BAD Essay Prize 2017:

Is British dermatology better in or out of Europe?

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Introduction

On the 23rd June 2016, the United Kingdom held a referendum to determine its position in the European Union (EU). This resulted in a decision for Britain to exit the EU, colloquially known as 'Brexit'; however, currently there has been no consensus as to how or when this will be done. The decision made has been predicted to impact on politics, economics and legal matters on both a global scale and at home.

Dermatology services in the UK are in high demand with 54% of the entire population each year suffering with skin disease[1]. The NHS is already struggling to meet such clinical pressures with some services resorting to using private contractors[2]; however with the added uncertainty of the political climate, it is currently unknown how this decision will affect British dermatology. This essay aims to explore the potential effects of leaving the EU in terms of service provision, cross-border healthcare, public health and research.

Dermatology service provision

Commissioning and funding

During the lead up to the referendum, the 'leave' campaign suggested that the £350 million pounds per week spend on the EU could be used to better fund the NHS. The NHS and more specifically dermatology is experiencing staff and funding shortages[3]. Reduced funding and poor commissioning decisions have already led to the collapse of dermatology services such as those at Nottingham University Hospital, a former centre of excellence. A private contractor won a bid to deliver dermatology services despite concerns being raised, which resulted in a centre run mostly by locum doctors with loss of training and reduced research facilities[2]. Since the result of

the referendum, it has become unclear how this money will be spent; however it seems unlikely that it will all be put towards the NHS. However, any extra funding put towards the NHS, could be used to improve and increase dermatology training and knowledge, both in primary and secondary care.

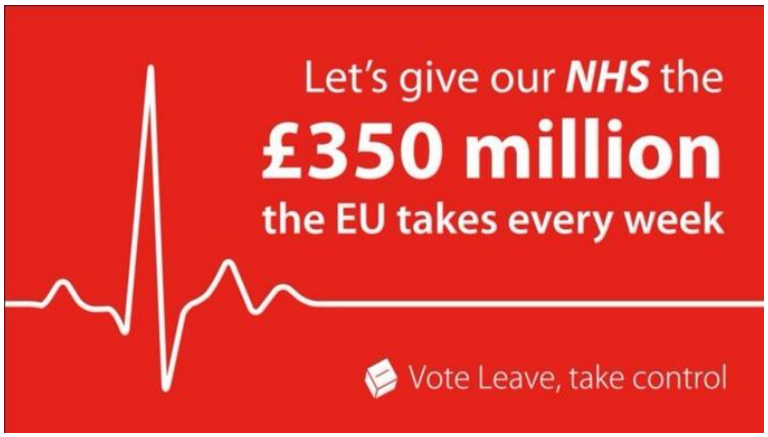

Figure 1: Vote Leave Campaign poster which has since been removed from the official campaign website[4]

Leaving the EU could result in the UK no longer being a member of the European single market (European Economic Area; EEA). This might mean that trading with countries within the EEA could become more costly. This could impact on imports and exports of drugs, medical supplies and equipment, resulting in higher costs to the NHS. Furthermore, the wider economic uncertainty following the referendum decision could result in cuts to all areas of public funding, in turn affecting NHS and dermatology service provision.

Workforce

Dermatology within the NHS is understaffed; the British Association of Dermatologists (BAD) statistics show there is a shortage of around 250 dermatology consultants, alongside cuts to training numbers[2]. The NHS is currently relying on a large migrant workforce; 4.95% of all NHS England employees are EU migrant workers[5]; a proportion similar to the population of EU migrants living in England[6]. Emphasis was placed on immigration during the lead up to the referendum, with the 'Leave' campaign promising tighter control and reduced levels of net

immigration. By leaving the EU and the EEA, there might be reduced EU migration to the UK. This reduction in EU migrant workers could result in increased employment of British nationals to fill NHS jobs; however recruitment shortages could also be possible. Furthermore the decision might act as a deterrent to migrants from outside the EU, causing problems for the NHS as, compared to EU migrant workers, a greater proportion of non-EU migrants are working for the NHS[7]. Such effects may not be seen immediately, but could potentially cause problems in the long term.

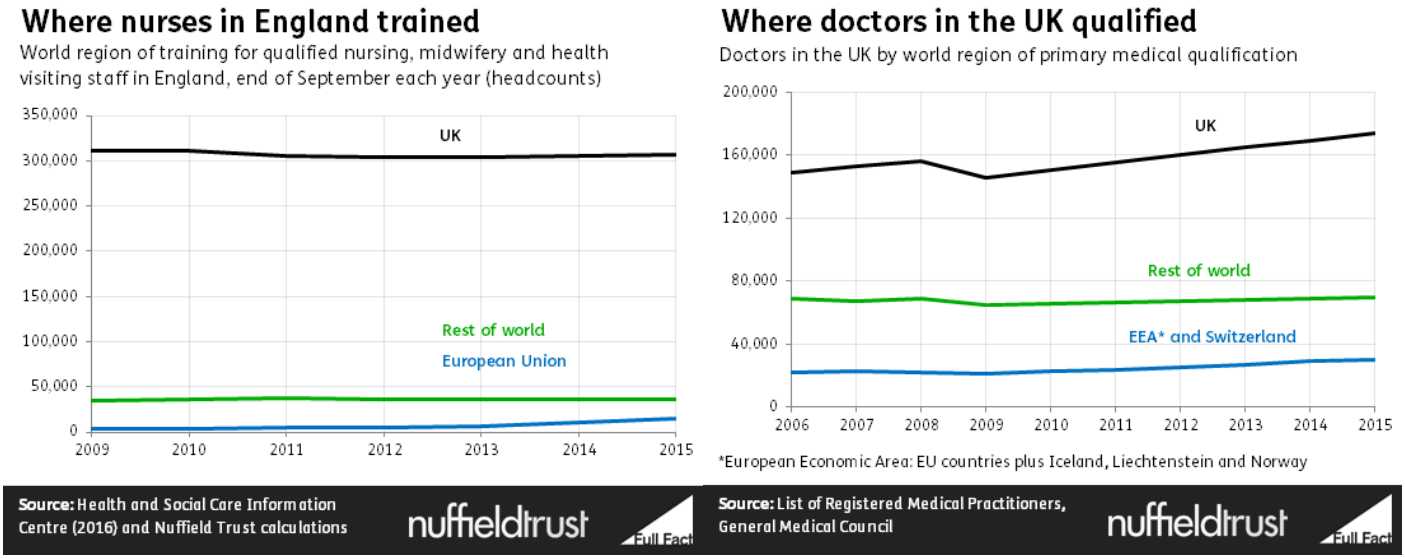

Figure 2: Most nurses and doctors working in England/the UK are trained in the UK however a proportion come from the EU[7]

The European Working Time Directive (EWTD) currently governs the legal working hours for NHS staff. Upon leaving the EU, Britain might decide to opt out of such legislation. This could be beneficial as those against the EWTD would suggest that this would allow more clinical experience and continuity of care for patients. On the other hand, the removal of this safeguard might promote longer and unsafe working hours. Any changes made could have an impact on all NHS employees, however it is unknown whether the EWTD will be changed or not/

Differences in service provision

There are differences in the way dermatology services are provided in the UK compared with Europe, which has implications for EU migrant workers working in dermatology. In the UK, skin disease represents a large proportion of the general practice (GP) workload, with around 13 million consultations per year[1]. Many patients are managed in primary care, with some referred for secondary care diagnosis or further treatment. Dermatology service providers in the UK include GPs (including those with a specialist interest in dermatology), dermatologists and trainees and specialist nurses. There is also close liaison with plastic surgeons for lesion removal in technically difficult areas, or those requiring more complex procedures.

European services practice dermato-venereology as a joint specialty[3] however in the UK these are practised separately. Separate practice may provide access to more specialist care; however the benefits of a joint specialty include a broader range of knowledge which could lead to faster diagnosis. The training pathways are also different between UK and Europe, with trainees in the UK having a heavier focus on general medicine (including passing membership exams of the Royal College of Physicians) before completing specialist training; whereas in Europe there is limited exposure to general medicine[3].

These differences in practice and training could make employing EU dermatologists problematic, due to different skills acquired[3]. Further training and completion of the UK certificate of completion of training (CCT) may be necessary to ensure the same level of expertise as their British-trained colleagues. This might incur additional costs to the NHS in employing EU dermatologists. On the other hand, employing dermatologists through alternative training pathways can also provide a diversity of experience within the workforce.

Cross-border healthcare

The European Commission published a directive regarding patients' rights in cross-border healthcare in 2008[8]. It allows EU citizens to access non-inpatient healthcare abroad without prior authorisation, and where inpatient stays or specialist care are required, prior authorisation can be granted. It allows reimbursement of costs up to the equivalent in the home country.

Membership within the EU has allowed easier and increased access to healthcare abroad, both for UK residents and for Europeans. This could be seen as beneficial as it provides greater patient choice and may empower individuals to access healthcare which may not be possible in their home country, for example in dermatology, specialist skin surgery or cosmetic techniques.

The decision for Britain to leave the EU might mean the UK becomes exempt from the cross-border healthcare directive. This might create difficulties in accessing healthcare abroad for the estimated 1.2 million British citizens living in Europe[9]. British citizens seeking healthcare may be required to buy private medical insurance or pay an upfront cost as the European Health Insurance Card (EHIC), which allows access to state healthcare across the European Economic Area and Switzerland, may no longer be available following withdrawal from the EU.

Likewise, European nationals might find accessing healthcare in the UK more challenging. This might reduce the burden on the NHS as European nationals seeking medical treatment in the UK would have to pay. Reducing the burden on dermatological services from Europe may help to provide a more efficient NHS service, however this would also mean revenue is lost from any services provided under the cross-border directive.

Medical tourism is a growing trend worldwide for actively seeking medical care abroad. Patients are increasingly accessing private cosmetic treatments abroad, for example in Eastern Europe,

under the promise of lower costs and waiting times[10]. Medical tourism presents challenges and opportunities for the NHS. While it can be profitable treating foreign patients privately through the NHS and this also brings in revenue for private medical providers, those returning to the UK with complications from treatment abroad can be extremely costly[11]. Consultations with non-English speaking patients can be complicated and more costly with the need for interpreters. Any barriers to free movement of people (which might be implemented after leaving the EU) may reduce medical tourism between Europe and the UK. This in turn could reduce burdens on the NHS, though this may not affect dermatology as much.

Public Health

Currently there are various items of EU legislation followed in the UK related to public health. After leaving the EU, such issues can be independently regulated which could provide greater control and better public health. The government would have to carefully decide which EU regulations should be followed and which should be amended. This process is not only time and labour intensive, but rushed decisions could have a detrimental effect on public health.

Case Study: Methylisothiazolinone-related contact allergy

Cosmetic products in the UK are currently regulated by the EU Cosmetics Regulation 1223/2009 (2013)[12]. Methylisothiazolinone (MI) is a biocidal preservative used in water based cosmetic products. A recent outbreak of MI-related contact allergy in Europe resulted in regulation of its use to 7.5 ppm in 'leave-on' and 15 ppm in 'wash-off' products[13]. Despite regulations, MI-related contact allergy still remains an issue and a public consultation on a ban has recently been issued[14]. Following 'Brexit', independent regulation of the use of chemicals in cosmetics could potentially reduce numbers of chemical-related contact allergy.

Research

Medical, including dermatological, research is funded by a number of bodies in the UK. These include the National Institute for Health Research (NIHR), the Medical Research Council (MRC) and various charities, such as Cancer Research UK and the British Skin Foundation. The EU funds scientific research across Europe through the 'Horizon 2020' programme This has a proposed value of €70 billion and €2 billion of this will be dedicated to the Health, Demographic change and Wellbeing programme in the first four years[15]. The UK has been the fourth biggest recipient of EU funded scientific research, obtaining €8.8 billion between 2007 – 2013 through the Seventh Framework Programmes (FP7)[16] which was invested into over 120 collaborative research projects, including in dermatology[17].

After leaving the European Union, such funding avenues will no longer be available to researchers in the UK. Plans have been made for the British Treasury to take over funding of EU funded projects once Britain has left the European Union[18], however this adds to its financial strain. The UK makes may valuable contributions to research across Europe, and it has been proposed that the UK should even take a leadership role in European collaboration for public health research[19]. Collaboration with European research departments remains important and efforts should be made to continue this, regardless of changes to funding of research.

Case Study: King's College London Research Funding

King's College London's Dermatology department research funding has been published online. EU funding amounts to £234,600 or 0.66% of all funding, compared to £10,336,234 or 29.26% of all funding coming from UK government and healthcare authorities[20].

Dermatology

Category	Number of current awards	Total value	%
Research Councils, incl. Royal Society & British Academy	7	£4,237,225	12.00 %
UK Charities	20	£3,233,464	9.15 %
UK Government and Local, Health & Hospital Authorities, excl. NIHR	2	£10,336,234	29.26 %
NIHR	5	£16,441,464	46.55 %
Industry - UK	1	£16,000	0.05 %
Industry - Overseas	3	£663,891	1.88 %
European Commission & EU Government	1	£234,600	0.66 %
Other Sources - UK	3	£109,360	0.31 %
Other Sources - Overseas	4	£51,170	0.14 %
Total	46	£35,323,408	100%

Figure 3: King's College London Dermatology Research Funding[20]

This should be compared with King's College London's overall research funding, where the European funding amounts to £107,092,894 or 13.32% of all current funding[21]. While dermatology funding may not be so severely affected by withdrawal from the EU, other areas of research might be.

Conclusion

It is difficult to determine whether British dermatology is better ‘in’ or ‘out’ of Europe as this involves comparing the current situation to a hypothetical situation when Britain officially leaves the European Union. The wider impacts of leaving the EU, such as leaving the European Economic Area and changing economics, could have great impacts on the NHS and consequently dermatology. Taking certain merits of EU membership and British practice would produce the best NHS dermatology service.

The uncertainty of ‘Brexit’ for the NHS and dermatology could result in changes to service provision, particularly as the NHS employs a large number of EU migrant workers. On the other hand, reducing the number of medical tourists from the EU to the UK might reduce the NHS burden, though it is vital to keep in mind the benefits of the cross-border healthcare directive for British citizens too. The loss of EU funding for research may only disadvantage some British researchers, however the additional costs to the treasury in providing such funding in the interim will be challenging. Despite such changes it is important that Britain maintains its ties to Europe through research in a mutually beneficial partnership. Additional funding made available from EU membership fees would be of great potential benefit to researchers and dermatology departments, and the government should be made aware of this when restructuring funding.

As Britain has already decided to leave the EU it is important that the best outcomes during exit negotiations are achieved for the NHS. Leaving the EU represents an opportunity to take more control, in terms of funding, workforce commissioning and public health matters. The previous successes of the NHS and British dermatology have not been dependent on being a member state of the EU. Uncertainty might be a difficult time for British dermatology, particularly as it

encounters difficulties with staffing and commissioning. Though 'Brexit' may not impact directly on British dermatology, it is likely to affect how the NHS provides services which would in turn affect dermatology service provision.

References

1. Schofield J, Grindlay D, Williams H. *Skin conditions in the UK: A health needs assessment*. Centre of Evidence Based Dermatology: University of Nottingham, 2009.
2. Eedy D. Dermatology: a specialty in crisis. *Clin Med (Lond)* 2015;15(6):509-10.
3. British Association of Dermatologists. How can dermatology services meet current and future patient needs while ensuring that quality of care is not compromised and that access is equitable across the UK? *The King's Fund* 2014.
4. ITV News. *Vote Leave Campaign Billboard Poster*. 2016. http://www.itv.com/news/update/2016-04-15/vote-leave-unveils-first-billboard-of-referendum-campaign/ (accessed 18/12/16 2016).
5. House of Lords. NHS and Social Care Workforce: Implications of Leaving the European Union. 2016.
6. Office for National Statistics. *Population of the United Kingdom by Country of Birth and Nationality*. 2015. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/datasets/populationoftheunitedkingdombycountryofbirthandnationality (accessed.
7. Full Fact. *EU Immigration and NHS Staff*. 2016. https://fullfact.org/immigration/immigration-and-nhs-staff/ (accessed 19/12/16 2016).
8. Commission of the European Communities. Proposal for a directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. 2008.

9. United Nations. International Migrant Stock - Migrants by Destination and Origin. Department of Economic and Social Affairs. 2015.

10. Birch J, Caulfield R, Ramakrishnan V. The complications of 'cosmetic tourism' - an avoidable burden on the NHS. *J Plast Reconstr Aesthet Surg* 2007;60(9):1075-7.

11. Hanefeld J, Horsfall D, Lunt N, Smith R. Medical tourism: a cost or benefit to the NHS? *PLoS One* 2013;8(10):e70406.

12. Department for Business, Energy and Industrial Strategy. Product safety for manufacturers. 2015.

13. Latheef F, Wilkinson SM. Methylisothiazolinone outbreak in the European Union. *Curr Opin Allergy Clin Immunol* 2015;15(5):461-6.

14. European Commission. *Public consultation on Methylisothiazolinone (MI) in the framework of Regulation (EC) No. 1223/2009 - rinse-off cosmetic products*. 2016. http://ec.europa.eu/growth/tools-databases/newsroom/cf/itemdetail.cfm?item_id=8740 (accessed 21/12/16 2016).

15. European Commission. *Horizon 2020: The EU Framework Programme for Research and Innovation* http://ec.europa.eu/programmes/horizon2020/en/ (accessed 15/12/16 2016).

16. The Royal Society. *How much research funding does the UK get from the EU and how does this compare with other countries?* 2016. https://royalsociety.org/topics-policy/projects/uk-research-and-european-union/role-of-EU-in-funding-UK-research/how-much-funding-does-uk-get-in-comparison-with-other-countries/ (accessed 19/12/16 2016).

17. European Commission. *Health Research and Innovation: Key Research Areas - Rare Diseases*. 2016. (accessed 19/12/16 2016).

18. HM Treasury. *Chancellor Philip Hammond guarantees EU funding beyond date UK leaves the EU*. 2016. https://www.gov.uk/government/news/chancellor-philip-hammond-guarantees-eu-funding-beyond-date-uk-leaves-the-eu (accessed 23/12/16 2016).

19. McCarthy M, Dyakova M, Clarke A. Public health research in the UK: a report with a European perspective. *J Public Health (Oxf)* 2014;36(2):325-35.

20. King's College London. *Research Funding: Dermatology Research Group*. 2015. https://kclpure.kcl.ac.uk/portal/en/organisations/dermatology(f24a88f2-c721-42a1-bc8e-c24f23096043)/projects.html (accessed 19/12/16 2016).

21. King's College London. *Research Funding: Summary*. 2015. https://kclpure.kcl.ac.uk/portal/en/projects/search.html?pagetype=summary&text=&field=fundingbody (accessed 19/12/16 2016).

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