

# **Health and Social Care after Brexit**

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## **Abstract**

The United Kingdom will exit the European Union (EU) by the middle of 2019 and will need to unpick forty years of laws and regulations. This paper will look at the implications of leaving the EU on Health and Social Care. 10% of our medical staff and 4% of nursing, midwifery and social care staff are from the EU. To mitigate the possible downturn in EU/EEA (Iceland, Liechtenstein and Norway) staff working in the UK from September 2017 the Government will introduce two new nursing courses, one being an apprenticeship qualification and the other a support role to nurses to be called nursing associates. The aim of these courses is to increase the population of the nursing force by 100,000 by 2020. At the same time, university places for medical students have been increased. This paper will also discuss other issues that must be considered, such as collaboration on research, drug regulation and public health, and also the more difficult issues of freedom of movement and collaboration.

## **Introduction**

Prior to the 23<sup>rd</sup> June Referendum, there were many documents relating to the difficulties that health and social care would encounter if the vote was to leave the EU. The main points were laid out by the Kings Fund, which is an independent charity working to improve health and social care in England. It would be normal practice to be consulted by the Government as issues arise. The concerns the Kings Fund brought to the Government's attention to be considered by the Health Service Select Committee were:

1. The UK's Health and Social Care workforce, both those here and those working in the EU/EEA.
2. Reciprocal health care and cross border access (E11 – the European Health Card).

3. Regulations, market function and networking to enable wider research/projects.
4. Cross border co-operation in public health and environmental protection, including communicable disease.
5. Finance, medicines and medical devices, including drugs.

The vote came as a surprise to our then-Prime Minister David Cameron, who immediately resigned as he felt he could not continue when he had led the campaign to Remain. The actual results from Brexit were that England voted strongly for Brexit, by 53.4% to 46.6%, as did Wales, with Leave getting 52.5% of the vote and Remain 47.5%. Scotland and Northern Ireland both backed staying in the EU. Scotland backed Remain by 62% to 38%, while 55.8% in Northern Ireland voted Remain and 44.2% Leave. More than 30 million people voted, which is one of the highest recorded turnouts, even larger than the recent Scottish Referendum. Scotland's First Minister, Nicola Sturgeon, declared that if Scotland was not able to stay in the single market she would call a second referendum to enable Scotland to be a separate country. On 14<sup>th</sup> March 2017, she announced that it would take place in the Autumn of 2018 or the Spring of 2019.

Despite having authorisation from her Government, a referendum cannot take place without the consent of the UK Parliament and the Prime Minister, Theresa May. However, even if Scotland became independent, its future with the EU would remain uncertain. EU inclusion is likely to be vetoed by the Spanish Parliament, which is fighting off Catalan plans and is supported by Italy, Greece, Belgium, Cyprus and Slovakia; these countries face separatist challenges and have concerns regarding independence. Jean-Claude Juncker, the President of the European Commission, has told Mrs Sturgeon that Scotland would not receive any special treatment. Added to this, she has been told by NATO's<sup>1</sup> Secretary General, Jens Stoltenberg that Scotland would need to apply to join NATO as an independent country.

Once it had been decided that the UK would exit the EU, the question was: How would forty years of cooperation be unpicked? In the course of the next few days, the country heard negative things about what would happen to the people of the UK. On 30<sup>th</sup> June, Helen McKenna wrote:

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<sup>1</sup>North Atlantic Treaty Organization

*“Health is not an area of significant EU competence; its role is by and large limited to supporting member states in their health endeavour”.*

Nevertheless, 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. While the impact on health and social care services of leaving the EU is impossible to forecast, it is clear that a number of important issues will need to be resolved (McKenna, 2016, no page given).

The country knew it would not be a smooth progress so it was not a surprise that in November the High Court ruled that Mrs. May and her Government had no right to trigger the formal two-year process of leaving the EU without there being a vote in Parliament. The Government appealed against the decision; however, the ruling meant that Members of Parliament and the House of Lords would have to accept that the Act would gain consent. *The Times* of 20<sup>th</sup> March 2017 suggested a possible time line:

*29<sup>th</sup> March: Article 50 was triggered at 12.25 Donal Tusk the President of the EU received the document from Sir. Tim Barrow Britain’s permanent representative to the EU.*

*31<sup>st</sup> March: the European Commission draws up guidelines for the divorce focusing on the EU’s red lines these set out the guidelines.*

*27<sup>th</sup> April: EU 27 summit to agree on the guidelines or change them.*

*Early June: Divorce terms will be presented at the first meeting between British and EU negotiators.*

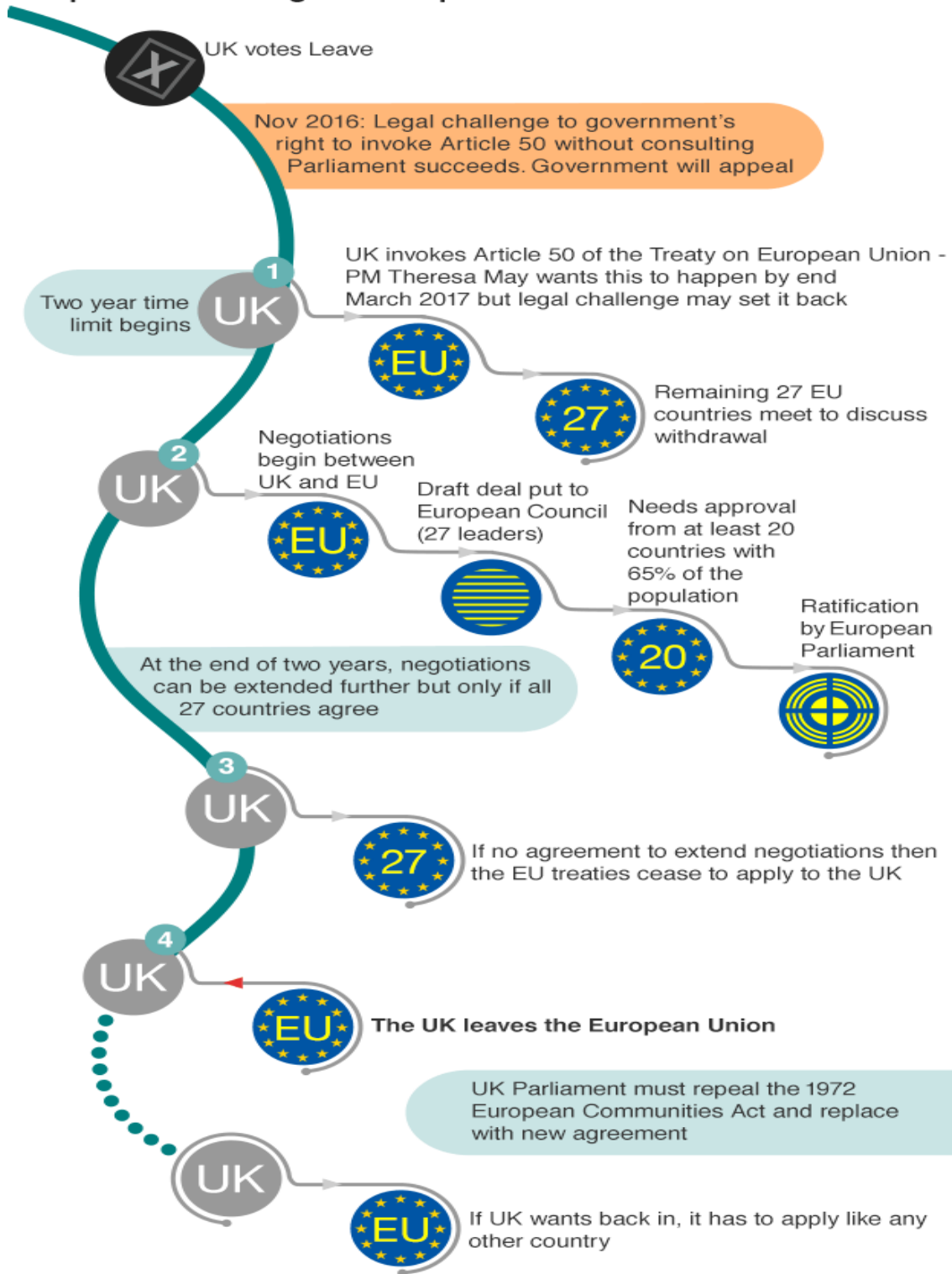
*Autumn: Potential clash over the divorce bill.*

*Once agreed, Mrs May will bring forward the **Great Repeal Bill**, this will allow the 1974 Act to be repealed, and the approximate 53,000 acts, court verdict, standards to be reconfigured. If agreed it will allow second legislation to amend references to EU/EEA, all other items will go to Parliament for agreement.*

*Autumn 2019 will give us the agreed charted between the EU and UK.*

Brexit process should be accomplished in a two year time framework. Meanwhile, the BBC’s website offered a helpful diagrammatic representation (BBC, 2016):

## Steps to UK leaving the European Union



However, there are a number of countries, including Germany and France, where elections will be occurring this year. Subsequently this may hamper serious negotiations, but this will not stop our Ambassadors in each country beginning their meeting with their

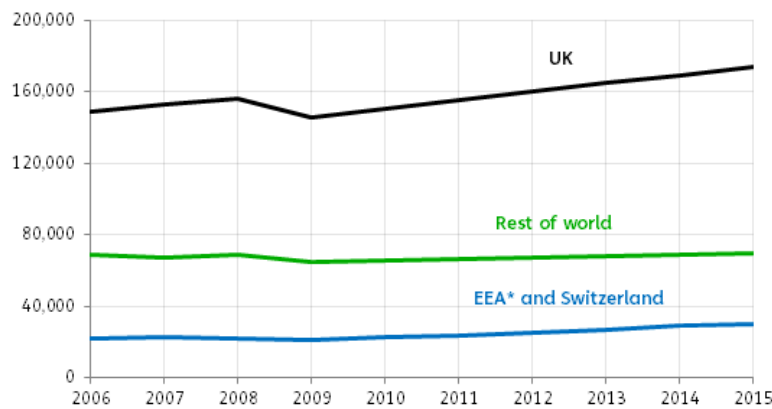
countries' representatives. We know Mrs May has been approached by several of the Commonwealth Countries to enable easier access to the UK; among these are India, Canada, New Zealand and Australia.

### **UK Health and Social Care Workforce (those here and those working in the EU, EEA).**

Now that we are on the way, what concerns are expounded by the NHS and its partners? First, we should look at the implications for staffing the NHS. We have about 130,000 EU and EEA (Iceland, Norway and Liechtenstein) nurses, doctors and care workers in the NHS and Social Care. Since 2000, there has been a deficit in staffing, possibly due to the cutback in student numbers by the Government. So if we look at the numbers, it can be seen that 10% of medical staff come from the EU/EEA and 4% of nurses, and it is thought another 4% in social care. This last figure is difficult to calculate as many work through agencies. In numbers it will approximate to 55,000 out of the 1.2 million total staff (EU immigration and NHS staff, 2017).

### **Where doctors in the UK qualified**

Doctors in the UK by world region of primary medical qualification



\*European Economic Area: EU countries plus Iceland, Liechtenstein and Norway

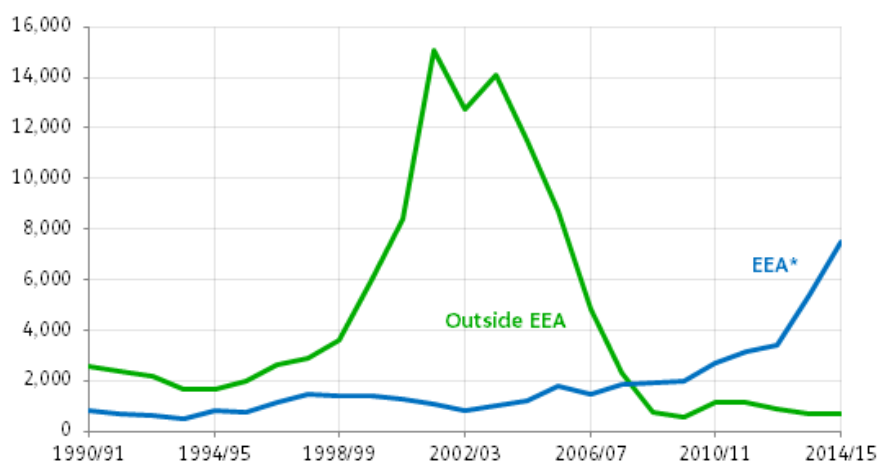
### **GMC figures 2016 EU immigration and NHS staff**

Historically, the NHS has relied on staff from overseas. For example, there was once an influx of Philippine nurses. So what will the future of these staff be? It would appear that anybody working in the NHS and Social Care before the 24<sup>th</sup> June 2016 will be able to continue to work as they do today. Mrs May's Government is hoping that they will be able to negotiate a continuation of this practice, as the few Polish nurses that we employ have already

lobbied their Government. This will be essential for the number of registered doctors, nurses and midwives who work in the EU/EEA.

## Where new nurses trained overseas

World region of training for newly registered nurses trained abroad



\*European Economic Area: EU countries plus Iceland, Liechtenstein and Norway

## NMC figures 2015 EU immigration and NHS staff

How might a staffing shortage be addressed if staff are not allowed to stay in the UK? Many professionals have been in the country a long time and might have married but not had the need to change to UK citizenship; they might have expected to live the rest of their lives as nationals of an EU/EEA country. This group feels more threatened than the more recent immigrants from Poland and Romania, particularly as they might have UK children who have not lived in their parents' countries. I (the lead author) live near the town of Bedford, which had a small long term population of Italians which number about 2,000. They have remained Italians and have the right to vote in Italian elections. However, over the past five years they have also received nearly 4,000 Polish citizens, a number which has increased year on year (Bedford Council, 2017). According to their records, this group is fluid, in that the people tend to stay about five years and then return to Poland.

In an editorial piece, Scott (2016) said that we should train our own staff instead of relying on immigration. Rosser (2016) wrote that perhaps our choice to exit Europe will trigger a move to purely competency-based outcomes rather than adhere to the current focus on hours completed under the present EU directives. Commonwealth countries have already ventured the prospect that their nationals might be able to come over for training or experience.

Possibly, therefore, we will go back to the numbers of commonwealth staff that we had before 1974. The Government's Health Secretary, Jeremy Hunt, announced on 30<sup>th</sup> November 2016 that he has asked the Nursing and Midwifery Council to consider regulation for the new Nursing Associate qualification. Over 1,000 Nursing Associates will begin training in September 2017 in eleven hospitals. The new role will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. The demand for this type of course has risen over many years, which was a reaction to the EU's rejection of our Enrolled Nurse Training. Another change co-terminus with the NA course will also happen this coming September: nurses' training will happen through an apprenticeship scheme where they will be paid while they train to complete a graduate route. They will be released by their employers to study part time and can join the course anywhere according to their prior qualifications. A Trust will be given £200,000 to release these trainees for study.

These new courses will complete their first cohorts as we exit the EU so some of the feared staff reductions will not occur (or at least not straightaway). Earlier this year, the Government committed to creating 100,000 apprenticeships within the NHS by 2020 to ensure it has a workforce with the right support, skills and numbers to provide consistently safe, high quality care 24 hours a day, seven days a week. So there may be a lean time between now and 2020 but it is being managed; if EU/EEA staff decided to leave the UK, their jobs would be filled by these new roles. Similarly the Government has increased the number of medical students and allowed them to APEL<sup>2</sup> in if they have prior qualifications. So a gap may occur but it will be short term. If we look at the top five overseas suppliers of doctors to the UK, we see India (25,005 doctors), Pakistan (9,770), South Africa (5,282), Nigeria (4,169) and Ireland (4,046); there is no reason to consider that these trends will change. Most come over for short periods or to undergo further training (EU immigration and NHS staff, 2017).

As we consider our NHS needs we must remember that a percentage of UK qualified staff are now working in EU/EEA countries. Therefore, it would seem necessary to consider both groups carefully and come to some kind of freedom of movement that allows the UK and the EU/EEA to establish guideline and recognise qualification related to health within the

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<sup>2</sup>APEL stands for the accreditation of prior experiential learning. It is the award of credit towards a university award in respect of skills and knowledge acquired through life, work experience, and/or study elsewhere.

EU/EEA countries which was the case before 1974. We hope to restore the reciprocity Australia and New Zealand which we had to lose in 1975.

### **The Working Time Directive**

Since the EU's introduction of these directives, problems have been encountered, and many members of the medical staff have asked for their profession to be exempted. The hours are stipulated so that junior doctors cannot be allowed to continue a patient's care to gain experience if there they have completed their specified hours, so instead the missing out. Lintern (2016) wrote protection of working hours for more than one million NHS staff could be in jeopardy in the wake of Britain's decision to leave the EU, many difficulties could occur if these directives were removed. There are many occupations that would like these directives relaxed, for example, farming during the harvest to be able to continue harvesting rather having to stop (because the next day it could rain). I know people will think we are going to the bad old days but that is unlikely as the NHS Health Commissioners would be looking at the local working practices.

### **Finance, Medicines and Medical Devices (including drugs);**

We would lose the European Medicines Agency, which is based in London. The EMA's work is to evaluate drugs and other medications that have been developed by pharmaceutical companies, making recommendations to the EU. However, the UK has always had its own regulation agency which authorises medicines for general use. Our agency links with the European Centre for Disease Prevention and Control give early warnings of communicable diseases and how surveillance can be more effectively coupled with the need to look for drugs that will be ready for use if we have a further epidemic of (for example) Ebola or SARS. There is concern that Public Health collaboration will be weakened, however this is doubtful as most countries feed into the World Health Organisation and collective findings are disseminated back to all countries.

### **Cross-Border Co-operation in Public Health and Environmental Protection**

Immediately the vote was announced, the Government stated that present research and that which was planned would be safe guarded (Selby, et.al. 2017). Nayanah (2016, p.116) wrote in July: *"We value very much that collaboration with the best possible providers across Europe, to conduct clinical trials, to progress medical science, and ultimately, to provide*



*better care for our patients*". Elisabetta Zanon, director of the NHS European Office (part of the NHS Confederation), says that our European alliance has also been important for the NHS, and she hopes that an agreement will be made that will allow the UK to continue to take part in these initiatives in an active role, not just as a passive observer as a full exit from the EU could entail (cited by Nayanah (2016, p.115)

The immediate reaction from the Universities was that they are not being approached by EU countries with regard to research starting after 2020. It has yet to be proved that this is happening, but it is early days. Selby et.al. wrote: "*Research funding streams from the EU are open to non-EU countries under a variety of negotiations and conditions. It is possible that the UK would be able to remain part of these and even conceivable that it would remain possible for the UK to 'punch above its weight' in terms of capturing the EU funding*" (Selby, et. al. 2017). It may be harder (but not impossible) to continue with a similar approach as the one that we follow today.

### **Reciprocal Health Care (E11 – the European Health Card).**

The Government has been trying to recover medical expenses from people who use the health service. This has led to calls for people who are coming for routine treatment or surgery that they should be asked to present their passport so it can be ascertained if they should pay. The trial area at the moment is maternity, as this aspect does not have to be sorted in a few minutes, it can be undertaken over a few weeks. St. Georges Hospital in London is the first to trial the requirement of checking passports. At present, all EU/EEA people can use there E11. It is hoped that one of the aspects of the discussions will consider the future of the E11. It is hoped that some sort of reciprocal policy will be achieved. However many tourist will be aware that outside that holidaying or working outside Europe they need health insurance. It would be much more effective if this aspect of the treaty could be retained as it would prevent an extraordinary amount of time taken by various agency to reclaim the moneys due.

### **Regulations**

There are many regulations which all EU/EEA members adhere too, some of which the UK wish to remove themselves from and over the next two years these will be examined critically. The ones they will want to keep are those regarding competence and skills of any person wishing to work in the UK as a doctor, nurse, midwifery and in social care. The UK

would always which to maintain the language test so that all staff obtain a standard of 7.5 in the International English Language Testing System (IELTS).

### Social Care

Are the people who work in social care any different from those who work in the NHS sector, yes? When we are considering the social care sector we are looking at various levels of care that is offered by the Local Authorities. The local authorities care supports:

#### Home care:

1. Personal care is needed so person can stay at home for example disabled, elderly, terminal care.
2. Temporary care following illness or surgery or accidents.
3. Supporting mentally ill, adults with educational problems, recovering addicts.

Care homes covering all situations in life from children to adults. Living in carers who provide total day care being night and day. These types of care come under both the local authority and many various private agencies. Those who work in these areas can be both trained and untrained. So the concern after Brexit was what percentage workers are at the lowest level, as they only get paid the minimum level which is called a living wage:

| Date         | 25 & over | 21 to 24 | 18 to 20 | Under 18 | Apprentice |
|--------------|-----------|----------|----------|----------|------------|
| 1 April 2017 | £7.50     | £7.05    | £5.60    | £4.05    | £3.50      |

An approximation is that at least 4% from the EU/EAU however it is still an estimate because it is not easy to find out the numbers from some of the agencies despite all agencies and care home are covered by the quality care commission. So following Brexit there was concern that if this level of staff leaving or are asked to leave there would be a gap in the possible care cover. To try and find staff from the UK population has proven difficult and they are unwilling to undertake these jobs as they are paid more money working Tesco's for example with all the staff benefits they are access. Hence if there is a loss of EU/EEA peoples these areas may have to look at pay rates. EU/EEA peoples working in private hospitals or care homes as they like the idea of working long shifts and their shifts consecutively so they can go home and see their families on their days off. If they are working in or near a town similar

to Luton which has an airport they can be home in possible as little as five hours. Even with going home they can save money as most have an ambition to buy a house in their home area.

## Conclusion

At present we are only just on the brink of change however having two years has enabled a useful time in which to address some of the possible problems that lie ahead. These cannot be taken alone but as part of the reorganisation on health and social care in the UK, as the population is aging and there is far more demand on the all health facilities.

## References

- BBC. (2016) Steps to leaving the European Union. Available at: <http://www.bbc.co.uk/news/uk-politics-32810887>. Accessed on 25 March 2017.
- Bedford Council (201) – Telephone call with lead author.
- EU immigration and NHS staff (2017) Full Fact Website. Available at: <https://fullfact.org/immigration/immigration-and-nhs-staff/>. Accessed on 24 March 2017.
- Lintern, S; (2016) Brexit risks work hours protection. *Nursing times* 112.26 (Jun 29, 2016): 2.
- McKenna, H. (2016) Five big issues for health and social care after the Brexit voted. The Kings Fund. Available at: <https://www.kingsfund.org.uk/publications/articles/brexit-and-nhs> Accessed on 24 March 2017.
- Nayanah, S; (2016) UK researchers digest the fallout from Brexit; *The Lancet*; London 388.10040 (Jul 9, 2016): 115-116.
- Rosser, E; (2016) Nursing education, the NHS and leaving the European Union. *British Journal of Nursing*, 25 (15), 878.
- Scott, G; (2016) (editorial) Brexit what are the implications for nurses? Available at: *Nursing Standard*. Accessed on 31<sup>st</sup> March at <http://journals.rcni.com/doi/pdfplus/10.7748/ns.30.44.3.s1>
- Selby, P; Lawler, M; Baird, R; Banks I; Johnston, P; & Nurse P; (2017) *The potential consequences for cancer care and cancer research of Brexit*” Accessed on 31<sup>st</sup> March available at: <http://ecancer.org/journal/editorial/63-the-potential-consequences-for-cancer-care-and-cancer-research-of-brexit.php> Published 24/02/2017
- The Times; (2017) How it will unfold (20 March) *Times News Paper*

## Appendix

### The White Paper's themes

It sets out the themes of the government's goals for its negotiations with the EU, as announced by Prime Minister Theresa May last month.

These include:

- **Trade:** The UK will withdraw from the single market and seek a new customs arrangement and a free trade agreement with the EU.
- **Immigration:** A new system to control EU migration will be introduced, and could be phased in to give businesses time to prepare. The new system will be designed to help fill skills shortages and welcome "genuine" students.
- **Expats:** The government wants to secure an agreement with European countries "at the earliest opportunity" on the rights of EU nationals in the UK and Britons living in Europe.
- **Sovereignty:** Britain will leave the jurisdiction of the European Court of Justice but seek to set up separate resolution mechanisms for things like trade disputes.
- **Border:** Aiming for "as seamless and frictionless a border as possible between Northern Ireland and Ireland."
- **Devolution:** Giving more powers to Scotland, Wales and Northern Ireland as decision-making is brought back to the UK.

<http://www.bbc.co.uk/news/uk-politics-32810887>

### Content of the White Paper.

1. Providing certainty and clarity – We will provide certainty wherever we can as we approach the negotiations.
2. Taking control of our own laws– We will take control of our own statute book and bring an end to the jurisdiction of the Court of Justice of the European Union in the UK
3. Strengthening the Union – We will secure a deal that works for the entire UK - for Scotland, Wales, Northern Ireland and all parts of England. We remain fully committed to the Belfast Agreement and its successors.
4. Protecting our strong and historic ties with Ireland and maintaining the Common Travel Area– We will work to deliver a practical solution that allows for the maintenance of the Common Travel Area, whilst protecting the integrity of our immigration system and which protects our strong ties with Ireland.

5. Controlling immigration– We will have control over the number of EU nationals coming to the UK

6. Securing rights for EU nationals in the UK, and UK nationals in the EU – We want to secure the status of EU citizens who are already living in the UK, and that of UK nationals in other Member States, as early as we can.

7. Protecting workers’ rights – We will protect and enhance existing workers’ rights.

8. Ensuring free trade with European markets– We will forge a new strategic partnership with the EU, including a wide reaching, bold and ambitious free trade agreement, and will seek a mutually beneficial new customs agreement with the EU.

9. Securing new trade agreements with other countries– We will forge ambitious free trade relationships across the world.

10. Ensuring the UK remains the best place for science and innovation– We will remain at the vanguard of science and innovation and will seek continued close collaboration with our European partners.

11. Cooperating in the fight against crime and terrorism – We will continue to work with the EU to preserve European security, to fight terrorism, and to uphold justice across Europe.<sup>8</sup>

The United Kingdom’s exit from and new partnership with the European Union

12. Delivering a smooth, orderly exit from the EU We will seek a phased process of implementation, in which both the UK and the EU institutions and the remaining EU Member States prepare for the new arrangements that will exist between us.

<http://www.politico.eu/article/uk-government-publishes-brexit-white-paper-theresa-may-david-davis/>