Immigration and Social Security Co-ordination (EU Withdrawal) Bill

This briefing, from impartial think-tank the Nuffield Trust, examines the potential impact of the Immigration Bill on the NHS and social care. It looks both at the direct provisions of the Bill, and at the context of Brexit and the Immigration White Paper which will determine its impact in practice.

Key points

- Social care and the NHS are both experiencing staffing pressures that obstruct vital care. The end of free movement poses some risk of worsening this in and of itself, by creating a deterrent effect. The measures in the Immigration White Paper would considerably worsen the situation.

- Shifting future EEA migrants from free movement to a restricted high-skill migration system will create additional barriers to their remaining permanently in the UK. 72% of nurses, 70% of scientific, therapeutic and technical staff and 36% of ambulance staff earn less than the required amount. MPs should seek assurances, possibly backed by provisions in the Bill, that exemptions will be maintained and expanded as a minimum.

- A blanket application of the proposed £30,000 salary threshold for nurses entering the UK as skilled migrants would cause a significant problem, ruling out one nurse in twenty of all those joining English trusts. The existing system of different limits and

exemptions should be kept and expanded to EU staff, but even under these most NHS support staff and some ambulance staff would be denied entry as migrants.

- The low skilled migration route proposed in the White Paper is poorly suited to adult social care because it is temporary and much less appealing than current options. In view of the multiple problems in the sector, MPs should ask for an alternative system to be considered, possibly backed by provisions in the Bill.

Reciprocal healthcare

The Bill will have important implications for the future UK access to EU reciprocal healthcare schemes. These include the European Health Insurance Care which provides access to care for travellers, used by 27 million UK citizens; and the S1 initiative which allows expatriate pensioners to access care on the same basis as a local, which is being used by 190,000 UK citizens.

It is Part 2 of the Bill which specifically grants the power to change the EU law creating these initiatives – Regulation 883/2004 and its successors. However, Part 1 and Schedule 1 which end free movement of people will have a more fundamental effect. Reciprocal healthcare rights are closely tied to the free movement of people, and there is no precedent for a country without free movement of people having access to EHIC, S1 or other similar schemes.

If a Brexit withdrawal agreement is passed, this Bill would therefore make it very difficult to negotiate a future relationship with the European Union where UK nationals can use these schemes – unless later legislation reintroduces the free movement of people. The recent Healthcare (International Arrangements) Act creates legal powers to negotiate new replacement agreements. This is a logical reaction, although outside the EU reciprocal healthcare arrangements tend not to be of comparable scope.

NHS staffing

The NHS is in a state of chronic staff shortage due to poor planning and insufficient training numbers over many years. There are 100,000 vacant posts in English trusts alone, although many will be filled by agency workers. The problem is concentrated in nursing and general practice.

With no immediate way to fill the gap domestically, migration has been an important stopgap: one in five nurses joining English NHS trusts in 2016-17 was of non-UK nationality. Our work with the King's Fund and Health Foundation shows that this will remain vital. Even

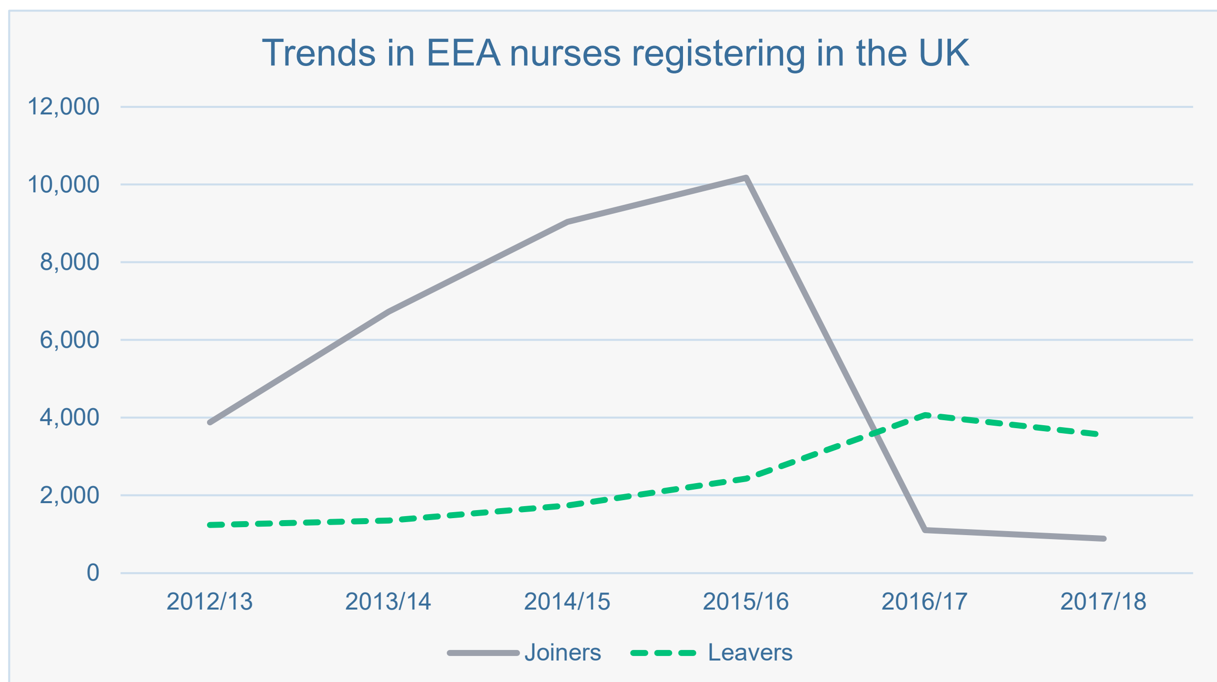
with a wide range of measures to attract more nurses domestically and keep them working for the NHS, the nursing gap will not shrink at all by 2023/24 without a recruitment drive attracting 5000 overseas nurses each year.

The proposed end to free movement of people will make it more difficult for the health service to use migration to fill in the gaps in its workforce. This is troubling: while we would agree that the underlying problem is largely a problem of the health and social care system's own making, it seems wrong that patients should pay the price. Proposals in the Immigration White Paper would present particular difficulties for certain staff groups.

Impact of ending free movement of people

Regardless of the specific provisions which replace it, the end of free movement is likely to have a significant disincentive effect to NHS migration.

No replacement system can offer the same degree of certainty to migrants as free movement under EU or EEA treaties, because these enshrine rights in trans-national law that cannot be changed. Combined with the political direction of travel which it signals, this means ending free movement is likely to somewhat discourage people from coming to the UK, regardless of the system we adopt to replace it. This dynamic is suggested by trends following the Brexit referendum. Despite continued free movement the number of migrants from the EEA has declined. For nurses, a previous heavy inflow has been dramatically reversed, as shown below, though this effect may have been exacerbated by new language requirements.



Impact of skilled migration provisions

The skilled migration proposals set out in the Immigration White Paper would have a more direct limiting effect. We welcome the abolition of the numerical cap, which had disastrous effects when it caused required salaries to soar until doctors and nurses were exempted from it last year. But the proposed minimum salary threshold of £30,000 is a potential concern.

Nuffield Trust analysis of NHS digital data from 2017-18 produced an estimate that 40% of all nurses joining English NHS trusts and CCGs were at pay points that would currently be paid at below £30,000 per year on a full-time basis. This is even after adjusting for nurses in London being pushed over the threshold by the extra pay they receive to keep up with the cost of living: we assumed all nurses in the capital would receive full extra pay, although in reality only those in inner London would. The calculation of what proportion of joiners would be above £30,000 is based on where nursing staff already working for the NHS sit in their pay scales. In fact joiners probably typically start at lower rates. The true figure is therefore likely to be higher than 40%.

The proportion of EU nurses which would have been caught by the threshold had they been new migrants is slightly higher at 42%. This would be around 1000 of the nurses joining trusts in 2017/18 in England alone, even if they had been paid today's higher salaries. An additional 1500 nursing joiners from outside the EU would not have been allowed as new migrants. The two combined, 2500 in total, would be equivalent to 5% of all nursing joiners in 2017-18. It is important to note that this would be an annual effect in the medium term, steadily adding to the gap in the nursing workforce described above.

At minimum some sort of exemptions must be applied. These were recommended by the Migration Advisory Committee, and exist in the current non-EEA system, but are troublingly absent from the White Paper. Options include continuing the lower requirements for nurses, medical radiographers and paramedics that currently exist, which require only a salary £20,800. Assurance of this as a minimum is important.

However, these current exemptions do not cover, for example, ambulance staff at band 4 or below, which would appear to rule out 16% of joiners in this category.

The Migration Advisory Committee's report on EEA migration recommended retaining a "new entrant" threshold at £20,500. However, like the lower threshold for nursing and paramedics, this is not mentioned in the White Paper. It is important to recognise that this only applies to new entrants on graduate schemes or post-work study, and many nursing joiners described above would not be included. It also does not currently apply to those

requiring sponsorship for more than three years, a serious problem for a sector where continuity and workforce stability are required.

MPs should ask the Government to consider temporary or permanent exemptions when they respond to the White Paper consultation. They could consider amendments to the Bill which add duties to create a tailored system to health care, or a duty to report to Parliament on how this has been guaranteed.

Impact of salary requirement to stay in the UK

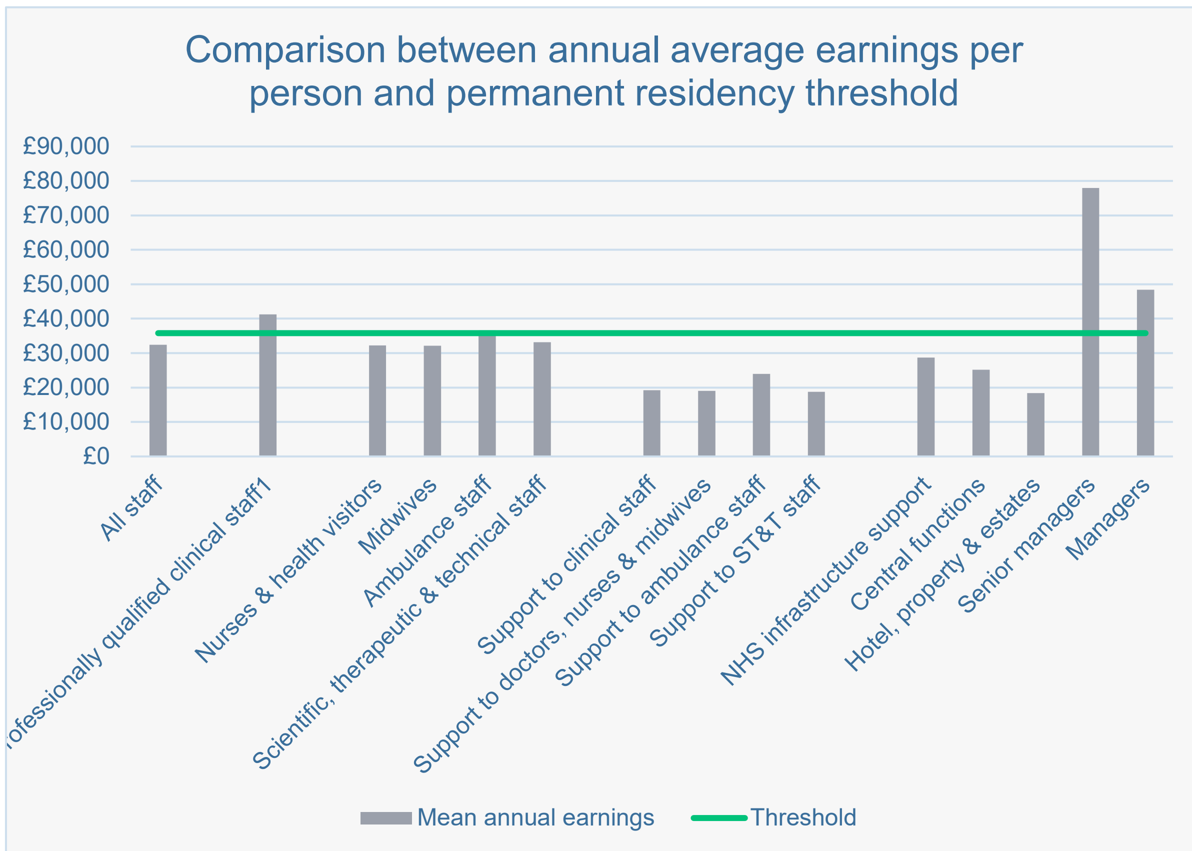
Part 1 of the Bill, ending free movement, would also change how the EU migrants who arrived under this skilled route could gain leave to remain permanently. EU migrants already here, or who arrive before the end of free movement, will be allowed to stay without conditions. But from the end of 2020 when free movement would end following a transition period, new arrivals would need to meet requirements for "indefinite leave to remain", one of which will be a minimum salary requirement.

Taking data on individual NHS staff earnings at the end of 2017 (provided by NHS Digital) and adjusting it for pay rises since suggests that 72% of nurses, 70% of scientific, therapeutic and technical staff and 36% of ambulance staff would fail to meet the current threshold of £35,800. The pay data is rounded to the nearest hundred, so these results are not exact. However, these figures do include overtime payments and extra pay for London: the large proportion still falling below the threshold underlines how high this requirement is compared to the reality of pay in the NHS.

Nurses and paramedics are currently listed as a shortage occupation and therefore not subject to the requirement – as a minimum this should continue. This has currently been guaranteed only as far as 2021, but our analysis with the King's Fund and Health Foundation showed shortages will remain a major concern at least until 2023/24 even with concerted action.

However, many other key groups are not listed as shortage occupations. EU and EEA staff currently make up over 5% of scientific, therapeutic and technical workers in English NHS trusts, more than 8000 individuals. While most are not currently in shortage, the recent GP framework rests heavily on deploying workers like pharmacists and physiotherapists in general practices where they have not traditionally worked – so the current healthy supply is very much being banked upon. Although the Migration Advisory Committee's recent review did recommend extending shortage status to certain groups, like some radiographers, the pharmacists and physiotherapists the NHS will rely on to close key gaps were not included.

The graph below shows how the average salary of different non-medical staff compares to the £35,800 threshold.



We would suggest at a minimum that shortage status should continue to be closely reviewed for these groups. A general NHS exemption, or setting the threshold for leave to remain based on whether people are paid at the relevant NHS pay band, might be simpler and provide more certainty.

Impact of new charges

As part of its single migration system across EEA and non-EU arrivals, the Immigration White Paper would also apply many additional charges, checks and requirements on EEA migration. Financially, a skills charge and health surcharge would apply, at £1000 and £400 per year respectively under current rates, in addition to a £1,476 sponsorship licence fee and £199 for sponsorship. Employers are liable for all these except the health surcharge, although some NHS employers have offered to pay this for their workers.

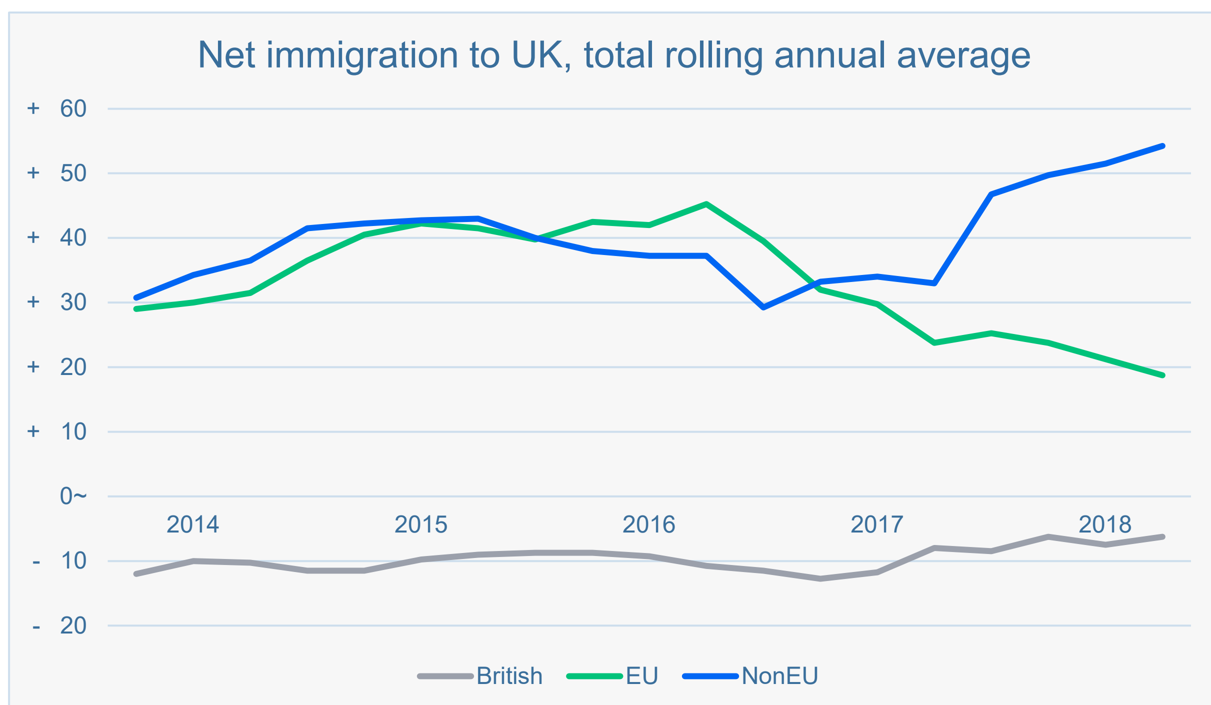
Based on the 11,593 joiners to English NHS trusts from the EEA in 2017-18, a figure already reflecting a slowdown since Brexit, this would imply total additional cost of £32 million per year's worth of migration, if we assume joiners staying for three years.

Assuming one dependent for each migrant on average, the additional health surcharge cost would be £28 million per year on the same basis.

The figure would in reality be considerably higher, as new joiners to GP practices, private contractors to the health service, and the Scottish, Welsh and Northern Irish health services would also be affected.

Ending freedom of movement

As with NHS staff, it seems likely that the end of freedom of movement under Part 1 of the Bill will create a deterrent effect. The EU referendum has been associated with a marked slowdown in total EU migration, a relevant metric in social care where many workers are drawn from a wider labour pool. Data from the sector do not yet show a marked slowdown in the increasing proportion of social care staff with EEA nationality, but they go only as far as 2017-18.



Which regions will be especially exposed?

Within England, London is the area most reliant on EU migration of NHS staff. 14% of nurses joining trusts in London in 2017-18 were from the EU. A similar picture exists for doctors. 16% of doctors joining trusts from London in 2017-18 were from the EU, with 12% in the Thames Valley.

However, our estimates suggest that areas in south-east England outside London, not benefitting from the same higher rates of pay, would be most exposed to a £30,000 restriction. The Thames Valley region would have had one in 20 nursing joiners (5%) blocked in that year by this restriction applied to EU staff at current pay rates. Taking into account migrant nurses from both the EU and the rest of the world, the East of England would have been the most affected, with one in seven (14%) of nursing joiners being migrants whose pay points fall below the threshold.

Comparable data on joiners is not available for Scotland, Wales and Northern Ireland, but there is information on all registered doctors. Here, Northern Ireland appears to be the part of the UK most reliant on staff who qualified in the EEA. These account for 9.3% of doctors registered in the country, compared to 8.6% in England and around 6% in Scotland and Wales. Many of these are likely to be from the Republic of Ireland, and so future arrivals would continue to be given access under Clause 2 of the Bill, which we would welcome for this reason.

Social care

Adult social care in England is heavily reliant on migration to fill vacancies, in direct care roles in particular, with 18% of workers coming from abroad, 8% from the EU. This proportion has grown markedly in recent years, yet even this has not prevented a rising vacancy rate.

We are worried that any further strain on this workforce will create a real risk that local authorities would not be able to meet their statutory requirements to provide care.

Far from putting forward constructive and realistic proposals to address the growing shortfall in staff in this sector, we are concerned that the Bill, and the White Paper which lays out the intentions associated with it, risk exacerbating an already difficult situation.

What impact will a minimum salary threshold have?

The White Paper's proposals for general skilled migration will exclude most workers entirely and be difficult even for better paid groups in social care.

Applying the threshold to nursing would again have an especially acute impact. Average nursing pay in social care is also below £30,000 and 17% of social care nurses are from the EEA, far higher than in the NHS. While data as detailed as for the NHS is not available, the £30,000 salary threshold is around the average for occupational therapists and registered managers in the independent social care sector. Unlike nurses, these groups are not on the shortage occupation list currently and do not currently have lower pay thresholds based on public sector pay bands.

Experienced but less qualified staff groups – such as senior care workers – who have "intermediate skills" would also be squeezed out by the salary threshold. These staff already face critical shortages and chronically high turnover.

While there are serious issues with the access of even more qualified and higher paid groups to the skilled migration route, for most workers in the sector using this route would be out of the question.

The "low skilled" migration route

The majority of social care workers fall into groups where the average pay is below £20,000, and most are also unlikely to meet the educational requirements for classification as medium or high skilled. The White Paper's framework would therefore categorise most of the social care workforce as "low skilled" – a characterisation we would dispute given that care work, in fact, requires considerable skill. The proposals for this group include:

a) Workers in this category will enter the UK on a temporary 12 month basis.
b) They would have no right to extend their stay or convert that 12-month stay into permanent settlement. After 12 months they would have to leave, and would not be able to return for a further 12 months.
c) They would have no right to access public funds (including health care other than in an emergency)
d) They would have no right to bring dependants
e) They will be able to move between employers

These raise a set of serious concerns.

The fixed 12 month visa and further 12 months 'cooling off' period will exacerbate existing recruitment and retention challenges, and are likely to lead to even higher staff turnover. In

addition, because people will be able to move between employers, there is a risk that they could be drawn swiftly into other sectors that pay better, such as the health sector or retail. The provider market remains fragile, and building in mechanisms that drive even higher staff turnover will not secure the long-term stability that the sector so badly needs.

Short-term visas will not help providers to offer the continuity of care and long-lasting relationships valued by users of care services, particularly people with dementia. Furthermore, providers are unlikely to invest in development and training for short-term staff.

As with health staff above, the effect on people's willingness to come should also be considered. We will be competing with other countries to recruit from the same pool of workers. Our work looking at long-term care systems internationally has found that at the moment that the UK is seeking to make its policies more restrictive, both Germany and Japan are making their immigration policies more attractive to migrants.

Plausible solutions

We would suggest a long term unskilled migration route for those working in social care. The Migration Advisory Committee has raised concerns that underfunding of social care is the underlying problem. However, we are concerned that firstly decisive action to address this has been repeatedly delayed, with an impact on vulnerable people now; and secondly the hypothesis that higher funding would address the workforce problem entirely remains untested, and relying on it would be risky. We would suggest that social care funding should be addressed, and only then should the Government look at to what extent migration to the sector remains necessary.

MPs would have a range of options in debates on the Bill. They could ask for assurances that the Government is considering both funding and migration in social care. As with health care migration, a duty to create a tailored solution or to report to the House on doing so could also be added directly to the Bill.

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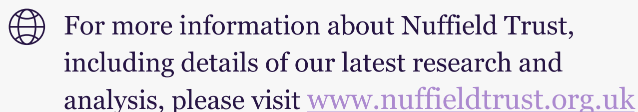
Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.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