The Brexit factor

SINCE THE UK voted to leave the EU, and Theresa May became Britain’s new prime minister, there has been endless unpicking of her oft-quoted but highly ambiguous statement “Brexit means Brexit”. What does it mean for the country? What does it mean for the world?

Here we focus on the possible meaning of Brexit for the NHS. It has potential implications for a number of critical areas, expressed by the handy acronym: Budget, Research, Employment, X-border healthcare, Innovation and clinical Trials.

First and foremost, there could be a budgetary impact on the NHS. Much discussion took place in the run-up to the referendum about possible additional funding for the health service as a result of leaving the EU. However, it has become clear that, if economic growth were to slow, funding no longer being paid to the EU could be more than cancelled out by the negative economic consequences of leaving.

While it is difficult to quantify the possible financial impact of an economic downturn on the NHS and views on the economic outlook vary, some predictions have been made. The Health Foundation has estimated that the NHS budget could be £2.8bn less than the amount currently planned for 2019-20; and the Economist Intelligence Unit has stated that, by 2020, the NHS will spend £135 less per head as a consequence of the UK leaving the EU.

In the case of a prolonged economic fallout, the effect on an already stretched NHS budget could potentially lead to longer waiting times or reduced access to innovative, expensive medicines and health technologies.

Brexit could also affect clinical research and innovation in the NHS. Collaboration with our European counterparts has helped us to develop new treatments, adopt advances more quickly and improve the quality of healthcare. It has also facilitated the enrolment of NHS patients in clinical trials, allowing them to access new and possibly life-saving treatments when no other medical option is available to them.

The NHS’s participation in EU collaborative research could be affected in the case of prolonged uncertainty about whether the UK will adhere (or not) to the EU regulatory framework on the authorisation and conduct of future clinical trials. A new EU clinical trials regulation is due to be enacted in 2018, which will streamline the procedures to assess and authorise clinical studies, removing duplication and reducing delays. Importantly, these new EU rules will introduce some flexibility and simplification that will make it easier for NHS trusts to participate in multinational clinical trials. For example, it will become possible to carry out a trial that involves patients in different member states with one application, instead of having to apply to carry out the trial in each country involved. This will speed up the time it takes to start such clinical trials. This is a positive change for studies into treatments for rare diseases which, by their very nature, require the participation of patients from several countries.

It will be crucial for the NHS that these positive changes are not lost because of Brexit and that NHS organisations and, more importantly, our patients, do not miss out on the opportunities offered by collaborative research with European partners.

BY ELISABETTA ZANON

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The prognosis for the NHS in a post-Brexit world is still very uncertain. What are the issues to watch out for as negotiations unfold?
In a similar vein, uncertainty has emerged about whether it will still be possible for NHS trusts to lead or be members of European reference networks for rare and complex diseases after Brexit. These networks are a new form of EU collaboration between specialised healthcare providers, which aim to pool knowledge in specific clinical areas to increase the speed and scale at which advances in medical science and health technologies are incorporated into care provision.

If the UK’s new relationship with the EU were not to allow us to take part in these networks, this would be a blow to our leading role in international medical science. It could have negative implications for patients, by potentially slowing down the take-up of innovations and putting them into NHS medical practice. In turn, this could damage the NHS’s ability to attract and retain some of the most renowned clinicians in the world, who often decide to work for the NHS due to its reputation in leading medical research.

**Known unknowns**

Brexit could also restrict our ability to recruit and retain EU employees. There are around 144,000 EU health and social care professionals currently working in England, equivalent to 10% of our doctors and 5% of our nurses. Some 80,000 work in adult social care, 58,000 work for the NHS and 6,000 work for independent health organisations. A weak currency, coupled with prolonged uncertainty on whether EU freedom of movement rules will continue to apply in the future, could make the UK a potentially less attractive destination for EU migrant care workers and other healthcare staff.

There could also be consequences for NHS patients in terms of their ability to access cross-border healthcare in the event that EU mechanisms and rules in this area no longer applied. This could mean that British citizens on holiday in Europe might no longer be able to use the European Health Insurance Card. The EHIC allows British citizens to receive emergency or immediately necessary healthcare on the same terms as the residents of the country they are in.

EU law also gives Britons who are on the continent for a longer period – such as pensioners and those working in other EU countries – entitlement to healthcare in the country where they live. These rules are extremely complex, but the key principle is that Britons are entitled to healthcare on the same basis as the local population, thanks to a system of reimbursement of costs between the UK and the host country.

In the future, this system might no longer apply, unless bilateral agreements are negotiated between the UK and each individual EU country. This could mean that our citizens might have to purchase private health insurance or come back to the UK when in need of healthcare.

It should be stressed that these EU rules are reciprocal and therefore uncertainty also exists over whether EU citizens will be entitled to NHS care in the UK following Brexit. Selfishly, we may believe that this could potentially help alleviate pressure on our stretched healthcare system, as there are around twice as many EU citizens living in the UK as there are UK nationals living in the EU. However, this is unlikely to happen, as UK nationals living abroad are often older and in greater need of care than the younger and therefore healthier EU citizens who work or study in the UK.

At this stage, it is impossible to predict whether these possible implications will materialise and, if so, to what extent, as we do not know what kind of new relationship with the EU the UK government will seek, how long negotiations with the EU will last, and what the outcome will ultimately be. Even with all these variables, it is clear that there are potentially important implications – particularly in relation to staffing issues – that will have to be taken into account.

A critical factor is whether the UK continues to have access to the EU’s single market in the future. Continued access to the single market is likely to imply adherence to EU policies and rules in the areas described above and hence a smaller degree of change from an NHS perspective. At the other extreme, a total exit from the single market would leave the UK free to determine its own policies and to seek bilateral agreements with selected countries in these areas, with a bigger potential impact on the NHS.

Over the coming months, as the UK government elaborates its leave strategy and eventually sheds some light on what the implications of “Brexit means Brexit” really are, we shall be conducting further analysis of how the proposed approach could affect the NHS, with the aim of briefing negotiators and, ultimately, securing a good outcome for healthcare services.