National Assembly for Wales
External Affairs and Additional Legislation Committee

Changes to freedom of movement after Brexit – implications for Wales

EAAL(5) FOM08
Evidence from General Medical Council

Executive Summary

1. The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training;
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers;
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

2. While regulation of the medical profession is reserved to Westminster, the GMC operates within the legal and legislative structures of the different jurisdictions within the UK.

3. We would like to take this opportunity to highlight several issues relevant to Wales arising from changes to freedom of movement, following the UK's withdrawal from the EU.

4. Our registration processes and procedures currently accommodate the movement of doctors between the UK and countries inside and outside the European Economic area (EEA). GMC registration with a licence to practice allows doctors to practice in all four healthcare systems in the UK.

5. Our statutory powers are set out in the Medical Act 1983. The way in which we regulate doctors from the EEA is determined by the recognition of professional qualifications Directive (2005/36/EC), which is transposed into UK law via the 1983 Act.

6. Leaving the EU, and the subsequent implications for freedom of movement, could have a significant impact on the regulation, movement and education of doctors throughout the UK.

The EEA medical workforce

7. As the regulator, the GMC holds a unique data set on the medical profession. Doctors from Europe make a vital contribution to the health services across the UK. As of September 5 2019, there are 33,060 doctors on the medical

register who gained their primary medical qualification (PMQ) from another country in the EEA. This constitutes around 10.7% out of a total of 309,320 on the UK medical register.

8. Brexit will instigate significant questions for workforce arrangements in all four countries of the UK. Our data shows that there are a similar proportion of EEA graduates in each broad area of practice in Scotland and Wales. Northern Ireland has the greatest proportion of EEA graduates who are GPs. England has the most EEA graduates who are specialists or on neither register and not in training.

9. There is a relative high dependency on EEA qualified doctors in certain areas of the UK. We know that in some remote and rural areas in Scotland and Wales, there are a higher percentage of non-UK licensed doctors than the overall UK figure.

10. Broken down by Health Board region, the EEA percentages in Wales are as follows:

- Aneurin Bevan University Health Board: 4.9% of a total of 1,202 doctors;
- Betsi Cadwaladr University Health Board: 8.9% of a total of 1,485 doctors;
- Cardiff and Vale University Health Board: 6.3% of a total of 1,381 doctors;
- Cwm Taf University Health Board: 5% of a total of 1,027 doctors;
- Hywel Dda University Health Board: 10.7% of a total of 895 doctors;
- Powys Teaching Health Board: 3.7% of a total of 135 doctors;
- Swansea Bay University Health Board: 5.4% of a total of 1,053 doctors.

11. We have not observed a reduction in the number of EEA graduates on the medical register since the referendum itself, nor in the number of EEA graduates who have joined the medical profession. We saw a slight surge in applications in the run up to March 29, although this has since levelled off. However, it remains too early to be certain what impact any changes to the UK's relationship with the EU might have on the numbers of EEA graduates applying to register in the UK.

12. Both the UK Government and the EU have given assurances that decisions on the recognition of professional qualifications (RPQ) made before EU exit will be respected. This means that the registration status of doctors with an EEA qualification who are currently on the medical register will not be impacted.

13. The draft Medical Act amendments legislating for a 'no deal' Brexit were adopted in March and will be enacted should we have a 'no deal' Brexit. We've worked very closely with UK Department of Health and Social Care (DHSC) officials and lawyers over the past 18 months to make sure we can register doctors who qualified in the EEA in a timely and streamlined way, without compromising standards. We are aware UK DHSC officials have been working closely with officials in the devolved governments. The GMC Wales Office has also engaged closely with Welsh Government officials to ensure we consider issues from a four-country perspective.

14. Under the 'no deal' framework, EEA nationals will be treated as International Medical Graduates (IMGs). We are amending the IMG framework to recognise

certain EEA qualifications as evidence of knowledge, skill and experience regardless of the nationality of the holder. The qualifications covered by this new route would be those primary, specialist and GP qualifications that are included in Annex V of the RPQ Directive as of exit day. This should avoid the need for most EEA doctors to follow our traditional IMG route to the register which can take a considerable amount of time and should ensure minimal disruption to the NHS workforce.

15. We have two outstanding concerns with the 'no deal' legislation:

- The lack of clarity about the process of designating an EEA qualification as non-comparable. While the Privy Council would have to approve such a measure, it is unclear on what grounds we would be able to make such a request and what information we would have to provide to satisfy the Privy Council.

- The lack of detail on the proposed scope of the two-year review. In our view, this should be thorough and allow us to explore wider ranging reforms to our international registration processes to make them fair, flexible and responsive.

16. UK Government has recently confirmed that rules allowing EU nationals to live and work freely in the UK would end immediately on the current departure date of 31 October, in the event of 'no deal' exit. If the UK leaves the EU without an agreement at the end of October. This will not impact the registration status of EEA doctors but could impact upon the numbers of EEA doctors living and working within Wales, particularly in the case of those who have not yet applied for, and received, settled status in the UK.

17. Looking ahead, it is unclear what impact the UK's withdrawal from the EU is likely to have on the future number of European qualified doctors on the register and whether we are likely to see a future reduction in the numbers applying from the rest of Europe.

18. In the meantime, we will continue to publish data about EEA doctors practising in the UK[1] to provide up-to-date information and assurance for employers. For the first time we will also publish country-level workforce reports to aid the four governments of the UK and their agencies with national planning.

Brexit and medical regulation

19. 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[2] are entitled to have their qualifications recognised and to

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[1] https://www.gmc-uk.org/publications/30409.asp

[2] Where those qualifications are compliant with the recognition of professional qualifications Directive (2005/36/EC)

pursue medical careers in the UK with the same rights as doctors who qualified in the UK.

20. 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 we 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.

21. Whether there are changes to how we register EEA qualified doctors in the future will depend on whether the recognition of professional qualifications framework is continued under the future agreement between the UK and EU.

22. While we do not have a position on what the UK's position on freedom of movement should be, we would like to highlight areas that will require careful consideration to ensure patient safeguards and workforce flows are maintained.

Medical education and training

23. The definitions of a primary medical qualification, as well as some specialist medical training, are enshrined in EU law by the recognition of professional qualifications Directive. This assumes comparability of medical education and training across the EEA. It is on the basis of medical qualifications that are deemed to have met certain minimum standards, that doctors can exercise their right of free movement within the EEA.

24. The arrangement to continue to recognise the majority of EEA qualifications will not be reciprocated by European medical regulators for UK qualifications.

25. We have contacted our European medical regulator counterparts over the past few months to find out how they will register UK graduates in the event of a 'no deal' Brexit and have shared these results with DHSC officials.

26. With the exceptions of Ireland and France, it appears that most regulators will not replicate our preferential treatment and will treat UK graduates (regardless of their nationality) as IMGs. Ireland will put in place a similar arrangement to our 'no deal' amendments and France will continue to apply the recognition of professional qualifications Directive to UK nationals for a period of five years.

27. This loss of automatic recognition for UK qualifications has potential implications for undergraduate and postgraduate medical education in the UK. Bearing in mind that, UK-wide, around 5% and 4% respectively of participants in those programmes are from the EEA, it remains to be seen whether UK medical education will continue to attract applications at this level when the qualifications conferred no longer benefit from automatic recognition throughout Europe.

Fitness to practise information sharing

28. It will be important to consider how health regulators ensure professionals practising in the UK are fit to practise medicine should the UK withdraw from the recognition Directive. It would therefore be helpful for us to retain access to the Internal Market Information (IMI) system, which we use to communicate with other medical regulatory authorities within the EEA.

29. IMI is a secure communications tool introduced by the Directive that we use to transmit and respond to queries about a doctor's registration documents. We also use it to send and receive alerts about doctors' fitness to practise. This warns us when a doctor has their practice restricted in one of the other 27 EU member states.

30. We are exploring how we will share fitness to practise information with European regulators once we no longer have access to the IMI system. Discussions are already well under way with the Medical Council of Ireland.

31. Our aim is to mitigate the impact of the loss of access to the IMI system through:

- Other means already in place to share fitness to practise and registration information with non-EEA countries. Before the European Commission introduced and mandated the use of IMI, we used these same processes in our interactions with EEA countries. We plan to revert to these should the Commission decide not to give IMI access to the UK post-EU exit.
- Existing strong bilateral and multilateral relationships through our joint leadership of the European Network of Medical Competent Authorities (ENMCA).

Potential impact of freedom of movement within health and social care in Wales arising from future trade agreements

32. Historically, we had reciprocity agreements in place with a number of old commonwealth countries including Australia, New Zealand, South Africa, Hong Kong, Singapore, Malaysia and the West Indies to grant easy access to the UK medical register. The 'old section 19' route ended on 17 December 2002 when it was abolished by the Medical Act 1983 (Amendment) Order 2002.

33. We supported the abolition of this route to registration, largely on the grounds of fairness - we had never reviewed the curriculum or training in any of the 'old section 19' countries. Registration on this basis was also largely at odds with our long-standing policy that we should be able to assess a doctor's capability for practice at the point of registration, rather than relying entirely on where someone had qualified.

34. It would be imperative that regulators such as the GMC were consulted on the equivalence (or not) of medical training in a particular country, should the UK's Department of International Trade be keen to include the recognition of

professional qualifications in the healthcare sector in any trade agreements with third countries. There would also need to be some sort of mechanism to ensure an ongoing assessment of the training to ensure it remained equivalent over the years and that the assumption of equivalence was not simply 'fossilised' into a trade agreement, like it currently is for many specialties in the RPQ Directive.

Conclusion

35. We thank the Committee for the opportunity to highlight these issues. If you have any queries or require any further information, please contact Wales Policy and External Affairs Officer Huw Anslow at huw.anslow@gmc-uk.org or by contacting the Wales Office at 02920 494948.