A momentous issue, the result of which could have huge implications for both the nation and indeed the medical profession.
The BMA in Europe

The upcoming referendum on the UK’s future membership of the European Union (EU) is a momentous issue, the result of which could have huge implications for both the nation and indeed the medical profession.

The impact – intentional or unintended, positive and negative – of EU policy and legislation on the UK’s medical profession and the health of the nation is significant, if not always immediately apparent.

Looking beyond the UK’s shores to advocate on behalf of members, the BMA was the first national medical association to recognise this and open (in 1994) an office in Brussels to ensure that members’ views were heard during the development and implementation of EU policy and legislation. In addition, and because we recognise that the complexity of the issues can dissuade members from engaging with the process, we developed a CPD-accredited e-learning module – ‘The EU and its impact upon the UK’s medical profession’. The module, the first of its kind within the medical profession, does not simply seek to inform but was designed to help you recognise how your clinical expertise can help to secure the BMA’s interests at EU level.

Having played a central role in the development of such policy and legislation over the last 20 years, we have analysed their application in the UK and have provided an objective assessment of how the key developments have affected both our members and the nation’s public health.

The debate on the question of membership of the EU will swell and grow over the coming weeks, and we’ll all have to take into account so many perspectives from different parts of our lives. I believe that the information here will be useful in thinking about your own answer to the question that faces us all, that of whether we believe we should remain a part of the EU.

Foreword by
Mark Porter
chair of council
A professional (international) workforce

With 11% (just over 30,000) of doctors working in the UK having received their primary medical qualification in another EEA (European Economic Area) state, the EU’s Mutual Recognition of Professional Qualifications (MRPQ) Directive, which allows doctors to practise in other members states, is a significant piece of legislation. Indeed, there are currently over 8,000 such BMA members from 27 other EEA states, with over 2,000 having qualified in Ireland and more than 1,000 in Germany. For comparison, there are currently over 500 BMA members practising in 24 other European countries with Ireland (149) and Germany (77) once again topping the charts.

The Directive, which governs the free movement of professions throughout the EEA and promotes the automatic recognition of professional experience, was amended at EU level in 2013 and came into force in the UK on 18 January of this year.

With such a significant portion of the UK’s medical profession having qualified elsewhere, the BMA is a staunch supporter of the principle of the free movement of professionals and worked hard to ensure that the amended Directive respected this principle while securing the highest possible quality of care and patient safety.

The fact that the Directive now permits European regulators to check applicants’ language skills ahead of registration is also due to BMA lobbying and a welcome boost to patient safety across Europe.

Patient safety will be further assured by the introduction of an alert mechanism, or early warning system, which will advise all European regulators when a doctor is banned or their ability to practice restricted.

Given the levels of pan-European professional migration, it is also important to ensure that minimum standards in medical education and training are met. Our work with European partners helped secure the Directive’s requirement that all EU countries must encourage continuing professional development and report on progress, and the affirmation of minimum training requirements for doctors.
In the longer term, and since the amended Directive provides for possible changes to the content of training curricula, such pan-European support will once again be vital as we would seek to ensure that standards are driven up across Europe and not levelled down to the lowest common denominator.

**Promoting an innovative research environment**

With medical research becoming increasingly international in focus and integral to tackling the main current and future societal challenges, action to promote and regulate such activity at European level is axiomatic.

With literally billions — €78.6bn for research from 2014-20 — available to support research across the EU, EU funding plays a huge supporting role in the vast majority of British research institutions. Indeed, Horizon 2020 — the EU’s leading research programme, has an indicative budget of €7-8bn to support research relating to ‘Health, demographic change and well-being.’

Many BMA members benefit directly or indirectly from such programmes with three of the University College London’s current flagship medical academic programmes receiving a combined total of just under €30 million. Of course, not all applications are successful, with deserving bids sometimes failing to secure funding in what can be extremely competitive fields.

In addition, and perhaps of greater significance than the funding, the free movement of researchers (and other professionals) across Europe, coupled with the growing dominance of English as the common language of research and education, has helped the UK cement its position in the vanguard of European medical research.
European Working Time Directive
The EWTD (European Working Time Directive) was adopted in 1993 and was implemented in UK law in 1998. It became applicable to junior doctors in August 2009 – reducing the maximum hours worked from an average of 56 per week to 48.

There have also been a number of European Court of Justice rulings on the EWTD, perhaps the most important of these for doctors are the SiMAP and Jaeger rulings which enshrined the principle of time spent on-call at the workplace being classed as work.

The BMA is satisfied with the EWTD as it stands and believes it protects doctors from the dangers of overwork while protecting patients from overtired doctors.

Numerous attempts by the EC (European Commission) to revise the EWTD have been made since 2007 with the most recent (2014) focusing on the potential organisational/financial costs to the healthcare sector. Despite the support of national governments, including significant support from recent UK Governments, all have been unsuccessful due to resistance from organisations like the BMA.
Securing patient safety and rights

Free trade not forced competition

The potential impact of FTAs (free trade agreements) upon the UK’s medical profession, may not be immediately evident but is actually hugely significant.

While the EU’s power to negotiate FTAs on behalf of the UK and other member states may increase economic growth and prosperity, we have concerns about how they may impinge upon national governments’ ability to legislate in the public interest.

As such, the BMA has carried out a twin-track approach seeking assurances at both EU and UK level that the NHS will be exempted from the scope of such agreements.

BMA legal analysis of the proposed TTIP’s (Transatlantic Trade and Investment Partnership) IP (investor protection)/ISDS (investor to state dispute settlement) mechanisms identified such risks.

Working with partners at both European and global level, we helped to secure improved proposals from the EC. These proposals will decrease significantly the possibility of corporate interests successfully challenging the implementation of legislation, which they deem to impact unfairly upon their investment. For example, their implementation would decrease the possibility of companies preventing a government decision to reverse the outsourcing of public healthcare services to the private sector.

Despite recently concluded FTAs not resulting in the wholesale commercialisation of participants’ publicly-funded health services, we are seeking additional legal safeguards to ensure that the NHS does not fall within the scope of future FTAs.

BMA lobbying also played a critical role in convincing the EP (European Parliament) to call formally on the EC, which negotiates on the EU’s behalf, to exclude public (health) services from the scope of the TTIP and TiSA (Trade in Services Agreement).

Despite extensive lobbying at national level, we have been unable to secure the same commitments from the UK Government, which would be expected to seek to rapidly conclude comparable FTAs in the event of a UK withdrawal from the EU.
As the EP has the power to reject FTAs, and did so overwhelmingly in 2012 with the ACTA (Anti-Counterfeiting Agreement), we will continue to work with MEPs so that they do not support any agreement that prioritises corporate interests over patients’ rights.

**Information for patients**

Based on the principle that, ‘if you are entitled to it here, you can get it there’ the EU’s Cross border Healthcare Directive allows EU citizens to choose to receive a healthcare service (including private and unplanned care) in another member state and to seek reimbursement of the costs.

The BMA welcomes the principle of greater choice for patients, supports the principle of cross-border patient mobility and worked to ensure that the Directive consolidated patients’ rights in this area. We do, however, recognise that implementation of this Directive will have a significant impact upon both patients and doctors in numerous areas relating to the quality, safety and continuity of care.

With the number of patients seeking to receive healthcare in another EEA state increasing, we are concerned that there is insufficient information about healthcare provision in other member states. As it is the patient’s responsibility to be clear on who in the member state of treatment is accountable for assuring their safety throughout the course of their treatment, more information must be provided to help them make informed choices about where to undergo treatment.

Accordingly, the BMA sought legal advice to clarify this point with specific relation to GPs, those doctors most likely to be asked to refer patients overseas. The advice confirms that a GP (in England and Wales) ‘could not be held directly responsible for negligent treatment administered by a wholly independent healthcare provider in another state of the Union’.

In addition, the EHIC (European Health Insurance Card) enables access to medically necessary, state-provided healthcare when travelling or residing temporarily in another EEA country. The healthcare is provided at the same cost (free in some countries) and under the same conditions as for the people insured in that country.
As the EU’s internal market provides for the free movement of services and goods, as well as patients and doctors, safeguards like the EU’s Falsified Medicines Directive and Medical Devices Directive are increasingly necessary to ensure patient safety.

Aiming to expose fake medicines, the Directive introduced an obligatory authenticity feature on the outer packaging of genuine medicines. It also tightened rules on the controls and inspections of producers of active pharmaceutical ingredients while strengthening record-keeping requirements for wholesale distributors.

Most significantly perhaps, given the rate of increase in the online purchase of pharmaceuticals, it introduced an EU-wide logo to identify legal online pharmacies, which allows consumers to check if an online pharmacy is listed as an authorised retailer of a particular medicine.

Negotiations to finalise the Medical Devices and In-Vitro Diagnostic Medical Devices Directives are ongoing and aim to provide a more rigorous and transparent framework to govern the use of medical devices and to ensure patients, consumers and healthcare professionals benefit from the use of safe, effective and innovative medical devices.
Public health

In an increasingly globalised world, public health threats do not respect borders. Working within the bounds of the subsidiarity principle — that member states retain the right to organise and finance their respective healthcare systems — EU legislation has led to significant improvements in the UK’s public health policy, many of which are in line with BMA policy, that may not have been delivered by our own governments.

Increasing tobacco control

In the face of massive lobbying by the tobacco industry, the BMA helped to secure a revised Tobacco Products Directive, which aims to prevent young people from starting to smoke and goes far beyond what Westminster could have been expected to introduce.

In addition to banning (by 2020) the sale of cigarettes and roll-your-own tobacco with characterising flavours — eg fruit, menthol or vanilla — which encourage initial uptake and downplay the damaging health effects, the Directive also bans slim ‘lipstick and perfume’ packs.

Health warnings, pictorial and textual, must now cover 65% of the front and the back of packaging, with misleading labelling such as ‘natural’ or ‘organic’ also being banned.

The Directive also regulates E-cigarettes and encourages member states to introduce additional safeguards, such as banning refillable cartridges or introducing purchasing age limits.

We will continue to work to ensure that the UK Government implements such tobacco control measures, including those which permit it to introduce more stringent rules on the packaging of tobacco products — ie standardised packaging — which has been proven to reduce smoking rates.
Trimming the fat
Within the UK, efforts to reduce the consumption of trans fatty acids (TFAs) – artificial fats which increase the risks of obesity and cardiovascular disease – have focused on promoting voluntary action by manufacturers and retailers to not use ingredients that contain artificial trans fats and/or to remove them from their products. Unsurprisingly, and as not all products are covered by the voluntary approach, this method has been relatively ineffective with the attendant risk that individuals in the UK who consume a 'high trans menu' have intakes far above recommended levels with a commensurate impact upon their health.

BMA lobbying, in addition to that of key food industry players, has led to the publication of a report by the EC which recognises the weakness of voluntary approaches and paves the way for 'setting a legal limit for industrial TFA content' as 'the most effective measure in terms of public health'.

Such legislation would supersede the existing UK voluntary approach so we will be working with partners from across Europe to ensure that the EC follows through on this commitment.
Limiting the promotion of unhealthy food and drink products

While some restrictions have been implemented to reduce the promotion of unhealthy food and drink products to children and young people in the UK, gaps remain and these vulnerable viewers are still heavily exposed to the marketing of such unhealthy products. Recognising the value of this opportunity to make vital changes, the BMA is working with the EC and other European stakeholders to secure regulation that severely limits the appeal of such products to children and young people by:

- preventing them being advertised in or around any programmes that appeal in any way to this demographic
- developing specific restrictions for non-broadcasting media (including in newspapers, magazines, on billboards and in cinemas, online advertisements, in-game advertisements and advergames) that prevent the marketing of these products to this group
- preventing the promotion of these products through the sponsorship of events, activities, individuals or groups.

Once again, the EU’s legal framework supersedes UK regulation in this area and a forthcoming revision of its Audio-Visual Directive may lead to the tightening of rules on the advertising of alcohol or the advertising of products high in fat, salt and sugars; another BMA priority.
Reducing the health impacts of alcohol
As doctors witness first-hand the significant medical, physiological and social harm caused by excessive consumption of alcohol, securing legislative change in this area at EU level has been a consistent priority for the BMA.

While powerful industry interests have secured the exclusion of alcoholic drinks from existing EU labelling rules on nutrition and ingredients, pressure from the BMA and other public health stakeholders has obliged the EC to consider how the legislation’s scope could be widened. Given alcohol’s causal relationship with over 60 different medical conditions, it is unacceptable that alcoholic drinks should be exempt from legislation, which requires the labelling on fruit juices and milk to list their nutritional information and ingredients.

While the BMA can use EU law to secure its public health objectives in the UK, it can also be used by industry to challenge UK legislation designed to improve public health. The Scotch Whisky Association, acting on behalf of a global consortium of alcohol producers, challenged the Scottish Government’s attempt to introduce minimum unit pricing (MUP) for alcohol, a policy which the BMA supports, on the grounds that it was not proportionate and that it would restrict trade under EU law.

After several years of BMA lobbying, the ECJ (European Court of Justice) has ruled that it is up to the Scottish courts to decide whether other measures – such as taxation – could protect human life and health as effectively as minimum unit pricing, while being less restrictive to trade.

This means that the Court of Session in Edinburgh will now decide whether the Scottish legislation – passed in 2012 – can be lawfully implemented as per BMA policy.
A momentous issue, the result of which could have huge implications for both the nation and indeed the medical profession.
Please contact our EU Public Affairs Manager, Paul Laffin at plaffin@bma.org.uk for further information.

British Medical Association
BMA House, Tavistock Square,
London WC1H 9JP
bma.org.uk

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