Faculty of Public Health
Of the Royal Colleges of Physicians of the United Kingdom
Working to improve the public's health

UK Faculty of Public Health Report on the Health-Related Consequences of the European Union Referendum

1. KEY MESSAGES

1. The EU Referendum represents an important decision about the future of the country. The EU affects the major determinants of health, both directly and indirectly.

2. European legislation on environment, consumer safety, food quality, human rights and social policy has powerfully contributed to better UK health and wellbeing.

3. The EU has a political commitment to supporting innovation and research for health. The EU provides substantial funding: UK public health researchers do well, competitively winning far more funds than the UK initially pays into these programmes.

4. Some 10% of the UK's health and social care workforce are from the EEA countries. Addressing potential staff shortages amongst key healthcare workers is a benefit of the policy of freedom of movement of citizens.

5. The EU is the world's largest trading block and is globally the best practice regulator for other jurisdictions and industries. If the UK leaves the EU, it will take time and money to build up the institutions and skills required to deliver any regulatory responsibilities which are relocated from Brussels to the UK.

6. A third of the EU budget goes towards investing in poorer regions across the continent. This solidarity mechanism has been extremely valuable for the UK, supporting regional growth and jobs, tackling inequalities and building social capital. There is no guarantee that an independent UK would fill such regional funding gaps in future.

7. Decision-making in a community of 28 countries is cumbersome and slow. By going it alone, the UK might develop a more streamlined and efficient government more responsive to population needs and concerns.

8. If the political vision and political will both existed, the UK would be free to take bolder or faster action in favour of public health (when not constrained by the readiness of other countries).

9. On balance, the EU has had a positive impact on population health and health service provision. When fully engaged in the EU, the UK has potential to contribute through leadership
10. and partner with other countries to achieve mutually beneficial goals.

2. About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.

As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With 3,300 members based in the UK and internationally, we work to develop knowledge and understanding and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

3. Statement of independence

FPH has not received EU level funding since 2012 and has no current plans to obtain EU level funding. It is therefore clear that FPH is not justifying a decision to engage in 'political activity' based on any potential loss of such funding. FPH has no EU level funding sources to declare.

FPH is an independent charity. This report, and its recommendations have been developed on the balance of the best available and most up to date evidence base. FPH has no political, including party political, affiliation, nor affiliation to any campaigning group or individual politician.

4. Executive Summary

This briefing considers the likely health consequences of leaving or remaining in the EU.
European integration is a concept that emerged after the Second World War period as a means of creating interdependencies and connections between countries and thus reduce the risk of further conflict. Over time, the EU has evolved into a mechanism to stabilise and embed democratic governance during times of change. The peace dividend generated by the EU is a clear asset for the health and wellbeing of the people of Europe.

Population health is a subject of political choices, particularly addressing the social determinants of health such as economic and social opportunity, poverty, decent housing and employment. A healthy population is an asset, driving economic growth. Conversely, unequal societies have big gradients in mortality and morbidity across the population resulting in heavy demands for health and welfare services. Wellbeing is among the key objectives of the EU according to the Treaty on European Union. EU legislation, policies and funding programmes affect health determinants both directly and indirectly.

This briefing considers the likely situation of remaining in the EU compared with leaving the EU. It is assumed that a 'remain' vote will result in current arrangements staying as they are along with any known developments that are planned. It is assumed that a 'leave' vote would result in a complete separation. This may have an impact on the internal stability of other EU countries that have strong independence or regional movements (Spain, Italy, France, Belgium, and Germany) and this may trigger similar referenda in these countries, thereby undermining the overall stability of the EU.

Should the UK decide to leave the EU, some kind of relationship could be negotiated with it, particularly in terms of accessing the single market and other systems such as the European Centre for Disease Control (ECDC). However, there would be a cost associated with such arrangements. That may mean that the UK could potentially remain subject to much EU legislation and costs, but with no chance of influencing or amending them. It is unclear how such an arrangement would be better than the status quo, hence the assumption of complete separation as a consequence of a 'leave' vote.

Some of the proposed benefits of leaving the EU would be a reduction in the administrative and regulatory burden on businesses generated by EU legislation. The UK, together with 17 other countries, has called for specific EU targets on reducing the red tape burden[1]. This current Commission has a formal commitment to streamlining legislation, producing just 23 new legislative proposals in 2015 compared to an average of 130 annually in the preceding five years. Furthermore 80 pieces of pending legislation have been withdrawn and there is a Commission Vice-President with specific responsibility for Better Regulation[2].

The UK benefits currently from block EU-wide negotiating power in global trade agreements.[3] It is hard to estimate the potential attractiveness of an independent UK for trade agreements, but key trading partners such as the US and Japan have stated that starting negotiations for a new bilateral agreement would not be a priority for them.[4] [5] Furthermore, leaving the EU would require both time and significant civil service resources to negotiate new trade agreements to replace the EU agreements with third countries.[6]

As a member of the World Trade Organization (WTO), the UK has already made commitments in terms of opening its market for products and services and public procurement. Some of these are a concern for public health (for example enhanced provisions of the Trade Related Aspects of Intellectual Property Rights Agreement, or private sector involvement in managing NHS services). Leaving the EU would not change this situation, because commitments made in the context of the WTO cannot be withdrawn without financial penalty.[7]

Environmental legislation is almost entirely adopted at EU level and implemented nationally or locally. This is logical given the cross-border nature of pollution, climate change and related health threats. The UK benefits from these arrangements as on its own, the UK (or indeed most countries) does not have the capacity to effectively control many of the most important determinants of our current and future health, including pandemics, the environment, healthy sustainable food, and climate change. If the UK leaves the EU, attention would need to be given to how the UK could continue to be part of efforts to address these international issues.

A third of the EU budget is spent on supporting agriculture, some €27.8 billion are to be invested in UK farming by 2020. It is unclear if an independent UK government would choose to match this level of financial support. The UK imports more food from the EU than from the rest of the world. Being outside the EU could trigger the imposition of new tariffs on food stuffs which could increase the cost of imported foods.

Health and safety at work legislation is basically European; likewise legislation ensuring the safety of food, medicinal products and medical devices. The Social Chapter mandates generous maternity and paternity leave, guaranteed holidays, the 48h Working Time Directive; equal rights for part-time workers and protection against unfair dismissal. (All are powerful social determinants of health from which UK citizens have benefitted). Once outside the EU, the UK would be free to sacrifice them in the name of efficiency or austerity, or further develop these worker protections if the political will is present.

Many UK areas have benefited from EU Regional Policy funding, including Scotland, Wales, Northern England, Northern Ireland and Cornwall. This is valuable given the current devolution trends in regional and local authorities.

Access to the EU Single Market greatly benefits the UK life sciences sector. If the UK were outside the EU, UK influence on EU medicines and device regulation would be minimal. Free movement of health and science professionals within the EU currently benefits the UK health sector because of the enlarged pool of talent.

EU Registration and approval of pharmaceutical products is carried out by the European Medicines Agency (EMA) - based in London - benefits include efficiency and regulatory predictability. If the UK were no longer a member of EU, new medicines developed in the UK would be subject to approval processes both domestically and at EU level. That would add time and increased costs to regulatory processes.

The EU is a major source of research funding for UK health and public health researchers: the UK contributes 11% of the EU research budget and receives 16% of allocated funding, a substantial net benefit. Matching this level of funding from the national budget in the event of a 'leave' vote would be difficult and yet still not provide the kind of international collaboration opportunities that are so critical to innovative research.

In conclusion, having objectively considered the best evidence available, a decision to remain in the EU would ensure continued protection for health, notably from legislation on clean air, water, safe food and consumer products, a flow of qualified workers for the NHS and funded opportunities for researchers to thrive in a dynamic scientific community.

In contrast, leaving the EU would, on balance, be likely to be detrimental to the health of the UK population, impede effective public health practice and act as a barrier to UK research.

5. Glossary

ABPI	Association of British Pharmaceutical Industry
AMBER	European Child Rescue Alert
CAP	Common Agricultural Policy
CHRODIS	Joint Action on Chronic Conditions
ECHA	European Chemicals Agency
ECJ	European Court of Justice
EEA	European Economic Area
EFSA	European Food Safety Authority
EHIC	European Health Insurance Card
EMA	European Medicines Agency
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPIET	European Programme for Intervention Epidemiology Training
EU	European Union
EU OSHA	European Agency for Health and Safety at Work
FVO	European Food and Veterinary Office
GMO	Genetically Modified Organism
MEP	Member of the European Parliament
MFF	Multi-annual financial framework
NGO	Non-Governmental Organisation
NHS	National Health Service
RAPEX	Rapid Alert System
REFIT	Regulatory Fitness and Performance programme
REACH	Registration, Evaluation, Authorisation & restriction of Chemicals
SME	Small to Medium Enterprise
TRIPS	Trade Related Aspects of Intellectual Property Rights
TTIP	Transatlantic Trade & Investment Partnership
UK	United Kingdom
USA	United States of America
WHO	World Health Organization
WTO	World Trade Organization

6. Introduction

The UK Government has determined that on 23 June 2016, the UK will have to make a significant decision: whether the UK should remain as a member of the EU, or leave it. That decision will have major implications for the future health of the UK's population.

The EU affects our health and health services in many and complex ways; usually to our benefit through legal frameworks to tackle the major social determinants of health (environmental protection, food, employment and anti-discrimination laws)[8]. Although formally a national competence, EU legislation also sets out the rights of patients to receive healthcare treatment in other countries and be reimbursed. The EU has a more limited role in both education and social care, both of which are drivers of health, particularly for young people.[9]

We currently participate actively in these legislative processes, through our elected MEPs, via the Council of Ministers and more informally via European Commission civil servants.[10] However, should the UK decide to leave the EU but try to retain a relationship with the EU, this is most likely to mean that the UK be required to contribute to EU costs and implement most EU laws without having any input into their design or amendment (Norwegian situation).

7. What would a post referendum UK-EU relationship look like?

So far, there has been no clarity among those arguing for a leave vote as to what form a future UK-EU relationship would take. The Lisbon Treaty (2007) details the process for a country to leave the EU (Article 50), but this has not been considered a real possibility until the UK referendum. The government has signalled that a 'Leave' vote would mean invoking the Article 50 mechanism which sets out a timeline (2 years) for the negotiations on withdrawal and that furthermore the withdrawal agreement would require approval of the European Parliament and a qualified majority of the European Council.

If, after a vote to leave, there should be agreement to opt back into many EU services, including the single market, the UK would then have to pay for these by continuing to contribute to the EU budget, and would have to apply most EU legislation to UK, without having any say in the nature or details of this legislation.

Norway has decided against EU membership in two referenda. However, it has signed an association agreement and applies more than three quarters of all EU legislation in order to access the single market. It pays into the EU budget almost as much as if it were a Member State (The UK pays into the EU £153 per person per year, Norway pays £106 per person)[11]. The agreement gives full access to the Single Market in return for implementation in national law of EU legislation covering goods, services and capital, as well as the free movement of people. It also covers cooperation in other areas such as research and development, education, social policy, the environment, consumer protection, tourism and culture, collectively known as 'flanking and horizontal' policies. Policies relating to trade policy, customs union, the monetary union and agriculture and fisheries, however, are outside the agreement. [12, 13, 14.]

A further degree of separation, as Switzerland has[15] would only allow more limited access to the internal market, including some restrictions on labour mobility (for example for health service workers). That agreement also excludes Switzerland from the single market in services, which would have profound implications for the UK economy which is almost 80 % service based[16]. (This explains why major financial organisations have indicated that they would move to Paris or Frankfurt if the UK decides to leave the EU). Crucially there would also be restrictions on UK institutions' participation in EU research projects and eligibility to receive EU funds (Swiss institutions are not eligible to lead research projects).

A decision to leave the EU would also imply a major loss of influence for some important UK institutions such as the Wellcome Trust and Cancer Research UK, both of which often lead EU research projects. UK NGOs and charities (for example those concerned with health matters, social issues, environment or other socio-economic determinants of health, etc.) which currently benefit from EU funding, could lose many millions of pounds in funds annually.

8. Peace in Europe

War and threats to peace present some of the most serious threats to good public health. After over 300 years of wars in Europe, the first original objective of the EU was the promotion of peace in Europe[17,18, 19]. Apart from a few exceptions, peace has been maintained in Europe since 1945.

Eleven of the EU countries became democratic and independent in the past 25 years (after the dissolution of the Soviet Union). Therefore their history of parliamentary democracy, independent judiciary and media, and a market economy is very recent. Europe went through a very dramatic period of regime change and apart from the war in the former Yugoslavia in the early 1990s, this has largely been a peaceful process.

The result is countries that have transitioned and achieved significant social, political and economic development. They are firmly embedded in a community of law, with relatively stable political systems and vibrant civil societies.[20] This is unique compared to the rest of the world where regime change has often led to prolonged uncertainty, conflict and instability. The countries on the EU borders are witness to this (Libya, Egypt, Tunisia, Syria, Georgia, and Ukraine – to name a few).

The European integration process has contributed significantly towards this, a fact that is recognised by other regions that take the EU as an inspiration for their own efforts at regional cooperation (for example, the Association of Southeast Asian Nations, African Union, or the Asunción Treaty) [21], [22]. The ongoing economic crisis and the migration situation have exacerbated the pressure on **some** governments in the region and **some** countries are experiencing a rise in nationalist, anti-liberal sentiment. The UK's contribution to this EU role as a stabilising influence for the region should be acknowledged. This successful and on-going investment in stability should be recognised as being in our national interest.

A decision to leave the EU could not only re-open the question of Scottish aspirations for independence but also Wales and possibly Northern Ireland given the proximity to the Republic of Ireland which will remain in the EU and will need to re-introduce a border [23, 24].

The current migrant crisis is arguably one of the largest challenges to Europe and its member states in modern times. Not only does this bring humanitarian and public health challenges, but also it demonstrates the modern necessity of cooperative public policy across member states for adequate and appropriate action to address modern complex challenge. More than one million migrants arrived in the EU in 2015, three quarters of them fleeing conflict in Iraq, Afghanistan and Syria mostly arriving in Greece, Spain and Italy. Many migrants seek to cross Europe – preferred destination countries include Sweden, Germany and the UK. Managing these kind of migrant flows requires cooperation between governments which currently takes place within an EU framework.

It should be noted that the UK has already secured opt-outs of the Schengen agreement and migration and asylum legislation in the late 1990s. [25] In 2014 Britain opted out of all EU justice and home affairs laws introduced prior to the Lisbon Treaty (2007). It then selectively opted back into 35, including Europol and the European Arrest Warrant, which it considered in its interests[26]. If the UK left the EU, new intergovernmental mechanisms would need to be established in order to cooperate with other countries over managing migrant flows.

9. Public health

EU supported public health powers are important – notably cooperation on the major risks to health, and legislation on safety of blood and blood products, human tissues and organs. [27, 28]

The EU has a number of technical agencies with relevance for health - European Centre for Disease Control (ECDC), European Food Safety Authority (EFSA), European Food and Veterinary Office (FVO), European Medicines Agency (EMA), European Agency for Health and Safety at Work (EU OSHA), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). These agencies gather data from Member States and undertake monitoring, surveillance, trends analysis and risk assessment. They provide

alert mechanisms for government officials and key stakeholders such as environmental health or trading standards officers. Cross-border cooperation is critical to addressing health threats, for example, tackling fraud in the food chain (2013 horse meat scandal [29]), responding to increasing resistance of sexually transmitted infections to antibiotics [30], making new psycho-active substances such as mt-45 subject to legal control [31]. There is also the Rapid Alert System (RAPEX), an EU alert mechanism for consumer products which could trigger action by local authorities such as trading standards when harmful products are identified.

EU agencies contribute to shared learning across borders and offer a platform for coordinated European responses to crises within the EU and globally (demonstrated during the Ebola crisis and pandemic influenza outbreaks[32]). The UK public, through the UK Department of Health and many UK agencies currently benefit from participation in the EU public health programme, such as the Joint Action on Chronic Conditions (CHRODIS). If the UK choses to leave the EU, it loses automatic access to these critical services. Future access would depend on negotiating a new arrangement which will almost certainly require the UK to contribute funds (for example, as Norway does in order to be part of the EU Public Health Programme).

The UK also benefits from a number of legislative processes that ensure the safety of medicinal products and medical devices. At present, standardised and effective medical technology approvals are easily available:

- Pan-EU medical devices regulation [33] offers speedy and cheap access to EU markets for medical technology firms. Small and medium-sized enterprises (SMEs) make up 97% of the sizeable UK med/tech industry. The cost of gaining approval for their product sales in the UK and EU separately could place an unrealistic cost burden on them – potentially preventing them from selling competitively into the EU market;
- Turnover in the medical technology sector in the UK has grown year on year since 2009 – is unclear if this trend would continue if UK companies were not able to access both the UK and EU markets through a single approval process;
- Currently, the EU medical devices approval process is recognised as being supportive of innovation – especially when compared to Food and Drugs Administration approval in the USA, which, on average, takes five years longer to approve new medical devices.

Coordinated improvements to public health and health security:

- Common standards across the EU facilitate the movement of tissues, cells and organs across member states, ensure traceability and standardise safety reporting systems to pool information from across the EU. Cell based treatments not available in the UK can be imported for named patients and UK citizens can receive suitable organs from across Europe;[34]
- Common standards make it easier to import foods from other EU member states to the UK [35] and vice-versa ensuring the quality of a wide choice of products. EU-wide rules against illicit trade of tobacco products, including an EU-wide tracking and tracing system for the legal supply chain and visible and invisible security features (e.g. holograms) which should facilitate law enforcement. This also applies in the case of combatting counterfeit medicines;
- There are also other systems of EU cooperation such as incentivising the development of new antibiotics and vaccines (for example, through the Innovative Medicines Initiative[36] better data and early warning systems across the EU), and conserving existing antibiotics. This can also apply in the case of new treatments for rare diseases and for joint or pooled EU-wide procurement policies for orphan drugs;
- Anti-microbial resistance represents a large and growing threat to the UK public. This major health threat can only be effectively dealt with at an international level, particularly through a 'one health' model that brings together animal and human health agencies as well as those responsible for the environment and food safety.

A UK that is outside the European Centre for Disease Prevention and Control (ECDC) process of

monitoring, surveillance and coordinated response to health threats then becomes highly dependent on the WHO Euro region for this function. The WHO Euro office has to deal with a 53 country region divided between the richer, more developed and mature EU countries and the countries in the East of the region which have weaker, less developed health systems and need considerable technical support and capacity building. This is a core focus for the WHO Euro office, for example assisting the government of Turkmenistan to develop a chronic disease strategy.

It is therefore unclear how it would find an appropriate mechanism for sharing of information, peer exchange and collaboration on communicable disease and cross-border health threats. The UK could, like Norway, Switzerland and Iceland, participate in the activities of the agencies such as the ECDC through specific agreements setting out the financial contribution and roles. However, it would not be a Member State with voting rights on the management board and a decision-making opportunity, but would still have to contribute to the relevant costs.

10. The environment and climate change

The environment cannot be controlled at the nation state level - air, water, other pollutants, and the climate itself are not limited by political borders. Therefore environmental legislation is almost entirely an EU competence.[37]

Significant improvements in air quality and quality of bathing water in the UK, to take two examples, have been due to environmental legislation at the EU level. It is not clear how a future UK Government would legislate around these standards if competence were to return to national level, not only for air and water pollution, but also with respect to chemicals and pesticide use, waste management, recycling and energy-saving legislation, labelling of household appliances, laws monitoring and limiting pollution and energy used by industrial installations, and those applying to power stations, emissions standards, and fuel-efficiency in transport. However it is likely that these standards would be maintained or even enhanced within the EU.

The EU has a key position in global efforts to address climate change[38, 39] and the UK has played a role in shaping this EU position. If the UK leaves, national commitments to reduce climate change might be affected. Furthermore, a future EU position may be weakened without a strong momentum from the UK to maintain the commitment to cut emissions by at least 40 % by 2030.

The European Chemicals Agency (ECHA) [40]is the body overseeing implementation of the Registration, Evaluation, Authorisation & restriction of Chemicals (REACH) legislation. That created a register and authorising body for chemicals in Europe. This has banned or introduced very strict controls on the most toxic substances. REACH legislation was achieved in spite of lobbying by industry. [41, 42.] The US chemicals authorisation regime is, by contrast, far more lax than this, e.g. it still has not entirely banned asbestos). If the UK were to leave the EU, it is unclear whether UK would still be party to ECHA information and if a UK approach to legislating on chemicals and health/environment risks would be different and more or less supportive of health.

Air pollution is a serious contributor to morbidity and mortality (an estimated 29,000 deaths annually in the UK) [43] and the EU is well placed to help address this. In addition to legislation, the EU is a powerful enforcement mechanism which is driving up quality standards. Countries that fail to implement EU legislation appropriately are subject to legal action at the European Court of Justice (ECJ). For example, the Court ruled in 2014 that the UK government was in breach of the EU AirQuality Directive because illegal levels of Nitrogen Dioxide were found in 40 of the UK's 43 urban zones in 2010, after the 1 January deadline for emission limits[44].

11. Agriculture food and nutrition

What we eat is first and foremost dependent on what farmers are encouraged to produce through subsidy, all determined at EU level. [45,46] which is also the world's largest exporter of food and drink products and its second largest importer. If the UK leaves the EU, it is unclear whether the government would choose to match

the planned €27.8 billion due to be invested in UK farming by 2020.

However, it would be an opportunity to re-orient potential subsidies towards a more healthy supporting food production cycle[47]. Current subsidy mechanisms both contribute towards climate change and unhealthy diet patterns[48, 49, 50.] European agriculture is responsible for release of more global warming gases than is any other industry[51] and the EU is beginning to address this. If farmers are to qualify for Common Agricultural Policy (CAP) subsidies, they have to comply with EU standards for environmental protection, animal welfare, and food safety. [52, 53] The UK would benefit from these developments if it remains within the EU.

Food labelling is an important mechanism for providing information about the food eaten by EU citizens, and the regulations are all set at EU level[54]. A recent Directive extended food labelling regulation considerably, but further reform (including provision of simpler guidance to consumers) is needed, and the UK is well-placed to take a lead here to promote appropriate policies (for example the voluntary, traffic lights scheme) and learn from the success of other initiatives such as the Nordic region's 'Green Keyhole' scheme.[55] It should be noted that under the EU's Regulatory Fitness and Performance programme (REFIT) better regulation process, the Commission has prioritised a review of EU food law to assess whether it is still fit for purpose and whether it could be simplified or streamlined[56].

EU regulation currently bans the use of hormones [57] and antibiotics [58] as growth promoters in livestock production (this is not the case in the USA). The goal of regulatory convergence between the EU and the US as part of the proposed TTIP raises some concerns about how public health legislation in Europe could be maintained. As already noted, EU regulation is also considerably stricter than is that in the USA on toxic pesticides. It is unclear whether these standards would be maintained or updated if the UK left the EU.

The UK is unable to produce on its own anything approaching a sufficient supply of fruit and vegetables in order to fulfil every citizen's daily recommended intake amount of 400gm. [59, 60] The UK imports two and a half times more food from the EU than from the rest of the world. If the UK leaves the EU, new agricultural tariffs would need to be re-negotiated. That could increase food prices, impact on overall food choices and exacerbate health inequalities.

12. Social dimensions

Health and safety at work legislation is basically European. If the UK leaves the EU, some social benefits may be vulnerable to erosion. For example, during the negotiations at EU level, the UK Government opposed equal treatment rights for agency workers, working time limits, and rights for workers to receive information and be consulted on changes in their workplace that could affect their jobs or terms and conditions[61]

The Social Chapter provides benefits for EU citizens, including maternity and paternity leave after birth of a child, or after adoption; guaranteed holidays (a minimum of four weeks paid leave) and right not to work more than 48 hours per week without financial compensation (Working Time Directive); equal pay and protection from sexual discrimination in the work place; equal rights for part-time workers to paid leave, pensions, and access to training; and protection against unfair dismissal. All of these are essential to addressing social and economic determinants of health, as well as contributing to the reduction of health inequalities.

The European Parliament is supportive of the concept of a minimum income (equivalent to at least 60% of the median income in the relevant Member State) and minimum wages set at a decent level (that is above the poverty threshold in combating poverty.) [62 63] The European Commission has also invested in a network to explore the role of minimum income programmes in promoting social inclusion and tackling poverty.[64, 65]

The UK currently benefits from the EU-wide framework for EU action on protection of children's rights, including child protection in cross-border movements, safeguards for children who are victims of crime, victims of sexual abuse and exploitation, and victims of trafficking: European Child Rescue Alert (AMBER).

13. Regional Policy

After the Common Agricultural Policy, Regional Policy comprises the next largest item in the EU budget; this is mainly used to promote social, economic, and infrastructure development in less developed areas in the EU. Many areas within the UK have benefited from Regional Policy support (usually from either the European Regional Development Fund or from the Social Fund), and some UK areas are still benefiting. In particular, Cornwall and some areas of Scotland, Wales, Northern England, and Northern Ireland are still net recipients from the Structural Funds budget. An estimated 50,000 jobs have been created in poorer regions of the UK through Structural Fund projects[66].

Earlier in 2016, the government provided no guarantees that it would replace any shortfall in Welsh regional spending [67] in the event of the UK leaving the EU.

Since 2007, health development has become recognised formally as a component of social and economic development, and the Regional Policy budget has included a sum of €5,000,000,000 "top-sliced" to support health development. This has led to some impressive developments (e.g. in Hungary, Italy and Spain). Recently, Northern Ireland has drawn on these funds to support building of a new hospital and primary care infrastructure, and similarly other UK health infrastructure projects are in development.

One of the key benefits of the Structural Funds is the long term planning horizon, where the EU multi-annual financial framework (MFF) gives a 5-7 year perspective in terms of budgets, extremely valuable for thinking about strategic planning and capital investments This would be hard to replicate in a purely national context because it goes beyond the short term of an election mandate.

14. The Single Market

EU procurement rules provide equal access to markets across the EU; Leaving the EU would mean that UK health-related industries do not have automatic right to bid for public contracts on the same basis as national companies across the EU.

The pharmaceutical industry has a strong presence in the UK (all 10 major pharmaceutical companies have bases in the UK) from which they sell into the 27 other national markets (and in addition, Norway and Switzerland), reaching over 500 million potential customers. As one of the largest UK industries, this reflects £billions for UK life sciences companies which would be at risk if the UK votes to leave[68].

Free movements of health professionals around the EU, with mutual recognition of professional qualifications, is a significant benefit to healthcare provision in the UK. Up to 10% of the health and social workforce in the UK is of European Economic Area (EEA) origin, [69] addressing existing shortages of skilled staff and able to work in the UK because of EU Treaty provisions. At EU level there is an awareness of the shortages of health workers that exist in a number of countries. It is estimated that the EU will need one million additional healthcare workers by 2020, an increasing urgent issue. Since 2008, the European Commission has funded studies looking at health workforce planning issues [70] such as skills gaps, staff retention strategies [71] and ethical recruitment practices as well as joint actions which bring together member states to explore these issues in detail.

At present, there is easy access to skilled labour, and this free movement of health professionals benefits health professionals individually, and the UK generally as a net importer of health and social care professionals. This ensures that skills gaps in the UK workforce are filled quickly, and is particularly important in the NHS and for medical specialties, as well as e.g. home and institutional care for the elderly, as part of UK current efforts to increase domestic medical workforce supply[72].

The UK life sciences sector also benefits from free movement of skilled people within the EU. The UK currently acts as a hub for global researchers, attracting more university-educated EU citizens than any other member state, and resulting in 20% of the UK academic community being made up of EU nationals. The UK benefits from access to the Erasmus and Marie Curie schemes that provide mobility of early career

researchers, as well as the EPIET programme, providing training in communicable disease control. The quality of UK science is strengthened and acts as a vital magnet for life sciences investment.

15. The Transatlantic Trade and Investment Partnership (TTIP)

In March 2015, FPH raised a number of serious concerns in relation to the TTIP agreement. FPH warned that the agreement may open commissioning of NHS and clinical services to further competition and private sector provision and lead to worsened health systems, weakened co-ordinated working across organisational boundaries and make it harder to ensure that public health considerations are addressed across the NHS. FPH also raised serious concerns in relation to the impact of the agreement on social and welfare rights, worker and employment rights, environmental protections and climate change, access to medicines (including impact on the developing world) and the right to regulate in the public interest. [73]

The European Commission's recent State of Play document, makes a joint commitment from Commissioner Malmström and US Trade Representative Michael Froman that "TTIP will safeguard the ways that national governments choose to deliver and run the public services they offer to their own citizens". This is encouraging, although without a full text of a final agreement, FPH continues to press for this commitment to be a reality in practice. FPH further notes the European Commission's proposal for reform of the ISDS mechanism, and welcomes this as a step in the right direction. However, FPH continues to have serious concerns in relation to the safeguarding of independence, fairness, openness, subsidiarity and balance, and seeks further reassurance on this matter.[74]

Ultimately, no guarantee has been presented that were the UK to leave that it may not be subject to many of TTIP's provisions, which would be determined though the process of transition. In addition, there is no guarantee a future trade agreement with the US could be negotiated quicker – or with greater guarantees of important population health, environmental, and social protections than under TTIP. President Obama has indicated that an agreement, should the UK leave the EU, may take up to ten years to negotiate.[75]

FPH considers that the EU, with bloc wide negotiating power, offers the most effective means and potential for the UK to address and resolve the challenges presented by the agreement.

16. Standardised medicines approvals

Registration and approval of pharmaceutical products is carried out for the entire EU by the European Medicines Agency (EMA) – based in London - providing a benefit in terms of efficiency and predictability. The Association of British Pharmaceutical Industry (ABPI) has stated that the European Medicines Agency (EMA) has reduced the burdensome process of submitting national applications for market authorisation to different countries. It describes the EMA centralised procedure as good for industry but also providing a uniform level of protection for patients through a standardised patient information leaflet for medicines.
If the UK leaves the EU, companies would need to meet national regulations in order for UK patients to access them, and UK companies would still be required to meet EU regulations in order to reach their customers. This raises the risk of two sets of regulatory hurdles for new medicines or devices, which may generate time and cost implications.

17. International influence on medicines and device regulation

As a member of the EU, the UK has a seat 'seat at the regulatory table' which is critical for the UK's thriving life sciences community and industry. Non–EU countries, such as Norway, can choose to sign up to (but not influence) EU regulations in order to lessen the regulatory burden on their companies that want to trade with the EU. For example, a revision of the regulations on medical devices is currently under way, and the UK is heavily involved in these negotiations - ensuring that government views and industry interests are heard.

By contrast, Norwegian, Icelandic, Swiss and Turkish counterparts, who will be effected by the resulting outcome, have no opportunity to comment or to participate in the legislative process. As already stated, the

EMA`s headquarters are in the UK and this would need to change if the UK was no longer in the EU. The Swedish, Danish and Italian governments have already formally registered their interests in hosting the EMA. It is as yet uncertain if the UK outside the EU would still be party to EMA decisions and approvals or if it would have to duplicate these at a national level.

18. UK Research excellence, and access to research funding

UK health researchers have automatic access to major EU sources of research funding and the opportunity to belong to the most significant public health research community in the world, through the EU.

Based on the proportional contribution to overall EU finances, the UK contributes around 11% of the EU research budget and receives around 16% of the allocated funding, making it a significant net beneficiary.

The UK is the third largest recipient of research and innovation funding[76] and the largest EU Member State beneficiary of EU funding for health research.[77, 78] Data released in October 2012 show that, in the health theme of the EU's 'Cooperation Pillar', the UK had attracted over €570 million in EU funding, 17 per cent of the whole EU contribution and €30 million more than Germany, the second highest beneficiary.

Accessing EU research funding depends on the ability to develop and submit good quality project proposals rather than the academic reputation or historical legacy of an institution. EU funding is competitive and meritocratic, being awarded on the basis of quality. This funding benefits the whole of the UK – not just South East England.[79, 80] Of the EU funding framework which ran from 2007-2013, 107 EU research infrastructure projects were supported in the UK, of which 69 (64%) were outside the 'golden triangle' of Oxford, Cambridge and London universities.

19. Cross Border Healthcare for UK citizens

The Cross Border Healthcare Directive enables residents of any EU member state to be able to obtain investigation and treatment anywhere in the EU, paid for by the purchasers in the patients` own home member states; these EU rules mean that British patients have clear rights to purchase healthcare in other Member States and then claim reimbursement from their UK healthcare purchasers under certain conditions. To some degree this assists the NHS by providing access to under used capacity in other EU countries, such as dental treatment in Hungary and joint replacements in France. Removing these arrangements may have an effect on local services and waiting times.

This Directive also sets out a commitment to create a system of European Reference Networks, which would create teams across EU member states which could share healthcare advice on (for example) rare diseases. This should lead to a wider pool of patients with rare diseases, which would allow Britain to continue to progress its world-leading research on rare diseases, which is currently hampered by lack of patients to help with research. There will be a call issued to establish the networks in May 2016, and the first networks will be set up in 2017.

In addition to the ability to use health services across the EU, there are longer-standing arrangements for access to emergency medical care. British patients have the right to access medically necessary healthcare services when abroad in other EU countries temporarily. Many UK citizens go on holiday within the EEA with the peace of mind that should they fall ill, their immediate health needs will be taken care of via the European Health Insurance Card (EHIC).

There are around one million UK citizens who are permanent residents in Spain, and over 300,000 live in France; most of these are pensioners who can benefit from free access to local health services as well as access to their (UK state) pensions.[81] It is unclear how arrangements for health service access and transferability of pension payments would be affected in the case of a UK departure from the EU. Maybe new rules would be have to be renegotiated bilaterally with each of the remaining 27 Member States on the permanent residency status of British citizens (pensioners, students, workers, etc.) living in the EU.

In 2012/13 the UK paid a net £805 million to other EEA countries to cover the healthcare costs of those for whom it is responsible, the majority of whom were for UK state pensioners living in other EEA countries. This is widely believed to underestimate the true cost to the countries in which they live. Many more UK pensioners choose to live in other EEA countries than pensioners from those EEA countries who live here. There is no guarantee that they would be able to remain in those countries if the UK was no longer a member of the EU.

20. Health as a policy priority for the EU

The Treaty on European Union identifies the legal mandate for EU action in a policy area. The strongest EU competence is in the area of the internal market – the free movement of goods, services, people and capital. In comparison to this core EU competence, the EU's mandate for action in public health is very limited – with little opportunity to introduce harmonising legislation. In addition, the current Juncker Commission has allocated a low priority to public health – it is largely absent from the 10 political priorities and the appointment letter from President Juncker to Health Commissioner Andriukaitas limits his tasks to food safety, the legal framework for Genetically Modified Organisms (GMOs), enhancing preparedness for food crises or pandemics and building knowledge of health systems to help them be more efficient[82].

The broader agenda of public health, prevention and health inequalities is simply not mentioned and therefore receives lower institutional support. This makes it even more critical that there is a vibrant public health community, with involvement by UK NGOs and researchers, who can make the case for a coherent, Health in All Policies approach at EU level.

21. The role of the European Court of Justice

The broader agenda of public health, prevention and health inequalities is simply not mentioned and therefore receives lower institutional support. This makes it even more critical that there is a vibrant public health community, with involvement by UK NGOs and researchers, who can make the case for a coherent, Health in All Policies approach at EU level.

One of the concerns raised about membership of the EU relates to the European Court of Justice (ECJ). As a result, a suggested benefit of leaving the EU is removal from control by the ECJ.

The uninterrupted functioning of the internal market in goods and services is the basis of most EU policies and laws. When taken together with the relatively weak public health competence, this creates a tension in relation to improving public health. This is manifested when a Member State wishes to impose measures which would benefit public health, but which could be construed either as interrupting the single market (for example in tobacco or alcohol sales, or food marketing), or as undermining the Common Market Organisation under EU agricultural policy.

On a number of occasions, national laws on health have been challenged at the ECJ as a breach of internal market rules: in the 1990s when Sweden acceded to the EU there was a challenge to its alcohol monopoly.

On reviewing the ECJ decisions, however, whilst it has consistently identified public health as a legitimate objective of EU public policy, it has tended to leave the decision about the proportionality and appropriateness of a specific measure to the judgment of the national courts. For example in the recent ruling on Scotland's proposed Minimum Unit Price for alcohol, the ECJ stated that it is for the national court to determine whether other measures are capable of protecting human life and health as effectively as the current legislation, while being less restrictive of trade in those products within the EU, and, if not the case, the policy is justified.[83]

22. The politics of health decision-making

There is a constant tension between the goal of promoting population health and the economic imperative to create jobs and generate economic growth. This tension exists at all levels of decision-making from local,

regional to national, European and globally.

The impact of growing burdens of chronic disease globally means that action needs to be taken on the drivers of lifestyle behaviours such as what people eat, drink, and smoke and whether they take exercise. Such actions may promote health but impact on the business models of private companies, for example, limits on advertising of unhealthy foods to children. Whenever profits are at risk or business models under threat, there is a strong reaction from the vested interests involved [84].

Political decisions are therefore made in a nexus of power, money and influence. Public health goals are often subjugated to goals of jobs and economic growth and this situation will occur whether the political decisions are made at EU level or national level[85]. Lobbying by commercial interests will always be powerful, they will usually outnumber health advocates, enjoy more points of access to decisions-makers and at higher levels as well as having more resources to outspend health groups. For example, the two most expensive pieces of EU legislation ever passed are linked to health.

The REACH law on chemical safety is estimated to have cost 700 million Euros in lobbying and the law on consumer information on food labelling is estimated to have involved more than one billion Euros being spent to influence the contents. A decision to leave the EU would simply shift this argument from Brussels to London. There is no guarantee that the UK would make better decisions in terms of championing public health over private sector interests than currently happens at EU level. Rather, with a myriad of political parties and affiliations one might expect a more measured and broader view point to emerge from a European agenda than from a single party or government in the UK.

Lobbying around law creation and policy development will continue whether the UK is a member of the EU or not. The difference will be whether the lobbying happens in Brussels or London, It is a matter of conjecture about which venue would result in better decision making in terms of championing public health over private sector interests. It could be said that, with a myriad of political parties and afflictions, a more measured and broader view point could emerge from a European discussion that from within a single country such as the UK.

23. Conclusions

The UK has world class public health, both in practice and research. These are supported and strengthened by access to EU collaborative opportunities and research funds. Analysis of the complex factors and situations outlined above can be summarised very simply. Membership of the EU is beneficial to the health of the UK population, a support to effective public health practice and a major encouragement to UK research.

Continued membership of the EU, will maintain our excellent public health practice and research for many years to come. By contrast, separated from the EU, the UK on its own would lose the capacity to effectively control many of the most important determinants of our current and future health. These include pandemics, the environment, healthy sustainable food, and, perhaps most significantly, climate change.

There will always be policy areas that could be improved or reformed. The EU functions as a living laboratory, encouraging exchange and debate between countries on common challenges. These formal and informal networks of civil servants and stakeholders have had a positive impact on service provision because they are an opportunity to understand how services are provided in other countries[86]. Through these relationships, the UK is able to benefit in many areas and influence the wider EU and global agendas. Indeed, the UK is ranked at the top of the list of countries globally that use soft power - the ability to coax and persuade to achieve foreign policy objectives[87, 88].

In our view, population health is likely to benefit from continued membership of the European Union.

Evidence based Faculty of Public Health position and briefing statements

The health needs of asylum seekers, 2008, http://bit.ly/1IiHubB

A CAP on Health? The impact of the EU Common Agricultural Policy on public health, 2007, http://bit.ly/27aRuRs

Sustaining a Healthy Future: taking action on climate change, 2008, http://bit.ly/1LDBLPf

Sustaining a Healthy Future: taking action on climate change– Special focus on the NHS, 2009, http://bit.ly/24rBztB

Trading health? Policy report on the Transatlantic Trade and Investment Partnership, 2015, http://bit.ly/1EgZilk

A public health approach to violence prevention, To be published July 2016.

Endnotes

[1] Department for Business, Innovation and Skills, HM Treasury, UK and 18 other EU countries call for business red tape reduction, November 2015, http://bit.ly/1NxKfM9
[2] Minto, R. Brussels in the shadow of 'Better Regulation', The UK in a Changing Europe, August 2015, http://bit.ly/1JcmMOC
[3] Keegan, W. The Guardian, Brexit would be a messy divorce, and very hard on the children, http://bit.ly/1Vte2bQ
[4] Russia Today, 'Back of free trade queue': Brits slam Obama for 'threats' over Brexit, April 2016, http://bit.ly/1Y2obwt
[5] Reuters, Japan's Abe says Brexit would make UK less attractive for Japanese investors, May 2016, http://reut.rs/1NkDQ7I
[6] BBC World Service, Reality Check: What trade benefits could UK keep if it left EU?, March 2016, http://bbc.in/1PjmDfD
[7] CBI, The Norway Option, http://bit.ly/1QmPQmW
[8] http://bit.ly/25y9vr6
[9] Greer LG. The Politics of European Union Health Policies. Open University Press, 2009. ISBN-13: 978-0-33-523624-4.
[10] EU Law Analysis: Expert insight into EU law developments. What happens to British expatriates if the UK leaves the EU.2014? Accessed on 16th March 2016 http://bit.ly/1jHjSlS
[11] The Guardian, Would British farmers be better off in or out of the EU?, February 2016, http://bit.ly/1sLCIAc
[12] EurActiv, Vidar Helgesen: Our EEA contribution costs almost as much as EU membership, May 2015, http://bit.ly/25yjdK2
[13] The Guardian, We pay, but have no say: that's the reality of Norway's relationship with the EU, October 2015, http://bit.ly/1RdiLJi
[14] Norway mission to the EU. Norway and the EU. 2014. Accessed on 16th March 2016 http://bit.ly/1Uumm8s
[15] European External Action Service. EU relations with Switzerland. 2015. Accessed on 16th March 2016 at: http://bit.ly/N6rtNY
[16] Financial Times, Services close to 80% of UK economy, March 2016, http://bit.ly/1ZjmmJK
[17] BlogActive, Peace1: Why doesn't Europe share the keys to its peace? May 2015, http://bit.ly/1TXIckK
[18]Test politics, The role of Robert Schuman and the Schuman Declaration, 2011, http://bit.ly/1r2HCI0
[19] European Union, The history of the European Union, http://bit.ly/1g2oBJj
[20] Foreign and Commonwealth Office, EU enlargement - a UK perspective, February 2011, http://bit.ly/1qDVF6A
[21] Council on Foreign Relations, The European Union as a Model for Regional Integration, September 2010, http://on.cfr.org/1WYE9ba
[22] Notre Europe, Europe and World Governance, June 2008, http://bit.ly/1UemIxa
[23] BBC News, Sturgeon: Independence poll 'highly likely' if UK leaves EU, April 2016, http://bbc.in/1Zdb3CZ
[24] The Guardian, Sinn Féin calls for vote on Irish reunification if UK backs Brexit, March 2016, http://bit.ly/1RcmxXL
[25] London School of Economics, Quitting the EU wouldn't give Britain more control over refugee and migrant flows, February 2016, http://bit.ly/1P5lZgk
[26] EU Law Analysis, The UK opts back in to the European Arrest Warrant - and other EU criminal law, http://bit.ly/1sOuFTi
[27] Greer SL, Fahy N, Elliott HA, Wismar M, Jarman H, Palm W. Everything you always wanted to know about European Union health policies but were afraid to ask. WHO Regional Office for Europe, Copenhagen. 2014. ISBN 978 92 890 50 272.
[28] Birt CA, "The Onward March of European Public Health", 1998. Editorial in the Journal of Epidemiology and Community Health, 52, 12, 770-771.
[29] European Commission, Horse meat: one year after - Actions announced and delivered! http://bit.ly/1FJVQOG

[30] ECDC guidance on chlamydia control in Europe, http://bit.ly/1t1kP15
[31] European Centre for Disease Prevention and Control, STI trends in Europe: chlamydia rates stabilise while gonorrhoea numbers go up, September 2015, http://bit.ly/1t1kP15
[32] European Centre for Disease Prevention and Control, Ebola emergency preparedness in EU Member States, June 2015, http://bit.ly/25ypDc7
[33] European Commission Directorate General for Internal Market, Industry, Entrepreneurship and SMEs. Medical Devices. Regulatory framework. 2016. Accessed on 16th March 2016 at:
[34] European Commission Directorate General for Health and Food Safety. Blood tissues and organs. 2016. Accessed on 16th March 2016 at: http://bit.ly/1IDO6jf
[35] European Commission. Health and Food Safety. Import Conditions. 2016. Accessed on 16th March 2016 at: http://bit.ly/1WwTGPA
[36] Innovative Medicines Initiative. The Innovative Medicines Initiative. 2016. Accessed on 16th March 2016 at: http://www.imi.europa.eu/
[37] European Commission. Environment. Implementation of Community environmental legislation. 2016. Accessed on 16th March 2016 at: http://bit.ly/1vX8SbJ
[38] Committee on climate change, Legal Context, http://bit.ly/1r2KHrr
[39] European Commission. Climate Action. European Climate Change Programme. 2016. Accessed on 16th March 2016 at: http://ec.europa.eu/clima/policies/eccp/index_en.htm
[40] European Chemicals Agency. An agency of the European Union. REACH 2018. 2016. Accessed on 16th March 2016 at: http://echa.europa.eu/
[41] Friends of the Earth, Hidden Voices, June 2005, http://bit.ly/1UezuMd
[42] Greenpeace, Toxic Lobby, May 2006, http://bit.ly/1WwTlfP
[43] RCP London, Every Breath we Take, February 2016, http://bit.ly/1PUBD09
[44] Russia Today, UK govt in the dock over 'illegal' air pollution levels, April 2015, http://bit.ly/1XPLcC9
[45] European Commission. The History of the CAP. Accessed on 12 November 2015 at: http://bit.ly/283hkar
[46] Civitas EU Factsheets: Common Agricultural Policy [CAP]. Accessed on 12 November 2015 at: http://bit.ly/1t1siNO
[47] European Public Health and Agriculture Consortium, response to "The reform of the CAP towards 2020 - Impact Assessment", January 2011, http://bit.ly/1O5rm4n
[48] Live Well for Life, http://bit.ly/1pVbYLI
[49] Which industries and activities emit the most carbon? Guardian. 28th April 2011. Accessed on 13 November 2015 at: http://bit.ly/1INX11Z
[50] The Guardian, Why farm subsidies don't always achieve the results intended, July 2012, http://bit.ly/1t1sNY2
[51] Which industries and activities emit the most carbon? Guardian. 28th April 2011. Accessed on 13 November 2015 at: http://bit.ly/25B1hSh
[52] Birt C, Maryon-Davis A, Stewart L, Parkin C, Capewell S, Mwatsama M. 2007. A CAP on Health? The impact of the EU Common Agricultural Policy on public health. London: Faculty of Public Health. ISBN: 1-900273-25-X.
[53] Jones M, Birt C, McCarthy M. 2003. Health at the Heart of CAP. London: Faculty of Public Health Medicine.
[54] European Commission. Food Safety. Food. Labelling and nutrition. 2016. Accessed on 16th March 2016 at: http://bit.ly/25yqB83
[55] The Norwegian Food Safety Authority and Norwegian Directorate of Health, April 2010, http://bit.ly/1Y2JjTl
[56] European Commission, Fitness Check of General Food Law, http://bit.ly/1LaN81k
[57] European Commission. Food Safety. Food. Chemical safety. Hormones in meat. 2016. Accessed on 16th March 2016 at: http://bit.ly/1VwvFqJ
[58] Hughes P, Heritage J. Antiobiotic Growth-Promoters in Food Animals. Food and Agriculture Organisation. 2002. Accessed at: http://bit.ly/1TXJkom
[59] Jones M, Birt C, McCarthy M. 2003. Health at the Heart of CAP. London: Faculty of Public Health Medicine.

[60] European Commission. Directorate General for Agriculture and Rural Development. 2003. The horticulture sector in the European Union. Accessed on 29 February 2016 at: http://ec.europa.eu/agriculture/publi/fact/horti/2003_en.pdf
[61] TUC, UK employment rights and the EU, http://bit.ly/24sEwgg
[62] European Parliament, The fight against poverty, social exclusion and discrimination, April 2015, http://bit.ly/1ZdmKtg
[63] Basic Income, European Parliament: first meeting of working group on minimum income, November 2015, http://bit.ly/25B25H2
[64] European Minimum Income Network, What is Emin, http://bit.ly/1TJZyPT
[65] European Commission, Social Agenda n. 39 - The new Commission, December 2014, http://bit.ly/1TLbjp4
[66] Department for Business, Innovation and Skills, Allocation of EU structural funding across the UK, March 2013, http://bit.ly/25zcjEi
[67] The UK in a Changing Europe, What a difference a decade can make: Cohesion policy and Brexit, May 2016, http://bit.ly/1TLbOzm
[68] The Guardian, Our health and wealth would benefit from staying in the EU, May 2016, http://bit.ly/1NpbCst
[69] HM Government, Review of the Balance of Competences between the United Kingdom and the European Union Health, July 2013, http://bit.ly/25y9vr6
[70] EU Joint Action on Health Workforce Planning & Forecasting, http://bit.ly/1IecaP6
[71] European Commission, Recruitment and Retention of the Health Workforce in Europe, 2015, http://bit.ly/1X0aiPF
[72] Office of Budget Responsibility. Economic and Fiscal Outlook March 2015. 2015. OBR, London.
[73] Ibid.
[74] Van Harten, G. A Parade of Reforms: The European Commission's Latest Proposal for ISDS. May 2015, http://bit.ly/1JpOm6B
[75] BBC News, Post-Brexit trade deal with US could take 10 years, Obama warns, April 2016, http://bbc.in/1SqUzmw
[76] Centre for Economic Performance, Life after BREXIT: What are the UK's options outside the European Union? http://bit.ly/1Q7sAJs
[77] Galsworthy M, Davidson R, Skentelbery C. Scientists for EU Campaign – evidence presented to the House of Lords Select Science and Technology Committee (EUM0058). 2015. Accessed on 15th March 2016 at: http://bit.ly/1TSkqzi
[78] Galsworthy MJ, Irwin R, Charlesworth K et al. An analysis of subject areas and country participation for all health-related projects in the EU`s FP5 and FP6 programmes. 2014. European Journal of Public Health, 24: 514-520.
[79] Galsworthy M, Davidson R, Skentelbery C. Scientists for EU Campaign – evidence presented to the House of Lords Select Science and Technology Committee (EUM0058). 2015. Accessed on 15th March 2016 at: http://bit.ly/1TSkqzi
[80] Galsworthy MJ, et al. An analysis of subject areas and country participation for all health-related projects in the EU`s FP5 and FP6 programmes. 2014. European Journal of Public Health, 24: 514-520.
[81] The Economist. The balance of ailments. 2014. Accessed on 15th March 2016 at: http://econ.st/1vsJQP3
[82] European Commission, Commissioner Vytenis Andriukaitis, http://bit.ly/1E0hspi
[83] Scottish Health Action on Alcohol Problems, Alcohol Minimum Unit Pricing (MUP). http://bit.ly/25B0u0e
[84] World Health Organization, Guidelines for implementation of Article 5.3: Guidelines on the protection of public health policies with respect to tobacco control from commercial and other vested interests, http://bit.ly/1IVVv24
[85] Book 'Issues in Public Health', edited by Fiona Sim & Martin McKee, Open University Press
[86] Chartered Institute of Public Finance and Accountancy, Health and Integration, http://bit.ly/22zEl0E
[87] The Economist, The awesome influence of Oxbridge, One Direction and the Premier League, July 2015, http://econ.st/1LediRj
[88] World Economic Forum, Which countries come top for 'soft power'?, July 2015, http://bit.ly/285m6UK