The UK and the European Centre for Disease Prevention and Control (ECDC)

Blueprint for a post-Brexit relationship

FACULTY OF PUBLIC HEALTH

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1. Background

As the UK negotiates its exit from the European Union (EU) this briefing has been written by the Faculty of Public Health (FPH) to begin a dialogue around the ways in which current systems and arrangements to mitigate global threats to UK and European citizens from infectious diseases are protected and enhanced. The briefing begins by summarising the need for international health protection cooperation, describes the UK's relationship with the EU's main communicable disease agency, the European Centre for Disease Prevention and Control (ECDC), then explores different options for consideration by government for how the UK could approach international health protection post-Brexit.

2. Introduction

Despite significant advances over the past hundred years, infectious diseases remain a major burden on the UK health system and economy. The UK Office of Science and Innovation in 2006 estimated infectious diseases to be implicated in 10% of deaths annually, to comprise 35-50% of primary care consultations and to cost in England alone around £6 billion a year in treatment.

Health agencies typically approach such threats strategically through the establishment of surveillance systems that ensure systematic monitoring, analysis, early warning of threats or outbreaks and a coordinated response to incidents.

Repeated threats of infectious diseases from overseas in recent years have highlighted the necessity of arrangements that enhance cooperation between countries in order to protect the health of the UK public and our nearest neighbours. Since infectious diseases do not conform to national borders, it is arguably imperative that countries collaborate to develop robust systems for surveillance and preparedness.

During the UK's 45 years of EU membership, arrangements for international health protection have been shaped across Europe in order to respond to the increasingly complex requirements of a robust health security network. As the UK plans for a post-Brexit state, careful consideration of current provisions for health security is needed, in order to protect and enhance the health of the British public.

We welcome the Secretary of State for Health and Social Care's recognition that 'with emergencies such as Swine Flu and Ebola, health transcends global boundaries", and his commitment that "improving health security will form an important part of our negotiating position." As part of that position, the Secretary of State has further affirmed the Government's ambition for an "agreement that allows us to maintain the important and mutually beneficial collaboration with Europe on health issues" and which "guarantees equivalent or higher standards of health protection." [i]

FPH further welcomes the Government's commitment that the duty to 'Do No Harm', currently enshrined in Article 168 of the Treaty of Lisbon, which makes clear that "a high level of human health protection shall be ensured" in all policies and activities, will continue after the UK leaves the EU. FPH looks forward to continuing to engage with and support the Government in realising its ambitions on health security now and as we leave the EU. [ii]

3. Current relationship with ECDC

Founded in 2005, ECDC is an EU agency tasked with strengthening Europe's defences against infectious diseases. The agency works in partnership with national health protection bodies, such as Public Health England (PHE), to strengthen continent-wide disease surveillance. While activity of the agency is wide ranging, it can be distilled into three broad domains: (1) risk assessment; (2) a hub for data analysis and interpretation to enable disease surveillance across borders; and (3) coordination between national public health agencies during outbreaks and emergencies. The UK, as a current member of the EU, benefits from and contributes to a number of specific ECDC systems that fall under these domains including:

I. The Early Warning Response System (EWRS)

This surveillance system notifies member states of information regarding emerging communicable disease threats and control measures, progression of current epidemics, unusual disease phenomena or new threats from disease of unknown origin and proposed mechanisms to prevent and control communicable disease threats, particularly in emergency situations. Access is limited to formally appointed contacts in member states who receive real-time notifications of communications.

II. The European Surveillance System (TESSy)

TESSy is a unified data collection system comprising all data on communicable diseases provided by member states. Data is analysed and aggregated by ECDC and reports disseminated to member states. Nominated users in member states are granted access to the entire data system.

III. The Epidemic Intelligence Information System (EPIS)

EPIS is a web-based communication platform that allows nominated public health experts to exchange technical information to assess whether current and emerging health threats have a potential impact in the EU.

IV. The Threat Tracking Tool (TTT)

A database of verified events used to detect and assess emerging communicable disease threats.

V. The Field Epidemiology (EPIET) and Public Health Microbiology (EUPHEM) fellowships

These 2-year fellowship programmes train practitioners from across Europe in either intervention epidemiology or public health microbiology, enabling individuals to access high standards of training with some of the most talented individuals in these fields across Europe. The EPIET fellowship allows for 'cross fertilisation of knowledge' across Europe and helps build professional networks and collaborations. The UK has historically seen a large number of its practitioners join this programme, while the UK's Field Epidemiology Training Programme (FETP) competency standards are currently approved by ECDC.

4. Hub for international collaboration

Over the past 13 years, health protection experts from across Europe have come to regard ECDC as an important facilitator of professional networking, partnership and collaboration, leading to each member state having access to a wealth of expertise. One example of this type of collaboration is the disease and laboratory network system. ECDC supports and facilitates 17 networks and consortia of experts from a range of member states, aiming to enhance capabilities and strengthen capacity for pathogen detection, characterisation and surveillance of specific diseases and antimicrobial resistance. Examples include the European Antimicrobial Resistance Surveillance Network (EARS-Net), the European Network for STI Surveillance, and the European Influenza Surveillance Network.

5. Examples of communicable disease threats crossing borders

Proximity to Europe and high levels of cross-border travel means cases of infectious disease in the UK are regularly imported from Europe and vice versa. Outbreaks of measles in England and Wales have been repeatedly linked to ongoing outbreaks in countries in eastern Europe, [iii], [iv] while cases of hepatitis A among men who have sex with men across Europe have been shown to be linked, with 3813 cases identified to date. Further diseases regularly emerging in the UK from Europe include legionella, an often severe form of pneumonia, and food-borne sources of infection such as the multi-country outbreak of salmonella that was linked to Polish eggs in 2017. [vi] Just this year a case of multi-drug resistant Neisseria Gonorrhoeae was confirmed in the UK and found to be acquired from South-East Asia. [vii]

6. Legal basis for ECDC

ECDC is regulated by (EC) No 851/2004 which came into effect on 21 April 2004. It establishes an independent European agency for disease prevention and control. It is composed of a management board, a director and staff located in Sweden, and an advisory forum. So far two independent external evaluations have been conducted, in 2008 and 2015, which demonstrate that ECDC is largely meeting its objectives.

Regulation EC 851/2004 states that ECDC in its relations with Member States cooperates with 'coordinating competent bodies (CCBs)' which in the UK falls to PHE, in the area of surveillance, responses to health threats, scientific opinions, scientific and technical assistance, collection of data and identification of emerging health threats and public information campaigns.

In 2005 ECDC and WHO/Europe signed a Memorandum of Understanding (MOU) recognising that both are involved in public health development in Europe and should work together. In March 2011 a new administrative agreement was signed that streamlined the implementation of previous agreements on surveillance. As a result, WHO and ECDC have a joint working group which addresses annual work plans and collaborative activities. For example, WHO/Europe and ECDC work together to develop a single European reporting and response system, and to implement the 2005 International Health Regulations (IHR).

7. EU Health Security Committee

With regard to international health security, ECDC works within a larger system of European collaboration. The facilitator of this network is the EU Health Security Committee, which functions as an advisory group on health security at the European level. Member States aim to use the committee as a tool to coordinate national responses to serious cross border threats to health and to strengthen capacity. A small number of non-EU nations, including Norway, Iceland and Lichtenstein, have 'observer' status on the committee. Examples of the on-going work of the committee include:

- Managing the health impact of the refugee crisis
- Assessing the health impact of the 2010 Icelandic volcano eruption
- Managing a Europe-wide shortage of radio-isotopes for medical use in 2008. [ix]

Whether the UK is part of ECDC or not, we would urge the Government to ensure that the UK remains a member of the Health Security Committee, and continues to benefit from its coordinated action on cross border health threats.

> "…Failure to collaborate on health protection with European public health agencies can have consequences not only for public health, but also in terms of wider societal impacts including economic and UK reputation…"

8. The Opinion of Health Protection Experts

In March 2018, FPH's Brexit Project Group sent a number of UK health protection experts an online questionnaire to gather their views on ECDC and establish their preferences for the UK's future relationship with ECDC.

Respondents unanimously felt that it was very important (mean score 9.6/10) to retain a working relationship with ECDC post Brexit to be able to respond effectively to cross-border threats and for UK health security. 91.7% wanted that relationship to remain as is, with no significant change, whilst 8.3% wanted to create a new relationship with ECDC. When asked to rank the functions of ECDC in order of importance for UK health protection, EWRS was ranked the highest. Data collection and analysis, access to scientific evidence and guidance in management of cross-border threats were also seen as important.

In terms of the UK's contribution to ECDC, respondents unanimously identified the UK as playing a leadership role, particularly with regards to academia and innovation. However, despite the range of expertise within the respondent pool, many felt their ability to manage future outbreaks post-Brexit would be weakened if the UK were to move outside of ECDC, mainly due to the loss of EWRS and professional collaborative opportunities. Many respondents indicated that they had been supported by ECDC during previous outbreaks, particularly large-scale international outbreaks such as Zika and Ebola.

> "….of outbreaks spanning international borders ECDC have often played an important role in risk assessment and bringing such incidents and outbreaks to an earlier conclusion than otherwise may have been possible."

9. Alternative models of health security cooperation

The UK is legally bound by the International Health Regulations to build national capacity for surveillance and response in the event of a public health emergency of international concern, and to share information about such emergencies. However, methods used to fulfil these obligations differ from country to country, and the regulations have come under increasing scrutiny – particularly in the wake of the 2014 Ebola outbreak. [xi]

At minimum, regional surveillance systems can be expected to ensure: common laboratory standards, harmonisation of reporting between countries, an effective national surveillance system to identify cases of a disease, robust systems for disease control, and effective communication and trust between countries in the network. [xii]

Different arrangements for health security cooperation do exist for countries across the wider European neighbourhood area. Norway, Liechtenstein and Iceland, though not member states of the EU, currently cooperate with ECDC with full access to information sharing and alert systems such as EWRS and EPIS. Budget contributions to ECDC are provided by the European Economic Area (EEA) of approximately €1.5 million per year, with each country contributing proportionally to its GDP. Switzerland on the other hand, while not a member of the EEA, has partial access to such information sharing systems.

Formal bilateral agreements also exist between ECDC and public health agencies in the USA, Canada and China, granting these countries access to intelligence gathering platforms and to facilitate coordination of health protection efforts. [xiii]

ECDC's international relations policy has weaker links with countries seeking future EU membership and among the 16 closest eastern and southern neighbours including Egypt, Israel and Russia. Such links mainly comprise technical cooperation, alignment of standards and in capacity building.

Another important aspect of health security, not addressed in this briefing, is the regulation and procurement of medicines and vaccines. Currently this is managed by EU-wide systems which facilitate trade under the single market.

10. Options for UK-ECDC post-Brexit:

With regard to Brexit, both the Prime Minister and the Secretary of State for Health and Social Care have communicated a strong desire to maintain current standards for security in many sectors, including health. In an April 2018 article, the Secretary of State commented:

> "As we've seen over the years with emergencies such as Swine Flu and Ebola, health transcends global boundaries and, as the negotiations move forward to agreeing the terms of our future relationship, improving health security will form an important part of our negotiating position.' [xiv]"

With this position in mind, FPH is proposing three potential options for the UK's future relationship with the European Centre for Disease Prevention and Control. They are listed in order of preference.

I. Retaining our current relationship with ECDC

Full membership = €6 million per annum

In order to ensure the UK continues to achieve and deliver the highest standards of health protection, maintaining our relationship with ECDC post Brexit, ideally with full member status, presents the best case scenario. While this may require some flexibility in relation to the current legislative framework for ECDC, we are confident that this could be possible as part of the negotiations. Whilst, the UK has considerable expertise in health protection and indeed is regarded as one of the EU's leaders in communicable disease control, part of our leadership is conferred by our membership with the EU. Post Brexit, without a formal relationship with ECDC, important and expert social networks and professional relationships may start to fragment and our ability to tackle infectious diseases is likely to decline.

Brexit, however, may present an opportunity to ask for certain reforms within ECDC and revisit the terms of reference of our relationship. For example, ECDC has often been quoted as too bureaucratic and non-transparent. Further clarity on its role in relation to non-infectious hazards is required. In turn, EPIET training, whilst valuable for building UK expertise and relationships across Europe, could be enhanced by improvements to their modules.

In terms of cost, the EU contributes €56 766 000 to ECDC and the UK currently provides 10.7% of EU contributions, therefore it can be assumed that full membership of ECDC will require annual contributions of approx. €6 million. However, this would be the subject of ongoing negotiations.

Note: An arrangement similar to those held by Norway/Iceland/Lichtenstein or Switzerland would be likely to require smaller contributions, but the exact nature of this contribution is difficult to estimate, as the UK is unlikely to have the arrangements around immigration and trade that are currently in existence in other partner countries.

II. Creation of a bespoke relationship with ECDC and other international Health Security organisations

Post Brexit, if an agreement with the EU is not reached, creating a bespoke relationship with ECDC would be the next preferred option. This would be a long-term project and would require significant investment in system strengthening. However, the UK has been a member of the EU since 1973 and ECDC since it commenced in 2004 and it's likely there would a willingness from both the UK and ECDC to negotiate a bespoke relationship. Indeed it would be in the interests of both parties as the UK has a played a key strategic leadership role in European health security to date and leads across a number of infectious disease areas.

A new bespoke relationship, by way of governance, would encourage the UK to better monitor how much it contributes to ECDC, the value it receives in return and how much influence it has on ECDC's agenda. It would offer an opportunity, were ECDC's strategic priorities to not be sufficiently aligned with the UK, to re-negotiate the relationship and consequently payments.

ECDC is currently prioritising efforts to collaborate with WHO Europe. The creation of a network of information sharing, incorporating both ECDC and WHO, may help with infectious disease surveillance. However, to create a network of information sharing, similar to the existing arrangements with ECDC, will likely require expansion of the PHE National Infection Service and training in surveillance.

Creation of a bespoke relationship will also require 'future-proofing' of ongoing health security strategies. With chemical, biological and radiation incidents increasingly seen to be within the purview of health security, the UK would need to ensure that its future relationships allow for the constantly changing nature of international health protection. In addition, consideration of professional networks that go beyond infectious disease surveillance, such as the Disease Specific Networks and the Health Security Committee (mentioned above), will be required.

> "Infectious disease control requires a strong framework of cross-border collaboration, including common methods, training and information sharing agreements. These are best served within the current ECDC structures."

III. European Neighbourhood Policy Agreements

ECDC is in the process of drafting bilateral/regional agreements with neighbouring non-EU countries in Northern Africa and Eastern Europe. A similar partnership may be an option for the UK in the future, particularly as this is currently a policy priority. However this type of agreement is unlikely to go much further than basic technical cooperation. This would, however, give the UK access to the MediPIET training scheme, which has a similar model to EPIET[xv]. By 2020, ECDC aims are[xvi]:

- All ENP countries have nominated national ECDC correspondents and ECDC has established contacts with them (2014).
- The European Neighbourhood and Partnerships Instrument (ENPI) project has been initiated and the first annual work plan implemented (2015).
- Sustainable procedures are in place for technical cooperation between ECDC and ENP countries
- MediPIET has contributed to capacity building and networks with ENP countries

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