EUROPEAN MOVEMENT IN SCOTLAND: HOLYROOD 2021 ELECTIONS

HEALTH

Manifesto commitments recommended by EMiS

- Press UK government for an immigration system that responds to demand and is free from the visa issues that non-EEA NHS staff have encountered
- Maintain system of mutual recognition of qualifications
- Work closely with EMA, and flag concerns if MHRA ability to replicate EMA is compromised given specialist nature of work and lack of specialised staff
- Monitor issues in medication and radioisotope supply, ensuring Scotland has adequate alternative supply routes if necessary; and ensure no patient in Scotland loses out due to delays in new or orphan medications reaching the UK
- Minimise duplication of effort and delays having separate clinical trial registers, and seek to rejoin the European Reference Networks for rare diseases
- Pursue full re-instatement of reciprocal health care arrangements for those moving between UK and EEA countries
- Work closely with the ECDC, particularly around the Early Warning Response System, learning lesson from the Covid-19 pandemic
- Lobby UK Government to ensure NHS is not undermined in its ability to provide comprehensive publicly-funded health service free at the point of delivery, by deregulation or through the awarding of contracts to US private healthcare companies.

Background

Research indicates that any form of Brexit is bad for the NHS, primarily due to the impact on the economy and consequent reduction in available public funds. It comes at a time of unprecedented pressure on the NHS from the pandemic. Specific areas of concern include the following:

Workforce issues: The loss of Freedom of Movement and limited mutual recognition of professional qualifications which existed when the UK was an EU member are set to compound staffing issues, at a time when health and social care already face a staffing shortfall and depend on an international workforce (with a high proportion of current staff hailing from EEA countries). Though data on the nationality of NHS staff may not be entirely accurate, numbers of nurses arriving from the EEA have decreased rapidly since the 2016 referendum. All workers arriving from EEA and non-EEA countries are now subject to the new points-based immigration system. These new arrangements are widely predicted to make recruitment harder, compounding the pressures on these workforces.

While the mutual recognition of professional qualifications no longer applies, the UK government has decided to extend recognition of EEA qualifications until 2023. However, this is not a reciprocal arrangement and there is no guarantee of extension beyond 2023. That uncertainty is in turn likely to hinder recruitment.

Regulation and supply of medicines and medical devices: The UK (a net importer of drugs and medical devices) is now outside the regulatory oversight of the European Medicines Agency (EMA), which allows for only one set of licences to be needed across member states. This means additional checks are now needed before goods, including medical devices, can cross borders. The Medicines and Healthcare products Regulatory Agency (MHRA) is to become the UK regulator, but concerns have been raised that a stand-alone regulator such as this is likely to encounter operational and logistical challenges. There is a commitment to regulatory alignment, but concern about duplication of effort for manufacturers and traders, leading to increased costs. The former chair of the MHRA has said that leaving the EMA could see the UK de-prioritised, meaning delays for patients accessing new medications, in particular "orphan" medications (those that, being for rare medical conditions, would be unprofitable to produce without government subsidy). Concerns about the supply of time-critical radioisotopes and impacts on patient care have been raised repeatedly.

Collaborative working in healthcare: Now the UK has left the EU, UK clinical trials need to be registered in accordance with MHRA requirements, and any collaborative work with European colleagues will be subject to EU regulations as well. This means that UK trials have to comply with two approval systems, meaning extra costs, more bureaucracy and slower trials. Ideally, the UK should seek to re-join the EU clinical trial registry.

The UK is also now excluded from the EU References Network for rare or low prevalence complex diseases. The UK needs to find practical ways of working closely with European colleagues to mitigate the impact on patients suffering from such conditions.

Reciprocal healthcare: The Global Health Insurance Card (GHIC) is set to replace the European Health Insurance Card (EHIC) for short-term travel within the EEA, and will have more limited coverage. Arrangements for access to healthcare for those who move from the UK to the EEA or vice-versa will vary between member states but entail additional bureaucracy, as those affected will no longer have the automatic entitlement to access healthcare on the same basis as nationals of the country they are moving to.

Public health and health security during the Covid-19 pandemic: The UK has now left the European Centre for Disease Prevention and Control (ECDC), the EU agency responsible for monitoring infectious diseases. This includes the Early Warning Response System that alerts members to new diseases and emerging epidemiological threats. The UK will be able to request access on a case-by-case basis, but the details on how this will work are unclear and therefore a cause for concern.

Threat from deregulation and private US healthcare: The recent vote by the Conservatives to block amendments in the House of Lords that would have protected the NHS in trade negotiations is deeply troubling, and sends a clear signal that the NHS will not necessarily be protected. Under WTO rules, any NHS service that has previously been competitively tendered must be opened up to bidding by companies from the US and elsewhere for whom profit may be a greater consideration than patient health. And even in the event of a trade deal with the US, it seems unlikely – given the signal they have already sent – that the UK government will be willing or able to ensure adequate protections for the NHS.

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