

Written submission

Written evidence submitted by The King's Fund to the Health Committee inquiry into Brexit and health and social care

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

In line with the terms of reference for the inquiry, our response focuses on the issues to which attention will need to be paid in the withdrawal negotiations in relation to health and social care and, where applicable, the outcomes that should be sought. Our response is largely based on our briefing – '[Five big issues for health and social care after the Brexit vote](#)' – that we published in June 2016 shortly after the UK's vote to leave the EU (McKenna 2016).

Executive summary

- The impact of the UK's vote to leave the EU could have major implications for health and social care, not least because it has ushered in a period of significant economic and political uncertainty at a time when the health and care system is facing huge operational and financial pressures.
- With little clarity as yet over the nature of the UK's exit deal, a number of important issues will need to be resolved during the negotiations on the UK's withdrawal from the EU. The key priorities are: the recruitment and retention of EU nationals in the health and social care workforce; arrangements for accessing treatment here and abroad; regulation; cross-border co-operation; and the impact on funding and finances.
- Health and social care has long relied on EU and other foreign nationals in all parts of the workforce. Without them quality of care and the sustainability of some services would inevitably suffer.
- An immediate priority is for the government to clarify its position on the status of EU nationals currently working in health and social care roles in the UK. We recommend they are granted the right to remain in the UK. In

the longer term, providers of NHS and social care services should retain the ability to recruit staff from the EU.

- The rules governing UK citizens' access to health and care in the EU, and EU citizens' access to UK services will need to form part of withdrawal negotiations. The most straightforward approach would be to continue existing arrangements.
- In many important areas, the government will need to clarify whether its intention is to repeal EU regulations and replace them with UK-drafted alternatives or to continue to abide by them. These include: the Working Time Directive; procurement and competition law; regulation of medicines and medical devices; and regulation to enable common professional standards and medical education between European Economic Area (EEA) countries.
- As well as playing an important role in a range of public health issues, the EU operates systems for the surveillance and early warning of communicable diseases. Collaboration across the EU has also enabled the UK to further its scientific research agenda. We would argue that both issues should be priorities in forthcoming negotiations.
- The economic impact of the vote to leave will have significant implications for health and social care, with the fall in the value of sterling feeding through into higher prices for some drugs, for example. In the long term, the performance of the economy will be a key determinant of health and social care funding.

1. Workforce

1.1 The NHS and social care has long relied on EU and other foreign nationals in all parts of the workforce. As the Cavendish Coalition¹ has stated, if a significant proportion were to leave 'the sustainability of some services and the delivery of high quality services would be jeopardised' (2016). It will therefore continue to be essential for health and care organisations to be able to recruit from the EU in the future.

1.2 The EU's policy of freedom of movement and mutual recognition of professional qualifications within the EU means that many health and social care professionals currently working in the UK have come from other EU countries. This includes approximately 58,000² of the NHS's 1.3 million workforce and around 90,000 of the 1.3 million workers in the adult social care sector (NHS Digital 2016; Skills for Care 2016a).

1.3 It is widely acknowledged that the NHS is currently struggling to recruit and retain permanent staff. There was a shortfall in 2014 of 5.9 per cent (equating

¹ A group of 29 organisations representing staff and employers from across health and social care, formed in the wake of the UK's vote to leave the EU

² Headcount, as at March 2016

to around 50,000 full-time equivalents) between the number of staff that providers of health care services said they needed and the number in post, with particular gaps in nursing, midwifery and health visitors (National Audit Office 2016a). Although some progress is being made following action by the national bodies (Dunn *et al* 2016), major imbalances between the supply and demand for nurses means that NHS trusts continue to rely on employing more costly temporary staff to fill the gaps. Our own research also shows particular workforce issues in general practice and community health services (Baird *et al* 2016; Maybin *et al* 2016). These pressures are unlikely to ease in the future – a recent report from the Royal College of Nursing, for example, found that half of nurses are aged 45 or over and within ten years of being eligible for early retirement (Royal College of Nursing 2016).

1.4 Similar problems exist in the social care sector, with providers across the country struggling to recruit and retain staff (Humphries *et al* 2016). The care sector as a whole has a vacancy rate of 4.8 per cent (compared with a vacancy rate of 2.6 per cent across the economy). For qualified nurses the vacancy rate is 9 per cent; estimates suggest that slightly more than a third of nurses have left their role within the past 12 months (Skills for Care 2016b). One estimate suggests that the sector could face a shortfall of more than one million care workers by 2037 (Independent Age 2015).

1.5 Brexit must not compound the existing workforce pressures outlined above. Until the UK extracts itself from its obligations under EU treaties, the policy on freedom of movement remains unchanged; however, given the current shortfalls being experienced in the health and social care sector the government must clarify its intentions on the ability of EU nationals to work in health and social care roles in the UK, not least to avoid EU staff who are currently working in the sector deciding to leave to work in other countries or discouraging others from coming to the UK to take up vacancies. Since the referendum result was announced, the Secretary of State and health and social care leaders have stressed the importance of EU staff working in health and social care (see, for example, Lintern 2016a, 2016b; Albert 2016). However, these reassurances are in contrast to the government's official position – that whether EU nationals living in the UK are allowed to stay depends on how British nationals are treated by their EU counterparts – and the uncertainty caused by statements from some other senior ministers.

1.6 In his speech to the Conservative party conference in October 2016, Jeremy Hunt announced plans to train up to 1,500 more doctors every year, resulting in 'more home-grown doctors' with the aim of making the NHS 'self-sufficient in doctors' by the end of the next parliament (Hunt 2016). While recognition of the workforce pressures facing the NHS is welcome, it will take a number of years for these extra staff to filter through to the front line. This is a long-term policy and will not address the current shortages being faced across the sector. It also needs to be remembered that it is expensive to train doctors. While the main

costs of the plans to train more doctors will fall into the next Spending Review period, these costs will need to be met and ideally, not by cutting other areas of health and care services.

1.7 Furthermore, it is important to recognise that the impact of the UK leaving the EU will not solely affect the supply of doctors, it will impact on nurses and non-clinical staff too including the relatively unskilled, as well as social care. The impact across all staff groups must not be overlooked. Wider life sciences – such as the pharmaceutical and biotech industries as well as those individuals working in publicly funded research – have also benefited from freedom of movement as well as cross-EU collaboration.

1.8 Providers of NHS and social care services should retain the ability to recruit staff from the EU. The Migration Advisory Committee's shortage occupation list already enables employers to recruit nurses and midwives from outside the European Economic Area.

2. Accessing treatment here and abroad

2.1 There has been a great deal of debate about the impact of immigration on the NHS. Where immigration increases the overall population, it is likely to raise the demand for health and care services. However, the average use of health services by immigrants and visitors appears to be lower than that of people born in the UK, which may be partly due to the fact that immigrants and visitors are, on average, younger (Steventon and Bardsley 2011) and healthier. However, there is a lack of reliable data on the use of health services by immigrants and visitors, so it is impossible to make a robust estimate.

2.2 EU citizens are entitled to hold a European Health Insurance Card (EHIC), which gives access to medically necessary, state-provided health care during a temporary stay in another EEA country. The costs of treatment under these schemes can be subsequently reclaimed from the visitor's country of residence via reciprocal health care agreements. This could have potentially significant implications for the nature and scope of future charging arrangements, both for EU nationals living in the UK and for British nationals in EU countries, and will be a key area to work through during the withdrawal negotiations (National Audit Office 2016b).

2.3 More generally, at present EU rules govern the access of EU citizens to health care in other EU countries. These rules will now need to be negotiated. While migration has increased the size of the UK population, as noted above many EU migrants have tended to be younger and make less use of health and care services than older people. This means that the future rules and regulations determining the rights of UK citizens who have relocated – and often retired – to countries such as Spain could be important. The costs of treating British people in these circumstances fall to the Department of Health and any increases – for

example, if a EU country looked to raise the prices for treatment – would also fall on the Department.

2.4 The government should negotiate new reciprocal agreements (such agreements already exist with some non-EU countries) or alternatively seek to continue existing arrangements.

3. Regulation

3.1 In many important areas, the government will need to clarify whether, as part of the Great Repeal Bill, its intention is to repeal EU regulations and replace them with UK-drafted alternatives or to continue to abide by them. These include:

- the Working Time Directive
- procurement and competition law
- regulation of medicines and medical devices
- regulation to enable common professional standards and medical education between EEA countries

Working Time Directive

3.2 One of the most contentious pieces of EU legislation affecting the NHS is the European Working Time Directive, which was introduced to support the health and safety of workers by limiting the maximum amount of time that employees in any sector can work to 48 hours each week, as well as setting minimum requirements for rest periods and annual leave. The directive allows doctors to opt out of the 48-hour limit (the UK is one of the few countries to make use of the opt-out); some specialties have been concerned that the 48-hour limit affects training, and a Royal College of Surgeons (RCS) review of the directive called for more widespread use of the opt-out (Independent Working Time Regulations Taskforce 2014).

3.3 If the government decides to repeal or amend The Working Time Regulations 1998 (the UK law enacting the EU directive), this would have implications for NHS employment contracts and require significant changes to the Agenda for Change pay framework.

Procurement and competition law

3.4 The impact of EU competition and procurement rules on the NHS is contentious. As the relevant EU directives have already been incorporated into UK law, the government would need to repeal or amend the law if it wished to reverse current arrangements. Although a combination of the Competition Act, Monitor's provider licences and the NHS Procurement, Patient Choice and Competition Regulations continues to prohibit anti-competitive behaviour by NHS

providers and commissioners, withdrawal from the EU would allow policy-makers to modify these arrangements. However, this will depend on the agreement the UK reaches with the EU on their future trading relationship as well, of course, as overall policy stance of future UK governments towards competition. This could present an opportunity to clarify current procurement and competition rules, which can act as a barrier to developing the new models set out in the *NHS five year forward view*.

Regulation of medicines, medical devices and clinical trials

3.5 EU legislation provides a harmonised approach to medicines regulation across the EU member states. The UK is currently part of the centralised authorisation system, which is operated by the European Medicines Agency (EMA), based in London. A statement released by the EMA in early July stressed that operations would continue as usual. However, it also welcomed 'the interest expressed by some Member States to host the Agency in future' (European Medicines Agency 2016), and a number of countries are reported to have done so (Boffey 2016).

3.6 The EMA is responsible for the scientific evaluation of human and veterinary medicines developed by pharmaceutical companies for use in the EU. Companies are able to submit a single application to the EMA to obtain a marketing authorisation that is valid in EU, EEA and European Free Trade Association (EFTA) countries.

3.7 The UK has its own national regulatory agency, the Medicines and Healthcare products Regulatory Agency (MHRA). However, this deals with national authorisations intended for marketing only in the UK. The inclusion of EEA and EFTA countries for centralised marketing authorisation may mean that, despite leaving the EU, the UK could continue its relationship with the EMA. If this is not the case, however, pharmaceutical companies may need to apply to the MHRA for authorisation for any medicines they wish to supply to the UK. Concerns raised in a recent report from the UK life sciences sector included that no longer being in the EU regulatory system could result in the UK becoming 'a second priority' launch market, that 'there is no appetite to add regulatory bureaucracy by losing European scale and consistency', and recommending that alignment with the EU regulatory system be maintained (UK EU Life Sciences Transition Programme Steering Group 2016).

3.8 Regulation of medical devices is currently devolved to third parties called 'notified bodies' that authorise the use of devices across the EU and carry out all pre-market assessments. In the UK, these bodies are accredited by the MHRA. The MHRA does not conduct regulatory assessments and approvals, and establishing an equivalent regulatory structure would be a significant undertaking.

3.9 While clinical trials are currently carried out on a national level, regulations due to take effect in 2018 will harmonise arrangements across the EU with the aim of creating a single entry point for companies that wish to carry out trials of new drugs in different countries. During – and since – the referendum campaign, concerns were expressed by some in the pharmaceutical industry that leaving the EU would result in the UK losing out on some trials that might benefit patients as we would no longer be part of the harmonised procedure.

4. Cross-border co-operation

4.1 As well as playing an important role in a range of public health issues, the EU operates systems for the surveillance and early warning of communicable diseases, managed by the European Centre for Disease Prevention and Control. These facilitate the rapid sharing of information and technical expertise in response to potential pandemics, communicable diseases and other cross-border health threats. Recent examples of such collaboration include the H1N1 pandemic and efforts to tackle anti-microbial resistance (AMR).

4.2 Collaboration across the EU has also enabled the UK to further its scientific research agenda, through our ability to access both European research talent and important sources of funding. For example, between 2007 and 2013 the UK contributed 5.4 billion euros to EU research and development (Office for National Statistics 2015) but also received 8.8 billion euros for research, development and innovation activities (European Commission 2015). There are also other formal and informal networks across Europe – for example for some rare diseases, where the low number of people affected make it beneficial to work across the EU – that may be affected.

4.3 Members of the academic and medical communities have already expressed serious concerns about the impact of leaving the EU on the free movement of researchers across Europe and on the ability of UK researchers to attract research funding (see, for example, Ghosh 2016; Lechler 2016; Mossialos *et al* 2016). We share these concerns and would argue that the UK should aim to retain the benefits of cross-border co-operation as an objective in the forthcoming negotiations.

5. Funding and finance

5.1 Although not an area for negotiation at an EU level, it is important that the impact of the UK's vote to leave the EU on public finances, in particular in relation to health and social care, is not overlooked.

5.2 The claim that money spent on the UK's membership of the EU could be used to increase funding for the NHS was one of the most high-profile and contentious of the referendum campaign. Vote Leave argued that membership of

the EU was costing the United Kingdom £350 million a week, which could be spent on 'other priorities like the NHS'. Senior figures from the campaign, including the current Foreign Secretary, Boris Johnson, pledged additional funding for the NHS of at least £100 million a week (Vote Leave 2016).

5.3 2016/17 is already set to be a very challenging year for the NHS, with service leaders facing huge financial pressures and performance against key targets deteriorating (Murray *et al* 2016). The immediate impact of the vote to leave, in terms of the resulting fall in the value of the sterling and rising inflation, will mean higher prices for some drugs and other goods and services that the NHS purchases, and may increase pressure on wages.

5.4 In the long term, the performance of the economy will be a key determinant of funding for health and social care.

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