Scottish Parliament Health and Sport Committee
Tuesday 6 March
Inquiry into Leaving the European Union (Impacts on Health and Social Care)

"Risks of Brexit"

Mark Dayan (Policy analyst for the Nuffield Trust)

- There is a laundry list of ways in which Brexit risks extra pressure on the health service, such as a reduction in the amount of tax revenue that there would be to put into it and trade disruption potentially raising prices, which would take money away from investment in the service and impact on the ability to pay for supplies.
- There is also the possibility that Brexit would disrupt the medicines market so that we will no longer be able to buy from cheaper countries where that would make sense. It is an indirect relationship but, depending on how Brexit is handled, the additional pressure that it could put on the health service generally across the UK relates to health inequalities in some ways.

Preventative services, ECDC, and pandemics

Dr Syed Ahmed (Clinical director, Health Protection Scotland)

- From a health protection point of view, most of the preventative services—screening, immunisation, dealing with major outbreaks and so on—are mainly funded by the Government. There is limited scope for the private sector to go into those arenas.
- The ECDC (European Centre for Disease Prevention) gets data from individual member countries. He said that Scotland already has a very effective surveillance system and we feed the information through Public Health England to the ECDC, which collates the information for all the EU countries.
- Information on things such as flu pandemics and swine flu is co-ordinated by the World Health Organization, and the international health regulations, which will remain in place, automatically alert all the WHO member countries of any emerging new virus that might cause a pandemic.
- Public Health England is the national focal point for the whole of the UK, so HPS work with the ECDC through it. Public Health England has just set up a group to look at the implications of Brexit regarding surveillance and our ability to respond to any major outbreaks.

European doctors with UK residency

Dr Peter Bennie (Chair, BMA):

- The Brexit process has been immensely disruptive and disturbing to European doctors. The BMA do not think that a substantial number have left the country yet, but they know from their survey that at least a third of them are considering it. Many feel that their efforts to keep the NHS operating are not appreciated.
- On potential problems, specifically with regard to the situation with doctors, there is currently mutual recognition of professional qualifications within the EU. As a result, the process by which a doctor from any of the EU or EEA nations can apply for and take up a

post in the UK is entirely straightforward. We do not know what the situation will look like after Brexit.

- The current noises from the UK Government are reasonably positive about maintaining freedom of movement for doctors, but we do not yet know for certain. If that goes, it will have a major effect on our ability to fill recruitment gaps. We simply cannot fill those gaps with home-grown doctors; we just do not have enough of them at present, and it takes upwards of 15 years to train a doctor to be able to take on those responsibilities fully. We cannot just snap our fingers and sort this out locally.

Paul Buckley (Director of strategy and policy, GMC)

- The contribution of EEA doctors to the Scottish medical workforce is undoubtedly immense. They comprise 6 per cent of that workforce, but their contribution must not be understood purely on the basis of the raw numbers. As the Scottish Government's submission to the Migration Advisory Committee pointed out, this is also about the specialties in which the doctors work. Some of the specialties—for example paediatrics, oncology and radiology—are on the Scottish shortage occupation list. It is also about geography: the territorial health boards in remote and rural areas depend heavily on the contribution of EEA doctors.
- There is an issue in relation to the stock of doctors currently working in Scotland and their future plans but there is also an issue about future flow into the UK. All that is uncertain. The GMC feel that we can deal with most things, but uncertainty is the most difficult thing to deal with.

Legal status of foreign doctors and consultants

Dr Bennie gave an example of a colleague, which is below (verbatim):

"A colleague of mine came to the NHS from India and took a decision, with the health board, to start work at specialty doctor level, even though he was technically entitled to work at consultant level. He did that on a trial basis, and then, when he and the health board were clear that he was capable of working at consultant level, he went through an appointment panel and was appointed as a consultant. However, nobody spotted that the Home Office had to be told about that, so he was told some years later and with absolutely no notice that he was working outside legislative requirements and faced deportation there and then. He was not deported, but he spent three weeks uncertain about whether he and his family would be allowed to stay in the country.".

Medical student numbers

Dr Bennie

- New graduate entry medical student programme, which will come on stream later this year, is designed to retain more Scottish graduates in Scotland. In particular, it will try to encourage greater recruitment into general practice and rural practice. It remains to be seen how successful that programme will be. However, moves are afoot to try to increase the number of medical students in Scotland and therefore, by definition, increase the numbers of those who stay in Scotland to work.

- Retention seems not to feature anything like as much as recruitment in our considerations, yet recruitment—particularly to medical school—does not solve a problem until 10 or 15 years down the road. Given that, when people get to 55 or 60 they stop working, retention—or the lack of it—is a far more immediate issue, but there tends to be less focus on it.
- It is reasonable to assume that fewer people will wish to come from the rest of Europe to Scotland and the UK to study medicine after Brexit day. Medical schools have always been hugely oversubscribed, with many more people wanting to study medicine than places. The BMA have tended to view that as not a bad thing, because it has meant that competition is strong to get into the training in the first place.
- A key issue is to ensure that we select as best we can. Selection for medical school used to be based pretty much on whether applicants had the main qualifications, which in Scottish terms means the highers. We have moved away from that to try to identify people who are most likely to have the attributes to be good doctors. They have to have the qualifications, but now they need the attributes as well.

Mutual recognition scheme

Paul Buckley

- GMC see significant benefits in the current mutual recognition regime. However, there are some downsides, too, and it is possible that, in looking to a future beyond 29 March 2019, we might have opportunities to achieve a slightly better balance between flexibility and speed with regard to getting people on to the front line and assuring patients of the capabilities of doctors and other healthcare professionals.
- The current regime is too permissive, but there are also examples of areas where the GMC feel that it is too restrictive. For example, if someone is training in postgraduate paediatrics and they want to change to be a general practitioner, they get no discount or allowance under the directive for the paediatrics training that they have done to date and which they can carry across, and they get only a discount of up to 50 per cent if they complete that training. Most people who want to change courses do so midstream instead of when they get to the other side, and the GMC think that that is another area that needs to be revisited. The system is by no means perfect.

Dr Bennie

- It has been the BMA's view for a long time that moving between specialties during training should be more straightforward. We are all aware of people who have done seven or eight years' training in a specialty, have decided that they would prefer to do something else and have had to start from scratch and do another six or seven years in a different specialty. There is clearly some common ground in learning to be a doctor. Of course, that issue is not purely bound up with Brexit, and the BMA are trying to make changes through the shape of the training process.

UK practice programme

Paul Buckley

- The GMC is trying to contribute where they can. For example, their welcome to UK practice programme helps healthcare professionals and doctors who come from other parts of the world to understand the context of practising in the UK. It is a small programme, but the GMC feel that it is a valuable contribution to setting them up to succeed.
- There is a need to keep good doctors in the system. That is why, within the GMC's education and training responsibilities, they take issues around culture and bullying seriously. Those kinds of problems drive people out of the profession or elsewhere. It is, therefore, really important that issues around retention are addressed as well as the need to get people on to the register in the first place.

Medical Act 1983

Paul Buckley

- It would be possible to simply roll forward the current regime, although there would probably need to be minor changes to the Medical Act 1983, to remove any references to directives or European institutions to which the UK would no longer be subject. In drafting terms, that would be relatively straightforward. The principle of mutual recognition could be rolled over without any difficulty. However, we need to consider whether there might be a slightly better, more proportionate way of doing that. The GMC want that opportunity at least to be considered before it is dismissed, but they recognise the workforce pressures that might lead you to say that you do not want any changes.

Working time regulations

Paul Buckley

- A few years ago, the GMC commissioned some research from the University of Durham on the impacts of the working time regulations. Paul Buckley detailed a couple of things that came out of that research.
- First, the issue is not simply about the quantum of hours worked; it is also about the intensity of what happens during those hours, and we need to look at both of those things.
- Secondly, part of the difficulty—in so far as there has been some difficulty—has been to do with the interpretation by the European Court of Justice in two particular cases regarding medical training. The SiMAP and Jaeger rulings basically said that rest periods must be counted as work, which has caused some difficulty in the designing of rotas. At times, we get into a paradoxical position in which something that is intended to help with the health and safety of the employee—the doctor—can have unintended adverse consequences. The GMC do not think that anybody would argue for going back to the long hours of the past, but it may be helpful to look at one or two issues around interpretation as we move forward.