Effect of EU withdrawal on health and welfare of UK citizens and residents

House of Lords, Thursday 29th March 2018

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The challenges posed by Brexit are considerable: from access to medical radioisotopes and new medicines, to reciprocal healthcare, the treatment of rare diseases, and the staffing of UK health services, there is barely a part of the health service and patient care that will be unaffected. We urge the Government to take the necessary measures to mitigate any negative effects arising from Brexit on the health and welfare of UK citizens and residents. Our manifesto, Healthcare first – a Brexit blueprint for Europe sets out what we believe must be achieved during the Brexit negotiations and beyond to secure this certainty.

Key points

- **Northern Ireland:** We are calling for the continuation of the open border so healthcare professionals can move freely to deliver vital cross border health services to patients in both Northern Ireland and the Republic of Ireland.
- **Workforce:** There is a very real risk that some EU nationals, including highly skilled doctors and medical researchers, will choose to leave the UK because of ongoing uncertainty in the Brexit negotiations. Nearly half (45 per cent) of EEA doctors surveyed by the BMA in November 2017 said they are considering leaving the UK following the referendum vote.
- The NHS cannot afford to lose highly skilled EEA medical staff, or deter those who may want to work in the UK, at a time when they are needed the most- the implications for the staffing of health and social care services, quality of care and patient safety could be significant.
- **Euratom:** We are urging the UK Government to seek a formal agreement with the EU on Euratom to ensure consistent and timely access to radioisotopes, which is vital for patient diagnosis, treatments and therapy.
- **Reciprocal healthcare:** We are calling on negotiators to retain, or agree comparable alternatives, for reciprocal healthcare when the UK leaves the EU. A failure to do so could have a severe impact on the healthcare arrangements of UK and EU nationals and place additional strain on an already stretched NHS if UK citizens living abroad need to return to the UK for treatment.
- **European Reference Networks:** The UK should continue participating in the European Reference Networks, which are key in helping healthcare providers ensure patients with complex or rare medical conditions continue to receive the best possible care.

NORTHERN IRELAND

Health services in Northern Ireland and the Republic of Ireland working separately often do not have sufficient demand to provide cost effective, highly specialised medical services. However, cross border

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1 BMA Brexit manifesto
2 BMA (Nov 2017) EU Doctor Survey
cooperation on health services with the Republic of Ireland over the last two decades has allowed high quality specialised services to be delivered on an all-island basis, with patients in Northern Ireland no longer having to travel to England to receive their care. Between 2003 and 2015, over €40 million was invested in cross-border health and social care initiatives via Cooperation and Working Together (CAWT), a partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland. Additional project applications amounting to €53 million were submitted in relation to acute hospital services, prevention and early intervention, tackling health inequalities and other services. Examples of this include:

- The paediatric cardiology service based at Our Lady’s Children’s Hospital in Dublin enables children from throughout the island of Ireland to receive treatment without having to travel to England
- The radiotherapy unit at Altnagelvin hospital provides access to radiotherapy treatment to over 500,000 cancer patients living in both Northern Ireland and the Republic of Ireland. The creation of this radiotherapy unit has had the greatest impact on patients in the North West and Donegal, removing the need for lengthy journeys to Galway, Dublin or Belfast for treatment.
- The cross-border cardiology service at Altnagelvin Hospital has enabled patients from County Donegal with a diagnosed heart attack to receive lifesaving treatments.
- Shared dermatology clinics at four sites along the border
- Out of hours GP services in Castleblayney County Monaghan and Inishowen in County Donegal
- ENT Services at Monaghan Hospital and Northern Ireland’s Daisy Hill and Craigavon hospitals. Cross border collaboration has enabled ENT waiting lists in the Health Service Executive Dublin North East area to be significantly reduced by facilitating ENT consultants from Northern Ireland’s Southern Trust to practise in Monaghan

**Vital cross-border health projects, which have largely been dependent on the provision of EU funding, must not be put in jeopardy by Brexit. We are urging authorities on both sides of the border to give assurances that these services will continue be funded in the future after the UK leaves the EU.**

**NHS WORKFORCE**

**EEA doctors**

Nearly 10% of doctors working in the UK are from the EEA, and, alongside the thousands of other NHS staff from the UK and overseas, these health professionals deliver key public services, conduct medical research, and contribute to the overall economy. Ongoing uncertainty and insecurity in the Brexit negotiations is having a destabilising effect on the medical workforce, affecting morale and causing a great deal of stress to those whose futures remain uncertain. Despite recent efforts by the UK Government to reassure EEA nationals working in the NHS about their ability to live and work in the UK after Brexit, we are aware that some EEA doctors in the UK continue to feel unwelcome and uncertain about their futures here. The potential of a ‘no deal’ scenario arising at the end of the talks, and the proviso that ‘nothing is agreed until everything is agreed’ is affecting morale and causing a great deal of stress to those whose futures remain uncertain. A BMA survey of 1720 doctors in November 2017 found that:

- More than nearly half (45 per cent) of EEA doctors surveyed are considering leaving the UK following the referendum vote. This compares to 42% of EEA doctors surveyed in February 2017.
- Of those considering leaving, more than a third (39%) have made plans to leave, meaning almost one in five EU doctors (18%) have made plans to leave the UK.

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1 BMA Brexit Briefing: Workforce and Immigration
2 BMA (Nov 2017) EU Doctor Survey
3 BMA (Feb 2017) EU doctor survey
That many EEA doctors are either considering or actively planning to leave the UK because of anxiety around Brexit is a cause for real concern. Amid an already growing workforce crisis, any reduction in the number of doctors migrating to the UK will undoubtedly exacerbate workforce shortages and have an impact on staffing levels on hospital wards, in GP practices and in community settings across the UK. The quality of patient care and patient safety will be put at risk if the UK health services are restricted from recruiting highly skilled staff. This could have particularly dire consequences for specialties already facing acute shortfalls including general practice, emergency medicine, paediatrics, occupational medicine, radiology and psychiatry.

**MUTUAL RECOGNITION OF PROFESSIONAL QUALIFICATIONS**

The BMA is calling for the maintenance of reciprocal arrangements, such as the mutual recognition of professional qualifications (MRPQ) after Brexit, to enable professionals who qualified in one member state to practice their profession in another. For the NHS, MRPQ has been a significant factor in enabling EEA doctors to work in the UK to deliver key health services, fill vacant posts and maintain patient safety: removing this automatic recognition could result in an additional barrier to those considering working in the UK and could exacerbate existing workforce shortages in health services across the UK, which could have consequences for patient care.

The NHS cannot afford to either lose highly skilled EEA medical staff, or to deter those who may want to work in the UK, at a time when they are needed the most- the implications for the staffing of health and social care services, quality of care and patient safety could be significant.

**DOCTORS’ FITNESS TO PRACTISE**

The BMA believes the General Medical Council should be retain access to the Internal Market Information System (IMI) alert system as part of the MRPQ Directive. The Alert system allows the GMC and medical regulatory authorities within the EU to communicate with each other when a doctor has their practice restricted in one of the other 27 EU member states. It will be important to consider how health regulators ensure professionals practising in the UK are fit to practise medicine should the UK withdraw from the MRPQ Directive after Brexit.

To avoid any risks to patient safety, it is vital that the GMC retains access to the IMI system after Brexit.

**EURATOM**

When triggering Article 50 to start the process of leaving the EU, the UK Government also invoked Article 106(a)c of the Euratom Treaty, signalling its intention to leave Euratom. Euratom has responsibility for establishing a single market for the trade in nuclear materials and technology across the EU. Euratom facilitates a secure and consistent supply of radioisotopes, which have a range of applications in medicine including the diagnosis of diseases through nuclear medicine imaging techniques, treatment of cancer through radiotherapy, as well as palliative relief of pain, and biochemical analysis of blood, serum, urine and hormones in clinical pathology.

As Euratom does not allow for membership by non-EU or EEA member states, the BMA is urging the UK Government to seek a ‘formal agreement’ with Euratom after the UK leaves the EU. The UK relies on international supplies of nuclear radioisotopes – for example, its supply of Technetium 99 (which is the most common radioisotope used in nuclear diagnostic imaging in many UK hospitals) is imported largely from the Netherlands, France and Belgium. As isotopes have a short half-life and cannot be stock piled, continuous and timely access is vital for patient safety.

6 In her Mansion House speech, the Prime Minister called ‘for the UK to have a close association with Euratom’
There is a risk, that if the UK Government is unable to formalise an agreement with Euratom, the UK would lose the guarantee of consistent and timely access to radioisotopes, potentially resulting in delays in diagnosis and cancelled operations for patients. Any disruption to the supply chain, or delays at customs after Brexit could lead to the cancellation of appointments and operations, with diagnoses and operations continuing to be delayed until supply was guaranteed again. This would have wide-ranging consequences for hospitals – resulting in added pressure, backlogs and disruption to a system which is already under considerable strain. For patients, the implications of disruption could range from stress and inconvenience caused by delays, to harm and discomfort if radiotherapeutics are not available, to the most extreme consequences if, for example, radiotherapy treatments are cancelled.

*We are calling on the UK Government to seek a formal agreement with Euratom to ensure consistent and timely access to radioisotopes for medical purposes.*

**RECIPROCAL HEALTHCARE**

27 million people hold a UK-issued EHIC and 190,000 UK pensioners living elsewhere in the EU are registered to the S1 scheme. We therefore welcome developments in the negotiations so far which have enabled the Government to achieve its aims for reciprocal healthcare in the first and implementation phases of negotiations, such as access to the European Health Insurance Card for those visiting the EU on exit day and continued access to the S1 scheme for existing retirees living abroad. The next phase of negotiations needs to secure ongoing access to EHIC and reciprocal healthcare arrangements either through the retention, or comparable replacement of existing reciprocal healthcare arrangements with the EU after Brexit.

Should a ‘no deal’ scenario arise, the impact of the loss of reciprocal care on patients would be significant, especially given the number of beneficiaries that are pensioners living abroad. Evidence given to the House of Commons Health Select Committee has suggested that many of them will be unable to fund private healthcare and so will be forced to return to the UK. UK citizens travelling within the EEA, and EEA citizens visiting the UK, will also need to purchase their own travel or health insurance should access to reciprocal arrangements be lost. This is a particular concern for those with disabilities or long-term conditions, as the cost of health and travel insurance for those with pre-existing conditions could be prohibitively high.

The same applies to EEA citizens living in or visiting the UK, who, were the UK to lose access to existing reciprocal arrangements and no alternative be established, would also face a significant change in their access to care. Depending on the deal secured between the UK and EU on citizens’ rights, this could mean that EEA residents might face the same costs and terms of access to the NHS as other non-EEA visitors and migrants do currently. This may lead to EEA visitors and residents in the UK becoming liable to pay the IHS (Immigration Health Surcharge), or individual fees for the care they receive.

*If the UK loses access to these arrangements, or fails to agree comparable alternatives, it could severely impact the healthcare arrangements of UK and EU nationals and place additional strain on an already stretched NHS if UK citizens living abroad need to return to the UK for treatment.*

**EUROPEAN REFERENCE NETWORKS**

European Reference Networks (ERNs) have been set up by the EU to enable health professionals and researchers to share expertise, knowledge and resources on the diagnosis and treatment of complex and rare medical conditions. ERNs cover the majority of disease groupings such as bone disorders, childhood cancers, and immunodeficiency. There are 24 networks, involving over 900 medical teams
in more than 300 hospitals from 25 EU countries, plus Norway⁷. The UK co-ordinates a quarter of the 24 networks and participates in nearly all, with around 40 NHS hospitals involved. ERNs receive support from several EU research funding programmes, including Horizon 2020.

After Brexit, it is essential that the UK continues to have ongoing access to and participation in the European Reference Networks. This will help ensure healthcare providers across Europe are able to tackle complex or rare medical conditions requiring highly specialised treatment and patients continue to receive the best possible care.

ACCESS TO MEDICINES AND MEDICAL DEVICES
We welcomed the announcement in the Prime Minister’s Mansion House speech⁸ that the government wants to explore associate membership of the European Medicines Agency (EMA) after the UK leaves the EU. A formal agreement with the EU on the EMA and the regulation of medicines, medical devices and medical products after Brexit, which secures ongoing collaboration with the EMA’s network of post-approval regulation and pharmacovigilance, would provide medical professionals and the NHS with assurances that the medicines they are prescribing are safe and robustly tested. We would also welcome an agreement between the UK and EU on the mutual recognition of the CE (“Conformité Européenne”) marking scheme for medical devices would help manufacturers to avoid having to satisfy different safety, health and environment protection standards, thereby reducing delays in devices developed in other European countries reaching the UK market, and vice versa.

There is a risk, that should the UK develop a significantly different regulatory process to the EMA over time, the increased burden incurred by duplication of processes and the associated increased investment in time and costs, would lead the pharmaceutical industry to prioritise launching new medicines in the much larger European market over the UK. This could potentially lead to delays of up to 24 months in new drugs being made available to patients and the NHS in the UK, because of becoming a ‘second-tier’ priority market.

MAINTAINING HEALTH PROTECTION AND HEALTH SECURITY
All countries face global hazards and threats which they need to plan for and respond to, to protect the health of the population. Health protection and health security issues include tackling infectious diseases, antimicrobial resistance, climate change, water, waste and air pollution, and maintaining high food standards. The EU’s centralised pandemic preparedness planning ensures that member states share information and best practice with each other to tackle cross-border threats. If the UK decreases its level of collaboration and information sharing with the EU after Brexit, this would reduce the ability of both the UK and EU to respond to threats effectively.

We are calling upon the Government to maintain an aligned approach to the EU on environmental standards and to work with experts and stakeholders to develop the UK’s environmental plan including how it affects water, waste and air quality. Similarly, we would like to see the UK continue to work with the EU, and specifically the EFSA (European Food Standards Agency) to maintain health standards on imports and exports.

We are urging the UK and EU to negotiate an agreement to maximise continued information sharing and access to data, evidence and planning arrangements with ECDC and other relevant bodies.

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⁷ European Commission (28 February 2017), "Questions and Answers about European Reference Networks⁸ Prime Minister’s speech on our future economic partnership with the European Union, March 2018