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Brexit: The Implications for Health and Social Care

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Brexit has major implications for health and social care in England. Here we look at some of the latest developments that could impact the health and care system in England.

The deadline of 29 March 2019, set when Article 50 was triggered, is rapidly approaching but many important issues are still to be resolved. Brexit has already had an impact, especially on the recruitment and retention of EU nationals in some parts of the workforce which is contributing to shortages of key staff. In addition, the ongoing debate in parliament and uncertainty about whether a deal can be agreed mean considerable work has gone into preparations for a no-deal Brexit. The Department of Health and Social Care has published guidance for organisations to prepare contingency plans and has established a national operational response centre to lead on responding to any disruption to the delivery of health and care services.

Staffing

Across NHS trusts there is currently a shortage of more than 100,000 staff (representing 1 in 11 posts), severely affecting some key groups of essential staff, including nurses, many types of doctors, allied health professionals, and care staff. Vacancies in adult social care are rising, currently totally 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled. International recruitment is a key factor in addressing these vacancies. Brexit and immigration policy will have an impact on the ability of the NHS to successfully fill these vacancies.

The 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 nearly 62,000 (5.2 per cent)1 of the English NHS's 1.2 million workforce and an estimated 104,000 (around 8 per cent)2 of the 1.3 million workers in England's adult social care sector (NHS Digital 2018; Skills for Care 2018). The proportion of EU workers in both the NHS and the social care sector has grown over time, suggesting that both sectors have become increasingly reliant on EU migrants.

The UK has a greater proportion of doctors who qualified abroad working than in any other European country, except Ireland and Norway. Latest General Medical Council (GMC) data shows that the number of doctors from the European Economic Area (EEA) joining the medical register is holding steady (but still down 40 per cent on 2014 after new language requirements were introduced). A combination of relaxed visa restrictions and active recruitment by trusts means that the number of non-EEA doctors joining the register doubled between 2014 and 2017 (GMC 2018). However, some specialties not currently on the Home Office's shortage occupation list are still facing difficulties, for example child and adolescent psychiatry.

Similarly the number of nurses and midwives from Europe leaving the Nursing and Midwifery Council's register has doubled from 1,981 in 2015/16 to 3,692 in 2017/18, while the number joining fell by 91 per cent (Nursing and Midwifery Council 2018). This fall has been somewhat mitigated by more non-EEA nurses joining the register (Nursing and Midwifery Council 2018). However, even with both EEA and non-EEA registrants taken into account, these figures are considerably below the peak of around 16,000 international registrations in 2001/02. Although there are other contributing factors, including the introduction of new English language requirements in 2016, Brexit has had a significant impact (Murray 2017).

One of the main priorities in the first phase of the UK's negotiations with the EU was clarifying the status of EU citizens currently living in the UK and of UK citizens living in other EU countries. Any EU Citizen currently living in the UK, including the 165,000 EEA staff already working in health and social care are able to apply for the EU Settlement Scheme. They will need to apply by June 2021 (December 2020 in in the event of no deal) in order to be able to stay in the UK.

The government published an immigration White Paper in December 2018 for a new skills-based immigration system to begin in 2021, treating EEA migrants in the same way as non-EEA migrants. It removes the limit on numbers of skilled workers but proposes an earnings threshold which is likely to impact the ability to attract certain health professionals to the NHS. The threshold has generated fierce debate, and the government is expected to consult for another year on where to set the salary threshold for skilled immigrants.

The white paper acknowledges England's reliance on migrants in the social care workforce. However, it proposes that for a transitional period such workers would only be allowed to come for a limited time, with no entitlement to bring dependants. Again, this is likely to impact the ability of the social care system to attract sufficient workers. In the event of a no-deal Brexit, for an interim period EU citizens would be able to enter the UK as they do now but if they wish to stay longer than three months they would have to apply for permission under a new European Temporary Leave to Remain scheme. People who obtain this status would be entitled to live, work and study in the country for a further three years. Other workforce issues that will need to be addressed include:

- mutual recognition of qualifications: the current EU withdrawal bill suggests that

there will be appropriate arrangements in the future relationship for reciprocal professional qualifications. Future arrangements about the process for health and care professionals (including UK citizens) who have an EU/EEA or Swiss qualification and who have not applied to have their qualification recognised by 29 March 2019 are currently before parliament.

- the additional cost implications for the NHS of needing to sponsor visas.
- the need to update employment law: protections for health and care staff regarding employment rights and health and safety at work currently covered by EU legislation. This would include the working time directive, although the current government has committed to preserving this after the UK leaves the EU. These are still under discussion.

Our position

The health and social care sectors have long relied on EU and other foreign nationals in all parts of the workforce and will continue to need them in future.

In the short term, we hope the recent announcement about the EU settlement scheme concerning the status of EU citizens currently living in the UK will provide them with reassurance and persuade as many as possible to stay and continue to make a valuable contribution to the health and social care workforce.

In the longer term, while we welcome efforts to increase the domestic NHS workforce, it will take time for many of these policies to result in extra staff on the front line. Providers of NHS and social care services need the ability to recruit staff from the EU and other countries when there are not enough resident workers to fill vacancies. We recommend a broadening of the shortage occupation lists to include a wider range of medical specialties, allied health professionals and social care managers.

We welcome discussions to lower the earnings cap for skilled workers but remain concerned that the current proposals will impact the ability of both the NHS and social care to recruit lower-skilled workers from the EU and elsewhere.

Finally, it is important to recognise that, while Brexit has the potential to compound workforce pressures, the recruitment and retention problems being experienced in health and social care predate the UK's decision to leave the EU. International recruitment has been very effective in the past and we strongly recommend the government should create a robust and ethical infrastructure for recruiting internationally. Coming to work in the NHS is still not as easy as it should be, and for EEA migrants it is about to get more difficult.

Accessing treatment here and abroad

Currently, EU rules govern UK citizens' access to health and care in the EU, and EU citizens' access to UK services.

EU citizens are entitled to a European Health Insurance Card (EHIC) which gives access to medically necessary, state-provided health care during a temporary stay in another EEA country.3 The cost of treatment under these schemes can be subsequently reclaimed from the visitor's country of residence via reciprocal health care agreements. Around 27 million people currently hold European Health Insurance Cards issued by the UK (Fahy et al 2017).

In addition, under EU rules, people who come from elsewhere in the EU to live in the UK, or who leave the UK to live in another EU country, have access to health care on the same basis as nationals of that country.

Both sides in the Brexit negotiations have agreed in principle to preserve reciprocal health care rights until the end of the transition period, at least for those citizens already residing in another EU country. However, until the final outcome of the talks is known, uncertainty remains about the future. Estimates of the number of people this involves differ among the available sources. However, it has been suggested that there are around 1 million British migrants living in other EU countries, compared with around 3 million EU migrants living in the UK (Department for Exiting the European Union 2017c). UK citizens living abroad tend to be older, and therefore more likely to use health and care services, than EU citizens living in the UK. Were significant numbers of UK citizens to return to the UK this would have implications for health and care services.

In a no-deal scenario, the government will seek to protect current reciprocal healthcare rights through transitional bilateral agreements with other member states, which would include whether or how residents who are citizens of other states would be charged for services. However, there is no certainty on this so the current position is that the EHIC will no longer be valid so British citizens travelling to the EU would need to take out private travel insurance.

> **Our position**
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> Without an arrangement similar to the EHIC, costs will transfer to the individual – people travelling abroad in the EU would need to take out private travel insurance in the same way as they would when travelling outside the EU. The extent of the impact on the health and care system of UK citizens living abroad returning to the UK in the event of no deal is uncertain and requires further modelling.

Regulation

There are a number of EU regulations that impact on the health and care system, including:

- the regulation of medicines
- competition law
- the working time directive.

Regulation of medicines

EU legislation provides a harmonised approach to medicines regulation across the EU member states. The UK is currently part of the centralised authorisation system operated by the European Medicines Agency (EMA) which has now moved from London to Amsterdam, and participates in the EU medicines regulatory network (EMRN).

The EMA is responsible for the scientific evaluation of human and veterinary medicines developed by pharmaceutical companies for use in the EU. Under current arrangements, companies can 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. Being a member of the EMA also gives the UK 'tier 1' market status, meaning that pharmaceutical and medical device companies prioritise the UK as a market for launching their products.

The UK has its own national regulatory agency, the Medicines and Healthcare products Regulatory Agency (MHRA). However, this currently deals with national authorisations intended for marketing only in the UK.

The EU withdrawal agreement sets out a transition period until the end of 2020, during which time the UK will continue to abide by all EU rules, to provide time for the UK to negotiate its relationship with the EU. This would apply to the regulation of medicines. The intention is that eventually the MHRA will operate as a sovereign regulator outside the EMA, but with regulatory equivalence and working closely with the EMA and other international partners. There are already precedents for such arrangements – the EMA currently co-operates with regulatory bodies around the world and has specific agreements in place with countries including the United States, Canada and Switzerland. However, if there is no deal, the UK's participation in the EMRN would cease and the MHRA would take on the functions currently undertaken by the EU for human medicines on the UK market. Contingency legislation would be needed in order for the MHRA to be able to take on regulatory processes for medicines and devices that are currently undertaken by the European Medicines Agency and other bodies.

Some have also expressed concern that if the UK leaves the EMA arrangements and develops its own drug approval system, the UK may lose its 'tier 1' status and end up at the

back of the queue for new medicines (Rawlins 2017). For example, in Switzerland and Canada, which have separate approval systems, medicines typically reach the market six months later than in the EU (Fahy et al 2017).

Pharmaceutical companies and industry bodies have particularly expressed concern about the potential consequences of a no-deal scenario. European and UK supply chains of medicines and medical technologies are 'profoundly integrated', meaning that any new tariff agreements or inspections could cause significant disruption to the supply of medicines to patients, particularly those that are time and temperature sensitive, such as cutting-edge cell and gene therapies (Association of the British Pharmaceutical Industry 2017; AstraZeneca 2017). The government has put in place contingency plans for no deal which include stockpiling medicines and devices.

All medical devices in the UK are currently subject to EU regulations and must comply with EU standards. Higher-risk devices must be certified by an independent body, called an EU Notified Body, which is designated and overseen by the relevant national authority (the MHRA in the UK), following joint audits by two other national authorities and the European Commission. In the event of a no-deal Brexit the government has said that the UK will recognise medical devices approved for the EU market and CE-marked and comply with other EU regulation for medical devices though will have no formal presence at EU committees in respect of devices.

The UK faces a similar issue in relation to future access to medical radioactive isotopes, which are used in the diagnosis and treatment of cancer. In 2016/17 the NHS performed more than 592,000 diagnostic procedures that rely on radioactive material (NHS England 2017).4 The European Atomic Energy Community (Euratom) creates a single market for nuclear energy in Europe and is responsible for co-ordinating and regulating access to these materials. The government has stated that when the UK leaves the EU it will also leave Euratom (Department for Exiting the European Union 2017b), although it hopes to continue working closely with it in future.

Although the government has stated that the UK's exit from Euratom will not have an impact on the availability of radioactive materials, many are concerned about the impact on future supply, including increased costs and a risk to patients should access be disrupted (British Nuclear Medicine Society 2017; Strickland 2017).

There are concerns that supplies of medicines will be interrupted after Brexit. Around three-quarters of the medicines and more than half the devices that the NHS uses, come into the UK via the EU. The government has asked suppliers of medical goods to build up at least six weeks of extract stocks above usual levels, as government plans show that in the event of a no-deal Brexit there is likely to be significant disruption to cross-channel import routes for up to six months. In addition, it has recently supplemented those actions by looking at alternative transport routes and buying extra ferry capacity. GPs, hospitals, community pharmacies and patients have been told they should not stockpile medicines beyond usual levels.

Our position

There are considerable benefits to the UK being a member of the EMA, including a simplified system for companies seeking market authorisation for their products and priority access to new drugs and treatments. Similarly,

being a member of Euratom enables the UK to quickly and safely access nuclear materials that are essential for the diagnosis and treatment of cancer. Whatever the future arrangements, the priority should be for UK patients to have timely, low-cost access to drugs and medical radioactive isotopes. If the MHRA is to become a 'sovereign regulator' it will need to rapidly increase its capability and capacity to manage the increased workload.

Competition law

The impact of EU competition and procurement laws on the NHS is contentious. Although a combination of the Competition Act, provider licences and the Procurement, Patient Choice and Competition Regulations continues to prohibit anti-competitive behaviour by NHS providers and commissioners, leaving the EU would allow policy-makers to modify these arrangements and other relevant legislation. As the relevant EU directives are incorporated into UK law, the government would need to repeal or amend UK law if it wished to reverse current competition policy so there are unlikely to be changes in the short-term.

Many in the NHS would welcome changes in this area. Simon Stevens, Chief Executive of NHS England, has previously remarked that competitive tendering, in which commissioners invite bids from other NHS and private providers, can often create 'frictional cost and dislocation' in the NHS, and has said that the UK will be in a position to 'shape our own decisions' in this area once the UK leaves the EU (Dunhill 2017). Removing the overly rigid competition and procurement regime currently applied to the NHS is one of a number of proposals for legislative change set out in the NHS long-term plan with the aim of accelerating progress towards integrated care.

There has also been discussion about the impact of trade deals with the EU and with countries outside the EU, particularly the United States. The government has stated its intention to 'ensure we protect our ability to maintain control of the provision of public services, like the NHS, in new trade agreements' but its ability to do this will depend on the UK's future trading relationship with the EU, and its success in trade negotiations with other countries, which have not yet been agreed.

Our position

In recent years, the NHS has been shifting away from competition towards a more collaborative approach to delivering services, as set out in the NHS long-term plan and exemplified by the new models of care currently being developed in many areas of England. Leaving the EU could provide the impetus to align the law with this approach, providing greater clarity and certainty to local areas as they implement new care models although this would require significant further legislation.

Working time directive

Among the most contentious pieces of EU legislation affecting the NHS are the European Working Time Regulations – usually referred to as the working time directive – which were introduced to support the health and safety of workers by limiting the 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.

In the short term, the government has signified its intention to convert existing EU law into

domestic law to ensure that, as far as possible, the same rules and laws will apply after Brexit. This means that workers' rights under EU law will continue to exist under domestic law after the UK has left the EU, providing continuity to employers and employees in the short term.

Brexit may allow future governments to amend domestic legislation to remove this regulation, should they wish to, although their ability to do so will be subject to wider negotiations regarding access to the single market. However, the current government has committed to preserving the working time directive after the UK leaves the EU (Department of Health 2017).

> **Our position**
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> Any decision to amend the working time directive would need very careful consideration. While amendments would be welcomed by those who argue that the current limit reduces flexibility for providers and restricts training opportunities in some specialties (see, for example, Independent Working Time Regulations Taskforce 2014), it would remove an important legal protection for workers and could result in health and social care staff working longer hours, exacerbating the pressures they are under and potentially posing risks to patient safety.

Cross-border co-operation

Public health

Public health legislation for a number of policy areas, in particular food safety and nutrition, tobacco, alcohol, radiation, environment, housing standards and chemicals is drawn from established EU legislation, standards and regulations, with relevant directives transposed into UK legislation.

EU legislation has had a significant impact in some areas, such as air quality, that cannot be successfully controlled at national level alone. In other areas, such as tobacco control, the UK currently leads the way in Europe, having gone further than required by a recent EU directive, by introducing standardised packaging (Joossens and Raw 2017).

The government has signified its intention to transpose key legislation that maintains EU public health regulations, particularly the 'do no harm' duty of the Lisbon Treaty which means that the Government is required to consider 'a high level of human health' when making policy. On the other hand, decision-making in a community of 28 countries

can be cumbersome and slow, and the UK could choose to take bolder and faster action on public health after leaving the EU (Faculty of Public Health 2016).

The EU also operates systems for the early warning of communicable diseases, managed by the European Centre for Disease Prevention and Control (ECDC). 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 collaboration include managing the H1N1 'swine flu' pandemic and efforts to tackle anti-microbial resistance. Leaving the EU does not necessarily mean the UK has to leave the ECDC; both Norway and Switzerland (non-EU member states) work with the ECDC, but do not have a formal role in its decision-making, however the future arrangements for work with the ECDC are not mentioned in the withdrawal bill.

> **Our position**
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> Once the UK leaves the EU, it will be up to the government to decide whether it wants to go further and faster than the EU in matters of public health or instead implement less stringent public health standards. However, in some areas of public health, particularly those relating to health security and air quality, it makes sense to continue current arrangements as closely as possible.

Research

Members of the academic, pharmaceutical and medical communities have expressed serious concerns about the impact of leaving the EU on science and research in the UK (see, for example, Lechler 2016; Mossialos et al 2016). Nobel Prize winner Professor Sir Paul Nurse, Chief Executive of the Francis Crick Institute, has warned that Brexit could be a disaster for science in the UK because of its impact on the free movement of researchers across Europe and on the ability of UK researchers to attract research funding (Ghosh 2016).

The UK has furthered its scientific research agenda through EU collaboration, as a result of access to European research talent and to important sources of funding. For example, between 2007 and 2013 the UK received 8.8 billion euros for research, development and innovation activities while contributing only 5.4 billion euros to EU research and development (The Royal Society 2015). NHS organisations benefit from a range of EU funding schemes including Horizon 2020 and the European Structural Investment Fund (ESIF). The government has set an ambition for the UK to be a world leader in life sciences and medical research but this will require it to address the loss of EU funding for research and development and the benefit from the collaboration of researchers and scientists across the EU.

In the short term, the government has committed to honour funding agreements for ESIF projects that were signed before the Autumn Statement 2016, even where these continue after the UK has left the EU. Funding for projects signed after the Autumn Statement will be funded if they provide strong value for money and are in line with domestic strategic priorities. For Horizon 2020 projects, the government will underwrite the funding for all successful bids that are submitted before the UK leaves the EU (Gauke 2016).

In the longer term, arrangements are unclear. However, the government has stated that it wishes to 'establish an ambitious agreement on science and innovation that ensures the

valuable research links between us continue to grow' (Department for Exiting the European Union 2017a). While it may be possible to continue to participate in some research programmes after the UK leaves the EU (non-EU countries are able to participate in Horizon 2020 as associates or third countries, for example), it is unlikely that projects in the UK would be eligible to receive EU funding and the UK would have limited influence over work programmes.

Restrictions on the movement of researchers will have a significant effect on research with about three-quarters of researchers having spent part of their career in a non-UK institution and more than 28 per cent of university academics currently from outside the UK (Royal Society 2016). Senior academics have highlighted the need for an immigration system that allows the recruitment and retention of international talent.

Clinical trials

Clinical trials for new drugs are currently carried out at a national level but are subject to EU regulations, including registration of trials. Revised EU clinical trials regulations will not be in force in the EU at the time that the UK exits the EU and so will not be incorporated into UK law on exit day. The government expects to align where possible with these new regulations, subject to parliamentary approval. Any divergence between the UK and the EU on the regulation of clinical research would have a number of consequences:

- an impact on the status of UK-based patients who are participating in multinational EU clinical trials
- recruitment issues for clinical trials, especially for rare diseases and paediatric medicine; if the UK becomes isolated it may become a less attractive option for clinical trials recruitment
- increased burden on researchers and clinical trials sponsors if two different systems operate in tandem in the EU and UK.

Regulations on the transfer of personal data for research (currently overseen through the EU General Data Protection Regulation (GDPR) will also be affected by the Brexit deal.

> **Our position**
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> The UK currently lags behind comparable economies in investing national funds in research and development (Fahy et al 2017). Without access to EU funding, the UK risks falling further behind. It will be important that the UK continues to benefit from the collaboration of researchers and scientists across the EU, and that its immigration system supports its position as a global leader in life sciences. Clarity about clinical trials regulations will be critical, particularly for research into rare diseases and paediatric medicine.

Funding and finance

In the long term, the performance of the wider UK economy will be one of the most important influences on funding for the NHS and social care.

With negotiations over the UK's exit from the EU ongoing, it is difficult to predict the economic outlook with any certainty. However, a range of independent economic forecasts suggest that Brexit is set to have a significant long-term impact on the UK economy, whatever the final outcome. (Bank of England 2018; OECD 2018; Office for Budget Responsibility 2018).

The 2018 NHS funding settlement provides some certainty for the NHS over the next five years but does not cover wider health and care services such as public health and social care. If there are economic consequences to Brexit that result in lower growth in public spending, then the implications would be significant, particularly given existing pressures on the social care sector. Implications might include increased costs of many goods and services for the NHS and social care sector, and could also impact on supply, including of drugs and treatments, though the funding commitment for the NHS is stated in real terms and takes into account the effect of inflation. Much will depend on the UK's future trading relationships which are unclear.

> **Our position**
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> The NHS and social care are already struggling to manage within their existing budgets. If economic performance dips, the government may squeeze funding for public services although the five-year funding settlement provides some certainty for the NHS, if not for wider health and care services.

Conclusion

The UK's decision to leave the EU has already had an impact on the NHS and social care: for example, the decision has now been taken to move the EMA to Amsterdam and the number of some types of health and social care staff joining the workforce from Europe has fallen.

Brexit may present some opportunities for the UK, in particular the chance to go further and faster on public health regulation and remove rules on competition that are seen to present obstacles to the integration of and collaboration between health services.

However, if freedom of movement and membership of the single market and customs union end when the UK leaves the EU, as currently planned under the Prime minister's deal, then the NHS and social care face a number of significant threats. These include: the potential impact on the health and social care workforces that rely considerably on staff who are EU nationals; the impact on future trading relationships, which could affect the affordability and

supply of drugs and other products; and, of course, the impact on the wider economy, the performance of which will affect future funding for health and social care. A no-deal scenario would have even more significant consequences for the health and social care system, compounding these threats and potentially causing significant disruption to medical supplies, a serious weakening of the UK's ties with key EU bodies and information exchange about public health, and the end of reciprocal health agreements, leaving British citizens travelling to EU countries to take out private insurance and causing even more uncertainty for UK citizens living abroad.

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