NHS Wales Executive Board

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This paper is for discussion and provided in confidence

1.0 PURPOSE

The purpose of this paper is to share with Chief Executives an early and initial assessment of implication of the leave vote on health and social care. The Board is being asked to note the content of the paper and to flag any other areas of potential impact to inform our work/negotiations in Welsh Government.

2.0 KEY SUCCESS CRITERIA

N/A

3.0 FINANCIAL CONSEQUENCES

N/A

4.0 HUMAN RIGHTS, EQUALITY LEGISLATION AND WELSH LANGUAGE ACTS

N/A

NEXT STEPS

Chief Executives to consider the paper and respond to Joanna Jordan with any further ideas for areas of potential impact.

3.0 Background

Overview

1. The EU competence in health and social care is more limited than in areas like agriculture, fisheries and the environment. The Treaty makes explicit that Member States are responsible for …the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. (Article 168.7, Treaty on the Functioning of the European Union [TFEU]).

2. This aside, there will undoubtedly be an impact on the UK in relation to health and social care; the extent of which is dependent on a number of factors.

NHS Wales Executive Board

3. In these unprecedented times, the implications of the UK's exit from the EU on health and social care policy are unclear but will largely depend on the negotiated exit settlement reached by the UK and the future model of engagement with the EU – issues on which there is still significant uncertainty. Messages from Brussels suggest that the UK will not be able to pick and choose which elements it wants without having to concede to the EU in other areas. There is a clear message that the EU will not accept the UK 'cherry-picking' the terms of its new relationship, with the insistence that the EU's 'four freedoms' - free movement of goods, services, people and capital - cannot be split up.

4. However, the UK Prime Minister has stated the UK would not seek an "off the shelf" model for its future relationship with the EU. This means controls on the numbers of people who come to Britain from Europe but also a positive outcome for those who wish to trade goods and services in Europe.

5. The key question therefore continues to be he relationship the UK will have with the EU after its exit, in terms of access to the EU internal market and obligations in regard to freedom of movement. This has important implications for the NHS both from a financial and regulatory point of view, for example in the mobility of health (and other) professionals, the treatment of patients abroad including the EU Directive on Patient Mobility and the EHIC system, the charging of people from the EEC for secondary health care received in Wales, health and safety at work (including the Working Time Directive), public procurement and competition, the conduct of clinical trials, the authorisation of medicinal products, and data privacy.

6. If the UK was to secure the same type of deal as Norway, with the same access to the EU internal market, but with the full range of EU policy, regulation and budgetary obligations, then the NHS would change little in terms of the application of EU policy and rules, ability to recruit EU staff, access to EU research funds and involvement in EU collaborative initiatives.

7. Conversely if the UK were to leave the EU internal market, changes would be significantly greater and uncertainty much bigger from both an economic and regulatory perspective. The UK would be required to set its own policy and laws on migration, competition and procurement.

8. Negotiations for the exit can only begin once the UK Government officially notifies the EU of its intention to leave under Article 50 of the EU Treaty, The UK government has indicated it will not trigger Article 50 until the start of 2017 at the earliest.

9. From that moment, discussions over the terms of the UK's exit will conclude in two years unless all 28 members of the EU agree to extend them.

NHS Wales Executive Board

10. The King's Fund has published a paper[1] outlining the five big issues they see for health and social care following the Brexit vote. The authors see five major implications for health and social care as a result of political and economic instability.

a) Staffing (with the NHS already struggling to recruit and retain permanent staff). Consequently it is argued that providers of NHS and social care services should retain the ability to recruit staff from the EU and suggested adding specific occupations to the Migration Advisory Committee's shortage occupation list.

b) Accessing treatment here and abroad. Evidence suggests that the average use of health services by immigrants and visitors appears to be lower than that of people born in the UK, though if UK migrants living in other EU countries return, there may be an increasing pressure on health and social care services.

c) Regulation. Whether or not the UK government decides to repeal EU regulations and replace them with UK drafted alternatives or continue to abide by them will be crucial. The key ones are:
   - 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.

   Overall, it seems unlikely that leaving the EU will have a significant impact on NHS procurement and competition regulation.

d) Cross border cooperation – in terms of scientific research, the impact on the free movement of researchers across Europe and the ability of UK researchers to attract research funding is of concern.

e) Funding and finance. In the long run the most important influence on NHS funding will be the performance of the economy. A prolonged decline in the pound would lead to higher prices for some drugs and other goods and services the NHS purchases. Even if the health budget continues to be ring fenced any further cuts to social care funding will have a significant impact on the NHS.

11. The report concludes that it is imperative that health and social care not be forgotten when negotiating Britain's exit from the EU and if an economic shock materialises the government need to be honest about the implications for patients and service users.

[1] 30 June 2016 (http://www.kingsfund.org.uk/publications/articles/brexit-and-nhs)

NHS Wales Executive Board

Specific impact on HSS Group policies

Public Health

12. While EU competence in the area of health policy is more limited than many other areas, **public health** is listed in Article 6 of the Treaty on the Functioning of the European Union amongst a range of policy areas where the EU can *"carry out actions to support, coordinate or supplement the actions of the Member States."* In areas such as food safety, nutrition, and environmental health, much of UK and Welsh law is derived from European legislation. A number of major public health threats naturally cut across national boundaries, requiring an effective international response: the EU currently provides an infrastructure for much of that engagement.

13. Where Welsh Government has **competence** it can continue to drive progressive public health policies, so the impact is more predictable. But there is greater uncertainty where outcomes are dependent in part on action at UK or EU level – such as on levels of funds to compensate for the gap left by future withdrawal of EU funds. Of even greater uncertainty is the longer term impact of withdrawal on the major determinants of health, which the EU has a major impact both directly and indirectly. The hotly debated issue of impact on jobs and growth, which are inextricably linked to better population health outcomes, is the most obvious of these.

14. Finally, there is a risk that our influence as an advocate of progressive policies on health promotion across Europe is constrained. The UK, with Welsh Government as a strong advocate within it, has driven proposals on issues such as plain packaging for cigarettes, minimum pricing units of alcohol, or the emerging proposals on sugar tax which exceed the aspirations of EU legislators. Withdrawal may limit our ability to drive change on the preventative health agenda, where collective action is arguably more effective than individual action.

NHS Recruitment and Retention

15. The EU's policy of freedom of movement and mutual recognition of professional qualifications within the EU means that many health professionals currently working in the UK have come from other EU countries. The latest analysis shows that 518 of 8,759 doctors (5.9%) in Wales and 262 of 25,821 registered nurses (1.01%) qualified in EU countries. Reliable data for other staff groups is not currently available.

16. It is widely recognised that NHS Wales is experiencing recruitment and retention difficulties in some medical specialities, amongst some staff groups such as nursing and is some parts of the country. EU law on mutual recognition or professional qualifications has facilitated and speeded up NHS recruitment of those professionals to fill job vacancies and reduce dependency on expensive agency staff.

17. In the short term Brexit could discourage EU citizens from coming to the UK due to fears of being unwelcome and/or concerns around pensions and employment

rights. There is also speculation about the impact of a less favourable exchange rate, making the UK less attractive destination for healthcare workers to live and work.

18. However, even if the UK choses not to retain access to the single market, it is unlikely that a future government would make it difficult for the NHS to recruit and retain staff it needs. The UK could unilaterally decide to relax entry restrictions for certain groups of workers in shortage occupations and make it easy for them to stay, in the same way as Australia uses a points-based system.

19. Until the EU extracts itself from its obligations under EU treaties, the policy on freedom of movement remains unchanged.

Education, training and workforce planning

20. Currently students from other EU countries can come to the UK and pursue medical training on the same basis as UK students, and without having to obtain Tier 4 visas that apply to non-EEA overseas students. British students can also study in other EU countries. European rules on mutual recognition of qualifications mean that medical graduates from some EU countries can apply for foundation year 1 places as trainee doctors. Some of the shape of the training proposals on reforming the future of medical training could, if implemented, affect (and probably increase) the number of future European applicants.

21. Under a Norwegian style agreement, current workforce planning assumptions on numbers of training places and on trainee mobility will, broadly speaking, continue. Depending on what successor arrangements were put in place, a more radical option could significantly alter inward and outward flows and might encourage greater mobility between English speaking non-EEA countries, rather than between the UK and European countries.

Professional registration

22. Current EU legislation on professional qualifications fast-tracks EU citizens holding a qualification from an EU country as a doctor, nurse, midwife, dentist or pharmacist by automatically recognising their qualification, subject to satisfying regulators' other requirements in order to practise. Automatic recognition can therefore facilitate mobility by cutting through red tape. It also allows British health professional to live and work more easily in other European countries.

23. The EU also has a secure online patient safety alert system, whereby regulators can warn each other about rogue professionals who, having been struck off or had their practice restricted on one member state, seek to move across borders and practice elsewhere.

24. If the principles of freedom of movement were to be restricted, without negotiating access to the single market, then it is possible that EU professionals could be treated in the same way as overseas national for the purpose of

professional registration, and regulators might lose access to the EU-wide information exchange system. However, a future government could make legislative changes and/or agreements to ameliorate this situation.

EU employment law

25. The European Working Time Directive (EWTD), 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 in each week, as well as setting minimum requirements for rest periods and annual leave.

26. 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). Despite this, some medical specialities have been concerned that the 48-hour limit affects training, and the Royal College of Surgeons review of the directive called for more widespread use of the opt-out.

27. The directive is one of the most high-profile elements of EU-derived law affecting employment – before it was transposed into UK law, UK workers did not have a statutory right to paid annual holiday. The directive ensured that all workers should be entitled to at least 20 days' paid annual leave, but the UK government increased this entitlement to 28 days, including bank holidays. This is an example of how the UK government has chosen to 'gold-plate' some aspects of EU law, providing more generous provision for UK workers.

28. If the UK government decided to repeal or amend the working time regulations (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. Any analysis of what the future holds for EU-derived employment law would be speculation; any reliable commentary will have to wait until what appears on the negotiating table. Any changes to workplace rights will depend on the shape of the political and economic relationship that the UK negotiates with the EU. However, trade agreements that would allow the UK continued access to the single market or joining the European Economic Area, like Norway, could require the UK to accept the majority of EU regulations. Furthermore, there will be legal and practical challenges associated with any attempt to unravel EU-derived requirements from non-EU derived requirements, especially where case law has drawn on domestic courts' interpretation of EU directives and on European Court of Justice rulings.

29. Overall the major caveat that what happens to EU law depends on the future negotiating agenda and any changes in employment rights are highly unlikely to happen in the short to medium-term.

#LoveOurEUStaff campaign – England

30. A social media campaign in England kick-started by NHS Employers to show appreciation for EU staff in NHS England has been warmly received and gained

national media coverage. Using the hashtag #LoveOurEUStaff, NHS Employers chief executive encouraged the NHS England workforce to ensure that staff from elsewhere in the EU know that they are valued and welcome, to hep allay concerns that might have been brought up by the vote to leave the EU.

Risk to Innovation

31. If UK pursues an approach of direct trade agreements with individual countries, EU law would not apply in the UK. While this could bring regulatory simplification in some areas, it would also mean that British citizens, companies and organisations, including NHS, would not benefit from the advantages brought by EU law. For example, the value chain for pharmaceuticals, medical and health technology products, including research, development and production, clinical trials and bringing medicines to market could be negatively impacted by regulatory divergence. This could lead to **less clinical research and innovation** taking place in Wales and **potentially higher costs for innovative health technologies** to be borne by the NHS.

Access to EU Funding Programmes

32. NHS organisations have benefited from EU funding programmes and much of my current activity is aimed at increasing the access to these funds. The First Minister is pushing to ensure access to European Structural & Investment funds (largely managed by WEFO in Wales) continues up to 2020, which means funding for approved projects could continue until 2023. We are working with WEFO, universities, UHBS and Public Health Wales on proposals for ESIF projects – these will be listed in a separate briefing. We also benefit from funds managed by EC directly, including Horizon2020 for Research and Innovation, the 3rd Health Programme and Territorial cooperation programmes. It is estimated that the potential funding for these programmes would be in the region 10 million. We will continue to be able to access these for at least the two years following the trigger of Article 50. Given the importance of these programmes to research and innovation in UK, it is expected that the UK Government will negotiate continued access – many countries outside the EU currently access them. Our more immediate challenge may a lack of willingness of other EU organisations to include UK/Welsh Partners in proposals.

Broader International Funding and Partnerships

33. There international funding programmes beyond the EU that we should continue to explore, as well as opportunities to influence international policy – the CNO and previous CMO have been very active here. In particular, links to WHO are good and could be further strengthened. Whether in or out of EU, the health and wellbeing challenges faced by our counterparts in other regions and countries are very similar to ours. There is therefore still merit in strengthening our approach to international research and sharing of good practice, particularly in relation to service improvement. The Trieste/Hywel Dda partnership on mental health is an example of where there is value and mutual benefit regardless of EU membership and funds.

NHS Wales Executive Board

International recognition and influence is also important, e.g. The recent award of 4 stars to Wales for innovation in active and healthy ageing.

Structural funds

34. A third of the EU budget goes towards investing in poorer regions of the continent and EU funding has made a significant contribution towards supporting regional growth in Wales and targeted efforts to improve employability and skills in deprived areas. The employment and skills focus of the programmes and projects have a bearing on your portfolio - employability is a significant determinant of better life chances and health outcomes.

There are also two projects 'owned' by the health group:

i) an in-work support project supporting European Social Fund objectives on tackling poverty and social exclusion by preventing job loss due to work-limiting health conditions. The Operation achieves this by providing rapid access to early, work-focussed interventions, including physiotherapy, psychological therapy and occupational therapy. These help employees on, or at risk of, a long-term sickness absence to remain in work, or to return to work sooner than would be possible without the intervention. ESF funding of £3.3m has been approved and committed covering the service. The project is being delivered by Abertawe Bro Morgannwg University Health Board and Rhyl City Strategy , and

ii) an out-of-work peer mentoring project supporting people with substance misuse (including alcohol) and/or mental health conditions. . ESF funding of £4.8m has been approved and committed covering the service for people aged 25 or older. Approval is expected for a further £1.2m of ESF funding, to allow the service to include young people aged 16-24. The framework for delivery of the service has been procured and delivery will start in August 2016.

35. Discussions are ongoing with WEFO on the wider use of structural funds in health. The most advanced of these is AgorIP, a Swansea University initiative aiming to provide an Open Access Open Innovation framework for commercialising ideas from academia, health boards & trusts across Wales. The project is currently on track for approval by WEFO in early autumn. Total project value is £13.5M including £2M from the Welsh Government and £4.8M Structural Funds.

36. The First Minister has made clear the Welsh Government's commitment to negotiate continued participation, on current terms, in structural funds arrangements until the end of 2020 but at the present time there is no certainty on this.

EU legislation generally

37. The vote to leave the EU has no immediate effect on UK law. Until the UK withdraws from the EU it remains a Member State and all its obligations under the Treaties and legislation remain in force.

NHS Wales Executive Board

38. UK and Welsh Government legislation which implements EU law would need to be reviewed in advance of withdrawal and consideration given to whether we would **want** to keep, amend or replace the legislation and, if so, **how** it could be made workable.

39. The above work will be an immense and intense task. The NAW Research Service argue that it is so great that it is likely that the responsible government would seek to enact transitional provisions to keep all/much of those laws in force during a period after withdrawal. It would also be premature to repeal/amend these laws until it is clear whether the UK will be bound in future by EU obligations under a future model of association (EEA, EFTA etc.)

40. The rationale for new or different legislation will need to focus on the core public health/public good arguments. The fall-back argument of legislating being a necessity of EU membership will, of course, no longer be relevant.

Paragraph 41 – 45 not within scope of request.

Health protection

41. Cross-border cooperation is critical in addressing health threats. Wales and the broader UK derive significant benefits from engagement with technical agencies which gather data and undertake monitoring, surveillance, trends analysis and risk assessment. Most notable from a public health perspective is the European Centre for Disease Control (ECDC), which enables the sharing of information about communicable diseases across member states and coordinates an early warning and response system.

42. In the short to medium term we will continue to have access to all the relevant risk assessments and guidance on emerging infections and threats. Longer term, the UK's access to the outputs of, and engagement with, the ECDC will need to be negotiated. It is legitimate to expect a requirement of our engagement to be the ongoing adoption of legislation of equivalent effect to any EU legislation on communicable diseases. An alternative approach would be to depend on the World Health Organisation's apparatus for these functions, but we would need to recognise that its resources and focus are pulled in many different directions.

International health

43. As well as being a mechanism for cooperation on public health issues across the continent, the EU is a powerful voice on health matters (for instance the global response to anti microbial resistance) in international affairs (e.g. with the World Health Organisation, where the 28 Member States adopt an agreed position). In very general terms the UK benefits from adopting more UK-specific positions on issues but it could be more difficult to secure as much influence.

Intelligence sharing, research and networks

NHS Wales Executive Board

44. Membership of the EU brings with it access to a range of support for research and networks. The public health system in Wales benefits from significant research grants from the ECDC as well as access to joint learning through the EU Public Health Programme. Contributions for the funding of specific posts in Public Health Wales come from EU agencies. Both Welsh Government and Public Health Wales have significant links into and profile within European health networks. Should these ongoing relationships be prioritised, additional effort would be required to ensure they are maintained.

NHS Wales Executive Board

Pharmaceuticals

45. The pharmaceutical industry makes a significant contribution to the UK economy. The trade surplus (the money coming into to UK above that which leaves) associated with the pharmaceutical industry was £2.8bn in 2013. Many of the largest global pharmaceutical companies base themselves in the UK to sell into the European market. Any restriction of free trade between the UK and EU could act as a disincentive to the industry's further investment.

46. The European Medicines Agency (EMA) is based in the UK. The EMA has established a single process for authorising medicines across EU this has increased the speed with which products are brought to market. It is highly likely that in due course the EMA will relocate to another part of the EU. Following the UK's departure from the EU a decision will be required as to whether to opt out of the EMA arrangements or to replicate the system at significant expense.

47. A significant proportion of the EMA's work is undertaken by the UK's Medicines and Healthcare Products Regulatory Agency (MHRA) and it would therefore be possible to replicate the EMA's work in the UK. Capacity, however, would be significantly reduced inevitably leading to delays in authorising medicines for use in the UK. The MHRA also plays a significant role in the EU's approach to drug safety, in particular through the Pharmacovigilance Risk Assessment Committee (PRAC).

48. Whilst the majority of pharmaceuticals supplied in the UK are manufactured for the UK market, the free trade in goods between EU member states allows for equivalent products marketed in one member state to be exported to and supplied in another. At any one time 15% of pharmaceuticals supplied in the UK may be parallel imports.

49. Parallel importing is important for a number of reasons firstly it provides a degree of resilience in the supply chain by bolstering stocks of medicines where goods for the UK market are in short supply; and secondly it creates a downward pressure on medicine prices for the NHS (because the medicines margin survey identifies excess profit made by pharmacies and corrects generic medicine prices to account for it).

50. In the long term the parallel import market in the UK will be affected by changes to trade arrangements between the EU and UK this has potential adverse implications for continuity of the supply chain and NHS medicines expenditure. Even in the short term there are likely to be adverse effects associated with the referendum result; parallel importing of pharmaceuticals is influenced by a range of factors, most important of these in the EU context is the exchange rate between Sterling and the Euro.

NHS Wales Executive Board

Innovative finance and the European Bank

50. On our relationship with the EIB, the EIB is owned by its shareholders, the 28 EU member states. The UK has a 16.11% shareholding in the EIB and is one of the four main shareholders of the Bank. On seceding from the EU, it is reasonable to assume that the UK will cease to be a shareholder.

51. Whether the commercial relationship between the UK and the Bank will be affected is currently a matter of speculation. The EIB has said that "It is premature to speculate on the impact of the referendum result on the EIB, including the Bank's future relationship with the UK government and its future engagement to support long-term investment in the UK without clarity on the timing, circumstances and conditions of a withdrawal settlement."

52. On the question of whether this will affect our ability to borrow from EIB, in principle, seceding from the EU will not affect our ability to borrow from the EIB. However, it should be noted that EIB lending outside the EU is governed by a series of EU mandates in support of development and cooperation policies in partner countries. [Therefore, a specific mandate might be required].

53. Whether the cost of borrowing from the EIB will increase following secession is currently a matter of speculation. The cost of borrowing (from any lender) is an amalgam of many factors, which includes credit worthiness, exchange rates, inflation and interest rates, as well as the risk and reward profile of the specific project for which finance is required. Seceding from the EU could trigger volatility in respect of some of these factors (as has been seen already).

54. For now, the Government remains in close dialogue with the European Investment Bank, collaborating on a list of infrastructure projects that could require debt finance, potentially from the European Fund for Strategic Investment. The Bank continues to lend significant sums to infrastructure projects in Wales, stimulating private investment in the Welsh economy.

Social Services

55. Officials have undertaken an initial assessment of the impacts on social services of the decision to leave the European Union. Our initial view is that these impacts will be limited and quite technical in the short to medium term, applying mainly to the inward migration of care workers or to changes to the basis of recognition of qualifications. Both will potentially be heavily influenced by any decision on remaining in the European Economic Area.

56. These projected impacts could rise to moderate or potentially significant over the longer term if it is the case that either or both of the following scenarios is realised. The first is that inward migration of care staff is substantially reduced without replacement by suitably-skilled UK citizens, thus depleting the workforce. The second is that European funding to the more deprived areas of Wales is not

substantially replaced, thus potentially driving up need in these communities whilst the provision of preventative services and community-based care and support stagnates or is cut back as a result of lack of funds. Either could potentially significantly hamper our attempts to transform the basis of social care in Wales.

Registration of Social Workers from Overseas

57. The Act provides a system of regulation that is able to respond to social workers from anywhere across the world coming to work in Wales. The vote to leave the European Union does not prevent registration applications from social workers in EU countries being processed by Social Care Wales. Once the UK is outside of the EU, officials expect that their applications would be considered in the same way as those from social workers outside the EU.

Wider implications for the social care workforce

58. The social care workforce includes significant numbers of workers from the wider EU. There is a potential for the supply of such workers to be affected by confidence in the future.

59. There could be some short term impacts if individuals from the EU decide to stay in Wales, leave, or not to come and work here at all. We could see an increase in recruitment and retention pressures across social care and in particular in relation to:

- Nurses in care homes – particularly in speciality areas where there are already recruitment challenges, such as provision for the Elderly Mentally Infirm
- Social Care worker recruitment & retention in care homes and domiciliary care, where there are already recruitment challenges generally

60. The implications of withdrawal on working conditions are harder to quantify as they would be dependent upon the approach taken to the retention or otherwise of legislative approaches such as the Working Time Directive which sets a limit on the number of hours that can be worked in an average working week.

61. There could also be implications for skills and research funding that has been supported via European initiatives, depending on the extent to which this is continued by the UK Government.

Impact on recognition of qualifications (registration of social workers from overseas)

62. The Regulation and Inspection Act makes provision under section 85 about registration of social workers, covering in particular those who are allowed to work as social workers by virtue of being an exempt person under part 3 of the relevant regulations. This applies to applicants for registration from all European Economic Area countries (EU member states plus Iceland, Norway and Liechtenstein). Were

the UK to decide not to become a member of the EEA, then applications for registration from social workers in EEA countries would be treated in the same way as those from countries outside the EEA.

Impact on safeguarding and inter-country adoption including Hague Conventions concerning adoption, child protection and child abduction.

63. The UK Government is one of a number of member states who are signatories to three specific Conventions that facilitate formal arrangements for co-operation between members which impact upon Welsh Ministers' social care responsibilities:

i. the Hague Convention on Protection of Children and Co-operation in Respect of Inter-country Adoption;
ii. the Hague Convention on parental responsibility and protection of children; and
iii. the Hague Convention on the Civil Aspects of International Child Abduction.

64. Brussels IIa is a European Union Regulation on conflict of law issues particularly related to divorce, child custody and international child abduction. This, partially, overlaps with the Conventions in bullets two and three above and has direct effect in the UK while it remains a member of the EU. When the UK ceases to be a member of the EU, it will no longer be bound by Brussels IIa but can continue to be a signatory to any of the Hague Conventions. It should be noted, however, that the mechanisms under the Conventions are voluntary and do not have the same force as Brussels IIa has for those covered by it.

65. Officials have already flagged Welsh Minister's interests in these issues with the UK Government to ensure there is no lessening of these protection and partnership arrangements. They will need to be considered as part of any negotiation of the UK's relationship with the EU. These are considered to be extremely technical matters.

EU Cross Border Healthcare

66. There are two key areas with implications for Wales. The first relates to EU Directive 2011/24/EU on Cross Border Healthcare and Patient Mobility in Europe. The Directive enables UK residents to access both pre-planned healthcare and emergency care in EU countries that they would be entitled to receive in the UK. The majority of EU citizens receive healthcare in the Member State where they live, via the health system through which they are covered or insured. However, in some instances, it may benefit the patient to obtain healthcare in another European country – for example, where there may be better expertise available, lower costs, better availability of certain highly specialised treatments or where waiting times are shorter. If we wish to continue these arrangements we will either need new UK/Wales only legislation in place to cover all or parts of the EU or to negotiate individual reciprocal agreements with individual EU countries.

NHS Wales Executive Board

67. The second area is the charging for healthcare for overseas visitors. The current legislation provides that overseas visitors who reside in an EEA state (including non EEA nationals) are exempt from charges for any medically necessary treatment they receive, as long as they present the appropriate EEA healthcare documentation. As for the EU Patient Mobility Directive, if we wish to continue this arrangement we will either need new UK/Wales only legislation in place to cover all or parts of the EU or to negotiate individual reciprocal agreements with individual EU countries.