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THE NHS and the EUROPEAN REFERENDUM

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As the debate hots up in the UK about continued membership of the EU this short note has a look at the current European health agenda. It is not huge as the provision of health and social services remain a national competence.

The migrant crisis which is seriously challenging the unity of the EU has a number of health dimensions ranging from health in refugee camps [where the UK is active] to assimilating refugees into local health systems once they have settled in an EU country.

It is the latter that is currently proving highly controversial in many countries and increasing pressure on an already over stretched NHS. However most migrants are in reasonable health on arrival in their new country although children with special needs of one sort or another are a challenge given the Government's decision to give them priority when applications for refugee status are being evaluated.

Many of these children will be unaccompanied thus creating really challenging problems for Social Services. A united European political response to the crisis has proved difficult but this has not stopped discussions amongst health and social care experts about how to manage the problem on the ground.

If the number of migrants to the UK does increase substantially then the NHS will feel the impact as will many of the other health systems in Europe. The NHS will need to work out how to handle the process of integration.

One initiative that the UK is not yet committed to join is the new European Medical Corps which will be available to respond rapidly when an emergency arises. It is a voluntary arrangement amongst EU countries. The UK may be confident that it already has the resources and expertise to respond to emergencies in the UK so the question is whether our undoubted skills in this area should be made available to others.

Antimicrobial resistance has been on the EU agenda now for some years. The latest estimates put the cost of inaction in Europe at 25,000 deaths and E1.5 billion in extra healthcare costs. The latest focus has shifted to the agriculture sector as the Commission debate a new five year action plan.

The UK has to remain part of the world wide efforts to make progress in this field. It is not a problem we can solve on our own. In a modern world infection control goes well beyond national boundaries and the UK is right at the centre of EU attempts to improve the detection of diseases and act when necessary.

We would undoubtedly remain involved if the UK left the EU but the UK but would no longer be at the centre of the European decision making machinery.

The cost and regulation of medicines has always been a key priority for the EU. The Commission have recently returned to the question of patient access and cost as well as the potential for greater collaboration between countries.

Tough questions here about the balance between free markets and price regulation on the one hand and on the other the need to promote and sustain a European Pharmaceutical industry that can compete in world markets.

The Commission are also active in the field of blocking fake medicines with new regulations about unique identifiers and anti-tampering devices. The Commission have now published proposals for the regulation of generic medicines within the framework of the Trade Agreement with the USA.

We do need regulation to ensure the safety and efficacy of medicines. In this area the strength of the European hand in negotiating with the US is related to size. We could of course simply accept that whatever the US decides is right for its citizens will be alright for ours!

Workforce planning and the Working Time Directive have created problems for the UK and the medical profession in particular. What started as a well-meaning and quite important attempt to limit unreasonable working hours has been beset by problems relating to the inflexibility of the Regulation when applied to particular groups of workers.

The UK is now a major recruiter of skilled health manpower from within Europe and this seems likely to continue.

The NHS has a crucial interest in European regulations about professional recognition and CPD. If the UK left the EU it is unlikely that these regulations would be downgraded.

Professional training remains a major earner for UK institutions and strong links in Europe makes good business sense.

The UK has always done well in accessing EU research funds which will total over 80 billion Euros over the next seven years. Germany is the only country that fares better. UK institutions can expect to win contracts valuing 2 billion Euros in the first two years of the next seven year plan. In this field we take out far more than we put in.

The UK also has a strong commercial and NHS interest in EU efforts to promote eHealth interoperability and the alignment of standards for health information sharing. We are one of Europe's major players in the field of medical devices and rely heavily on European markets.

A new European policy framework for mental health has been published recently and WHO Europe continues their work on a European Code against Cancer. The referendum does not affect the UK membership of WHO and it's European Office.

In both cases this work, and that in other speciality areas, is worthy without being decisive in terms of action. The same might be true of all the energy being invested in looking at services for the elderly.

The recent EU call for volunteer reference sites to test new ideas for caring for the elderly is similar to the NHS England call for volunteer health town sites to spearhead an attack on obesity. EU action in field of rare diseases has been quite productive with national rare disease plans slowly evolving.

There is of course much collaboration between health systems in Europe that is self-generated including an interesting Network that brings together hospitals interested in sharing experiences and good practices when

providing care to cross-border patients. Some European professional associations are quite strong and well organised. Patients from the UK play a major and productive role in European patient groups and are quite deeply embedded in health policy committees.

Europe and other international organisations can sometimes put UK health care into a valuable comparative context. The OECD recently concluded that despite the UK role as a global leader in quality monitoring and improvement the UK does not consistently demonstrate strong performance on international benchmarks of quality.

Amongst the disappointing results are the survival estimates for breast, colorectal and cervical cancer. Another challenging paper from Europe draws attention to what might be a “fatal flaw” in hospital mortality models which have had a devastating impact on some UK hospitals.

The potential flaw relates to spatiotemporal variation which has been discounted in many current methodologies. Being part of a wider community can be both uncomfortable and stimulating.

Whilst ever the UK remains outside the Euro zone there will be little pressure from Europe to reform the basic principles of our NHS. Whether we can afford an NHS free at the point of need, or not, will remain a matter for the four UK governments .Those within the Euro zone will however feel the pressure to harmonise social benefits including health.

It is the European Court of Justice and the European Court of Human Rights that have attracted much criticism in the UK usually related to the application of the Human Rights Law. However the Courts span all aspects of EU business.

It has taken the European Court some years to decide that a care home company in Belgium could claim VAT exemption. The Court recently rejected a complaint by a large Pharmaceutical company against a judgement European Medicines Agency.

Many take the view that Courts have exceeded their intended function and have got bogged down in interminable legal process and accumulated a huge number of small cases, including many on appeal, when they should have limited themselves to matters of grand principle. Many of their decisions might be better made by elected politicians.

The overall governance of the EU is out of balance and needs to be modernised. Pity David Cameron did not seek a commitment from Mrs Merkle and others to a fundamental review of the machinery of European government. The complex governance structures are supported by a sluggish, multinational bureaucracy.

Many complain about EU regulation but in the health sector it is not onerous. As far as the NHS is concerned it applies predominantly to buildings, drugs and medical devises, and some elements of manpower and procurement.

Clinical systems might be a target for the future with the justification of removing dangerous and outdated practice leaving best practice to national governments’ and professional associations. Any regulation in this area will be irksome but it is difficult to argue that it would have no value. The same is true about the regulations relating to food safety.

Public health ought to lay a bigger role than it does in European affairs.

Those who believe that the NHS will secure a huge financial bonus once the UK stops paying its EU dues should get a commitment in writing now from the politicians who make such a promise. It is unlikely to happen.

Health is not going to be at the centre of referendum arguments in the UK but it seems to me that the NHS has little to gain from an exit and perhaps something to lose. The NHS could play a much bigger role in a modernised EU than it currently does.

Professor Brian Edwards is a former President of the European Hospital and Health Care Federation.