Memorandum of evidence from the BMA - Health Committee inquiry on Brexit and health and social care

2017
About the BMA

The British Medical Association (BMA) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The BMA is committed to safeguarding the future of the profession and the patients we serve. As the representative of over 168,000 of the UK’s doctors, we must be consulted and involved in consultations to inform negotiations to leave the European Union (EU) which would affect the medical profession and our patients. Ahead of the referendum vote, the BMA produced a document, BMA in Europe, for our members which objectively analysed the impact of existing EU policy and legislation for the medical profession and the nation’s public health¹.

We, therefore, welcome the health committee’s inquiry and have identified a number of priorities for health which should be considered by the Department of Health, government and national agencies, and others, in the negotiations on the UK’s withdrawal from the EU. These include the retention and recruitment of EU staff; mutual recognition of professional qualifications; science and research; health and safety legislation, public health protection and procurement.

The BMA is a member of the Cavendish Coalition, a coalition of 29 health and social care organisations, which is seeking certainty for the current health and social care workforce originating from the European Economic Area (EEA) to remain in the UK.

Executive summary

- The UK’s decision to leave the EU may result in a domestic economic downturn, or in the very least, economic uncertainty. This in turn, is likely to reduce public spending in general and, specifically, the level of funding which is available to the NHS.
- A significant number of EU nationals work in health and social care organisations across the UK. The EU’s policy of freedom of movement and mutual recognition of professional qualifications facilitates this, helping NHS trusts and providers ensure gaps in the UK medical workforce are filled quickly by qualified workers with the appropriate level of training and education.
- There are approximately 135,000 EU nationals working in the NHS and adult social care system in England, which represents about five per cent of the NHS workforce and six per cent in adult social care. In 2014, more than 10,000 doctors working in the NHS (6.6% of the UK medical workforce) received their primary medical qualification in another European Economic Area (EEA) country² with additional staff working in public health and academic medicine- these individuals are vital to our NHS and the health and success of the country.
- The ongoing political uncertainty surrounding the future of EU nationals living and working in the UK will inevitably lead to some of these doctors choosing to leave the UK. While we welcome comments from the Secretary of State for Health that the government wants these doctors ‘to be able to stay post-Brexit’³, the government must offer these highly skilled professionals the confirmation and reassurance they need regarding their rights to live and work in the UK. Specifically, we believe these highly skilled professionals should be granted permanent residence in the UK. This would provide stability both to these individuals and to NHS workforce numbers.

² BMA, 2014 Medical Workforce Briefing, 2015, pg. 11.
³ Secretary of State for Health, Jeremy Hunt speech to Conservative Party conference 2016
- The government announced plans to fund the training of up to an additional 1,500 students through medical schools each year from 2018, with the intention of expanding the supply of UK trained doctors and reducing the NHS’s reliance on doctors from overseas. Given that it takes at least a decade for extra places at medical school to produce more senior doctors, this initiative will not stop the NHS from needing to recruit international doctors from within the EU and overseas, who bring great skill and expertise to our health service.

- Following the UK’s departure from the EU, it is essential that the immigration system remains flexible enough to recruit doctors from overseas, especially where the resident workforce is unable to produce enough suitable applicants to fill vacant roles.

- The BMA is deeply concerned about the impact of the UK’s decision to leave the EU on science and medical research. Safeguards must be put in place to maintain access to research funding, the right regulatory environment, and the mobility of research staff⁴.

- There may be wide ranging ramifications for the regulation and education of health professionals, including language testing, clinical skills and knowledge testing, and the transferability and recognition of qualifications for doctors. This will need to be urgently addressed.

- The BMA is satisfied with the EWTD and the measures it has introduced, including a reduction in the maximum hours worked to an average of 48 per week, as transposed into the UK Working Time Regulations. We urge the government not to repeal these Regulations for new workers.

- Government must maintain the public health regulations, originating from EU Directives, which have been transposed into UK law. The Tobacco Products Directive, for example, contains vital measures which aim to deter young people from taking up smoking and encouraging current smokers to quit.

### NHS funding

1. The UK’s decision to leave the EU may result in a domestic economic downturn which, in turn, is likely to reduce public spending in general and, specifically, the level of funding available to the NHS. The Department of Health itself acknowledges that the ‘UK economy is experiencing some turbulence following the decision to leave the EU’⁵.

2. According to the Health Foundation, the NHS budget will be £2.8 billion lower than currently planned for 2019/2020 if the UK leaves the EU due to a predicted fall in economic growth, caused in part by reduced access to markets after the UK’s exit, and other factors. The National Institute of Economic and Social Research, for example, predicts the UK economy would be approximately 2.5% smaller two years after a decision to leave the EU.⁶

3. If predictions regarding an economic downturn are proved to be correct, this could mean that in the longer term, and assuming that the UK is able to remain part of the European Economic Area (EEA), the NHS funding shortfall could be at least £19bn by 2030/2031—equivalent to £365 million a week. Should the UK not retain access to the EEA, the shortfall caused by the domestic economic downturn and consequent loss of income is predicted to be as high £28 billion—equivalent to £540 million a week.⁷

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⁴ The Academy of Medical Sciences: Academies publish joint statement on research & innovation after the EU referendum, 19 July 2016
⁷ Health Foundation (2016) Briefing: NHS finances outside the EU
4. Media reports also suggest that the Chancellor’s Autumn Statement on 23 November 2016 will contain no new money for the NHS, despite calls from leading NHS organisations for extra health spending following the UK’s decision to leave the EU. Given the weak tax receipts reported in the UK, which will slow efforts to reduce deficits, and the recent fall in Sterling, which will have a significant effect on the cost of medicines and other health products, the outlook for NHS finances following the UK’s decision to leave the EU looks deeply alarming.

5. A central point to the ‘Leave’ campaign was a promise of £350m a week to be redirected to the NHS as we cease our funding to the EU. Given the economic predictions and the potential impact on NHS funding, we are calling on the government to make good on the promise made to the British public and give the NHS this funding which it requires so that doctors can provide the service for patients which they deserve.

Retention and recruitment of EU staff in the NHS

6. Much of the rhetoric about immigration during the EU referendum campaign focused on the pressures increased immigration has placed on public services including the health service, housing and schools. Studies looking at migrants arriving in the UK since 2000 show they have made a positive contribution to public finances, paying more in taxes than the value of public services they have used. It is important to acknowledge the contribution made by European migrants, including doctors, in delivering and sustaining public services, such as the NHS, care services, and our universities. We unreservedly condemn the xenophobic attacks by individuals who have taken the referendum result as a green light to attack the NHS staff who care for them.

7. The EU’s principle of freedom of movement of people and the mutual recognition of professional qualifications within the EU has enabled many health and social care professionals from countries within the EEA to work in the UK. There are approximately 135,000 EU nationals working in the NHS and adult social care system in England, representing about five per cent of the NHS workforce and six per cent in adult social care. In 2014, 10,242 doctors (6.6% of the UK medical workforce) received their primary medical qualification in another European Economic Area (EEA) country.

8. Doctors from the EU have become essential members of the UK’s medical workforce and the NHS is dependent on them to provide a high quality, reliable and safe service to patients: our health service would not be able to cope without them. These highly skilled professionals have enhanced the UK health system over the years, improving the diversity of the profession to reflect a changing population, bringing great skill and expertise to the NHS and filling shortages in specialties which may otherwise have been unable to cope.

9. The government must offer these highly skilled individuals from the rest of the EU reassurances about their future rights to live and work in the UK. Not doing so risks undermining workforce planning in the NHS but also the ability of the health service to maintain safe staffing levels and patient safety.

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8 The Guardian, Friday 14 October 2016 No extra money for NHS, Theresa May tells health chief
10 King’s Fund, Five Big Issues for Health and Social Care after the Brexit Vote’, 30 June 2016
10. Statements made by the Secretary of State for Health that the government wants EU doctors to remain in the UK post-Brexit, and that there is no intention to deport EU nationals currently in the UK, do not go far enough. We believe EU doctors and medical academic staff should be granted permanent residence in the UK; this would provide stability to these individuals and to NHS workforce numbers in the longer term.

11. The Secretary of State for Health recently announced proposals for the government to fund the training of up to an additional 1,500 students through medical schools in 2018, with the intention of expanding the supply of UK trained doctors and reducing the NHS's reliance on doctors from overseas to ‘make the NHS self-sufficient in doctors’ by the end of the next Parliament. While the BMA welcomes the expansion in medical school places, it is essential that alongside any increase in medical student numbers, there must also be an increase in foundation places for these students to fill as they progress through their medical training. Additional resourcing to provide capacity for clinical academics, supervisors, and the training administration to support the expansion while maintaining the quality of existing training is also vital.

12. Medicine thrives on the interchange of experience, knowledge and training across countries and backgrounds: closing our borders would be bad for medicine, bad for patient care and bad for medical research. It would also contravene the principles of equalities and diversities to which the NHS has committed.

13. This announcement is symptomatic of the government’s poor workforce planning. Given that it takes a decade for extra places at medical school to produce more senior doctors, this announcement will tackle neither the current shortage of doctors nor reduce the NHS’s continued need to recruit highly skilled staff from overseas. The UK immigration system must therefore remain flexible enough to recruit doctors from outside the UK where necessary in to the NHS and research workforce.

14. Furthermore, if the government were to introduce a cap on EU workers following the UK’s decision to leave the EU, it would be crucial to ensure that sufficient provision was made for healthcare workers through flexibility in the UK immigration rules. We note that the introduction of much stricter restrictions for non-EU workers entering the UK since 2010 had a detrimental impact on NHS recruitment and workforce numbers. Shortages in the nursing workforce became so acute that nurses were added to the shortage occupation list to allow hospitals to recruit from outside the UK with no cap on numbers.

**EU policy of mutual recognition of professional qualifications**

15. The EU’s policy of mutual recognition of professional qualifications, alongside its policy of freedom of movement within the EU, has enabled many health and social care professionals from countries within the EEA to work in the UK. It also allows UK doctors to work in other European countries, thereby sharing expertise and knowledge across Europe.

16. The government should maintain reciprocal arrangements, involving mutual recognition of qualifications along with measures to ensure patient safety, once the UK leaves the EU.

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11 Secretary of State for Health, Jeremy Hunt speech to Conservative Party conference 2016
Current regulations have helped create an environment which has facilitated and encouraged movement of workers and students, sharing of data and ideas as well as ensuring EU nationals are quickly able to fill gaps within specialties in UK medical workforce and the wider health service.

17. Should reciprocal arrangements be lost once the UK leaves the EU, there is a risk that this will not only have a detrimental impact on the UK’s ability to fill gaps within the NHS but also on our ability to collaborate with our EU partners, to retain research staff and learn from colleagues.

18. The UK’s decision to leave the EU has the potential to have wide ranging ramifications for the regulation and education of health professionals, which will need to be urgently addressed. These issues include language testing, the potential introduction of clinical skills and knowledge testing, the transferability and recognition of qualifications for doctors (as mentioned above), the structure of undergraduate and postgraduate training, and access to the specialty register (Certificate of Eligibility for Specialist Registration / Certificate of Eligibility for GP Registration and Certificates of Completion of Training).

Science and research

19. We have serious concerns regarding the UK’s ongoing access to EU research programmes and research funding following the vote to leave the EU and in particular, the implications this will have for the future of science and research in the UK.

20. EU research programmes have made a significant contribution to UK research: the UK received €8.8billion in 2007–2013 having contributed €5.4 billion during the same timeframe\(^\text{12}\); the UK currently has 15% of all awarded grants in Horizon 2020, the greatest share amongst those countries participating\(^\text{13}\). While participation in programmes such as Horizon 2020 is not conditional on membership of the EU (Israel and Switzerland are amongst the highest net recipients), we are calling on the UK government to act quickly to ensure ongoing participation in such programmes and to limit any potential damage to the UK’s medical research base.

21. The UK government’s recent commitment to underwrite EU funding awards secured while the UK remains a member of the EU is a welcome acknowledgement of the importance of this issue. It is, however, insufficient without further detailed commitments on ensuring access to such programmes in the longer term. Such commitments will be essential to mitigate any risks to the future of science and research in the UK and to ensure the quality of research from our universities is maintained in the future.

22. As with EU nationals working in the NHS and adult social care, we are seeking reassurances from government that UK-based researchers and staff from other EU nations will be given the right to continue to live and work in the UK. This is vital given that 15% of all academic staff contributing to the UK university workforce originate from other EU nations\(^\text{14}\). Equally, it is essential that the government seeks to secure opportunities for UK researchers to gain experience in other EU nations: nearly 72% of UK-based researchers spent time at non-UK

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\(^{12}\) Academy of Medical Royal Colleges: [Leaving the EU – What needs to happen to maintain the standards of healthcare in the UK](https://www.rcplondon.ac.uk/sites/default/files/Leaving%20the%20EU%20-%20What%20needs%20to%20happen%20to%20maintain%20the%20standards%20of%20healthcare%20in%20the%20UK%20%2028%20July%202016)\, 28 July 2016


institutions between 1996 and 2012\textsuperscript{15}. Both measures are vital for collaboration and we are calling on the government to ensure the UK continues to have the opportunity to shape the EU’s research and innovation agenda.

23. The BMA has significant concerns about the implications of the vote to leave the EU on the regulation of medicines and siting of the European Medicines Agency (EMA)\textsuperscript{16}. The EMA is currently based in the UK: this not only reflects the size and significance of the UK’s pharmaceutical sector, but also helps anchor pharmaceutical and associated companies in the UK.

24. Much of the regulation of medicines in the UK (including those under development, approved products, medical devices and in vitro diagnostic testing) derives from EC Regulations and Directives via the EMA. Following Brexit, there are concerns that the loss of these regulations could require the UK to rewrite significant amounts of our own legislation to cover the gaps arising from our departure.

25. Unless these are matched by EU regulations or were recognised by the EU, there is a risk that UK-based pharmaceutical companies would be put at a competitive disadvantage compared with their EU competitors in accessing and participating in the Single Market. Alternatively, it could mean that the UK has to adhere to regulations over which it has no influence.

26. There is also a risk that the UK’s departure from the EU will mean the UK will not be able to participate in a range of measures relating to the regulation of medicines. This includes the European-wide approval system for new medicines; revisions to already approved products; the Orphan Drug Designation or the Small to Medium Sized Enterprise schemes; the centralised approval process for paediatric drugs; and the process that supports new medicine development for children. The UK also risks losing access to the EU wide Pharmacovigilance networks (whereby the EMA monitors and supervises the safety of medicines that have been authorised in the EU to ensure their benefits outweigh their risks) as well as the EU Clinical Trials Database, to which the UK is a major contributor. This vital issue must be addressed in the government’s negotiations as prepare to leave the EU and we are urging the Committee to look into this issue further.

27. Safeguards like the EU’s Falsified Medicines Directive and Medical Devices Directive are increasingly necessary to ensure patient safety. These directives 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. We are urging the government to maintain these safeguards.

Health and safety legislation

28. The BMA is satisfied with the EWTD and the measures it has transposed into the UK Working Time Regulations, namely the limit of a 48 hour working week, rest breaks and statutory paid

\textsuperscript{15} Elsevier (2013) \textit{International comparative performance of the UK research base, 2013}

\textsuperscript{16} BMA briefing: (October 2016) \textit{The future of the European Medicines Agency}
leave. The BMA believes these Regulations protect doctors from the dangers of overwork and protect patients from overtired doctors. It is perfectly possible to design adequate training without needing to break the 48 hour average weekly limit, provided rotas are planned properly. We are urging the government not to repeal the Regulations, or limit their application, for new workers.

Public health protection

29. It is essential that that government maintains public health regulations originating from EU Directives which have been transposed into UK law. The Tobacco Products Directive, for example, contains vital measures which aim to deter young people from taking up smoking and encouraging current smokers to quit. The measures include larger health warnings on the front and back of cigarette packs, the removal from the market of packs containing less than 20 cigarettes, restrictions on the use of characterising flavours, and regulations for electronic cigarettes.

30. Legislation to limit industrial trans fatty acid content (artificial fats which increase the risks of obesity and cardiovascular disease) and restrict the promotion of unhealthy food and drink products to children and young people is currently being developed by the EU. This legislation may be concluded before the UK’s formal exit from the EU and may, therefore, be transposed into UK law and applied. We note that the EU is also considering how existing labelling rules on nutrition and ingredients could be widened to include alcoholic drinks.

31. In its childhood obesity plan, the government states that the UK’s decision to leave the European Union could create greater flexibility in determining what information should be presented on packaged food, and how it is displayed. This could include changes to the current labelling scheme, allowing for the introduction of a mandatory requirement for traffic-light labelling on all pre-packaged food and drink. We would view this as a welcome development in helping individuals and families make healthier choices.

32. We would oppose any move by the government to repeal existing, or any other, vital public health measures.

Procurement

33. The EU procurement regulation was transposed into UK law as the Public Contracts Regulations 2015 and came into force on 26 February 2015. These regulations oblige commissioners to advertise all contracts for health and social care services valued above €750,000 in the Official Journal of the European Union (OJEU), including the information on which their decision would be based and the process they intend to follow.

34. The BMA is concerned that the regulations may lead both to unnecessary tendering by commissioners simply to defend against future legal challenge and to a further increase in independent sector provision of NHS-funded healthcare. Competitive tendering, which is costly, will not help greater integration of health services and could instead lead to service fragmentation and the destabilisation of existing NHS providers and networks. We would support any move by the UK government to repeal this legislation.

17 HM Government (August 2016) Childhood obesity: a plan for action