Effect on the NHS of the UK leaving the EU

Westminster Hall, Thursday 22nd 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 to health services across the UK by Brexit are considerable: from the workforce to regulation and research, there is barely a part of the health service that will be unaffected by the UK’s decision to leave the EU. The ongoing uncertainty and insecurity arising from Brexit is having a destabilising effect not just on the medical workforce, but on the wider health system.

While progress has been made in the Brexit negotiations, most recently with the publication of the draft Withdrawal Agreement on 19 March 2018, the caveat that ‘nothing is agreed until everything is agreed’, means that the uncertainty facing the NHS is likely to continue until a final agreement is reached in all matters relating to the UK’s withdrawal from the EU. It is vital therefore that the Government takes the necessary measures to mitigate any negative effects arising from Brexit on the NHS, patients and the medical workforce.

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 for the NHS.

Key points

• 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.

• EEA doctors: EEA doctors play a key role in staffing vital health services. Across the UK, approximately 7.7% of doctors (12,029) currently working in the medical workforce in England are EEA graduates, while the figures for EEA graduates for other UK nations are 5.7% (1,139) in Scotland, 8.8% (550) in Northern Ireland and 6.4% (624) in Wales.

• Immigration: We are urging the Government to publish its long-awaited Immigration Bill and to clarify what system will be put in place to manage migration from the EEA after Brexit. The BMA is calling for a flexible immigration system, which facilitates the entry of doctors and other key health and social care staff to the UK, while enabling UK-trained doctors to work in the EU should they so choose.

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1 David Davis’ statement: EU-UK Article 50 negotiations Brussels, Monday 19 March 2018
2 European Council (Art. 50) guidelines following the United Kingdom’s notification under Article 50 TEU
3 BMA Brexit manifesto
4 BMA (Nov 2017) EU Doctor Survey
5 GMC (November 2017) Our data about doctors with a European primary medical qualification in 2017
• **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 practise 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.

• **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**: We are calling for the UK to 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.

**EEA NHS workforce**

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.

This ongoing uncertainty and insecurity 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.

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. These highly skilled individuals, who staff our hospitals and GP surgeries, look after vulnerable patients in the community, and conduct vital medical research to help save lives, are not used as ‘bargaining chips’ during the negotiations. The NHS cannot afford to either 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.

We urge the Government to offer permanent residence to EU doctors and medical academics who are currently working in the UK, and their family members, whether they have been living here for

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6 BMA Brexit Briefing: Workforce and Immigration
7 BMA (Nov 2017) EU Doctor Survey
8 BMA (Feb 2017) EU doctor survey
five years or not. EU medical students currently studying in the UK should be given sufficient stay to enable them to complete their courses and continue to foundation and training posts.

NHS workforce
Although, at this stage, we do not have conclusive evidence of the impact of Brexit on the movement of doctors, recent figures from the General Medical Council show that the number of doctors coming to the U.K. from the European Union fell by 9 percent in 2017. The data revealed that 3,458 new doctors from EU countries registered with the GMC in 2017, compared with 4,644 in 2014. The NHS is already under immense pressure in the face of rising demand and insufficient resources, and with workforce shortages in key specialties, it is becoming increasingly difficult to recruit and retain medical staff across the system, even with current levels of migration.

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.

Efforts to increase the domestic supply of doctors are underway, including the announcement this week that five new medical schools will be created over the next three years. While this is a welcome development, this expansion in medical school places will not tackle shortages in the UK’s medical workforce in the short to medium term given that it can take up to ten years to train a senior doctor. NHS England has found that to meet its target of recruiting 5,000 GPs by 2020, it has had to actively recruit more than 2,000 of those from the EEA and overseas.

Given that the UK will continue to need to recruit doctors from overseas to fill workforce gaps, we are urging the Government to provide clarity as soon as possible about what future immigration system will be put in place to manage migration from the EEA once the UK leaves the EU to enable better workforce planning.

Delays in the publication of the Immigration White Paper and Immigration Bill
We welcome confirmation in the Draft Withdrawal Agreement that EU nationals arriving in the UK during the implementation period will get the same rights as EU nationals arriving before the UK leaves the EU; this should provide more certainty for EU nationals and employers who now have confirmation of their rights and more time to plan for their future.

However, the lack of clarity over the rights of EU nationals during the implementation phase (until recently) combined with delays in publishing the Immigration Bill has had a knock-on effect on the recruitment plans of employers within the NHS. Data shows that in 2017, 41% of NHS trusts surveyed felt that Brexit would have a negative impact on their workforce (compared to 19% in 2016). The same survey also found that due to the uncertain future for EEA nationals working in the UK, only 35% of trusts had plans to recruit from the EEA (compared to 49% in 2016).

We continue to be concerned over ongoing delays in the publication of the Immigration White Paper and Immigration Bill, which will outline how the Government plans to manage migration from the EEA

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9 Bloomberg (Feb 2018) European doctors are giving up on the UK
10 BBC (March 2018) Under doctored areas to get five new medical schools
11 Cavendish Coalition publishes Brexit impact feedback from NHS employers
once the UK leaves the EU. Recent reports suggesting the Government’s plans for managing migration from the EEA will now not be published until late 2018 are alarming\textsuperscript{12}.

Any future immigration system must provide the flexibility necessary to address NHS workforce shortages, especially where the resident workforce is unable to produce enough suitable applicants to fill vacant roles, and considers the needs of the wider health and social care systems.

Mutual Recognition of Professional Qualifications

After Brexit, the BMA is calling for the maintenance of reciprocal arrangements, such as MRPQ to enable EEA doctors to work in the UK and to facilitate the ongoing exchange of medical expertise across Europe. The EU’s policy of MRPQ has been key in enabling many health and social care professionals from countries within the EEA to work in the UK and vice versa. Having a common framework for training and standards, coupled with an alert system in relation to fitness to practise concerns, has made it possible to fill gaps in the medical workforce quickly whilst ensuring patient safety. Approximately 7.7\% of doctors (12,029) currently working in the NHS medical workforce in England are EEA graduates, while the figures for EEA graduates for other UK nations are 5.7\% (1,139) in Scotland, 8.8\% (550) in Northern Ireland and 6.4\% (624) in Wales\textsuperscript{13}.

EEA doctors are particularly important for Northern Ireland and different parts of the UK, particularly London and the South East of England. Nearly three quarters of the EU graduates working in Northern Ireland obtained their primary medical qualification in a single EU country – the Republic of Ireland. Similarly, many NHS Trusts in London and the south east rely on EEA doctors to provide patient services. At both the Royal Brompton and Harefield Trust and Oxford University Hospitals, 19\% of doctors are EU nationals; figures from Imperial College Healthcare show 17\% of doctors are EEA nationals while St George’s University Hospital, University College Hospital and Great Ormond Street Hospital are 16\% and 14\% respectively.

The Draft Withdrawal Agreement published on 19 March 2019 confirms MRPQ will remain in place until the end of the transition phase on 31\textsuperscript{st} December 2020. However, the next phase of negotiations on the future relationship between the UK and EU, must give priority to ensuring that the same certainty is provided to medical students, studying outside their country of origin, who have yet to secure their professional qualifications. Removing automatic recognition, which is currently provided by MRPQ, may result in an additional barrier to those considering working in the UK.

Commitments by the UK Government and EU negotiators in the phase one withdrawal agreement to recognise existing medical professional qualifications, and to extend MRPQ until the end of the implementation phase in December 2020, are welcome developments. During the next phase of negotiations between the UK and EU, priority needs to be given to ensuring that the same certainty is provided to medical students, studying outside their country of origin, who have yet to secure their professional qualifications. This is essential to not only remove unnecessary anxiety among medical students, but to help ensure that health workforce planning in the UK is undertaken in optimal conditions.

Alert system

The BMA is also calling for the GMC to retain access to the Internal Market Information System (IMI) alert system, which warns the GMC when a doctor has their practice restricted in one of the other 27 EU member states. Specifically, the IMI, which allows medical regulatory authorities within the EU to communicate with other authorities, enables the GMC to transmit and respond to queries about a doctor’s registration documents as well as sending and receiving alerts about doctors’ fitness to

\textsuperscript{12} Politico (March 2018) UK cabinet at odds over delay to bill

\textsuperscript{13} GMC (November 2017) Our data about doctors with a European primary medical qualification in 2017
practise across the EU. 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.

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

**Reciprocal healthcare**

We 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.

27 million people hold a UK-issued EHIC and 190,000 UK pensioners living elsewhere in the EU are registered to the S1 scheme. The Nuffield Trust has calculated that if the 190,000 UK state pensioners signed up to the S1 scheme and living within the EU need to return the UK to receive care, it could incur additional costs to health services of between £500 million and £1 billion per year\(^\text{14}\).

This simultaneous increase in cost and demand would place even greater strain on the UK health and social care sector and the BMA’s strong position is that this must be avoided. Ending reciprocal arrangements may also require the application of existing cost recovery methods for non-EEA patients to EU and EEA patients in the UK, or the development of new, alternative system. This could potentially increase the complexity of the cost recovery process as well as the administrative burden on clinical staff. The BMA’s longstanding position is that doctors and clinical staff should be able to devote their attention to treating patients and not to recovering the cost of care.

**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**

**Euratom**

We are calling on the UK to continue to work closely with Euratom, which facilitates the movement of isotopes around Europe and provides for funding of research development programmes, after we leave the EU\(^\text{15}\).

A formal agreement on Euratom would allow the UK to guarantee continuous and timely access to radioisotopes for medical purposes. This is vital as isotopes used in medicine have a short half-life and cannot be stock piled. The UK imports medical radioisotopes from an international supply – for example, its supply of Technetium 99m (the most common radioisotope used in nuclear diagnostic imaging in many UK hospitals) is imported from the Netherlands, France and Belgium. As the UK will not have access to a supply close to the point of use, failing to agree ongoing membership of Euratom will increase the risk of supply issues. Breaks in this supply can lead to delayed diagnosis and treatment, as occurred in 2009 and 2013 when maintenance of reactors resulted in facilities going offline temporarily\(^\text{16}\).

Should the UK fail to negotiate a deal with the EU by March 2019, the UK would have to operate outside of Euratom and source radioisotopes from outside this framework. Any disruption to the

\(^{14}\) Nuffield Trust—NHS could face bill of over half a billion pounds from brexit

\(^{15}\) BMA briefing: Euratom

\(^{16}\) Radioisotopes: The medical testing crisis (last accessed on 13.07.2017).
supply chain, or delays at customs after Brexit could lead to the cancellation of appointments and operations. Diagnosis would be delayed until supply was guaranteed again and operations would be cancelled, potentially at short notice. This would have wide-ranging consequences for hospitals – resulting in added pressure, backlogs and disruption to a system which is under considerable strain.

For patients, the implications of disruption can 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. Patients would also potentially have delayed access to diagnosis, treatments and therapy if there were any barriers to UK and EU research. While the Government should prioritise a deal that guarantees access to radioisotopes, it is also important that contingency plans are in place should no deal be reached.

*It is vital that the UK Government seeks a formal agreement with Euratom to ensure consistent and timely access to radioisotopes for medical purposes.*

**Access to medicines and medical devices**

We welcomed the announcement in the Prime Minister’s Mansion House speech 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.

**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 Norway. 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.*

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17 Prime Minister’s speech on our future economic partnership with the European Union, March 2018
18 European Commission (28 February 2017), “Questions and Answers about European Reference Networks”