than the requirements they set out.[10,11] For example, while EU legislation specifically prohibits cross-border marketing, UK legislation is much broader in prohibiting all domestic tobacco advertising, promotion and sponsorship.

The EU's influence in developing policy is also evident in other areas. For example, the EU sets the basis for which member states can tax wine and cider — by volume rather than alcohol content. For alcohol, other drinks and food products, the EU also sets regulations for marketing as part of the AVMSD (Audio-Visual Media Services Directive). EU regulation also determines the provision of food information to consumers. It should be noted that the UK's voluntary front of package traffic light labelling system goes further than EU requirements,[12] and the UK Treasury has previously stated it would support future changes to allow duty on wine to rise in line with alcohol strength.[13]

— **Facilitating evidence-based decision making**
The EU also works with member states to facilitate a two-way exchange of data and information which supports evidence-based decision making. For example, the UK currently shares information with organisations such as the EMCDDA, which in return shares comparable European information on illicit drugs with the UK. This supports the identification of trends and best practice which inform the UK's drug strategy and general approach to tackling the harms caused by illicit drug use.

Similarly, EUROCARE works with EU member states to bring together domestic cancer registries to highlight regional variations in cancer trends. When the EUROCARE project was first launched, data comparing the UK with other EU countries showed unexpectedly large variations, with the UK faring comparatively badly to other European countries.[14] Exposing this variation created political pressure leading to the formation of the NHS cancer plan which delivered a subsequent improvement in cancer survival rates in the UK.[15] This was in part due to a greater focus on the lifestyle factors linked to the causes of cancer.

— **Supporting investment in economically disadvantaged areas**
The UK has some of the highest levels of inequality in the EU and there is a widening gap between London and the rest of the UK.[2,3] The ESIF (European Structural and Investment Funds) (see box 2) provide financial support and a long-term framework to address regional disparities within EU member states. This in turn supports improvements in living conditions, training and employment services, transport, technologies and health and social care infrastructure — all factors in the social determinants of health.

Box 2: European Structural and Investment Funds

The ESIF are five main funds, jointly managed by the EC and EU countries, with the purpose of investing in job creation and a sustainable and healthy European economy and environment. They focus on five main areas: research and innovation; digital technologies; supporting the low-carbon economy; sustainable management of natural resources; and small businesses.

The ESIF include:
— ERDF (European regional development fund) – promotes balanced development in the different regions of the EU;
— ESF (European social fund) – supports employment-related projects throughout Europe and invests in Europe's human capital.

Financially, between 2014 and 2020, the UK stands to gain €16.5 billion[16] from ESIF which has helped to support a wide range of development projects.[17] These are often in areas where there has been a lack of investment by the UK government. ESIF provide long-term planning beyond budget and electoral cycles, requiring national and local government to work with the EU and partners to address the social determinants of health. Investment in the wider determinants of health is vital for tackling health inequalities, as the BMA has consistently highlighted, including in our 2017 report: Health at a price: reducing the impact of poverty.

Potential consequences of the UK's exit from the EU for health improvement

— **The UK will have to develop new health improvement policies and legislation**

Following the UK's decision to exit the EU, key EU policy instruments which support health improvement in the UK, will have to be transposed, updated and reshaped through the EU Withdrawal Bill, and beyond. The Government will have to consider a range of factors when developing an approach to health improvement outside of the EU and negotiating future trade deals. This will create potential risks and opportunities for developing measures to prevent ill-health.

In prioritising our global trading relationships, the UK may risk health improvement if it agrees to accept lower health and safety standards of some products from non-EU countries in order to facilitate a potential trade deal. For example, concerns have consistently been raised around future trade of food products.[18] Conversely, renegotiation of trade deals may allow the UK to enhance measures for protecting and improving health. For example, the EU currently regulates food and drink labelling — Regulation (1169/2011) — and the UK has adopted a voluntary approach to front of package traffic light nutrition labelling. Once outside of the EU, the UK may be able to mandate a standardised approach.[19] These opportunities and risks are likely to be replicated across all areas of health improvement where EU legislation has previously underpinned UK regulations.

— **Weakened or duplicated approaches to evidence-based decision making**

Should the UK reduce its collaboration with EU institutions and agencies by less proactively sharing information and data on key health improvement issues, it may result in weakened evidence-based policy making, or duplication of effort. For example, should the UK no longer have access to the EMCDDA, it would limit the UK's ability to identify regional trends in the movement of illicit drugs, monitor change in regional deaths and infectious diseases associated with drugs and influence the development of best practice across the EU. For the UK, this would be challenging not least because the EU's collaboration on health data is more advanced than comparable international efforts.[15] Therefore duplicating or accessing these evidence sources may be costly or impractical.

— **Risk widening health inequalities in the UK**

After the end of the current funding cycle for EU development programmes (2020), the UK will have to negotiate access to the EU's future programmes. Failure to do so or to replace this funding with domestic, long-term funding may have an adverse impact on social determinants of health, and risk widening health inequalities. Some regions could be impacted more than others, for example, in the current funding round (2014-2020), Wales receives €2,413 million compared to the South-East region which receives €286 million.[20] Moreover, some regions are more dependent on the EU for trade, for example Yorkshire and Humber rely on the EU for 62% and 55% of their region's exports, respectively. Ultimately this could risk the UK falling further behind EU and international comparators in reducing health inequalities.

Maintaining a focus on prevention in the UK and EU

The UK and EU will continue to face common challenges in supporting health improvement after March 2019. It is therefore vital that the UK and EU recognise the need for continued collaboration moving forward, in order to maintain a robust and evidence-based focus on prevention.

When transposing legislation from EU law into domestic law, the UK should ensure no measures in the EU Withdrawal Bill widen inequalities or increase pressure on the NHS by undermining efforts to tackle lifestyle-related ill-health. It has been suggested this could take the form of a 'do no harm' clause in the Bill.[21] This would support an ambition to maintain UK and European cooperation on public health.[22] Where there are opportunities to go further than EU legislation — for example, by introducing mandatory traffic light nutrition labelling — the UK should consult widely with the public health community and ensure proper parliamentary scrutiny to develop robust measures to support prevention and health improvement.

In order to support evidence-based decision making the UK and EU should negotiate a commitment to continue to share evidence as a general principle to support health improvement, as well as negotiating agreements with specific agencies such as EMCDDA and EUROCARE. There is precedent for such collaboration with non-EU member states, for example, the EMCDDA works with Norway and Turkey.[23] The House of Commons Library also points out that an EU Council regulation (302/93) states that it is possible for non-EU member states to be involved in ad hoc working parties.

To mitigate against the losses of EU funding for regional development, the UK government should replace this with new domestic funding and introduce a transparent mechanism for prioritisation based on need and opportunity. The UK should ultimately seek to take comprehensive action to become a world leader in addressing health inequalities and implement the recommendations set out in our 2017 report: Health at a price: reducing the impact of poverty. With the clear influence that economic and social policies can have on health, it is important that the Government continue to adopt a 'health in all policies' approach, to ensure that all policies are focussed on the impact they have on people's health.

For the UK, this approach would:
— maintain measures currently in EU legislation that benefit public health, with the opportunity to go further in promoting prevention after March 2019;
— support measures to improve the social determinants of health in the UK; and
— guarantee the UK maintains its reputation and influence internationally in our approach to prevention, and has access to the best available evidence.

For the EU, this approach would:
— ensure a consistent approach to issues such as the marketing, labelling and content of products which cross borders and contribute to the burden of long-term disease;
— maintain access to UK expertise and influence in taking forward the EC's public health goals.

Key developments
— In August 2016, the Chancellor announced that all structural and investment fund projects signed before the Autumn statement 2016 would be fully funded, even when these projects continue beyond the UK's departure from the EU.[24]
— In October 2016, the Chancellor announced that beyond the Autumn statement 2016, the Treasury would offer a guarantee to bidders whose projects 'meet UK priorities and value for money criteria'.[25]
— In December 2017, the European Council formally agreed that sufficient progress had been made in negotiations between the UK and EU on a number of key separation issues to allow negotiations to move onto the future partnership. The agreement stated that the UK would continue to participate in EU programmes financed by the 2014-20 budget framework until their closure and UK participation would be unaffected by withdrawal from the EU for the lifetime of such projects.
— In February 2018, the EC published a draft withdrawal agreement between the UK and EU. This included a specific focus on the requirement of EU law governing the marketing of goods, including the conditions for the marketing of goods, to continue to apply to the market of any goods in circulation in the UK or EU before they reach the end-user.[26]
— In February 2018, the Prime Minister set out her vision on the future economic partnership with the EU in her speech at the Mansion House. On trade in goods, the Prime Minister, talking in a general sense, confirmed UK regulatory standards would remain at least as high as the EU's.[27]

Summary

Lifestyle factors such as smoking, alcohol use, physical inactivity and unhealthy nutrition contribute to an avoidable burden of long-term disease. These factors are strongly linked to inequalities in health outcomes. The EU works with member states to improve public health, prevent illness and eliminate sources of danger to physical and mental health. This includes a commitment to tackling health inequalities, including actions to address the social determinants of ill health. The UK's decision to leave the EU will have a number of consequences for health improvement – the UK will have to develop new health improvement measures, while ensuring the UK and EU do not weaken or duplicate evidence and data sharing, and that health inequalities do not widen. It is important that the UK and EU continue to collaborate on tackling cross-border prevention challenges, and that the UK ensures future policy development, supports improvements in public health and focusses on tackling health inequalities.

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