Royal College of Physicians of Edinburgh

House of Lords: EU Home Affairs sub-committee
Brexit: reciprocal healthcare
Call for evidence

1. 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 work in the NHS in England, and we welcome the opportunity to submit evidence to the EU Home Affairs sub-committee on *Brexit: reciprocal healthcare.*

Government's proposals for UK citizens already living and working in the EU
What is your assessment of the Government's current proposals to the EU regarding reciprocal healthcare arrangements post-Brexit? What changes, if any, would you recommend?

2. College Fellows support the proposal to protect current health care arrangements and support reciprocal health care entitlements being enshrined in any withdrawal law.

3. Although details are complex, the basic principles are simple: rights are built up and passed on as a person lives and works in different countries. Anyone requiring health care in a different EU country is treated as if they live there, with their home country reimbursing the country where care was provided. The EU-UK post-Brexit deal could continue this system and the UK Government appears to want to do so, although how this system can be reconciled with wider Brexit objectives (in particular, leaving the future jurisdiction of the European Court of Justice) is unclear.

4. Leaving this system will jeopardise access for people covered by the NHS who are travelling to the EU for work, study, or leisure. Around 27 million people hold European Health Insurance Cards (used to show home country coverage) issued by the UK.[i] This system has several important advantages over the alternative, voluntary private insurance, which would transfer the costs to the individual. First, the European Health Insurance Card does not exclude pre-existing conditions; second, all existing private insurance schemes are priced according to individual risk, which would make coverage prohibitively expensive for older people, or those with chronic conditions; third, it would not replace some specific EU arrangements, such as provision for people requiring dialysis.

Affected groups
Which groups (e.g. people with disabilities, long-term conditions, children, etc.) and/or categories (e.g. residents, students, non-residents, etc.) will be most affected by any changes to existing reciprocal healthcare arrangements?

5. It would be helpful to examine the options for what can be done to mitigate possible effects on those with disabilities and chronic health conditions that are likely to have more health needs than the general population. In the College's understanding, the EU insurance card scheme almost certainly keeps private insurance costs down in the UK.

6. There are 190,000 UK pensioners currently living in the EU, who may choose to return to the UK. According to the Nuffield Trust, if they all returned home after reciprocal healthcare arrangements stopped, then an extra 190,000 people could require hospital beds and 1,600 nurses, as well as doctors, other health professionals, and support staff[ii].

7. A priority for these groups in terms of the negotiations and future UK law would be to ensure no detriment to that which currently exists, to protect health care arrangements as currently set out, and to ensure no detriment to any other group.

What should be the priorities for these groups in terms of the negotiations and future UK law?

8. Fellows have suggested it may be appropriate here to use the UN Convention on the Rights of Persons with Disabilities to protect these vulnerable groups? The Convention as well as the WHO definition of disabilities clearly encompasses most potentially vulnerable groups. In addition, there is no longer a split between disabled and able bodied persons, (as presently defined by WHO and Enable the UN organisation responsible for the implementation and development of the UNCRPD), it is a dynamic and ever fluctuating continuum at the societal and personal level, where 'it is normal to be different'. The Convention therefore applies to the aforementioned affected groups.

9. In any negotiations or legislation regarding future reciprocal health arrangements with the remaining 27 EU countries, the UNCRPD should be highlighted such that it forms a safety net ensuring that the affected groups will have the same rights and entitlements as everyone else. Article 25 of the Convention states *(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes*[iii].

Implications for the UK health and social care sectors

What impact would ending reciprocal healthcare arrangements with the EU have on the UK health and social care sector?

10. As discussed earlier, ending reciprocal healthcare arrangements with the EU could potentially change the balance of circumstances of individuals living abroad who may choose to return to the UK and then require health and social care services. This could have a significant impact, requiring additional hospital beds, nursing and social care to respond to those currently using EU health services.

What would be the financial, staffing, and other implications for the UK health sector if reciprocal healthcare arrangements were to end?

11. The UK health workforce is especially vulnerable to the effects of Brexit, with major effects on recruitment and retention of EU nationals within the NHS and social care. It will be very difficult for the UK to be self-sufficient in the NHS or social care workforce in the foreseeable future. As of 2017, over 60 000 people from non-UK EU countries work in the NHS and 90 000 work in adult social care[iv]. One in ten doctors in the UK is a European Economic Area (EEA) graduate[v]

12. Brexit has the potential to make the UK less attractive to health workers from the rest of the EU because it could undermine their legal entitlements and those of their families. These entitlements include not only residency rights but also:

- the right to not be discriminated against on nationality grounds,
- access to employment, housing, and other benefits
- access for their children to primary, secondary, and higher education;
- accumulation and transfer of pensions, social security, and welfare; the right to health care anywhere in the EU on retirement and when visiting their home country (eg, for childbirth)
- some democratic rights, such as voting rights in local elections
- mutual recognition of qualifications from any EU country (subject to linguistic competencies)

13. Health and social care staff are protected by numerous employment rights under EU law. These include EU equality law (which protects against discrimination on sex, race, disability, and other grounds); EU health and safety at work law (including maternity leave rights, working time); and EU employment law on restructuring (such as security of rights when another employer takes over a contract to provide services).

14. Comparable information at EU level has been a substantial force for improvement in health care. For example, European comparative data on cancer outcomes, generated by the EU-funded EUROCARE studies, have had a profound impact on cancer care in the UK, highlighting variations in outcomes and scope so that the UK can rise to the level of better performing systems elsewhere in Europe. Yet producing this comparable data is an enormous and technically complex endeavour, and it has taken decades to generate even the limited datasets that are currently available. Similarly, in the area of communicable diseases, the European Centre for Disease Prevention and Control in Stockholm has over 200 staff working simply to ensure effective monitoring of this one relatively small domain.

15. There is little reason in theory for cooperation on information sharing not to continue, provided that a regulatory framework for transfer of personal data is in place, and that the UK gains adequacy status as a non-EU country under the General Data Protection Regulation 2016/679. However, in practice this kind of work depends heavily on sustained financing and

investment in collaboration.

16. Though the EU treaties leave the primary responsibility for the organisation and delivery of health services and medical care to Member States, there are some areas where Brexit will impact on service delivery, where perhaps the highest profile example is the working time directive. Alongside it, though, are less well-known networks for accessing specialist care for rare diseases throughout the EU, and the specific cases of cross-border care provisions in Northern Ireland and Gibraltar.

17. For rare diseases, it can be impractical or impossible to access care in every individual country, since there might only be a handful of centres of expertise in the whole EU. The EU has set up European Reference Networks to bring together these highly specialised centres into networks dedicated to particular treatment areas, to enable patients to be diagnosed and treated by the best available expertise, even when in another EU country. These networks also facilitate research and clinical trials by drawing on a larger pool of patients than would otherwise be possible, the sharing of knowledge, and the development of guidelines. The UK has 40 hospitals participating across various networks[vi].

18. Two regions likely to experience substantial disruption in service delivery because of cross-border care due to Brexit are Northern Ireland and Gibraltar. In Northern Ireland, efforts to promote cross-border collaboration in health as part of the peace process have existed for decades, creating projects with active support from the EU and the administrations in the UK and Ireland. These projects deliver care for many patients with specific medical needs including diabetes, sexual health, eating disorders, and autism, and serve communities on both sides of the Irish border, thereby reaching sufficient patients to secure the economies of scale necessary to justify provision. The matter of the UK-EU post-Brexit land borders is high in the EU's negotiation priorities, but attention to the health aspects of the negotiation, not solely to the security and trade aspects, will be crucial.

19. This building block covers a wide range of system-level issues, such as regulation, where EU rules on the environment and public health, as well as competition and trade rules, are particularly relevant; supporting functions such as research, where again the impact of Brexit is substantial; and also the processes of scrutiny and stakeholder engagement.

20. The UK benefits greatly from its participation in EU specialised agencies, such as the European Food Standards Agency and the European Centre for Disease Prevention and Control. These agencies perform essential roles and, if the UK is unable or unwilling to continue participating in them, it will have to find alternative arrangements. Working through and with the WHO or the UN Codex Alimentarius system as the UK, rather than as part of an entity the size of the EU, will inevitably entail a loss of influence. However, given the persistent threat of infectious diseases crossing borders, any lesser engagement potentially poses concern.

21. Although direct EU funding accounts for only 17% of research contracts held by British universities[vii], it accounted for almost three-quarters of the growth in funding in the past decade. However, the consequences go far beyond funding. British researchers and institutions benefit from access to EU networks and infrastructure, and from the free movement of personnel within the EU. An estimated 16% of the academic workforce in the UK comes from other parts of the EU[viii]. Additional benefits flow from the common legal frameworks and standards that underpin research, in areas such as data protection and clinical trials regulation. The UK Government has attempted to assuage these concerns, offering to underwrite continued funding for existing EU projects, but there remains concern for commitment to long-term support. There are also at least six issues of direct relevance to health, including research funding, mobility of researchers, harmonisation of regulations, intellectual property, research collaborations, and science policy.

22. The UK is a net beneficiary of EU research funding[ix], attracting substantially more funds than it contributes to the common pool, and the loss of this funding would have severe consequences. It is thus crucial that the UK finds a mechanism to continue to participate in the EU Horizon 2020 programme, as other countries (such as Israel) do, by paying into the scheme. Other sources of funding have also been important, such as the European Fund for Strategic Investment in support of exports, and loss of these sources will also need to be addressed.

23. However, there is more to continued research success than funding. Freedom of movement is also central, with the UK attracting almost a quarter of the researchers moving within the Marie Curie scheme, which supports mobility of researchers within the EU and some associated countries[x]. Additionally, health research in particular operates within an EU regulatory framework. For example, clinical trial legislation, although initially overly burdensome, has been revised to strike a good balance between safety and administrative burden. Any divergence in standards would add greatly to the administrative burden of undertaking collaborative research and, potentially, to obtaining approval for new products that emerge from that research. Likewise, with the developing EU intellectual property regime, departure from the EU risks increased difficulty in the protection of intellectual property generated by UK research.

Options for future arrangements

What should post-Brexit healthcare arrangements with the EU look like? What guiding principles should shape the UK's approach to negotiating future reciprocal healthcare arrangements?

24. A guiding principle to shape the UK's approach to negotiating future reciprocal health care arrangements should ensure that no UK citizen is less well protected than under the current arrangements and that any new opportunities benefit the country and its people.

The EU Withdrawal Bill

What provisions of the EU Withdrawal Bill should be amended, clarified, or added, in order to secure appropriate arrangements for reciprocal healthcare on Brexit Day, during a transitional arrangement, and in the future?

25. More information will be needed on health care arrangements and entitlements (nearer to the time) for those with cross-border status on the day of exit or during any transitional period. When Parliament votes on the Bill the resolutions need to be clearly laid out so the public know what is being voted on.

What should the role of the devolved nations/regions be in future provision of reciprocal healthcare?

26. In the event of Brexit, the Bill should have secured reciprocal arrangements and set out the continuing devolution of health care decision making in these terms. This should be an active and positive decision.

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[i] House of Commons: Health Committee: Brexit and health and social care—people & process Eighth Report of Session 2016–17 https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/640/640.pdf

[ii] http://www.nhsconfed.org/news/2017/10/worst-case-scenario-brexit-could-cost-nhs-500m-a-year

[iii] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html

[iv] https://www.theguardian.com/society/2017/feb/25/brexit-fears-eu-nationals-working-social-care-theresa-may-sarah-wollaston

[v] GMC: Our data about doctors with a European primary medical qualification - February 2017 https://www.gmc-uk.org/static/documents/content/2017.02.21_GMC_data_on_EEA_doctors_in_the_UK.pdf

[vi] http://www.nhsconfed.org/regions-and-eu/nhs-european-office/eu-knowledge-sharing/european-reference-networks

[vii] House of Lords: Library Note: Leaving the European Union: Funding for Universities and Scientific Research (October 2016) http://researchbriefings.files.parliament.uk/documents/LLN-2016-0055/LLN-2016-0055.pdf

[viii] https://royalsociety.org/topics-policy/projects/uk-research-and-european-union/role-of-eu-researcher-collaboration-and-mobility/snapshot-of-the-UK-research-workforce/

[ix] https://www.timeshighereducation.com/news/european-union-eu-referendum-does-uk-research-really-benefit-from-membership

[x] https://royalsociety.org/topics-policy/projects/uk-research-and-european-union/role-of-eu-researcher-collaboration-and-mobility/would-researcher-mobility-be-affected-if-the-UK-left-the-EU/