Brexit and health and social care

Nuffield Trust submission to the Health Select Committee Inquiry

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nuffieldtrust

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Introduction

This submission aims to give an overview of the key issues at stake in negotiations over the UK's exit from the European Union from the perspective of the NHS and social care.

Reflecting the Committee's terms of reference, it focuses on areas where the Department of Health will have a principal or supporting role in negotiations.

The economic implications of Brexit and the consequences for funding and real terms pay in the health and care sector are not one of these areas. However, this will be of great importance. Estimates from Government and independent sources suggest that deterioration in the public finances of £20 billion to £66 billion is possible by 2020 due to economic slowdown.[1] [2] If this resulted in a lower budget than planned for the NHS, the already very difficult task of continuing to provide the same range of services under rising cost pressure could become impossible. Inflation and a lower value of the pound are also widely expected to characterise the coming years.[3] These mean lower real wages for health and care staff and a lower value of remittances sent by migrant staff: both risk exacerbating the serious ongoing workforce shortage.

1 https://www.ifs.org.uk/uploads/publications/comms/r116.pdf
2 http://www.telegraph.co.uk/news/2016/10/11/revealed-hard-brexit-will-cost-britain-66billion-per-year/
3 https://www.theguardian.com/business/2016/aug/16/first-post-brexit-data-shows-uk-inflation-rose-to-06-in-july

Key points

1. The functioning of health and social care in the UK is dependent on EU migrants who make up a significant proportion of the medical, nursing and social care workforces. EU migrants in some areas make up a disproportionately large share of those newly joining the workforce (up to 32 per cent in the case of nursing), implying that future staffing may be even more dependent on them.

2. As well as guaranteeing the security of EU migrant staff already here, the Department of Health should negotiate to maintain the free movement of labour for qualified doctors, qualified nurses, and those arriving to work in social care.

3. UK citizens benefit from the EHIC and S1 schemes, which guarantee free or reduced price health care for visitors, students and pensioners across the EU. These come at a significant cost to the UK Government, but they would especially complex to replace bilaterally and there is a case for aiming to remain a member of them.

4. Several EU directives underlie the laws and regulations that govern the NHS across areas such as procurement and working time. In the medium term, these will be passed into British law. The UK should weigh against other factors whether it will want to be able to change them after 2019, or is willing to remain locked into some in an exit deal.

5. Cooperation across Europe on clinical trials, rare diseases and research funding benefits UK patients, and improves the attractiveness and capabilities of NHS hospitals. The Department of Health must add its voice to representatives of the university sector and scientific community in arguing for it to be retained as far as possible.

1. Staffing and migration

1.1. Reliance of health and social care on migrant staff

The United Kingdom depends on migrants from the European Union to meet its staffing needs across all the largest care-giving professions.

The UK has been identified in comparative studies over many years as having an exceptionally high reliance compared to other developed countries on importing foreign medical doctors in order to meet its needs.[4] 11 per cent of doctors registered with the GMC – 30,584 – qualified within the EEA.[5]

In nursing, around 4 per cent of the workforce registered with the NMC – 13,000 – is made up of those who originally trained in the EU. Based on the Labour Force Survey, the proportion born in the EU (counting nursing assistants) is around 7 per cent.[6]

In social care, meanwhile, the proportion of UK workers with EU nationality is around 6 per cent: 80,000 out of 1.3 million.[7] This may underestimate the total number of EU migrants, as some who have been in the UK longer may have acquired British nationality.

Any policies which risk causing existing European migrant staff to leave the UK would have serious consequences for health and social care. For context, the number of EU-qualified medical staff registered to practise in the UK exceeds the entire combined medical workforce of the Scottish and Welsh health services.

4 http://www.euro.who.int/__data/assets/pdf_file/0006/248343/Health-Professional-Mobility-in-a-Changing-Europe.pdf
5 http://www.gmc-uk.org/doctors/register/search_stats.asp
6 https://www.rcn.org.uk/professional-development/publications/005779
7 https://www.nmds-sc-online.org.uk/Get.aspx?id=/Research/Adult%20social%20care%20workforce%20reports/Reports/Nationality%20of%20the%20adult%20social%20care%20workforce%202015.pdf

1.2. Future reliance on migrant staff

The future importance of EU migration is likely to be greater than implied by looking at these current numbers. Since 2010, there are clear signs that the UK has increased its reliance on EU health and care staff, following restrictions on migration from outside the EU.

This is particularly clear in nursing. During a previous period of nursing shortages, with the spending increases which began around the millennium, the UK imported several thousand nurses each year. Most, over 70 per cent in 2006/07, were from outside the European Union. With the current shortage emerging around 2012, the number of nurses registering to work in the UK has risen again, steeply, to more than 11,000 in 2015/16.

However, there has been a sharp change in countries of origin: over 80 per cent are now coming from within the EEA. A significant contributor is likely to be that immigration restrictions introduced between 2008 and 2011 made it more difficult to recruit from outside the EU, as well as that active recruitment from the developing world was discontinued.

Figures obtained by the RCN show 32 per cent of all new nurses last year were drawn from the EEA. With UK-trained nurses accounting for only 60 per cent, shutting off EEA clinical migration even partially would result in a significant emerging gap in the workforce.[8]

The Government's nursing funding reforms may help provide a domestic alternative to EEA clinical migration by removing the limit on domestic places. However, they will not begin to produce additional graduates until 2020, and there is a significant obstacle in the shape of the limited availability of training places in the UK. Even immediate achievement of the ambition of 10,000 nursing and AHP graduates each year may not substitute for the current level of EEA nursing migration to the UK, which is around 10,000 for nursing and midwifery alone.[9] [10]

8 https://www.rcn.org.uk/professional-development/publications/005779
9 https://www.rcn.org.uk/professional-development/publications/005779
10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/539774/health-education-funding-response.pdf

There are signs consistent with a similar pattern in social care. Whereas Asian and African countries of origin were the most significant sources of migrant labour around the turn of the millennium, since 2011 Poland and Romania have become the most common countries of origin.[11] Whereas limited training places arguably provide an artificial constraint on the supply of nurses, increasing the number of British social care workers in order to substitute for migrants is likely to require improving wages and conditions at a time when employers already claim that they will seriously struggle to pay the National Living Wage.[12]

A reversal of recent immigration reforms which restrict the numbers of non-EEA migrants could compensate for a decrease in EEA migration. However, there is a need for realism about the likelihood of what would be highly visible steps to relax migration policy, given clear signals from the Government that it seeks a very large overall reduction in total migrant numbers.[13] Similar considerations apply to relaxing the 2006 restriction on actively recruiting staff from developing countries.

1.3. Impact of migration on demand and funding for health care

EU migration contributes to the annual increase in demand for NHS services. However, this is relatively insignificant, at an estimated £160 million each year, compared to an estimated annual increase of £3.3 billion across the UK. The main drivers of pressure on NHS finances are the growth and aging of the native population, and the emergence of new technologies and possibilities for treatment.[14]

The evidence also suggests that EEA migrants contribute more through taxation than they consume in public spending, at least relative to other groups.[15] [16] Policies that limited lower skilled migration could increase this net contribution. However, any positive impact

11 http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf
12 https://www.independentage.org/sites/default/files/2016-05/IA%20Moved%20to%20care%20report_12%2011%2015.pdf
13 http://press.conservatives.com/post/151334637685/rudd-speech-to-conservative-party-conference-2016
14 http://www.nuffieldtrust.org.uk/blog/facts-eu-immigration-and-pressure-nhs
15 http://www.cream-migration.org/files/FiscalEJ.pdf
16 https://www.migrationwatchuk.org/pdfs/BP1_37.pdf

would be outweighed heavily in the shorter term if this was achieved through a system that imposed any restrictions on clinician migration.

1.4. Negotiating position on migration

The Department of Health should aim for a settlement on movement of labour after Brexit that retains as much openness to the immigration of health and social care staff as possible. If a work permit system is adopted, this should allow for the current level of migration of nurses and social care workers from the European Union, if not a higher level given that the current situation is one of shortage.

2. Reciprocal health care arrangements

2.1. Short-term reciprocal health care arrangements

European residents benefit from reciprocal programmes which fund health care they need while living in or visiting other EEA countries and Switzerland. The European Health Insurance Card (EHIC) scheme provides free or low-cost health care to visitors and students. The S1 scheme provides free or low-cost health care to citizens receiving a state pension who go to live in another member state. Both schemes are governed by the EU's Administrative Commission for the Coordination of Social Security Systems.[17] Under agreements, the European Economic Area countries and Switzerland also fall under this area of cooperation.

When a member state's citizens claim care under these programmes, that member state has to reimburse the country which provided the care. Figures released in response to a parliamentary question earlier this year showed that the UK pays £674 million to other countries under this scheme, receiving only £49 million in return.[18] This may be partly because although far more EU citizens live in the UK than vice versa, UK citizens living in at least some European countries are disproportionately over 65 and may therefore incur

17 http://ec.europa.eu/social/main.jsp?catId=849&langId=en
18 http://www.mann4bassetlaw.com/john_mann_mp_reveals_massive_european_health_bill_for_uk

more health costs.[19] [20] However, a very significant factor is that the NHS fails to make most claims. A total annual recoverable figure may be higher than £240m.[21]

This is because of the administrative burden on trusts involved in collecting this information in a system not generally set up to charge patients. The incentives to invest in this are often poor given the ease of reclaiming money for a patient recorded as being a UK resident, and the lack of any particular proof required to do so. The Department of Health has made efforts to change this, but the National Audit Office has found that success has so far been limited.[22]

2.2. Considerations for negotiations

The British public has an interest in retaining these systems, which reduce or eliminate the cost and burden of arranging private insurance for visits to the EU. The convenience they provide EU citizens visiting the UK is a positive factor in facilitating tourism and trade.

The schemes impose a significant direct net cost to the UK Government. However, there is room to bring in significantly more money under the current system. There is also a risk that without S1 and EHIC, more unwell British citizens facing high private insurance premia would return to the UK to exercise their right to free health care, effectively cancelling out significant proportion of any savings.

International arrangements of this sort are otherwise relatively uncommon, only otherwise existing with Australia, New Zealand and some Balkan countries.[23] Developing a full set of separate arrangements with EU members would be a formidable task.

The rest of Europe has a superficially relatively strong financial incentive to retain the current system, given their net benefit. However, there is a risk of overestimating this –

19 https://fullfact.org/immigration/eu-migration-and-uk/
20 http://www.insee.fr/en/themes/theme.asp?theme=2&sous_theme=5&type=2&type=3&nivgeo=0&produit=OK
21 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331623/Impact_assessment.pdf
22 https://www.nao.org.uk/wp-content/uploads/2016/10/Recovering-the-cost-of-NHS-treatment-for-overseas-visitors.pdf
23 http://www.nhs.uk/NHSEngland/Healthcareabroad/countryguide/NonEEAcountries/Pages/Non-EEAcountries.aspx

those British nationals who still visited or retired would presumably have to pay equivalent costs through full private travel insurance. In Switzerland, access to EHIC is included within a package of agreements which also enshrine the free movement of labour, and the UK's attitude to inclusion within these EU provisions may be seen as relevant.[24]

2.3. Longer-term arrangements

Separate arrangements apply to those who move permanently between the UK and EU.

It may be in the narrow interest of the NHS to move to a system in which future EEA migrants make additional contributions – as exists for many categories. However, it is widely believed that there will be an element of reciprocity in future agreements regarding the rights of British migrants to the EU, and EU migrants to the UK: British citizens living or moving abroad would therefore be likely to pay a price.[25] As with the S1 form for pensioners, there is a possibility of creating an incentive for the most ill to return to the UK, with potentially limited support, to use NHS care.

Again, less convenient arrangements will have implications for trade and the ability to attract skilled migrants – including those needed in health and social care.

24 http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:22002A0430(01)
25 https://www.theguardian.com/politics/2016/jul/27/theresa-may-eu-citizens-rights-britons-abroad

3. Regulation

3.1. European law affecting health and social care

A number of European economic and labour rules have important consequences for the NHS and social care. In several cases credible arguments for change have been put forward. While it would be beyond the Committee's current remit to endorse changes to any particular law, it could be argued that the flexibility to do so would be a significant positive outcome of Brexit negotiations.

The 2003 Working Time Directive, as currently interpreted by the NHS, imposes a limit of 48 hours average weekly working time for staff. While agreeing that previous much longer working hours should not be reintroduced, several bodies representing doctors across the UK have expressed serious concerns about the Directive's impact.[26] [27] The rigidity imposed on arrangements for on-call working is a source of particular concern. The Association of Surgeons in Training is typical in arguing that the Directive limits the opportunity of trainees to take part in activities needed to develop their skills, and encourages dishonesty around how many hours are actually worked: 71 per cent of trainees polled felt the regulation had a negative effect.[28]

The 2014 EU Public Procurement Directives require the open competitive tendering of all contracts above EUR750,000 in value. The directives apply to the English NHS, because it is now run on the basis of contracting between separate bodies with the characteristics of

26 http://blogs.bmj.com/bmj/2016/07/20/clare-marx-making-the-best-of-brexit-for-the-nhs/
27 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjuvOGotvPPAhUSM8AKHdg4D0UQFgggMAE&url=https%3A%2F%2Frcpsg.ac.uk%2Fmedia%2Fpa%2FP3%2FFiles%2FConsultations%2FCollege%2FWorkingTimeDirective.docx&usg=AFQjCNG3LglzaaAXBPa4ySVi3yJ7QyamRA&sig2=6W2hA2CpZ8vbeG_oyLTofQ
28 https://www.asit.org/resources/press-notice-18th-july-2016/res1248

enterprises.[29] They are now enshrined in UK law, and indeed arguably UK law contains even more stringent requirements.[30] [31]

Again, there is a significant body of opinion that these laws are not helpful, especially as the English NHS moves towards more collaborative models.[32] In the 2015 election, the Labour Party ran on a platform of exempting the NHS from procurement law.[33]

Other significant laws include the Acquired Rights Directive, which transfers employees' rights when they change employers, and the principle of not permitting anti-competitive behaviour, which is part of fundamental EU treaties.[34] Both are also enshrined in UK law.

3.2. Future status and negotiation

In the medium term these regulations will remain in force. The Government plans to put forward a Great Repeal Bill which will convert the entirety of the *acquis commaunitaire*, the body of European law, into British law. The *acquis* includes judgements made by the European Court of Justice[35], and based on this it would appear that precedents set by past cases, such as Kiel v Jaeger which made time on call subject to the Working Time Directive, will continue to apply.

However, the negotiations will determine whether or not the UK can change them after this point. This will be an issue in negotiations even if the UK is outside the EEA.

29 http://www.nhsconfed.org/regions-and-eu/nhs-european-office/influencing-eu-policy/public-procurement
30 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560261/Brief_Guide_to_the_2014_Directives_Oct_16.pdf
31 http://www.publiclawtoday.co.uk/local-government/procurement/308-procurement-and-contracts-articles/29149-brexit-and-public-procurement
32 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/procurement-competition-rules-kings-fund-mar-2015.pdf
33 https://www.theguardian.com/society/2015/mar/18/key-labour-nhs-pledge-impossible-to-deliver-says-influential-thinktank
34 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/procurement-competition-rules-kings-fund-mar-2015.pdf
35 http://researchbriefings.files.parliament.uk/documents/SN05944/SN05944.pdf

Switzerland's bilateral agreements with the Union commit it to follow similar rules regarding public procurement, and it has implemented the Working Time Directive.[36] [37]

The Department of Health should consider which options it may want to hold open to change NHS regulation in future. It is reasonable that the interests of the NHS would be weighed against those of other sectors affected, and the wider scope of a future trade arrangement.

36 http://www.europarl.europa.eu/meetdocs/2009_2014/documents/deea/dv/2203_07/2203_07en.pdf
37 https://www.addleshawgoddard.com/globalassets/insights/employment/employment-law-consequences-of-brexit.pdf

4. Life sciences

4.1. Research and rare diseases collaboration in the EU

The EU is currently planning to introduce several initiatives to fund and coordinate medical research. Horizon 2020 is a seven year EUR70 billion funding initiative.[38] There are already concerns that UK institutions, including NHS trusts, are being shut out of cross-border bids due to concerns over uncertainty. While some countries outside the EU are permitted to access the fund, it is significant that Switzerland's access has been explicitly linked to it accepting the free movement of people.[39]

A new Clinical Trials Directive is to be introduced in 2017, making cross-border trials easier by harmonising regulations and applications.[40] The EU also plans to introduce a new framework of European Reference Networks to coordinate and pool expertise on rare diseases.[41] Whether the UK will be included in these will be a subject of exit negotiations.

4.2. Implications for the NHS and UK patients

Any potential loss of involvement in clinical trials and in rare disease networks is obviously bad for patients who lose access to treatments and expertise. It may also remove opportunities to learn from and disseminate the most advanced practice. Putting in doubt the funding of research and innovations through Horizon 2020 and other programmes would have a similar effect, as well as putting in doubt a significant source of funding for some NHS trusts. While the Treasury has guaranteed underwriting of grants through

38 http://www.nhsconfed.org/regions-and-eu/nhs-european-office/innovation-and-eu-funding/horizon-2020
39 https://www.euresearch.ch/en/european-programmes/horizon-2020/swiss-participation-in-horizon-2020/
40 http://www.nhsconfed.org/regions-and-eu/nhs-european-office/influencing-eu-policy/clinical-trials
41 http://www.nhsconfed.org/regions-and-eu/nhs-european-office/influencing-eu-policy/cross-border-healthcare/european-reference-networks

Horizon 2020 and some other programmes, exclusion would remove opportunities for collaboration and future funding applications.[42]

More nebulously, there is a risk that both these developments would make working in NHS hospitals across the UK less appealing to the most able and mobile clinicians and scientists.

Although the Departments for Business and Education are primarily responsible for research and science policy, the Department of Health should have a significant voice in arguing for stability and collaboration in negotiations to leave the European Union.

42 http://www.nature.com/news/uk-government-gives-brexit-science-funding-guarantee-1.20434

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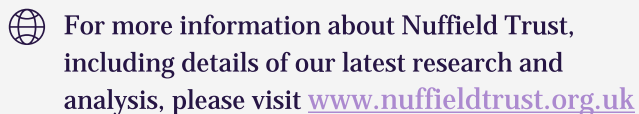
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