Royal College of Physicians of Edinburgh

UK Parliament Health Committee
Brexit and Health and Social Care - Call for written evidence

The Royal College of Physicians of Edinburgh ("the College") was founded in 1681. We support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties. 50% of our UK Fellows and Members working in the NHS in England, and we welcome the opportunity to submit evidence to the UK Parliament Health Committee on *Brexit and Health and Social Care*.

The College suggests that the following are priority issues which the Government will need to address in the negotiations on UK withdrawal from the EU:

1. **Reciprocal access to healthcare:** EEA residents and Swiss residents are entitled to hold a European Health Insurance Card (EHIC) which gives access to state-provided healthcare during a temporary stay in another EEA country. Additionally, under current EU rules, citizens who come from elsewhere in the EU to live in the UK, or who leave the UK to live in another EU country, have access to health care on the same basis as nationals of that country. The available data suggests there are around 1.2 million British migrants living in other EU countries, compared with around 3.2 million EU migrants living in the UK[i]. There has been speculation in the media that the referendum result will mean that UK pensioners currently living elsewhere in the EU may return, increasing pressures on health and social care services.

2. The government will need to negotiate arrangements with the EU as to how both 'ordinarily resident' UK citizens and citizens from elsewhere in the EU will access health care services in future. With regard to the treatment of visitors from the EU in the UK and vice versa, the government will need to negotiate new reciprocal agreements (such agreements already exist with some non-EU countries) or alternatively seek to continue existing arrangements.

3. **Research and innovation**: the UK contributes only 11% of the EU research budget but receives 16% of allocated funding[ii]. Collaboration across the EU has enabled the UK to further its scientific research agenda, through our ability to access both European research talent and important sources of funding. A decision to leave may weaken the UK's influence on research priorities[iii] and could place barriers in the way of mobility of researchers, notably a need for work permits and a loss of schemes such as Marie Curie[iv] that fund individual exchanges. Continued access to Horizon 2020 programmes[v] (which disburse 80 billion euros and facilitate collaborations worldwide) could be possible if the legal basis of the programme is changed but it would require the UK to pay an 'entrance ticket' and limit the role of UK universities (no lead role in consortia)[vi].

4. There are also other formal and informal networks across Europe – for example for some rare diseases, where the low numbers of patients make it beneficial to work across the EU – that may

be affected. Members of the academic and medical communities have already expressed serious concerns about the impact of leaving the EU on the future of science and research in the UK. Nobel Prize winner Professor Sir Paul Nurse warned that Brexit could be a disaster for British science because of its impact on the free movement of researchers across Europe and on the ability of UK researchers to attract research funding[vii].

5. **Regulation of medicines and clinical trials**: EU legislation provides for regulation of medicines across the EU through the European Medicines Agency (EMA)[viii]. This offers a consistent approach to medicines regulation in Member States. The EMA is based in London. The implications for regulatory procedures, for example marketing authorisation applications or clinical trial authorisations, must be fully analysed and the UK's future relationship with the EMA carefully considered: currently countries such as Iceland, Liechtenstein and Norway have access to centralised marketing authorisations via the EMA. The UK has its own national regulatory agency, the Medicines and Healthcare products Regulatory Agency (MRHA). However, this deals with national authorisations intended for marketing only in the UK.

6. While clinical trials are currently carried out on a national level, regulations due to take effect in 2018 would have harmonised arrangements across the EU with the aim of creating a single entry point for companies that wish to carry out trials of new drugs on patients in different countries. There are concerns that by leaving the EU some of the pharmaceutical industries will take their trials away from the UK. This would mean the UK losing out on some trials that might otherwise benefit patients, as the UK would no longer be part of the harmonised procedure.

7. **EU Regulations:** the government needs to clarify whether its intention is to repeal EU regulations and replace them with UK-drafted alternatives, or to continue to abide by them. These include: the working time directive; procurement and competition law; regulation of medicines and medical devices; and regulation to enable common professional standards and medical education between EEA countries – this could impact on Specialty Certificate Examinations and possible development of MRCP(UK) in European countries.

8. The working hours of doctors: The European Working Time Directive (EWTD), which includes a general limit of 48 hours on the working week, has applied to most health service staff since 1998. An independent review was chaired by Professor Sir John Temple on the impact of the EWTD on the quality of training. A 2010 report of this review, *Time for Training*[ix], concluded that high quality training can be delivered in 48 hours but traditional models of training and service delivery waste training opportunities and will need to change[x]. Although it is still possible for doctors and other NHS staff to work longer hours by signing an opt-out clause, it could be argued that UK withdrawal from the EU would allow greater flexibility in devising NHS work and training rotas.
9. **Medical staff recruitment and mutual recognition of qualifications**: concerns have been raised over the potential impact of leaving the EU on the recruitment and retention of medical staff. Simon Stevens, the Chief Executive of NHS England, has said any extra pressure on the health

service from migration was outweighed by the benefits of EU membership[xi], noting how some of the NHS's 130,000 European doctors, nurses and care workers could leave the service in the wake of a Brexit because of uncertainty over work visas:

"Yes, there's a perfectly legitimate argument to be had on these topics but from the NHS's perspective it is pretty clear that the balance of the advantage is such that the risks would be greater were we to find ourselves in economic downturn, were we to find a number of our nurses and doctors leaving"[xii].

10. The EU's policy of freedom of movement and mutual recognition of professional qualifications within the EU means that many health and social care professionals currently working in the UK have come from other EU countries. This includes 55,000 of the NHS's 1.3 million workforce and 80,000 of the 1.3 million workers in the adult social care sector. 14% of clinically qualified staff and 26% of doctors are foreign nationals[xiii].

11. The NHS is currently struggling to recruit and retain permanent staff. In 2014, there was a shortfall of 5.9 per cent (equating to around 50,000 full-time equivalents) between the number of staff that providers of health care services said they needed and the number in post[xiv].

12. The policy on freedom of movement is an issue; given the current shortfalls being experienced in both the health and social care sectors, the government must clarify its intentions on the ability of EU nationals to work in health and social care roles in the UK. Specifically this needs to be addressed so that EU staff who are currently working in the NHS do not decide to leave to work in other countries.

13. The European directive on the recognition of qualifications[xv], allows for health and social care professionals who qualified within the EEA to have automatic recognition of their qualifications by the relevant regulatory body in any EEA country. Brexit may result in UK regulatory bodies introducing the same checks for EEA applicants as for non-EEA applicants and the government needs to clarify this.

14. **Funding and finance:** 2016/17 is already set to be a very challenging year for the NHS. In the long term, the most important influence on NHS funding will be the performance of the economy. Before the referendum, HM Treasury stated that a vote to leave the EU would result in 'an immediate and profound economic shock - creating instability and uncertainty' and that in the longer term the UK 'would be permanently poorer'.[xvi]

15. It is not yet clear if these warnings will be correct. If there are cuts in public spending, then the implications for a service already struggling to live within its existing budget would be significant. The NHS would also be affected by other consequences of economic instability. For example, a prolonged decline in the value of sterling could increase inflation, potentially leading to higher prices for some drugs and other goods and services which the NHS purchases.

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16. **The European Centre for Disease Prevention and Control (ECDC):** The ECDC is an EU agency aimed at strengthening Europe's defences against infectious diseases with a mission to identify, assess and communicate current and emerging threats to human health posed by infectious diseases[xvii].

17. In order to achieve this mission, ECDC works in partnership with national health protection bodies across Europe to strengthen and develop continent-wide disease surveillance and early warning systems. On its own, the UK's capacity to effectively control important determinants of health, e.g. pandemics, environmental quality, healthy sustainable food, and climate change could be severely weakened. The government must examine if exclusion from the European Centre for Disease Control is likely, potentially weakening systems of communicable disease surveillance and control in Europe and limiting UK access to early warning systems, contingency planning and technical assistance in disease outbreaks[xviii].

18. **The European Union Organ Donation Directive (EUODD)**: This sets minimum standards that must be met across all Member States in the EU, ensuring the quality and safety of human organs for transplantation[xix]. NHS Blood and Transplant implements the EU rules on the procurement, storage, use and monitoring of all human tissue and blood in the UK. The government must clarify how this relationship will be impacted.

19. **Public health strategies**: The EU has been especially active against tobacco use, which is among the leading causes of premature death among Europeans. Despite sustained challenges from national governments including, for many years, the UK, it has banned advertising in all those settings over which it has jurisdiction, in other words where there is a cross-border element, such as television and newspapers. The latest Tobacco Products Directive substantially extends restrictions on marketing and limits the use of additives designed to appeal to children[xx].

20. Drawing on encouraging evidence from elsewhere, recent UK governments have gone beyond the EU legislation, a freedom explicitly permitted by the Directive, with bans on smoking in public places and the implementation of standardised packaging. However, outside the protections granted by EU law, it is plausible that the UK could be a "target" for the tobacco industry, as has been suggested is the case in Switzerland.[xxi]

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk) *28 October 2016*

[i] Migration statistics (UK Parliament briefing); Oliver Hawkins - 7 September 2016
http://researchbriefings.files.parliament.uk/documents/SN06077/SN06077.pdf
[ii] Written evidence submitted by the Faculty of Public Health (HEU0003) to the UK Parliament Health Committee inquiry on *Impact of membership of the EU on health policy in the UK*

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/impact-of-membership-of-the-eu-on-health-policy-in-the-uk/written/32911.html

[iii] *Brexit and health services* doi: 10.7861/clinmedicine.16-2-101, Clin Med April 1, 2016 vol. 16 no. 2 101-102 http://www.clinmed.rcpjournal.org/content/16/2/101.full

[iv] Marie Curie, http://ec.europa.eu/research/mariecurieactions/about-msca/actions/rise/index_en.htm

[v] Horizon 2020, https://ec.europa.eu/programmes/horizon2020/h2020-sections

[vi] Written evidence submitted by the Faculty of Public Health (HEU0003) to the UK Parliament Health Committee inquiry on *Impact of membership of the EU on health policy* i*n the UK* http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/impact-of-membership-of-the-eu-on-health-policy-in-the-uk/written/32911.html

[vii] BBC (29 June 2016) http://www.bbc.co.uk/news/science-environment-36667987

[viii] Legal framework governing medicinal products for human use in the EU

http://ec.europa.eu/health/human-use/legal-framework/index_en.htm

[ix] *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple https://www.hee.nhs.uk/sites/default/files/documents/Time%20for%20training%20report_0.pdf

[x] Page VI, *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Professor Sir John Temple https://www.hee.nhs.uk/sites/default/files/documents/Time%20for%20training%20report_0.pdf

[xi] http://m.heraldscotland.com/news/14509453.NHS_chief_issues_Brexit_warning_over_health_care_staff_recruitment/ and http://www.bbc.co.uk/news/uk-politics-eu-referendum-36353145

[xii] http://m.heraldscotland.com/news/14509453.NHS_chief_issues_Brexit_warning_over_health_care_staff_recruitment/

[xiii] Health and Social Care Information Centre 2015; Skills for Care 2016

[xiv] Five big issues for health and social care after the Brexit vote (30 June 2016) http://www.kingsfund.org.uk/publications/articles/brexit-and-nhs

[xv] http://ec.europa.eu/growth/single-market/services/free-movement-professionals/policy/legislation/

[xvi] HM Treasury analysis: the immediate economic impact of leaving the EU (May 2016) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524967/hm_treasury_analysis_the_immediate_economic_impact_of_leaving_the_eu_web.pdf

[xvii] http://ecdc.europa.eu/en/aboutus/what-we-do/Pages/Mission.aspx#sthash.4gxPAaH0.dpuf

[xviii] Written evidence submitted by the Faculty of Public Health (HEU0003) to the UK Parliament Health Committee inquiry on *Impact of membership of the EU on health policy* i*n the UK* http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/impact-of-membership-of-the-eu-on-health-policy-in-the-uk/written/32911.html

[xix] http://www.odt.nhs.uk/odt/regulation/eu-organ-donation-directive/

[xx] European Union. Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC. Off J Eur Union 2014;L127:1–38.

[xxi] Lee C-Y, Glantz SA. *The Tobacco Industry's Successful Efforts to Control Tobacco Policy Making in Switzerland*. San Francisco: Center for Tobacco Control, Research and Education, Tobacco Control Policy Making: International (University of California), 2001.