



House of Commons
Health Committee

**Brexit and health
and social care—
people & process**

Eighth Report of Session 2016–17



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*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons to be
printed 25 April 2017*

Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health.

Current membership

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Publication

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee's website.

Committee staff

The current staff of the Committee are Huw Yardley (Clerk), Katya Cassidy (Second Clerk), Laura Daniels (Senior Committee Specialist), Stephen Aldhouse (Committee Specialist), Lewis Pickett (Committee Specialist) Dr Charlotte Refsum (Clinical Fellow), Cecilia Santi O Desanti, (Senior Committee Assistant), Lucy Hale (Committee Assistant), and Alex Paterson (Media Officer).

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Contents

Summary	3
1 Introduction	5
Our work	5
Issues arising from Brexit	5
2 The process of Brexit negotiations	7
Influence of health within the negotiations	7
Brexit cabinet committee	7
Departmental resources	8
Contingency planning	10
Consultation & scrutiny	11
3 Health & social care workforce	13
Trends	13
Workforce numbers	13
Recruitment	14
Regional impact	16
Experience of EU staff	17
Uncertainty for existing staff	17
Future staffing requirements	20
Self-sufficiency	20
Maintaining access to expertise	21
Public interest weighting	23
Revisions to professional regulation	24
Background	24
Competency testing	25
Access to alert mechanisms	26
European working time directive	28
Potential for reform	28
Barriers to reform	29

4	Reciprocal healthcare	31
	Uncertainty and distress	31
	Impact on vulnerable people	32
	Negotiation and bilateral agreements	34
	Costs of reciprocal healthcare	36
	Payments and receipts	36
5	Outstanding issues for our successor committee	40
	Medicines, devices and substances of human origin	40
	Public health	41
	Food, alcohol and tobacco	42
	Further topics for investigation	43
	Conclusions and recommendations	45
	Formal Minutes	48
	Witnesses	49
	Published written evidence	50
	List of Reports from the Committee during the current Parliament	53

Summary

Background

The UK's withdrawal from the European Union—"Brexit"—will affect many aspects of the provision of health and social care in the United Kingdom. Given the range and complexity of the questions involved, we took evidence in advance of the triggering of Article 50 of the Treaty on European Union (TEU). This report was intended to be the first phase of our inquiry, addressing the immediate issues faced by people, whether they are workers in health and social care or patients who rely on reciprocal healthcare arrangements. Further phases of our inquiry have necessarily been cut short by the general election but we hope that our successor committee will return to this issue.

Preparations and departmental resource

We have also considered the process and preparations being made by the Department of Health in advance of the Brexit negotiations. We urge the Department of Health to produce a comprehensive list of those issues that will require contingency planning.

Our concerns extend to the resource dedicated by the Department of Health to preparation and negotiation and we would urge the Department to ensure that it has sufficient staff working on the process of Brexit. Furthermore, we also believe the Government should consult more widely with external stakeholders and the devolved administrations.

Many of the issues relevant to health and social care that will require negotiation do not fit neatly into the EU's legal definition of 'health' policy. We urge the government to put fundamental health concerns front and centre of the British negotiating priorities. The Government should clarify the expertise of the negotiating team and, whenever health issues are being discussed, it is vital that ministers or officials from the Department of Health should form part of the UK representation in negotiations with the EU.

Workforce

Over sixty thousand people from EU countries outside the UK work in the English NHS and around ninety thousand in adult social care. Post-Brexit we will continue to need, and benefit from the presence of EU staff in health and social care.

The impact of Brexit on the morale of R-EU (the remaining 27 members of the European Union) staff is concerning and the uncertainty they face is unwelcome. Difficulties in negotiating the process of applying for permanent residency in the UK and bureaucratic hurdles such as the requirement for Comprehensive Sickness Insurance all add to the concerns of EU workers and their families.

The Government's plan for our post-Brexit future should both ensure that health and social care providers can retain and recruit the brightest and best from all parts of the globe and that the value of the contribution of lower paid health and social workers is recognised.

We wish to make clear the value that we as a Committee place on the health and social care workforce from R-EU nations.

We welcome the opportunity for the UK to negotiate a more pragmatic approach to the mutual recognition of professional qualifications directive within the British regulatory model and we make recommendations about how that might be achieved.

Reciprocal healthcare

The impact Brexit will have on people who rely on the EU's reciprocal healthcare arrangements should not be underestimated. Not only would travellers and holiday makers potentially lose cheap and easily accessible care provided under the European Health Insurance Card, we heard in evidence that retired British citizens in the EU, disabled people, and people with multiple conditions could face particular challenges.

The Government wishes to maintain the arrangements largely as they operate at present but no guarantee can be provided that this will happen. Consequently people both here and in the EU face uncertainty about their future healthcare arrangements.

We welcome the Government's signal that they wish to prioritise and resolve the existing rights of all R-EU nationals resident in the UK and UK nationals resident in the R-EU. We call on both sides of the negotiation to prioritise and resolve this matter at the earliest opportunity.

1 Introduction

Our work

1. The UK's withdrawal from the European Union—"Brexit"—will affect many aspects of the provision of health and social care in the United Kingdom. This report deals with the issues that require the most immediate detailed scrutiny.
2. Given the range and complexity of the questions associated with the impact of Brexit on health and social care, we have focused this first phase of our inquiry on the immediate issues faced by people, whether they are workers in health and social care or patients who rely on reciprocal healthcare arrangements. We also examine how the Department of Health plans to influence the UK's negotiations and the departmental preparations that are being made to deal with Brexit.
3. This report was intended to be the first stage of our work seeking to scrutinise and influence the Government's policy and negotiating position. Further phases of our inquiry have necessarily been cut short by the general election but we hope that our successor committee will return to this issue.

Issues arising from Brexit

4. Although health is frequently described as a 'member state competence', (i.e. a policy area beyond the competence of the European Union) there are a wide range of areas where Brexit will have an immediate impact. On the basis of the written evidence we received and a broad range of expert advice provided to us, we have identified six areas in particular where Brexit will have a critical effect:
 - (1) The UK's health and social care workforce—both those who are here now, and those who we will need in the future
 - (2) Reciprocal healthcare coverage and cross-border healthcare
 - (3) Medicines, products, medical devices, clinical trials and wider health research
 - (4) Public health, including environmental protections and communicable diseases
 - (5) Resources, including EU agencies, funding programmes, networks and health in overseas aid
 - (6) Market functioning and trade agreements.
5. The first stage of our ongoing scrutiny of Brexit focussed on points one and two. The next stage of our work intended to investigate point three in more depth. Before the announcement of the general election it had been our intention to launch a call for evidence on medicines, products, devices and medical research later this year. We hope that our successor committee will undertake this aspect of the inquiry once established in the new Parliament.

6. Already published on our website is a more detailed digest of the questions that we believe will need to be addressed in the Brexit negotiations.¹ **Giving evidence on the impact of Brexit, Jeremy Hunt MP, the Secretary of State for Health, told us that the Government would not be publishing its own digest of the implications of Brexit because “the publication of what might be called the worst-case scenario could itself have an impact on negotiations.”² We do, however, urge the Department of Health to produce a comprehensive list of those issues that will require contingency planning.**

1 [Letter from Dr Sarah Wollaston, Chair of the Health Committee, to Rt Hon Jeremy Hunt MP, 14 December 2016](#)

2 Q 39

2 The process of Brexit negotiations

Influence of health within the negotiations

7. The six major areas for negotiation which we have identified as relevant to health and social care do not fit neatly into the EU's legal definition of 'health' policy, a point acknowledged by the Secretary of State for Health in correspondence in January 2017.³ We heard evidence that it is crucial that the Department of Health play a key role in negotiations on the issues we have highlighted. For example, reciprocal healthcare arrangements are embedded within a wider EU regulation on social security so we would expect the Department of Health to play a key role in the negotiations; similarly in negotiations on working time, including for doctors in training. The Secretary of State's January 2017 letter to us touched on this point:

We are working closely with the Department for Exiting the European Union (DExEU) and other departments to coordinate the multiple complex strands of work involved in preparing to leave the EU. We will also be closely involved as the negotiations progress.⁴

Brexit cabinet committee

8. The Secretary of State for Health is not a member of the Cabinet Committee for European Union Exit and Trade.⁵ In January Mr Hunt sought to reassure us that despite his absence from the Brexit cabinet committee he could exert influence and make the case for health through the full cabinet and cabinet sub-committees.⁶ Influencing ministerial discussions to ensure that health and care is not weakened by Brexit should be a priority of the Government. We note, however, that David Davis MP, the Secretary of State for Exiting the EU, told our sister Committee on Exiting the EU in March 2017 that he had yet to look at the future of the European Health Insurance Card (EHIC). This is the foundation of reciprocal healthcare across Europe and an important resource for any British citizen visiting or working in another EU country.⁷

Conclusion

9. In 2013, discussing the importance of health in international trade negotiations, the World Health Organisation's Director-General, Dr Margaret Chan, warned:

Be sure that health has a place at the table when ministers of trade and finance negotiate trade agreements. My dear ministers of health, if you are not at the table, you are on the menu.⁸

10. Mr Hunt told us that he would "feed very closely into any discussions involving health" despite DExEU leading on negotiations. It is vital that health and social care issues

3 [Letter from Rt Hon Jeremy Hunt MP, Secretary of State for Health to Dr Sarah Wollaston MP, Chair of the Health Committee, 13 January 2017](#)

4 [Ibid](#)

5 [Q1](#)

6 [Q3, Q119](#)

7 [Oral evidence taken before the Committee for Exiting the EU on 15 March 2017, HC \(2016–17\) 1072, Q 1378](#)

8 [WHO Director-General addresses the Regional Committee for the Western Pacific, Manila, October 2013](#)

are effectively represented within the negotiations but it is not yet clear how this will be achieved in practice. Moreover, the negotiating procedures and responsibilities both within the UK government and in the R-EU/EU-27⁹ remain uncertain. **We recommend that whenever health issues are being discussed, in particular the areas which we have identified, ministers or officials from the Department of Health should form part of the UK representation in negotiations with the EU.**

Departmental resources

11. Although the central departments directly tasked with leading on Brexit have received additional resources to recruit staff, the Department of Health is allocating responsibility for Brexit preparations to existing teams within the department. We heard in evidence that there is a small team of 25 staff in the lead directorate (the Global and Public Health directorate) responsible for co-ordinating Brexit work within the department, but this team has other responsibilities and is not solely dedicated to Brexit.¹⁰

12. The Institute for Government (IFG), however, has highlighted the capacity concerns that exist within Government departments and questioned whether it is possible for Brexit considerations to be properly attended to without deprioritising other policy initiatives:

If Brexit is at the top of the Government’s list of priorities, departments need to differentiate between the activity that will support them in delivering it and the distractions. They must be able to divert resource accordingly and de-prioritise less critical programmes to cover Brexit demands.

John Manzoni, Civil Service Chief Executive, last month said that the civil service is 30% over-committed and should re-prioritise ongoing work to take account of Brexit. Despite this, the order to departments to date has been that nothing can stop—they must continue with existing policy commitments as they were and find a way to deliver Brexit as well. But we heard from Whitehall interviewees that departments need more resources.¹¹

13. Responding to these concerns, the Secretary of State said that no work had been deprioritised and he did “not accept that things will not be done that need to be done.”¹² Examining government departments’ preparations for Brexit, the IFG has noted that as well as taking on the burden of Brexit the Department of Health has been subject to a 26% reduction in staff since 2010.¹³ The Secretary of State confirmed in evidence that further to this reduction the departmental headcount will fall from 1,800 to 1,300.¹⁴ In addition, it has also been reported that the “number of DH deputy directors will also be reduced from 116 to 80.”¹⁵ The table below, reproduced from the National Audit Office’s health overview published in November 2016, provides a sense of the scale of administrative reductions within the Department of Health:

9 The remaining 27 members of the European Union post Brexit

10 Q 23

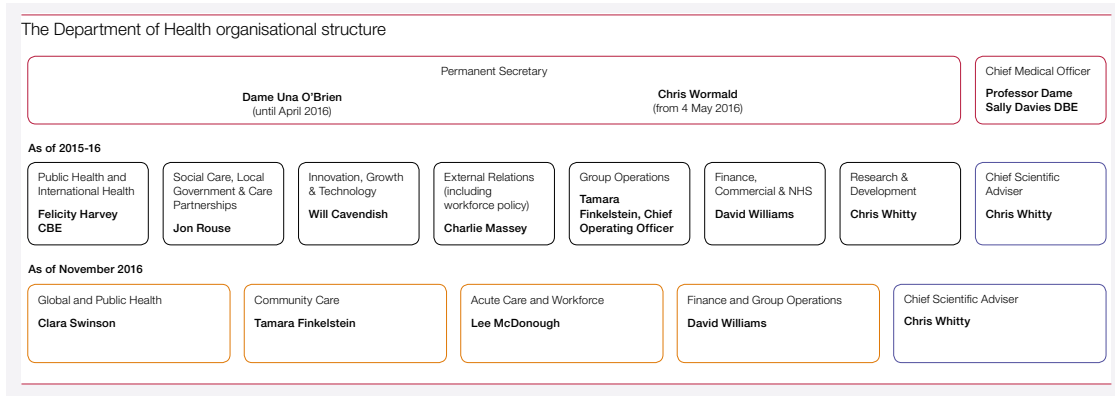
11 Institute for Government, [Whitehall’s preparation for the UK’s exit from the EU, December 2016](#), December 2016, p 22

12 Q 29

13 [IFG](#), December 2016, p 11

14 Q 23

15 Health Service Journal, [Department of Health to cut over 500 jobs](#), 16 December 2016



Source: National Audit Office, November 2016, p 3

14. Following the Department of Health's headcount reduction, the department now has the capacity to recruit an additional 340 posts.¹⁶ Paul MacNaught, Director of EU, International and Prevention Programmes, told us that undertaking restructuring after the referendum on membership of the EU had been advantageous because

we have been able to make sure the structure we have gone to is the right one not only for this work but for the rest of the work the Department has to do.¹⁷

15. However, we heard in evidence concerns that the process of reducing the total number of officials within the department may have reduced its ability to tackle Brexit effectively. Discussing the understanding of the healthcare risks faced by people as a consequence of Brexit, Martin McKee, Professor of European Public Health at the London School of Hygiene and Tropical Medicine, observed that:

I speak frequently to colleagues in other member state Governments who are, to put it mildly, alarmed by the level of understanding of many of these issues, particularly given that some of the key individuals in the Department of Health who understood the issues have recently been made redundant.¹⁸

Conclusion

16. There must be sufficient resource available within the Department of Health to meet the challenge of Brexit. We want health policies affecting the rights of British citizens in the R-EU and of R-EU nationals in the UK to be front and centre of the UK's early negotiating priorities. As the early negotiations progress, we will be looking to the Government to demonstrate that it is making health policy a priority, and that it is devoting sufficient resource to ensure a successful outcome. **We consider it essential that the negotiating team for the health related aspects of Brexit has the expertise, competence and appropriate support for this complex task. We recommend that the Department of Health identifies the dedicated senior officials handling negotiations for each of the areas we have highlighted, in addition to clarifying the expertise and make-up of the overall coordinating team for health.**

16 HC Deb, 10 February 2017, [62929](#), [Commons written answer]

17 Q 28

18 Q 200

Contingency planning

17. The Government's plan for legal continuity after the UK leaves the EU is the 'Great Repeal Bill'. This is intended to convert the 'acquis' of existing EU law into UK law, until Parliament (or the devolved assemblies) decides that it should be changed.

18. The Article 50 process is unlike any other international negotiation; if there is no agreement after two years, we cannot just carry on as before until agreement is reached. Rather, if there is no agreement within the Article 50 two-year period, the UK will leave the EU regardless, but in a vacuum relating to our legal relationships over a myriad of cross border issues, risking substantial uncertainty for health, social care and public health. Planning for that risk by the Department of Health is essential, because preventing it is not within the sole control of the UK, regardless of our negotiation objectives or strategy.

19. Areas that will require contingency planning include:

- Continued and timely access to medicines, products and devices that have been licensed by other EU countries, or need to be imported from the EU to the UK
- Patients needing care—both EU patients in UK hospitals and sick British citizens in the EU
- Access to healthcare for British citizens visiting the EU for work or leisure - in the case of some individuals, private health insurance will not be available or may be unaffordable
- Healthcare currently provided under reciprocal arrangements, as the position for British pensioners residing elsewhere in the EU could be especially precarious
- The close collaboration on access to specialist and other healthcare across the border between Northern Ireland and the Republic of Ireland
- EU staff in the NHS, social care and academic research roles without a formal statement of a right to remain and their families
- Future recruitment of staff for the NHS, social care and research from the EU.

20. Addressing the question of contingency planning, the Secretary of State for Health argued that even falling back on World Trade Organisation rules would not have serious repercussions for the provision of health and social care:

Obviously, we have to plan for all contingencies, but in that particular situation no one believes it would mean the end of trade with the countries of the EU. We would just fall back on WTO rules for trade, and those are the rules that apply in large parts of the world at the moment. Obviously, that is not the best-case scenario, but even in that case, although it would

be bumpier, I think that in the end the British economy would still thrive and be very successful. In terms of the long-term impact on the NHS, I am confident we will be all right.¹⁹

Pressed that there are a range of issues that will require thorough contingency planning, the Secretary of State said that this will be done, but emphasised that reciprocal interests mean that it is in the EU's interest to swiftly reach agreement.²⁰

21. To date little detail has been offered to explain the planning that will be in place for the broad range of issues under consideration. For example on 'Brexit day' itself, the transitional periods that then apply and longer term questions such as new medicines regulation will all require specific arrangements. In oral evidence Jean McHale, Professor of Health Care Law, at the University of Birmingham argued that many questions will need to be dealt with through the Great Repeal Bill's mechanisms if we are to avoid a 'cliff edge' situation where legal rights and entitlements are altered overnight.²¹

22. Paul MacNaught explained that the Government has been deliberately reluctant to set out in detail the plans that are being made and the contingencies that will be necessary:

At this point, we do not want to get into speculation about what those contingency options might be for fear of undermining the negotiation objective. You do not go into a negotiation and start by saying what you are prepared to do if the negotiation is not successful.²²

Consultation & scrutiny

23. Ensuring that healthcare figures prominently in the Government's negotiations will, in part, rely on thorough consultation and effective democratic scrutiny. Discussing the extent of the consultation taking place to inform the British negotiating position the Secretary of State for Health said:

Because of Brexit I have taken it upon myself to meet the chief executives of the pharma global top 10. I have met four and should be meeting another five in the next month.²³

Mr Hunt added that the Department of Health is "already engaging extensively with all the external stakeholders with which we need to engage."²⁴

24. Beyond this, however, very little additional detail or information has been forthcoming and the only commitment from Government is to consult on any legislative changes arising from Brexit, but not on the negotiations themselves.²⁵ As the White Paper on legislating for the UK's withdrawal from the EU makes clear, the two are unavoidably connected.²⁶ As the negotiations proceed the Department of Health does not have a transparent mechanism for wider consultation with stakeholders such as professional

19 Q 33

20 Q 34

21 Q 145

22 Q 306

23 Q 16

24 Q 109

25 Q 110

26 HM Government, The United Kingdom's exit from and new partnership with the European Union, [CM 9417](#)

bodies or patient groups. We do not believe that this approach will prove sustainable in helping the Government to avoid errors and unintended consequences in the process of negotiation.

25. Similarly, there is no transparent mechanism for consultation with devolved administrations, though many of these issues fall within the areas of devolved responsibility. The Secretary of State acknowledged that cooperation would be required on those issues that related to devolved competence, but he did not explain how this would operate or the extent to which the devolved administrations would influence the British negotiating position.²⁷

Conclusion

26. If significant changes are made to existing arrangements through secondary legislation under the Great Repeal Bill, risks may arise from a lack of scrutiny. The procedures for Parliamentary consideration of delegated legislation, which in the House of Commons at least, neither encourage nor routinely enable the involvement of Members with appropriate background knowledge or expertise, are unsuited to the scrutiny of fundamental changes to laws and rights. We welcome the Procedure Committee's inquiry into the delegated powers in the Great Repeal Bill, and will be watching carefully to ensure that any significant changes made to existing arrangements for health and social care are subject to appropriate Parliamentary and external scrutiny.

27. We recognise that the Government does not wish to set out the terms of its negotiating stance. It would nevertheless be helpful if the Department of Health could provide a list of issues under consideration to enable stakeholders and civil society to provide relevant input for the negotiations and to identify any important gaps.

3 Health & social care workforce

Trends

Workforce numbers

28. Today over sixty thousand people from EU countries outside the UK work in the NHS and around ninety thousand in adult social care.²⁸ In addition to health professionals and care workers there are many staff in important (but not directly caring) roles without whom the NHS and social care would struggle to function effectively. As an example, Professor Ian Cumming, Chief Executive of Health Education England, noted that “within catering in the NHS, within our hospital kitchens, you will find quite a lot of people who are EEA nationals, or indeed non UK, non EEA nationals.”²⁹ We welcome the Secretary of State’s unequivocal recognition of the value of R-EU workers in health and social care:

The 90,000 staff from the EU who work in the social care system and the 58,000 who work in the NHS do a brilliant job. Frankly, we would fall over without their help. That is why it is a very early priority for us to secure, as quickly as we can, agreement for their right to remain in the UK and continue their great work.³⁰

29. The analysis of the role of R-EU workers in health and social care encompasses the full span of the workforce in terms of skills and remuneration. In addition to any measure of the numbers of R-EU staff on which our services rely, it should, at the outset, be acknowledged that access to skills and expertise is as significant a part of the debate as the total headcount. This is also about the bureaucratic, financial and time barriers to recruiting and retaining staff from outside the UK.

30. The latest nationality figures published by NHS Digital for 30 December 2016 showed 60,058 EU national staff working in Hospital and Community Health Services (HCHS).³¹ This is a record figure and indicates a 10% increase in the number of EU staff working in the NHS since December 2015.³² EU national staff make up 5.1% of the EU workforce and doctors have the highest proportion of EU staff at 9.3% of the workforce.

31. Gavin Larner, Director of Workforce at the Department of Health, provided an overview of the turnover of EU staff for the period immediately after the outcome of the referendum compared to the same period in 2015:

A total of 4,863 EU nationals joined the HCHS³³ workforce between June 2016 and September 2016. This is just 126 fewer than who joined in the corresponding period of 2015. However the number of leavers increased between the two periods by 604, from 3,254 to 3,858.

28 Director of Workforce (Department of Health) ([BRE 97](#)) para 1

29 Q 352

30 Q 9

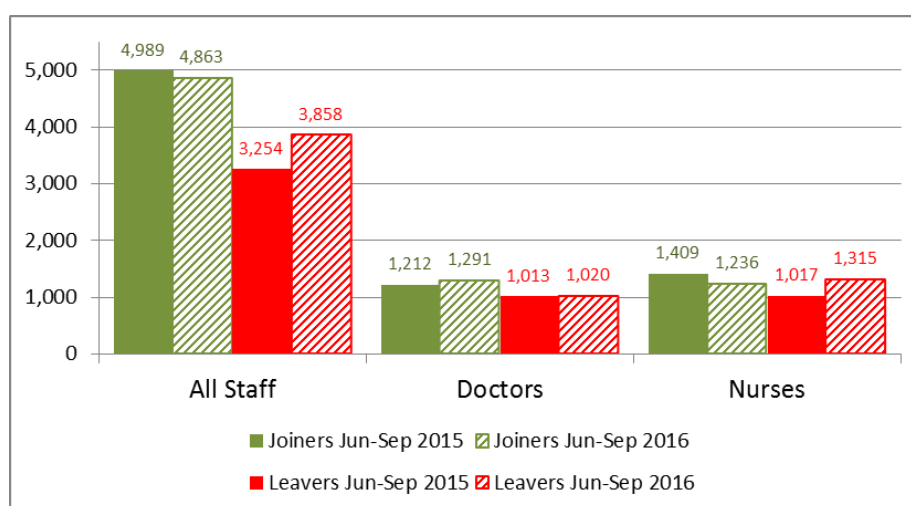
31 NHS Hospital and Community Health Services (HCHS): [Leavers from the English NHS by staff group and nationality group, in NHS Trusts and CCGs in England](#), 31 December 2013 to 31 December 2016, headcount

32 *Ibid*

33 NHS hospital & community services (including primary care)

Within this, the turnover of EU national doctors remained fairly constant between the two periods, with a slight increase of 79 in the number of joiners, from 1,212 to 1,291, whilst the number of EU national doctors leaving barely changed.

The number of EU national nurses joining fell by 173 from 1,409 in to 1,236, whereas the number leaving increased by 298, from 1,017 to 1,315.³⁴



Source: [BRE 97](#)

Recruitment

32. The impact of Brexit on recruitment across different sectors has proved difficult to measure and at this stage it is too early to make a comprehensive assessment.

33. Whilst there has been a slowdown in recruitment from R-EU nations this may not necessarily be wholly attributable to the outcome of the referendum, and this has been evidenced by the trends in registration of nurses and doctors. Data from the Nursing and Midwifery Council has shown a substantial reduction in the number of applicants to the nursing register from EU nationals since the referendum on the UK's membership of the EU. The NMC's data return sent to the Department of Health noted, however, that the reduction in applicants may, in part be a consequence, of the introduction of language testing for EU nurses.³⁵ In oral evidence Jackie Smith, Chief Executive of the NMC, noted that there had been a spike in applicants to the nursing and midwifery register in advance of new language testing being introduced and a drop off in applicants following it.³⁶ English language tests were introduced for nurses coming to work in the NHS from R-EU nations in January 2016. Ms Smith said in evidence that the NMC do not know conclusively what caused the decline in R-EU nursing applicants.³⁷

34 [BRE 97](#) p 3–4

35 The Nursing & Midwifery Council ([BRE 103](#))

36 Q 295

37 *Ibid*

34. Comparative data for the months September–December show a 75% reduction in applicants for the same period in 2016 compared to 2015:

Months	Monthly average of EU nurses and midwives joining the register for the first time
Sept–Dec 2010	226
Sept–Dec 2011	211
Sept–Dec 2012	277
Sept–Dec 2013	527
Sept–Dec 2014	707
Sept–Dec 2015	820
Sept–Dec 2016	204

Source: [BRE 103](#)

35. Similarly, the GMC record monthly statistics which have shown a decline in the number of applicants from the R-EU to the GMC’s register since June 2016, though not to the same extent as with nursing applicants. The GMC has noted that the decline in applications is broadly in line with a general downward trend in licensed EEA doctors on the register from most areas of the EEA in recent years—a trend that predates the outcome of the referendum. In 2014 the GMC was given the right to apply language tests to EEA doctors if concerns were expressed about competence and they said that this had an impact on registrations from EEA applicants:

Following the introduction of English language requirements in 2014, the number of new doctors who graduated in the EEA joining the profession halved from 2014 to 2015. From 2011 to 2014, the number of EEA graduates joining increased slightly, but the trend reversed in 2015 and fewer now join than in 2011. Between 2011 and 2014, the number leaving has almost doubled.³⁸

36. Commenting on the factors which may determine the trends in the recruitment of EU staff, Danny Mortimer, Chief Executive of NHS Employers, explained that changing recruitment strategies by trusts may have had an impact:

We are seeing a decrease in recruitment. There are lots of factors going on there. Some of it is because employers have not been out to recruit because of the lack of certainty. They would like more certainty before they go back out to recruit in southern Europe, in particular. Some of it is because we are not seeing the volume of applications that we have previously seen; some of it is because perhaps colleagues in those countries are making some slightly different choices.³⁹

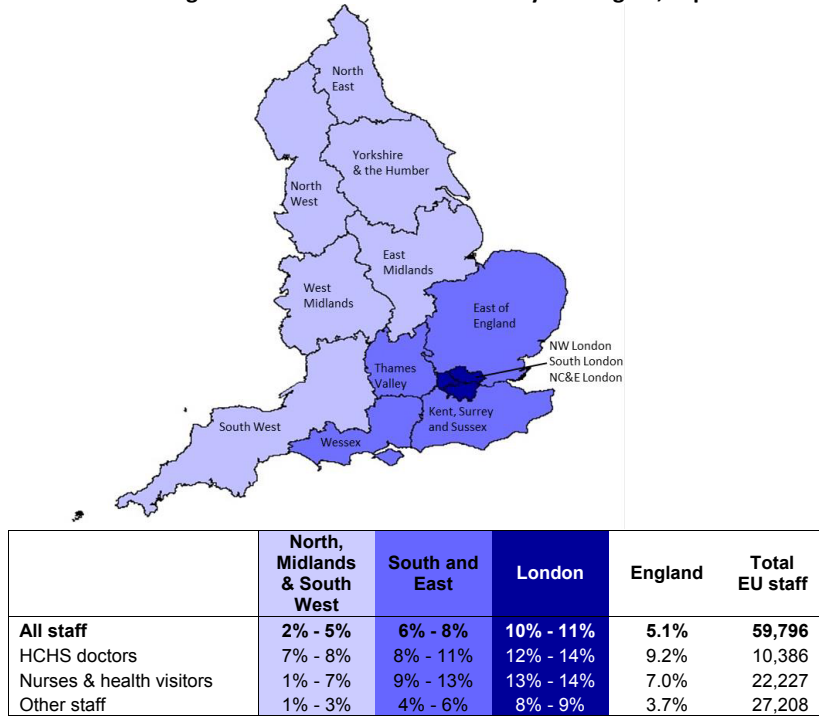
38 General Medical Council, [Our data about doctors with a European primary medical qualification](#), February 2017

39 Q 213

Regional impact

37. The Department of Health’s written evidence provided an overview of broad regional dependency on EU staff across England. Although not a comprehensive breakdown, it confirmed that London and the South East of England have the highest proportion of R-EU staff in the NHS:

Chart 2: Percentage of staff who are EU nationals by HEE region, September 2016



Source: [BRE 97](#)

38. We note that dependency on EU staff extends beyond England to all parts of the UK. For example, almost 6 per cent of doctors in Scotland obtained their primary medical qualification from non-UK academic institutions in the EEA.⁴⁰

39. Examining the regional effect in adult social care, Professor Martin Green, Chief Executive of Care England, described a slightly more nuanced picture. Professor Green noted that it is difficult for social care providers to recruit low paid workers in areas of low unemployment.⁴¹ In addition he said that rural areas are particularly dependent on people from R-EU taking low paid work in adult social care:

there are some areas where it is very difficult to recruit, certainly in social care. Often, people have come from the EU into those areas where it has been nearly impossible to attract candidates. For example, in some rural areas it is very difficult to attract people into social care, so EU nationals have gone into those services.⁴²

40 [GMC, 2016](#)

41 [Q 235](#)

42 [Q 217](#)

Experience of EU staff

Uncertainty for existing staff

40. In January 2017, Professor Ian Cumming, Chief Executive of Health Education England, wrote to us outlining Health Education England’s position on the impact of Brexit on the NHS workforce. He said that a significant area of concern is the uncertainty caused by the referendum:

Given the level of uncertainty involved in the final position related to freedom of movement, and any new migration controls which might replace these freedoms - and how these might apply to skilled and unskilled workers in the NHS, it will continue to be difficult to quantify any potential impact of any potential changes to applications to training and overseas recruitment of professionals until the details of a negotiated settlement are clear, and indeed we may not see until any impact until any changes come into force.⁴³

41. Exploring this theme further, Danny Mortimer, Chief Executive of NHS Employers, said that uncertainty around the future rights of EU nationals in the UK had an impact on recruitment and retention in the NHS:

Some hospitals in the NHS have done a lot of work with their EU nationals. Cambridge, for example, has done quite an extensive survey and had a series of conversations with its staff. A number report that the need for certainty and the lack of certainty at the moment is making them question whether they stay in the longer term. They have stayed in this period since the referendum result, but slightly more of them are worrying about whether they should leave in the longer term.⁴⁴

42. Professor David Lomas, Vice-Provost Health, UCL and spokesman for the Association of UK University Hospitals, described how University College Hospital Foundation Trust and University College London are attempting to reassure their clinical and research staff, and the impact on the retention of R-EU staff:

We have not seen people leaving. We have worked extraordinarily hard to reassure them, and we believe that you will give them the right to remain. [...] Our message is, “It will be okay. Trust us. We think it will be fine.” That is the message we are giving out to medical staff.⁴⁵

Professor Lomas also said that as a trust UCLH are advising their R-EU staff to be pragmatic and not to become entangled in the process of applying for permanent residency, a stance also taken by NHS Employers:

43 [Letter from Professor Ian Cumming OBE, Chief Executive Health Education England to Dr Sarah Wollaston, Chair, Health Committee, 19 January 2017](#)

44 Q 213

45 Q 214

We have had people going through the application process; [...] It is truly awful, and we are saying, “Don’t. Just hang on and keep your fingers crossed, and it should all be fine.”⁴⁶

Morale

43. The impact of Brexit on health and social care workers has yet to be fully measured or investigated. However, some worrying trends have emerged. Charlie Massey described a survey undertaken by the GMC to better understand how doctors from the R-EU are responding to Brexit:

About 2,000 EEA doctors replied, which is about 10% of the EEA doctor workforce in the UK. Of those, a slightly higher proportion said they were considering leaving the UK—about 60%—and, of those, about 90% said that was because of Brexit. Of the 2,000, just over half said they were considering leaving because of Brexit.

That needs to be treated with a degree of caution. This is a self-selecting group of people who have responded to that survey. What people say is not necessarily going to be predictive of future behaviour, but it sends a worrying signal in terms of the stock of doctors currently working in the UK.

44. Workforce data published by NHS Digital and referred to in evidence from the Department of Health has added a degree of credence to concerns that clinical staff from R-EU are now choosing to leave the NHS. In 2016 EU staff made up 6.6 % of all staff choosing to leave the NHS, up from 5.7% the previous year. Furthermore, the number of EU nurses choosing to leave the NHS increased from 7.5 of all leavers in 2015 to 10% in 2016.⁴⁷ There was no such growth in the number of doctors leaving but Charlie Massey provided an insight into the reasons why some doctors may eventually choose to leave their posts in the UK:

If you look at what people said in their free text comments in our survey, basically there were two reasons that came out as being the drivers of that: first, a question of whether doctors felt valued and wanted in the NHS; and, secondly, a question of the uncertainty over their continuing and future residence status.⁴⁸

45. The question of whether doctors felt valued was acknowledged by the Secretary of State, who expressed concern that the biggest risk arising from Brexit is “around the morale and motivation of the brilliant EU staff who already work in both the health and the social care systems.”⁴⁹

46 Q 214

47 NHS Hospital and Community Health Services (HCHS): [Leavers from the English NHS by staff group and nationality group, in NHS Trusts and CCGs in England](#), 31 December 2013 to 31 December 2016, headcount

48 Q 296

49 Q 9

Future rights and entitlements

46. Commenting on future arrangements for existing R-EU workers in health and social care, the Secretary of State of Health said “securing their rights to continue to live and work here is our top priority.”⁵⁰ Discussing how this might work in practice, Danny Mortimer noted that a cut-off date could be applied which would preserve the rights of workers already in the UK:

clearly, one of the practical things that needs to be resolved is what cut-off date would be used for EU citizens to have a right to remain. Our view, across health and social care, is that we would like that date to be as late as possible because we still have this pressing need to recruit colleagues to come and work within our system.⁵¹

47. Professor Martin McKee explained in his evidence that a loose discussion about ‘rights’ and, particularly, the right to reside does not address the fundamental concerns of R-EU people in the UK.⁵² He explained that the simple right to reside is relatively meaningless unless accompanied by a set of further rights:

There is an important distinction between the right to reside and rights as an EU citizen. The right to reside is one part of that. Unfortunately, in a lot of the discourse we hear about the right to reside, which really does not address issues like the right to own property, the right to transfer pensions and the right to transfer capital.⁵³

48. To date, however, no additional detail or reassurance has been forthcoming and the exact permutations of future rights or possible cut-off dates for entitlements are unclear. There exists a substantial difference between a person’s entitlement in theory (their position under future UK/EU international agreement) and a right which has an effective means of enforcement (their position under EU law).

49. It is not only workers in health and social care that benefit from a full set of entitlements but also their families and dependents. We heard that NHS organisations are advising R-EU staff to avoid the complex process of applying for permanent residency in the UK⁵⁴ One controversial aspect of this process has been the requirement for non-economically active EU migrants to hold Comprehensive Sickness Insurance (CSI). The CSI requirement has been one of the main causes of permanent residency applications to be rejected by the Home Office.⁵⁵ Whilst this requirement would not apply to a person working in health and social care (or any other field) it could potentially affect a spouse or partner who may have resided in the UK for many years or, in some cases, decades (and before the CSI requirement was introduced in 2004).⁵⁶ Evidence from Kent University and ECAS ‘EU Rights Clinic’ suggests up to 1 million people may be in this position.⁵⁷

50 Q 56

51 Q 230

52 Q 165

53 Q 164

54 Q 214

55 Exiting the European Union Committee, Second Report of Session 2016–17, [The Government’s negotiating objectives: the rights of UK and EU citizens](#), HC 1071, para 67

56 Council Directive [2004/38/EC](#)

57 EU Rights Clinic ([BRE 101](#)), para 15

50. We are concerned that the spouses and partners of NHS and social care staff may not be offered permanent residency in the UK purely as a consequence of the requirement for Comprehensive Sickness Insurance. We note that the UK’s interpretation of this directive has been a cause for dispute between the Government and the European Commission, and further note that the Exiting the European Union Committee has recommended that access to the NHS should be sufficient to fulfil the CSI requirement.⁵⁸

51. R-EU nationals in the UK enjoy a full set of easily enforceable rights and entitlements that put them on a par with British citizens. This should be acknowledged by the Government when undertaking any assessment of the incentives required to attract workers into health, social care, and supporting roles, especially low-paid jobs such as in adult social care. We wish to make clear the value that we as a Committee place on the health and social care workforce from R-EU nations.

Future staffing requirements

Self-sufficiency

52. The Government’s policy is that England should become ‘self-sufficient’ in its supply of clinical staff. Professor Ian Cumming described the interaction between the effect of Brexit and wider reforms to nurse training, but concluded that future number of nursing posts required across the NHS could potentially be filled by the current number of applicants to nurse training in England.⁵⁹ Professor Cumming noted, however, that should Brexit precipitate a major decline in the number of nurses from R-EU working in the NHS then there remains a possibility that the projected domestic training numbers would be insufficient.⁶⁰

53. In 2016 the Secretary of State announced the creation of an additional 1,500 medical training places to increase the supply of domestically trained doctors.⁶¹ Nevertheless, questions have arisen as to the nation’s ability to achieve this. The Association of UK University Hospitals (AUKUH) noted in its evidence that places at UK medical schools are not occupied only by British students and there had been a 16% reduction in the number of applications from R-EU nationals for places at UK medical schools.⁶²

54. Commenting on the Government’s objectives the Secretary of State for Health said that additional training places “will happen during this Parliament, but obviously it will not feed into the number of doctors actually practising until the middle of the next Parliament.”⁶³ Professor Cumming offered a more realistic appraisal of the road to self-sufficiency, noting that

for us to become completely self-sufficient and have no reliance whatsoever internationally, you are looking at somewhere in the region of 10 or 12 years from now.⁶⁴

58 European Commission Representation in the United Kingdom ([BRE 99](#)), [HC 1071](#), para 73

59 Q 348

60 Q 346

61 The King’s Fund ([BRE 90](#)) para 1.6

62 The Association of UK University Hospitals ([BRE 63](#)) paras 7–8

63 Q 45

64 Q 353

Professor Cumming also explained that the nature of medical training means that self-sufficiency is based on international applicants to domestic training as there is both an “inflow and an outflow” of doctors in England.⁶⁵

55. Professor Cumming wrote to us outlining Health Education England’s interpretation of the impact Brexit has already had on applicants to medical training:

HEE does not have evidence to suggest this is impacting our recruitment to training at present. You will have seen from our joint evidence to your Committee that proportionately more doctors come from the EU than for other large clinical groups, such as nurses. So it is significant that the first round of Specialty Recruitment in 2017 (run between November and December 2016) produced very similar numbers of applicants to previous years, and EU doctors continued to make up around one in six applicants.

In oral evidence Professor Cumming added:

About 18% of all applications for specialist training in 2015/16 were from EEA nationals and it is 18% again this year, and the overall figure has not gone down.⁶⁶

Maintaining access to expertise

56. The Cavendish Coalition, a body comprised of 30 health and social care organisations campaigning on workforce issues, sounded a note of caution in relation to the future deployment of domestically trained staff, noting that international recruitment has benefits beyond filling gaps in rotas:

The government has announced it is to raise numbers of medical training places by 1,500 in order to increase the supply of UK trained doctors and reduce reliance on doctors from overseas, including EEA countries, with an end goal of the UK being “self-sufficient” in doctors. Recognition of workforce shortages is to be welcomed, however, the value of an international workforce, bringing together skills and experiences from across the world enhances the medical workforce and should continue to be encouraged as well.

57. Danny Mortimer, who chairs the Cavendish Coalition in addition to his role at NHS Employers, made the case in oral evidence that existing immigration arrangements for non EEA workers make it difficult to recruit the best possible staff to the NHS from the international market:

there is a risk that the current system itself and the whole administration of it is designed to disincentivise people coming to the country; the paperwork is long and complicated and there are numerous hurdles to jump through. We all share an interest in wanting skilled, talented people to come in and

65 Q 354

66 Q 344

contribute to research or teaching, or front-line care. We want to make it as easy as possible for those people to come in, where we need them to provide those vital functions for our country.⁶⁷

58. Speaking from the perspective of the Association of UK University Hospitals, which represents the interface between clinical care and research, Professor David Lomas said

Having a big pool within which to fish gives us more opportunity to get the very best people in for the UK, and there is no doubt about that. My sense, and as you have seen from the numbers, is that it is relatively straightforward for us to employ medical staff from the EU in the UK, and that is why the numbers have grown over time. It is almost impossible for us to employ medical staff from the US, Australia, New Zealand, India, China, Japan or wherever, who may also have the expertise that we need.

Can I also mention that, as well as medical staff, we are also interested in non-clinical staff because the non-clinical staff often drive that research and innovation that we need? Again, we need to fish around the world and get the very best people in. The current system works well in the EU, but it is almost impossible to get people from outside the EU into the country.⁶⁸

Conclusion

59. England will not be self-sufficient in its supply of doctors until the end of the next decade at the very earliest. Even if the English NHS becomes self-sufficient in terms of initial training, we will still rely on (and benefit from) the skills and experience of overseas trained doctors who wish to build their careers here. It is in the interests of patients that we are able to attract the brightest and best from the EU and beyond and that we make the process of recruitment from an international workforce as straightforward as possible.

60. The extent to which the NHS will, in the long term, rely on foreign trained nurses remains uncertain especially as the impact of other changes such as the switch to student loans from bursaries is as yet unknown, but there will be a need for immigration at all levels to meet increased demand for staff, a point recognised by the Secretary of State himself:

Nurses remain on the tier 2 shortage occupation list. We do not envisage that there will be any cliff edges in immigration policy going forward, so we need to recognise that any possibility of reducing the need for people trained overseas to come and work in the NHS and social care systems will be a gradual process, not an instant one.

61. The requirement for the UK to maintain an immigration system which facilitates swift entry to the UK for the health and social care workforce is likely to continue for many years, despite the Government's increased investment in medical training and the expansion of nurse training posts. This is a particularly acute concern in adult social care where some parts of the country are highly dependent on EU migrants.

67 Q 223

68 Q 225

62. We are concerned that research and innovation in the NHS could be compromised by further restrictions to freedom of movement arising from Brexit. The Secretary of State told us that the Government wants “an immigration policy that continues to attract the brightest and best from all over the world” but the commentary provided by NHS Employers and the AUKUH showed that employers of high quality staff do not feel that the existing system for non EEA staff currently provides this. Patients benefit the most if the UK has access to the very best from any part of the international market. If the current system applies post Brexit, that will not happen.

Public interest weighting

63. The mechanisms for allocating visas to non-EU workers are complex and different requirements apply across different sectors of the economy. We heard in evidence, however, that the existing rules which focus on salary requirements make it extremely difficult for some health and social care providers to recruit the staff they require. Nursing is not subject to such stringent salary requirements because it has been placed on the shortage occupation list by the Migration Advisory Committee. According to Danny Mortimer, that has “made a material difference to health and social care in the last couple of years”.⁶⁹

64. Explaining the frustrations that adult social care providers experience when recruiting care workers who are not listed as a shortage occupation, Professor Martin Green called for reform of the system:

There needs to be a review of whether salary is a good proxy in terms of skill. If that is going to be used as the proxy, then the Government need to think carefully about how they resource the system, to enable people to get to that level, or how they run the system without the requisite number of staff.⁷⁰

65. Looking at how the immigration system could be improved Danny Mortimer said that salary requirements attached to tier 2 visa applications could be weighed alongside the social value of the post being filled. Discussing how the Migration Advisory Committee (MAC) has addressed these concerns he said the MAC had

looked at whether there should be a weighting for public service and public benefit in how they assess applications for tier 2 visas. Whatever system we have, we believe that, if there needs to be a focus on salary, there needs to be some appropriate weighting for the kind of public service that our organisations provide.⁷¹

Conclusion

66. Adult social care is a clear example of public service which is built around a low-pay workforce but has very high social value to the UK. The existing immigration system is characterised by bureaucratic and financial barriers to recruitment from outside the EU which do not currently exist for those from inside the EU. If such a system was extended to R-EU after Brexit it would create serious problems for the health and care sector.

69 Q 246

70 Q 241

71 Q 242

67. **The Government’s plan for our post-Brexit future should both ensure that health and social care providers can retain and recruit the brightest and best from all parts of the globe and that the value of the contribution of lower paid health and social care workers is recognised.**

68. **To inform this policy, we recommend that the Government undertake an audit to establish the extent of the NHS’s and adult social care’s dependence on both the EU and the wider international workforce in low paid non-clinical posts as well as in clinical roles.**

69. **The Government must acknowledge the need for the system for recruiting staff to the NHS, social care and research post Brexit to be streamlined to reduce both delays and cost. We call on the Government to set out how this will be managed in future.**

Revisions to professional regulation

Background

70. The written evidence submitted to our inquiry by the General Medical Council contained an overview of the impact the Mutual Recognition of Professional Qualifications Directive (MRPQ) has had on the regulation of medical professionals in the UK:

Under European law, doctors who are nationals of the EEA (and those who are entitled to count as such) and hold medical qualifications from another country in the EEA are entitled to have their qualifications recognised and to pursue the medical profession in the UK with the same rights as doctors who qualified in the UK. The advantage of the European framework is that those EEA applicants benefiting from automatic recognition can gain speedy entry onto the medical register. The significant disadvantage is that (unlike doctors who graduated outside of the EEA) the GMC cannot test their competence. Instead we must rely on the robustness of the medical education and regulation system in the doctor’s home country for that assurance.⁷²

71. The GMC’s evidence said that they “foresee three potential outcomes for medical regulation” as a consequence of Brexit:

- i) Maintain the status quo within the single market. If the UK were to remain within the single market we expect EEA qualified doctors would continue to have their qualifications recognised by the GMC under the framework of the recognition of professional qualifications Directive.
- ii) Maintain the status quo outside of the single market. If the UK left the single market, in the first instance it is likely that we would continue to abide with EU law. The recognition of professional qualifications Directive will be maintained as a framework for recognising the qualifications of EEA doctors if and until the Government repeals the relevant provisions within the Medical Act 1983.

- iii) Bring forward significant reform to the regulation of EEA doctors. If the UK left the single market the Government could enable significant changes to the way we regulate EEA qualified doctors via amendments to the Medical Act 1983.⁷³

Competency testing

72. The position of the GMC is that it believes that it should have the flexibility to assess the competence of foreign doctors. The GMC wishes to introduce a common assessment of competency for all medical graduates seeking a place on the medical register and this would include British doctors trained in the UK.⁷⁴ Therefore, it regards this aspect of Brexit as a potential opportunity:

We have always argued that the GMC should have the right to test the competence of European doctors, like we do for other doctors who qualified overseas, with rigorous assessments of their knowledge and clinical skills. We believe that the current European law which restricts us from doing so has created a weakness in the system.⁷⁵

73. Charlie Massey, the GMC’s Chief Executive, explained in oral evidence the elevated risk that some R-EU trained clinicians may carry with them when working in the UK:

There is quite considerable variability in the way in which doctors are trained in European countries. If you are an oncologist trained in the UK, you will have been trained in radiation therapy and drug treatments. In some European countries, it would be focused just around radiation therapy. If you are going into general practice, it is a core part of our general practice training in the UK to be trained in paediatrics, antenatal and postnatal, but that does not apply in some southern European states because of the way in which their systems are organised. It is that kind of area where we think a common assessment for entering the register would provide much more assurance to patients about the safety and doctors meeting the standards of good medical practice.⁷⁶

74. In its evidence, the Nursing and Midwifery Council said it also believes it necessary to be granted the freedom to test the competence of all foreign nurses and midwives, and called on the Government to prioritise this in negotiations.⁷⁷ Commenting on its position, Jackie Smith said that Brexit gives the UK “the opportunity to think about having a consistent approach that enables us to put people on a register to deliver care to UK standards.”⁷⁸

73 [BRE 89](#) para 18

74 Q 262

75 [BRE 89](#) para 17

76 Q 271

77 The Nursing and Midwifery Council ([BRE 12](#)) para 20.1

78 Q 260

75. Illustrating the type of limitations the MRPQ places on the NMC, the NMC’s written evidence described how automatic recognition of qualifications can operate in practice:

Under the conditions of automatic recognition enshrined in the Directive, we are required to recognise a nurse or midwife’s qualification even if they have been out of practice for a significant length of time. We believe that this poses a public protection risk.⁷⁹

Jackie Smith explained further:

if European applicants have been out of practice for 10, 12 or 15 years, we cannot put them through any sort of process before we allow them on to the register here.⁸⁰

76. The Department of Health’s evidence indicated that the Government would be willing to consider changes to the existing regulatory approach in order to enhance competency testing:

concerns have been raised about the constraints that the MRPQ places on the ability of UK healthcare regulatory bodies to carry out robust checks on both the clinical and language skills of EU health professionals seeking to practise in the UK. The decision to leave the EU will provide an opportunity to work with healthcare regulatory bodies, professional and patient groups to review these arrangements.⁸¹

77. In oral evidence the Secretary of State went further and said that he could “recognise the cogency of the argument made by the NMC and the GMC”.⁸² Describing how the UK could further strengthen professional regulation the Secretary of State highlighted improving the assessment of language skills:

under EU law we can test only people’s basic English, not their clinical English. Things like that do not seem logical and would be a natural priority for reform in a post-Brexit world.⁸³

Access to alert mechanisms

78. The Royal College of Nursing, however, said in its evidence that there is a degree of risk attached to any dilution of the principle of the MRPQ directive:

The Directive now includes language checks on EU nurses and a duty to inform other health regulators about suspended or banned professionals, both of which are important and positive developments for the UK. We are concerned that a potential disassociation from these jointly developed standards could lead to a loss of safeguards, loss of access to alert mechanisms, and other exchange between regulators and potentially much slower recognition mechanisms for both inward and outward mobility.⁸⁴

79 [BRE 12](#), para 12

80 Q 283

81 The Department of Health ([BRE 46](#)) para 42

82 Q 61

83 Q 17

84 Royal College of Nursing ([BRE 22](#)) para 2.1

79. The NMC’s written evidence acknowledged the concerns of the RCN, however, and said that in negotiations regarding Brexit the Government should ensure that “the UK (and NMC) is still able to access, and share fitness to practise data with, other EU countries.”⁸⁵ Charlie Massey reiterated the importance of the alert mechanisms:

One would hope that you would find it difficult for any member state to argue that there should not be some mechanism to continue with that sort of alert system going forward.⁸⁶

80. Maintaining access to the alert mechanisms was noted by the Secretary of State for Health as something that would be of benefit to all parties. Giving evidence Mr Hunt did not envisage that maintaining this arrangement would be particularly problematic:

it seems to me an obvious area where it is in everyone’s interests to continue to co-operate across national borders. All those things are subject to negotiation, but I do not imagine that that particular one will be controversial.⁸⁷

Conclusion

81. **We support the principle that all clinicians working in the UK should be asked to demonstrate relevant language, skills and knowledge competence. Nevertheless, the UK has an opportunity to negotiate a more pragmatic approach to the mutual recognition of professional qualifications directive within the British regulatory model.**

82. **Attention needs to be paid to the balance between patient safety as served by regulatory rules which may restrict access to the profession, and patient safety as served by having a workforce sufficient to meet the country’s needs. Regulation should not evolve into unnecessary bureaucratic barriers which inhibit the flow of skilled clinicians in to the NHS. Therefore, automatic recognition of some qualifications should not be excluded from possible future regulatory arrangements.**

83. **Future regulatory arrangements should be established by a process which involves consultation with all stakeholders and full Parliamentary scrutiny. The Government is considering new primary legislation to reform the professional regulation of health and social care and this should be the vehicle to reform the implementation of the MRPQ directive in UK law. It should not be amended using delegated legislation under provisions granted by the ‘Great Repeal Bill’.**

84. **The Government must take full account during the process of negotiations that it would not be in the interests of patients to lose access to the alert mechanisms which identify potentially dangerous practitioners and which exist as a central part of EU law on mutual recognition of qualifications.**

85 [BRE 12](#) para 20.2

86 Q 293

87 Q 63

European working time directive

Potential for reform

85. Reform of the application of the European working time directive (EWTD) in the UK has been identified as a potential opportunity arising from Brexit. Introducing its remarks on the EWTD, the King’s Fund’s written evidence noted that the directive is “one of the most contentious pieces of EU legislation affecting the NHS”.⁸⁸ Its submission described its operation and said it was

introduced to support the health and safety of workers by limiting the maximum amount of time that employees in any sector can work to 48 hours each week, as well as setting minimum requirements for rest periods and annual leave. The directive allows doctors to opt out of the 48-hour limit (the UK is one of the few countries to make use of the opt-out); some specialties have been concerned that the 48-hour limit affects training, and a Royal College of Surgeons (RCS) review of the directive called for more widespread use of the opt-out (Independent Working Time Regulations Taskforce 2014).⁸⁹

86. The Royal College of Physicians Edinburgh said in its evidence that the EWTD should not, in principle, inhibit the training of doctors but there may be benefits from not being constrained by it:

An independent review was chaired by Professor Sir John Temple on the impact of the EWTD on the quality of training. A 2010 report of this review, *Time for Training*, concluded that high quality training can be delivered in 48 hours but traditional models of training and service delivery waste training opportunities and will need to change. Although it is still possible for doctors and other NHS staff to work longer hours by signing an opt-out clause, it could be argued that UK withdrawal from the EU would allow greater flexibility in devising NHS work and training rotas.

87. Concern regarding the consequences of the directive were highlighted in the Nuffield Trust’s written evidence:

While agreeing that previous much longer working hours should not be reintroduced, several bodies representing doctors across the UK have expressed serious concerns about the Directive’s impact. The rigidity imposed on arrangements for on call working is a source of particular concern. The Association of Surgeons in Training is typical in arguing that the Directive limits the opportunity of trainees to take part in activities needed to develop their skills, and encourages dishonesty around how many hours are actually worked: 71% of trainees polled felt the regulation had a negative effect.⁹⁰

88 [BRE 90](#) para 3.2

89 *ibid*

90 Nuffield Trust ([BRE 81](#)) para 3.1

88. In oral evidence Professor David Lomas of UCL, speaking on behalf of the Association of UK University Hospitals, reflected the balance that needs to be struck if the application of the working time directive in the UK was to be significantly reformed:

The European working time directive has some real assets. It does not allow the three day weekends that I did as a junior doctor anymore; it does not allow starting at nine o'clock on a Friday morning and leaving at five or six o'clock on a Monday evening, as I did, and my predecessors did even worse than that for many years, but it has very much damaged the 'firm' structure because people will clock on and clock off. Rotas are generated so that we do not breach the European working time directive and there are penalties for hospitals that do.

From my preamble, you can guess that the answer is, yes, we could be far more creative. My generation would argue about the joy of going back to firms. Educationalists will tell me that is the wrong model to use, but I still stick with that and say that is the best training I have ever had and seen, but it may be a generational factor.⁹¹

Barriers to reform

89. The King's Fund's written evidence noted that if the UK were to remove itself from the limitations of the EWTD "this would have implications for NHS employment contracts and require significant changes to the Agenda for Change pay framework."⁹² Danny Mortimer, Chief Executive of NHS Employers, described the benefits of the directive and noted changes that would be required:

our junior doctors who are in training felt so strongly about the benefits of the European working time directive that they asked for it to be placed on the face of the contract that has been introduced in the NHS. Whether or not the European working time directive stands in English law after 2019, its requirements are incorporated into the new junior doctors' contract in England. It does not matter what happens to the working time directive; it is there now within the contract.⁹³

90. Professor Lomas agreed with Danny Mortimer's observations, but argued that the existing system of junior doctor training is flawed and that this may have been as a consequence of changes made after the implementation of the EWTD:

if you work on the wards with the junior doctors, they are not happy. They are not happy because they went through a very damaging strike, which was really unhelpful, but they are not happy because, when I teach them as medical students, they graduate as doctors and they say, "It is not like you told me it was going to be; it is not the experience." So, working as a junior doctor does not give the same job satisfaction that it has done in years gone by. There is something wrong.⁹⁴

91 Q 253

92 [BRE 90](#) para 3.3

93 Q 254

94 Q 255

Conclusion

91. Any changes to the arrangements necessitated by the working time directive would be controversial as we heard in evidence that junior doctors, in particular, had regarded this as a priority issue in the recent contract negotiations and the protections within the directive are now embedded in the contract.⁹⁵ It is also the case, however, that some junior doctors are frustrated with the impact the working time directive has on some aspects of training.

92. The medical profession should take the lead in examining the opportunities which would arise were the UK no longer bound by the requirements of the working time directive. The profession should advise how the junior doctors' contract could be adapted to improve training, team working and flexibility. The Government should then work with the profession to achieve the legislative and contractual changes which Brexit might enable.

4 Reciprocal healthcare

Uncertainty and distress

93. In its written evidence the Department of Health explained the principles under which the EU system of reciprocal healthcare operates:

Healthcare entitlements under EU law are tied to those of wider social security benefits - if a benefit (or pension) entitlement is exportable to another European Economic Area (EEA) country, healthcare entitlement automatically follows. These benefits are reciprocal and apply both to UK citizens in the EEA (plus Switzerland), and EEA (plus Switzerland) citizens in the UK. This includes European Health Insurance Cards (EHIC) which cover those temporarily in another EU country.

Entitlement to reciprocal healthcare under the EU rules depends on the concept of insurability—that is, which state is responsible, under the scope of the EU rules, for covering the cost of an individual’s healthcare. The central point of these arrangements is that the costs of healthcare are borne by the country in which the individual is ‘insured’, and where healthcare services are used in another European country, they are essentially provided on behalf of the individual’s home state—the treating country will bill the ‘home’ country.⁹⁶

94. The evidence we heard showed that there could be a significant impact on individuals as well as the NHS and social care if after Brexit people insured by the UK were to be obliged to return to the UK for care.

95. Speaking on behalf of a range of groups that represent British nationals in the EU, Christopher Chantrey, a British resident of France, said that it is “absolutely essential” that reciprocal arrangements are not dispensed with.⁹⁷ Mr Chantrey noted that many British pensioners in countries such as Spain and France have low incomes and would not be able to afford to replace their existing healthcare arrangements with private insurance.⁹⁸

96. Expanding on this theme, Christopher Chantrey explained in oral evidence why the Government’s position as expressed in the Brexit White Paper that “no deal is better than a bad deal” may not be acceptable for British retirees in R-EU:⁹⁹

If you have a pre-existing health problem, how will you get private insurance if the UK no longer pays for the cover you contributed to all your working life in the UK? The host country will not do it, because you have not contributed to that system. That is why the Europe-wide system of co-ordination exists in the way it does. [...]

The cliff edge has dramatically awful consequences. How can anybody say—I am afraid this was in the White Paper—that no deal would be better than a bad deal? It is the reverse. No deal would be far, far worse than a bad

96 [BRE 46](#) paras 15–16

97 Q 143

98 *Ibid*

99 [CM 9417](#), para 12.3

one; it is the worst possible deal. This will affect hundreds of thousands of UK citizens who have moved out there and are receiving their pensions and healthcare. They moved out in good faith on the implicit promise that these arrangements would continue. Suddenly, something happens that brings those arrangements to an end. It is absolutely terrible for many people.¹⁰⁰

Impact on vulnerable people

97. Professor Martin McKee provided us with a comparison of the reciprocal agreements the UK has with nations outside the EU/EEA. He described the extent of their limitations and highlighted why “healthcare is the principal concern of hundreds of thousands of UK pensioners living in other EU member states”¹⁰¹:

None of these is fully reciprocal, because they do not give the same entitlement. Australians in the United Kingdom have free access to general practitioners, but not vice versa. [...] All these things are possible, but compared with the unified single system of the EHIC, they introduce a greater burden.¹⁰²

98. Within the evidence submitted to our inquiry there was a wide range of examples of the risks facing vulnerable people if they cannot access free healthcare or suitable insurance post Brexit. Professor McKee described in oral evidence the problems and costs that would face British people making trips to R-EU in the absence of the European Health Insurance Card (EHIC):

If as a British tourist you want to travel to France you are covered, and vice versa. Therefore, our tourism industry will get a lot of people who come here. They will perhaps have pre-existing conditions, but they will not require healthcare. I put in a few co-morbidities, like diabetes and a history of mild depression, to see how much I would pay for health insurance for a one-week stay in France. It came out at between £800 and £2,500.¹⁰³

99. We received evidence from a retired British national, resident in Germany but insured by the UK, who lives with epilepsy and has done so for most of his adult life. Given the personal nature of the evidence we have chosen not to publish this submission, but the witness succinctly described the significant disruption to his life that will arise if reciprocal arrangements are not maintained. Without a comprehensive reciprocal healthcare arrangement, this witness said that his access to care would be compromised and his inability to pay for health insurance would call into question his legal residency in Germany.¹⁰⁴

100. Expat Citizens Rights in the EU (ECREU), an organisation of 6,000 members from 25 EU countries, argued in its written evidence that the loss of reciprocal health and social care arrangements would leave some retirees “destitute”.¹⁰⁵ In oral evidence Christopher

100 Q 157

101 Q 156

102 Q 146

103 Q 134

104 BRE 07 (Unpublished)

105 Expat Citizens Rights in the EU (ECREU) ([BRE 94](#)) para 13.2

Chantrey said that many British retirees have very low incomes and if forced to return to the UK would do so “in a state of poverty”.¹⁰⁶ Professor McKee agreed, highlighting the fact that many British residents of Spain live in properties which now have very little value:

Many will come back in a state of poverty because they bought properties in Andalusia and other places. The massive glut in the market already will be exacerbated by all the British people leaving, so that property will be essentially worthless. They will be throwing themselves on the mercy of the state when they come back.¹⁰⁷

101. The Papworth Trust, a disability charity and registered social landlord, submitted written evidence which argued that disabled people may be more severely affected by the loss of reciprocal healthcare rights than other groups. It said that a dilution of the existing arrangements could prevent some disabled people from travelling and / or working abroad:

Disabled UK citizens working or living in the EU are currently entitled to access social and health care in their host country and receive the same treatment as nationals of that country with disabilities. This has been an essential safety net for many, who have been given the confidence to live, work, study or travel abroad. Any loss of a UK citizen’s future access to healthcare in an EU/EEA Member State would constitute a major barrier to their travel to the EU to live, work or even take a holiday. [...]

Even if the UK follows the model of Switzerland and seeks to negotiate a form of European Health Insurance which allowed citizens to access state-provided healthcare in EU/EEA countries during a temporary stay, such a scheme would not benefit disabled UK nationals living in an EU/EEA Member State permanently.¹⁰⁸

102. Echoing Professor McKee’s commentary, Macmillan Cancer Support said in its written evidence that travel for people living with cancer could become prohibitively expensive if the reciprocal arrangements are not continued.¹⁰⁹ It is estimated that over 2 million people in England are living with and surviving cancer and Macmillan said that private health cover may not be a viable option for those wishing to travel.¹¹⁰

103. The British Association of Counselling and Psychotherapy highlighted in its written evidence that reciprocal healthcare extends beyond physical ailments and this is of particular relevance to the large number of British pensioners resident in other EU member states:

Of particular concern to BACP is the healthcare of the number of pensioners who have chosen to retire to the EU. The wellbeing of older people is often highly complex; for example, they can present with a co-morbid mental and physical condition. Dementia is also a serious condition mainly faced by older people. Research shows dementia affects one in every six people over

106 Q 143 (Mr Chantrey)

107 Q 143 (Professor McKee)

108 Papworth Trust ([BRE 09](#)) para 6.2–6.3

109 Macmillan Cancer Support ([BRE 61](#)) p 4

110 *Ibid*

80, and one in three over 95. Furthermore, one in three people over 65 will die with a form of dementia. It is imperative that the healthcare of these individuals is not compromised.¹¹¹

Negotiation and bilateral agreements

104. Looking at how the European Commission and member states will approach the negotiations, Christopher Chantrey argued that it would suit the remaining EU member states to maintain the existing arrangements:

The EU member states do not want to have to invent a new system just for Britain; they have a system that works to their satisfaction among 28 member states. There will be 27 member states in the future. Those 27 do not want to have to change the system they have; they find it works perfectly all right. If you are French and have an EHIC and go to Italy, that works.¹¹²

105. Evidence from the NHS Confederation indicated that it believes that the existing arrangements the UK enjoys as an EU member could be replaced by individual agreements. The Confederation's written evidence said that "If the UK were to leave the EU single market, these systems would in principle no longer apply in the future, unless bilateral agreements were negotiated."¹¹³

106. This consideration was also alluded to by Professor Martin McKee who explained that making use of bilateral agreements may not be a straightforward process for the UK to pursue:

Bilateral agreements could be reached, but there are many elements of health policy that are European competences, so you get into the difficulty of jurisdiction. Some of it could be done, and you might revert to pre-existing agreements. It is not clear whether you could revert to the pre-existing agreements.¹¹⁴

107. Under the EU regulations on the coordination of social security, member states can make bilateral arrangements for applying the Regulation in practice. Paul MacNaught described how the bilateral agreements in relation to reciprocal healthcare operate:

There are 27 of them, because the way the system works is that regulation 883 is the overarching framework, and then underneath that each member state reaches a bilateral arrangement with every other member state about the basis on which costs are going to be claimed or charged—for example, whether it is going to be average or fixed costs or actual costs.¹¹⁵

108. It was confirmed by Paul MacNaught, however, that the future of reciprocal healthcare arrangements will be determined by arrangements under a UK/EU deal. The negotiation will take place with the EU as the question of reciprocal healthcare arrangements will be

111 The British Association for Counselling and Psychotherapy ([BRE 21](#)) section 6

112 Q 137

113 NHS Confederation ([BRE 50](#)) para 3.8

114 Q 139

115 Q 337

addressed as a joint competency.¹¹⁶ A resolution of the European Parliament has forcefully stated that bilateral agreements could not be negotiated whilst the UK remains a member of the EU and negotiation must take place with the EU 27.

109. The Secretary of State maintained an optimistic tone in his approach to the negotiations with the EU:

It is perfectly possible to agree the continuation of reciprocal healthcare rights as they currently exist, but it is not possible to predict the outcome of the negotiations.¹¹⁷

110. The principle of the Secretary of State's position was not disputed in the evidence we heard, but the question of dispute resolution was highlighted as a potential stumbling block. Professor Martin McKee provided a view as to the implications for the United Kingdom if an agreement was reached whereby the existing reciprocal arrangements continued virtually unchanged:

The question that has to be asked is: if the UK is to continue to buy into or have arrangements under that system, how will it work? It will change over time as the EU position changes. Will it be, as in the case of Norway, essentially government by fax, as it is called, where they simply accept all EU legislation, including court judgments, and it is incorporated?

The second issue is dispute resolution. Who will resolve disputes? The Prime Minister has said she does not want the European Court of Justice to do it. If that is not the case, I cannot think who else will do it. I think she has also ruled out the EFTA Court. [...] it is very difficult to see how you could continue to keep the EHIC system until you have resolved the issue of the evolution of European Union policy in the future and the dispute resolution process. As the two simplest ways of doing that have been ruled out by the Prime Minister, I do not see how you can do it.¹¹⁸

Contingencies and residual rights

111. The future of reciprocal healthcare arrangements will be determined in the negotiation between the UK and the EU. The UK does have reciprocal agreements, such as those with the Republic of Ireland, which pre-date our EU membership. Professor McKee, however, suggested that they would be far from comprehensive if relied upon as a contingency:

Of course, we have a number of agreements that predate the European Union that we could fall back on, but each of those has different terms and conditions, different eligibilities, different limits and different numbers of people who can be covered.¹¹⁹

The status of these agreements and their applicability if no deal is agreed with the EU remains unclear.

116 Q 332

117 Q 117

118 Q 137

119 Q 136

112. Even if no deal is agreed, in some cases British insured people in other member states will retain entitlement to some aspects of healthcare via the domestic legislation of the countries in which they are resident.¹²⁰ Such rights, however, would be by no means universal and enforcement of entitlements is likely to be problematic.¹²¹

113. Because different residual rights apply in different EU member states, it is important that UK insured people are provided with timely and accurate information. Paul MacNaught told us that efforts have been made by the British Government through embassies and consulates to communicate information about healthcare rights to people insured by the UK living in the EU.¹²² Mr MacNaught added that more information will be provided as “soon as there is more to say”.¹²³ The position regarding residual rights in each EU member state is clear, if complex, now. Given the extent of the risk we believe more needs to be done to ensure that people understand how their rights might be affected so that they can begin to plan for different scenarios in the future and make their own contingency arrangements.

114. The impact Brexit will have on people who rely on the EU’s reciprocal healthcare arrangements should not be underestimated. Not only would travellers and holiday makers potentially lose cheap and easily accessible care provided under the European Health Insurance Card, we heard in evidence that retired British citizens in the EU, disabled people, and people with multiple conditions could face particular challenges.

Costs of reciprocal healthcare

Payments and receipts

115. As a consequence of our call for evidence we received and heard evidence which suggested that Brexit could help the NHS in England redress the balance in terms of costs of reciprocal healthcare arrangements.¹²⁴ There is a significant disparity in the sums paid by the Department of Health to other EU nations for UK insured persons and the revenue recouped from the rest of the EU. In 2015 member state claims against the UK amounted to £674 million whilst UK claims against member states were £49.7 million.¹²⁵

116. Paul MacNaught explained that the disparity is largely a consequence of “the volume of UK insured pensioners living in other EEA countries compared with the volume of EEA insured pensioners living here.”¹²⁶ Mr MacNaught provided a breakdown of the costs against the number of UK insured pensioners resident in other EU countries:

The actual amounts we pay in any given year are greatly affected by the exchange rate, but, if we are talking in general terms, we spend about £650 million a year on the reciprocal healthcare arrangements. Of that, about £500 million is on pensioners, so that is UK insured pensioners, of which there are about 190,000 in other EEA countries. I think the figures there

120 Cayon-De Las Cuevas, J. and Hervey, T.K. (2017) 12 (3) [A Place in the Sun](#). Health Economics, Policy and Law. ISSN 1744–134X (In Press)

121 Ibid

122 Q 341

123 Ibid

124 Joseph Meirion Thomas ([BRE 95](#))

125 HC Deb, 19 February 2016, [27365](#), [Commons Written Answer]

126 Q 302

are 70,000 in Spain, 44,000 in Ireland, 43,000 in France and about 12,000 in Cyprus. Those are the main countries. The other £140 million is spent on the people who hold EHIC cards, of which there are 27 million holders of UK issued cards. Then there is about £6 million on the dependants living elsewhere in the EEA of workers who are working in this country.¹²⁷

117. Whilst the cost of treating EU nationals was a matter of contention we received no evidence that EU reciprocal arrangements were being systematically abused. We note, however, that the challenge of accurately recouping costs of care is more considerable for patients from outside the EU than for those within. In February 2017 the Government announced new measures to recoup the costs of care to the NHS from overseas visitors which included an ambition to retrieve an additional £500 million.¹²⁸

118. The Committee of Public Accounts (PAC), however, has put the Government's target of £500m in the context of the national acute trust deficit of £2.45bn in 2015–16. In addition the PAC heard in evidence that £500m is not a fixed target:

The Department explained that the £500 million target should not be regarded as overly scientific, and was a top-down calculation based on assumptions about the number of visitors and the amounts charged. [...] The Department emphasised, however, the underlying principle that the NHS should charge the right amount, which might be higher or lower than £500 million a year. It viewed £500 million as a stretch target to create a culture within the NHS where people did charge the right amount.¹²⁹

119. Speaking about the treatment of EU nationals, the Secretary of State said in oral evidence in January 2017 that there are no plans to implement new charging systems for EU nationals post Brexit.¹³⁰ This position implies that even if it became desirable to charge EU nationals as part of future arrangements it may be by no means be practical. Professor McKee explained that the NHS is not set up to charge patients in large numbers:

In many parts of the country, there will be a very small number of patients who will have to pay. You will have to put in a system. It is not as if a hospital has one front door; it will be for every outpatient clinic and every ward. Remember that the NHS is cheap because we do not have linked systems. Most other health systems that spend a lot more do so, at least in part, because of the transaction charge costs.¹³¹

120. In addition Professor McKee argued that as it stands charging overseas patients from outside the EU may not be a profitable exercise. His research team had just completed

a study, which is under review at the minute, where we submitted freedom of information requests to every acute trust in England to ask them how much they spent collecting money from overseas patients and how much they recovered. Most of them were spending more money than they were

127 Q 309

128 [Recovering the cost of NHS treatments given to overseas visitors](#), Department of Health press release, 6 February 2017

129 House of Commons Committee of Public Accounts, Thirty-seventh Report of Session 2016–17, [NHS treatment for overseas patients](#), HC 771, para 6

130 Q 96

131 Q 182

recovering. They had a very low level of recovery, but as time went by they found they were often trying to recover from people who were entitled anyway.¹³²

121. Paul MacNaught made the case in evidence that a successful outcome to the negotiations from the perspective of the Government would be a continuation of the existing arrangements post Brexit:

a key objective in the negotiations ahead is to guarantee the rights of existing residents. With a fair wind, we might not need to do a wholesale reorganisation of these arrangements. The way the arrangements are organised at the moment, there is regulation 883, which is quite a complicated set of entitlements, and the administration of that in this country involves a team of about 120 people employed mainly through DWP and the NHS Business Services Authority, which gives you a sense of the scale of the activity.¹³³

122. It is perhaps unsurprising that the Government would like to maintain the existing arrangements given the financial benefit it delivers to the UK. The evidence indicates that the cost of paying for the treatment of British pensioners in the EU is substantially cheaper than if they were being treated in the UK. Professor McKee explained that “measuring the comparability of costings across Europe is extremely complicated” because “people who move abroad tend to be healthier when they move. They also tend to be somewhat more affluent, because they buy somewhere abroad.”¹³⁴

123. Speaking on behalf of British expatriates, Christopher Chantrey observed that there are some ways in which the NHS may benefit from large numbers of British nationals receiving healthcare abroad:

In France, the basic reimbursement level is, let’s say, 70% for a GP, so 30% is borne by the patient, and that is the co-payment. The 70% is all that the NHS would be charged.

A further point is that the capital costs of creating facilities—the resources used for medical procedures, hospitals and so on—are borne by the host country; [...] It means that in those countries the NHS is paying for certain treatments for S1 and EHIC beneficiaries on a variable cost basis only.¹³⁵

124. Paul MacNaught’s evidence confirmed that overall the average cost of treatment for a UK insured pensioners in the R-EU is significantly less than the cost of treatment in the NHS:

The average cost that Spain charges the UK per pensioner signed up to these arrangements is about €3,500 currently. Ireland charges about €7,500. Our cost in the UK is about £4,500, so let’s say €5,000. Overall, the average cost,

132 Q 149

133 Q 300

134 Q 162

135 Q 162

if you take the £500 million for pensioners and 190,000 pensioners, works out at about £2,300 per pensioner under those arrangements, which is significantly lower than the average cost of treating pensioners in the UK.¹³⁶

Conclusion

125. Far from being a drain on the public purse, the provision of care to UK insured persons in the 27 other member states represents excellent value to the British taxpayer. Moreover citizens across the EU can readily access vitally important, high quality healthcare without encountering financial or bureaucratic barriers. Just as this allows someone from the EU to work in the UK, it enables a British pensioner to retire to France, Spain or Italy.

126. It is in the interest of many hundreds of thousands of British people living across the EU to maintain simple and comprehensive reciprocal healthcare arrangements. The Government's negotiating objective should be preservation of the existing system of reciprocal healthcare so that EU nationals in the UK and people insured by the UK in other EU countries can maintain their access to healthcare.

5 Outstanding issues for our successor committee

Medicines, devices and substances of human origin

127. Judging by the comments of the Secretary of State for Health in oral evidence, it appears that the UK will require a new regulatory procedure for health-related products, and substances of human origin. Mr Hunt said that the UK will leave the European licensing system for medicines:

I do not expect us to remain within the European Medicines Agency, but I am very hopeful that we will continue to work very closely with the EMA.¹³⁷

128. The Government’s position on this issue, however, appears somewhat uncertain. Following the Secretary of State for Health’s remarks other Government Ministers have suggested that this approach is not set in stone. David Davis MP, Secretary of State for Exiting the EU, told the House of Commons that Mr Hunt did not say that the UK will leave the EMA and that he has been misquoted and misinterpreted.¹³⁸ We, however, did not perceive any equivocation in the Secretary of State for Health’s remarks, which left little room for misinterpretation.

129. In addition, the question of adjudicating disputes is fundamental to the UK’s future relationship with the EMA. The Secretary of State for Health has told us that Britain would not be subject to ECJ rulings and explained this this is a “matter of sovereignty”.¹³⁹

130. We are concerned by any policy changes that could deny patients in the UK swift access to the newest drugs and treatments. The King’s Fund’s written evidence highlighted the potential complications that will arise should the UK remove itself from the auspices of the EMA:

The UK has its own national regulatory agency, the Medicines and Healthcare products Regulatory Agency (MHRA). However, this deals with national authorisations intended for marketing only in the UK. The inclusion of EEA and EFTA countries for centralised marketing authorisation may mean that, despite leaving the EU, the UK could continue its relationship with the EMA. If this is not the case, however, pharmaceutical companies may need to apply to the MHRA for authorisation for any medicines they wish to supply to the UK. Concerns raised in a recent report from the UK life sciences sector included that no longer being in the EU regulatory system could result in the UK becoming ‘a second priority’ launch market, that ‘there is no appetite to add regulatory bureaucracy by losing European scale and consistency’, and recommending that alignment with the EU regulatory system be maintained (UK EU Life Sciences Transition Programme Steering Group 2016).¹⁴⁰

137 Q 67

138 HC Deb, 26 January 2017, [Col 439](#) [Commons Chamber]

139 Q 82

140 [BRE 90](#) para 3.7

131. NHS Providers’ evidence echoed the views expressed by the King’s Fund and said that there is a risk that Brexit may limit access to new medicines for British patients as they will not be introduced in the UK as quickly as is currently the case.¹⁴¹ The Academy of Medical Royal Colleges said in its evidence that the UK is “heavily reliant” on the European Medicines Agency (EMA).¹⁴² Its submission described the wider consequences if the UK were no longer to be part of the EU approval system:

If not part of the EMA we would be unable to participate in the European wide approval system for new medicines and the revisions to already approved products, to participate in the Orphan Drug Designation and the Small to Medium Sized Enterprise schemes that the EMA operate or to participate in the specific centralised approval process for paediatric drugs and the process that supports new medicines development for children. We would also lose access to the EU wide Pharmacovigilance networks and the EU Clinical Trials Database.¹⁴³

Conclusion

132. At this stage of negotiation it is premature for the UK to rule out continued membership of the EMA. Prior to the announcement of the general election our intention had been to investigate how the Government will meet its objective to “ensure that patient access to medicines will not be adversely impacted” by Brexit.¹⁴⁴ We note, however, that whatever the relationship we finally agree with the EMA, medical devices and substances of human origin are regulated by separate EU laws, which will also need to be replaced post Brexit.

133. In the next stage of our inquiry we had planned to explore the choices that will have to be made to ensure safe access to drugs, products, devices and substances of human origin. We had also intended to investigate any opportunities that may arise to plug regulatory gaps and adapt regulation to new technologies and personalised medicine. Given the subject matter, this topic needs Parliamentary oversight and we hope that our successor committee will prioritise this work in the new Parliament.

Public health

134. In its written evidence the Royal College of Physicians (RCP) outlined the public health issues that it believes will be a priority for the Government during Brexit negotiations. The RCP noted a range of areas where EU standards are central to health protection:

the EU has developed wide-ranging frameworks for controlling environmental pollutants, including water and air quality, as well as risks from chemical products, health and safety in the workplace and the safety of consumer products. No less important are the frameworks for control and marketing of pharmaceuticals (based on the European Medicines Agency, currently based in London), and medical devices. In all these areas

141 NHS Providers ([BRE 47](#)) para 5.4

142 Academy of Medical Royal Colleges ([BRE 17](#)) para 14

143 Ibid para 15

144 HC Deb, 28 February 2017, [65307](#), [Commons Written Answer]

EU systems and standards underpin health protection in the UK, and it is crucial that either the UK maintains its involvement in them, or that they are replaced by equivalent or stronger national ones.¹⁴⁵

135. NHS Providers' evidence said that the

benefits of maintaining the UK's participation in the European Centre for Disease Control should be a central consideration in respect of the health implications of Brexit.¹⁴⁶

This point was noted by the Department of Health in its written evidence which said that "The competence for responding to cross-border threats lies with Member States" but "coordinating through these systems enables us to be aware of emerging problems and thus respond rapidly to threats, for example Ebola."¹⁴⁷

136. The position taken by NHS Providers was echoed by both the Academy of Medical Royal Colleges and the RCP.¹⁴⁸ The RCP said in its evidence that this should be a priority in negotiation and warned of the risk of ending participation in the EU wide systems:

There is a need to provide effective surveillance of health threats, including communicable disease outbreaks and natural disasters. The EU has established several important alert, coordination and response mechanisms, many of which are operated via the European Centre for Disease Prevention and Control. The UK in isolation cannot effectively tackle what are inherently transnational threats and therefore needs to have continued access to these European structures and networks.¹⁴⁹

137. Maintaining pan-European cooperation on public health issues was viewed by the Secretary of State as an existing mechanism that would not be jeopardised by Brexit.¹⁵⁰ The Secretary of State outlined the rationale for his optimism but did not describe how the system would operate with the UK outside the EU:

Obviously, we want to continue all aspects of co-operation with our partners and friends in the EU post-Brexit in order to reduce public health risks. It is incredibly unlikely that they will not want to do that, because it is as much in their interests as it is in ours.¹⁵¹

Food, alcohol and tobacco

138. A range of opportunities arising from Brexit to enhance public health regulation were highlighted by witnesses to this inquiry. The Faculty for Public Health said in its written evidence that

Aspects of labelling, marketing, taxes and pricing are maintained at EU level. EU directives dictate that stronger ciders and wines be taxed based on

145 Royal College of Physicians ([BRE 25](#)) para 15

146 [BRE 47](#) para 5.6

147 [BRE 46](#) para 27

148 [BRE 17](#) para 17

149 [BRE 25](#) para 17

150 Q 97

151 Q 97

volume and not alcohol content. Government will have the opportunity to raise taxes on products e.g. high strength ciders and wine, often the drink of choice for heavy drinkers. Government should ensure its ability to tax wine and cider is proportionate to strength.¹⁵²

139. It was also observed by the Association of Directors of Public Health (ADPH) in its evidence that UK tobacco regulation has exceeded EU minimum requirements. It too called for further action to tackle alcohol misuse and advocate using Brexit as an opportunity to introduce Minimum Unit Pricing.¹⁵³

140. Similarly, the Faculty for Public Health believes that Brexit presents an opportunity to enhance front of pack of traffic light labelling for food:

The EU Nutrition and Health Claims Regulations provide consumers [with a] high degree of protection against misleading nutrient and health claims. This should be directly transposed into domestic legislation and not weakened. The Food Information Regulations dictate what information can and cannot appear on food packaging.

Brexit is an opportunity to strengthen these regulations by mandating the national front-of-pack colour-coded labelling scheme to ensure inclusion on all food products on sale; revising the traffic light bands (thresholds) for sugars downwards to be in line with new 2015 SACN population targets for sugar consumption.¹⁵⁴

141. The British Dental Association highlighted the potential to go further on these issues than has previously been possible because of resistance from other EU member states:

There is a positive opportunity in that traffic light labelling—a voluntary UK scheme challenged by some other EU countries—could be expanded in the future.

There are opportunities relating to alcohol duty, with potential for full reform of the duty structure in the long term. The exemption of alcohol from nutrition labelling requirements can also be reassessed in future.¹⁵⁵

Further topics for investigation

142. Our intention—prior to the announcement of the general election—had been for our Brexit inquiry to examine how cooperation will be maintained across a broad range of areas. Questions remain over the UK's continued participation in health-related EU research programmes such as those investigating rare diseases that rely on large sample populations.¹⁵⁶ The financial support for cross border work such as that provided by the European Investment Bank, Horizon 2020 funding, EU public health programmes, the European Social Fund and the Regional Development Fund is also in question. We believe that these are all areas that will require scrutiny by our successor committee.

152 Faculty of Public Health, Royal Society for Public Health, Association of Directors of Public Health and the UK Health Forum [BRE 86](#) paras 9 -10

153 The Association of Directors of Public Health ([BRE 43](#)) para 2

154 [BRE 86](#) paras 12 - 13

155 British Dental Association ([BRE 67](#)) paras 27 - 28

156 [BRE 25](#) para 8

143. Market functioning and trade agreements can also have a fundamental impact on the delivery of health services. Both the Nuffield Trust and NHS Providers highlighted concerns about the operation of the EU public procurement directives which can require open competitive tendering within the NHS.¹⁵⁷ Similarly, there is a potential to explore the implications of future bilateral trade agreements with countries such as the US which could have implications across health and social care.¹⁵⁸

157 [BRE 81](#) para 3.1, [BRE 47](#) paras 2.7–2.8

158 Q6, Q104

Conclusions and recommendations

Issues arising from Brexit

1. Giving evidence on the impact of Brexit, Jeremy Hunt MP, the Secretary of State for Health, told us that the Government would not be publishing its own digest of the implications of Brexit because “the publication of what might be called the worst-case scenario could itself have an impact on negotiations.” We do, however, urge the Department of Health to produce a comprehensive list of those issues that will require contingency planning. (Paragraph 6)

Influence of health within the negotiations

2. We recommend that whenever health issues are being discussed, in particular the areas which we have identified, ministers or officials from the Department of Health should form part of the UK representation in negotiations with the EU. (Paragraph 10)

Departmental resources

3. We consider it essential that the negotiating team for the health related aspects of Brexit has the expertise, competence and appropriate support for this complex task. We recommend that the Department of Health identifies the dedicated senior officials handling negotiations for each of the areas we have highlighted, in addition to clarifying the expertise and make-up of the overall coordinating team for health. (Paragraph 16)

Contingency planning

4. We recognise that the Government does not wish to set out the terms of its negotiating stance. It would nevertheless be helpful if the Department of Health could provide a list of issues under consideration to enable stakeholders and civil society to provide relevant input for the negotiations and to identify any important gaps. (Paragraph 27)

Future rights & entitlements

5. R-EU nationals in the UK enjoy a full set of easily enforceable rights and entitlements that put them on a par with British citizens. This should be acknowledged by the Government when undertaking any assessment of the incentives required to attract workers into health, social care, and supporting roles, especially low-paid jobs such as in adult social care. We wish to make clear the value that we as a Committee place on the health and social care workforce from R-EU nations. (Paragraph 51)

Future staffing requirements

6. The Government's plan for our post-Brexit future should both ensure that health and social care providers can retain and recruit the brightest and best from all parts of the globe and that the value of the contribution of lower paid health and social care workers is recognised. (Paragraph 67)
7. To inform this policy, we recommend that the Government undertake an audit to establish the extent of the NHS's and adult social care's dependence on both the EU and the wider international workforce in low paid non-clinical posts as well as in clinical roles. (Paragraph 68)
8. The Government must acknowledge the need for the system for recruiting staff to the NHS, social care and research post Brexit to be streamlined to reduce both delays and cost. We call on the Government to set out how this will be managed in future. (Paragraph 69)

Revisions to professional regulation

9. We support the principle that all clinicians working in the UK should be asked to demonstrate relevant language, skills and knowledge competence. Nevertheless, the UK has an opportunity to negotiate a more pragmatic approach to the mutual recognition of professional qualifications directive within the British regulatory model. (Paragraph 81)
10. Attention needs to be paid to the balance between patient safety as served by regulatory rules which may restrict access to the profession, and patient safety as served by having a workforce sufficient to meet the country's needs. Regulation should not evolve into unnecessary bureaucratic barriers which inhibit the flow of skilled clinicians in to the NHS. Therefore, automatic recognition of some qualifications should not be excluded from possible future regulatory arrangements. (Paragraph 82)
11. Future regulatory arrangements should be established by a process which involves consultation with all stakeholders and full Parliamentary scrutiny. The Government is considering new primary legislation to reform the professional regulation of health and social care and this should be the vehicle to reform the implementation of the MRPQ directive in UK law. It should not be amended using delegated legislation under provisions granted by the 'Great Repeal Bill'. (Paragraph 83)
12. The Government must take full account during the process of negotiations that it would not be in the interests of patients to lose access to the alert mechanisms which identify potentially dangerous practitioners and which exist as a central part of EU law on mutual recognition of qualifications. (Paragraph 84)

European working time directive

13. The medical profession should take the lead in examining the opportunities which would arise were the UK no longer bound by the requirements of the working time directive. The profession should advise how the junior doctors' contract could be

adapted to improve training, team working and flexibility. The Government should then work with the profession to achieve the legislative and contractual changes which Brexit might enable. (Paragraph 92)

Reciprocal healthcare

14. It is in the interest of many hundreds of thousands of British people living across the EU to maintain simple and comprehensive reciprocal healthcare arrangements. The Government's negotiating objective should be preservation of the existing system of reciprocal healthcare so that EU nationals in the UK and people insured by the UK in other EU countries can maintain their access to healthcare. (Paragraph 126)

Next stages of our work

15. In the next stage of our inquiry we had planned to explore the choices that will have to be made to ensure safe access to drugs, products, devices and substances of human origin. We had also intended to investigate any opportunities that may arise to plug regulatory gaps and adapt regulation to new technologies and personalised medicine. Given the subject matter, this topic needs Parliamentary oversight and we hope that our successor committee will prioritise this work in the new Parliament. (Paragraph 133)

Formal Minutes

Tuesday 25 April 2017

Members present:

Dr Sarah Wollaston, in the Chair

Dr James Davies	Helen Whately
Andrew Selous	Dr Philippa Whitford
Maggie Throup	

Draft Report (*Brexit and health and social care—People & Process*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 143 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 26 April at 9.00am.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 24 January 2017

Question number

Rt Hon Mr Jeremy Hunt MP, Secretary of State for Health, and **Paul MacNaught**, Director of EU, International and Prevention Programmes, Department of Health

[Q1–129](#)

Tuesday 21 February 2017

Professor Martin McKee CBE, Professor of European Public Health, London School of Hygiene and Tropical Medicine, **Professor Jean V McHale**, Professor of Health Care Law and Director of the Centre for Health Law, Science and Policy, University of Birmingham, **Meirion Thomas**, former Consultant and Lead Surgeon at Royal Marsden Hospital, and **Christopher Chantrey OBE**, British national resident in France

[Q130–211](#)

Professor David Lomas, Vice-Provost Health, UCL and spokesman for the Association of UK University Hospitals, **Daniel Mortimer**, Chief Executive, NHS Employers and Chair of the Cavendish Coalition, and **Professor Martin Green**, Chief Executive, Care England

[Q212–258](#)

Tuesday 28 February 2017

Charlie Massey, Chief Executive and Registrar, GMC, and **Jackie Smith**, Chief Executive and Registrar, NMC

[Q259–298](#)

Professor Ian Cumming OBE, Chief Executive, Health Education England, **Gavin Larner**, Director of Workforce, Department of Health, and **Paul MacNaught**, Director of EU, International and Prevention Programmes, Department of Health

[Q299–374](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

BRE numbers are generated by the evidence processing system and so may not be complete.

- 1 ABHI ([BRE0077](#))
- 2 Academy of Medical Royal Colleges ([BRE0017](#))
- 3 Academy of Medical Sciences ([BRE0051](#))
- 4 Action on Smoking and Health ([BRE0028](#))
- 5 Addison's Disease Self-Help Group ([BRE0084](#))
- 6 AIHO ([BRE0019](#))
- 7 Alzheimer's Research UK ([BRE0072](#))
- 8 Alzheimer's Society ([BRE0042](#))
- 9 Association for Clinical Biochemistry and Laboratory Medicine ([BRE0018](#))
- 10 Association of Directors of Public Health ([BRE0043](#))
- 11 Association of Medical Research Charities ([BRE0054](#))
- 12 Association of UK University Hospitals ([BRE0063](#))
- 13 BIVDA ([BRE0024](#))
- 14 British Dental Association ([BRE0067](#))
- 15 British Dental Industry Association ([BRE0014](#))
- 16 British Heart Foundation ([BRE0055](#))
- 17 British Medical Association ([BRE0026](#))
- 18 Bupa UK ([BRE0052](#))
- 19 Cancer Research UK ([BRE0074](#))
- 20 Care England ([BRE0062](#))
- 21 Cavendish Coalition ([BRE0088](#))
- 22 Christopher Chantrey ([BRE0100](#))
- 23 Department of Health ([BRE0046](#))
- 24 Department of Health-Director of Workforce ([BRE0097](#))
- 25 Dorothy Bowling ([BRE0093](#))
- 26 Dr Richard Lang ([BRE0080](#))
- 27 ECREU ([BRE0094](#))
- 28 EU Rights Clinic ([BRE0101](#))
- 29 European Commission Representation in the United Kingdom ([BRE0099](#))
- 30 FPH ([BRE0086](#))
- 31 General Medical Council ([BRE0089](#))
- 32 General Medical Council ([BRE0102](#))
- 33 Grant Thornton UK LLP ([BRE0053](#))

- 34 HCA Healthcare UK ([BRE0041](#))
- 35 Health and Care Professions Council ([BRE0034](#))
- 36 Health Research Authority ([BRE0079](#))
- 37 Healthcare Distribution Association (HDA UK) ([BRE0092](#))
- 38 Healthier Futures ([BRE0068](#))
- 39 Hertfordshire County Council ([BRE0039](#))
- 40 Independent Age ([BRE0060](#))
- 41 Institute of Physics and Engineering in Medicine ([BRE0015](#))
- 42 Institution of Mechanical Engineers ([BRE0104](#))
- 43 International Longevity Centre - UK ([BRE0066](#))
- 44 Jean McHale ([BRE0098](#))
- 45 Joseph Meirion Thomas ([BRE0095](#))
- 46 Kevin Kelleher ([BRE0002](#))
- 47 Leicestershire County Council ([BRE0035](#))
- 48 Local Government Association ([BRE0058](#))
- 49 Lord Nigel Crisp ([BRE0076](#))
- 50 Macmillan Cancer Support ([BRE0061](#))
- 51 Marie Curie ([BRE0045](#))
- 52 Medicines and Healthcare products Regulatory Agency ([BRE0087](#))
- 53 Mental Health Foundation ([BRE0032](#))
- 54 MHA ([BRE0036](#))
- 55 Moorfields Eye Hospital NHS Foundation Trust ([BRE0013](#))
- 56 Mr Joseph Meirion Thomas ([BRE0003](#))
- 57 Mr Richard Birmingham ([BRE0005](#))
- 58 Mr Stephen Rogers ([BRE0001](#))
- 59 Mrs Nimisha Kotecha ([BRE0006](#))
- 60 Muscular Dystrophy UK ([BRE0031](#))
- 61 Myaware ([BRE0091](#))
- 62 NHS Confederation ([BRE0050](#))
- 63 NHS England ([BRE0023](#))
- 64 NHS Partners Network ([BRE0016](#))
- 65 NHS Providers ([BRE0047](#))
- 66 Nuffield Trust ([BRE0081](#))
- 67 Papworth Trust ([BRE0009](#))
- 68 Professor Jean McHale ([BRE0048](#))
- 69 Public Health England ([BRE0075](#))
- 70 Recruitment & Employment Confederation ([BRE0029](#))
- 71 Richard Eaton ([BRE0004](#))

- 72 Roche Products Limited ([BRE0020](#))
- 73 Royal College of Anaesthetists ([BRE0027](#))
- 74 Royal College of General Practitioners ([BRE0085](#))
- 75 Royal College of Midwives ([BRE0040](#))
- 76 Royal College of Nursing ([BRE0022](#))
- 77 Royal College of Paediatrics and Child Health ([BRE0065](#))
- 78 Royal College of Physicians ([BRE0025](#))
- 79 Royal College of Physicians of Edinburgh ([BRE0044](#))
- 80 Royal College of Psychiatrists ([BRE0059](#))
- 81 Royal College of Surgeons of England ([BRE0056](#))
- 82 Secretary of State for Health ([BRE0096](#))
- 83 Shelford Group ([BRE0049](#))
- 84 The Association of the British Pharmaceutical Industry ([BRE0008](#))
- 85 The British Association for Counselling and Psychotherapy ([BRE0021](#))
- 86 The British Society for Rheumatology ([BRE0033](#))
- 87 The College of Podiatry ([BRE0064](#))
- 88 The Ethical Medicines Industry Group ([BRE0011](#))
- 89 The Health and Europe Centre ([BRE0037](#))
- 90 The Health Foundation ([BRE0071](#))
- 91 The King's Fund ([BRE0090](#))
- 92 The Nursing and Midwifery Council ([BRE0012](#))
- 93 The Nursing and Midwifery Council ([BRE 0103](#))
- 94 The Queen's Nursing Institute ([BRE0073](#))
- 95 The Royal College of Radiologists ([BRE0070](#))
- 96 UNISON ([BRE0030](#))
- 97 Unite the Union ([BRE0069](#))
- 98 United Kingdom Homecare Association ([BRE0057](#))
- 99 VODG (Voluntary Organisations Disability Group) ([BRE0083](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Child obesity-brave and bold action	HC 465 (Cm 9330)
Second Report	Appointment of the Chair of the Care Quality Commission	HC 195
Third Report	Appointment of the Chair of the Food Standards Agency	HC 663
Fourth Report	Primary care	HC 408

Session 2016–17

First Report	Impact of the Spending Review on health and social care	HC 139 (Cm 9385)
Second Report	Public health post-2013	HC 140 (Cm 9378)
Third Report	Winter pressure in accident and emergency departments	HC 277
Fourth Report	Suicide prevention: interim report	HC 300
Fifth Report/ First Joint Report	Appointment of the Parliamentary and Health Service Ombudsman	HC 810
Sixth Report	Suicide prevention	HC 1087
Seventh Report	Childhood obesity: follow-up	HC 928