Medical Services and Social Care Sector Report

1. This is a report for the House of Commons Committee on Exiting the European Union following the motion passed at the Opposition Day debate on 1 November, which called on the Government to provide the Committee with impact assessments arising from the sectoral analysis it has conducted with regards to the list of 58 sectors referred to in the answer of 26 June 2017 to Question 239.

2. As the Government has already made clear, it is not the case that 58 sectoral impact assessments exist. The Government's sectoral analysis is a wide mix of qualitative and quantitative analysis contained in a range of documents developed at different times since the referendum. This report brings together information about the sector in a way that is accessible and informative. Some reports aggregate some sectors in order to either avoid repetition of information or because of the strong interlinkages between some of these sectors.

3. This report covers: a description of the sector, the current EU regulatory regime, existing frameworks for how trade is facilitated between countries in this sector, and sector views. It does not contain commercially-, market- or negotiation-sensitive information.

4. This report covers the market provision of medical services in the UK. Public sector, non-market provision of medical services, including through the NHS, is not within the scope of this report.

Description of the sector

5. The market provision of medical services includes the following three sub sectors:

    a. The ophthalmology sub-sector, which combines provision of medical services and retail alongside provision of services to the NHS.

    b. The dentistry sub-sector, which provides private medical services alongside NHS services, as well as cosmetic dentistry, which is not available on the NHS.

    c. The community pharmacy sub-sector, which includes provision of retail alongside provision of NHS services. This sub-sector includes retail driven high street chains and an independent sector.

6. This report also includes provision of domiciliary and residential care services (for example care provided to older people).

7. Medical services are not highly traded. The UK exported £26 million worth of medical services in 2015 and imported £8 million. The UK therefore had a trade surplus of

£18 million in medical services. UK trade in the sector has decreased since 2013, when exports and imports were valued at £57 million and £18 million respectively.[1]

8. Due to statistical classifications, there are no discrete activity statistics provided for the market provision of medical services.[2] However, the ONS does publish data on "human health and social activities", which may be regarded as a reasonable proxy for the medical services and social care sector as a whole - both the public and market sectors.

9. The Gross Value Added (GVA) of human health and social activities was £127.7 billion[3] in 2016 and it employed 4.3 million[4] people (March 2017) in the UK. However, the market provision accounts for only a small proportion of those totals.

10. The regional and 2015 GVA data for "human health and social activities" in the English regions is provided in the table below.

Region	**GVA (£m, 2015)**
North East	5,476
North West	15,240
Yorkshire and the Humber	10,244
East Midlands	8,041
West Midlands	9,596
East of England	10,541
London	20,859
South East	17,300
South West	10,927

Source: 'Regional gross value added (income approach), UK: 1997 to 2015', ONS, December 2016

11. Similar GVA data is available for the Devolved Administrations, and is set out in the table below.

[1] 'International trade in services, UK: 2015' (Table C1), ONS, January 2017

[2] Medical services and social care are captured within the Standard Industrial Classification (SIC) section "Q - Human health and social activities". This SIC section (and therefore all GVA and employment estimates in this section) includes non-market medical services, such as services provided through the NHS

[3] 'UK GDP(O) low level aggregates', ONS, November 2017

[4] 'JOBS02: Workforce jobs by industry', ONS, September 2017

Devolved Administration	GVA (£m, 2015)
Wales	6,262
Scotland	13,090
Northern Ireland	3,818

Source: 'Regional gross value added (income approach), UK: 1997 to 2015', ONS, December 2016

12. The two tables above suggest that medical services activity is broadly spread throughout the UK.

Sub Sector analysis

13. Please note that ONS data is not broken down by these sub-sectors, and so official estimates of GVA and employment pertaining to each category are unavailable. In the absence of such data, this report draws on other sources of evidence such as the General Optical Council, General Dental Council and General Pharmaceutical Council.

Ophthalmology

14. The General Optical Council publishes figures on the volume of sight tests in the UK, which provide one measure of demand in the sub-sector. 12.8 million sight tests were provided in England during 2014/15. 750,000 such tests were carried out in Wales over the same period. During 2013/14, 2 million and 446,000 sight tests were carried out in Scotland and Northern Ireland respectively.[56]

15. In 2015/16, the General Optical Council (GOC) had 14,776 optometrists registered in the UK.

	2013/14	2014/15	2015/16	2016/17
Optometrists	13,969	14,354	14,776	15,151

Source: '2016 Annual Report', GOC, 2016

16. Whilst ophthalmology services themselves are very lightly traded, nearly all lenses and frames dispensed in the UK are produced abroad (France, Germany and Italy from the EU). Increasing proportions are imported from Asia.

Dentistry

17. Traditionally, dental services in the UK have been delivered by self-employed dentists who own their own business. In recent years, many dentists have incorporated their business and some have sold to newly formed chains as the

[5] 'Optical sector report 2014-15', GOC, November 2015.
[6] 'Annual Health Service Ophthalmic Statistics in Northern Ireland, 2013/14' and 'Ophthalmic Workforce Statistics, 2013. Information Services Division, National Services Scotland'

industry has started to consolidate. Despite this, dentists themselves retain their self-employed status and sub contract their services through the dental practice.

18. The UK has an established private sector dental market for primary care services. In the absence of more recent evidence, a LaingBuisson report from 2014 indicates that primary care dentistry was valued at £5.8 billion in 2013/2014, with £3.6 billion (63%) of this spent by government and patients on NHS dentistry, and £2.2 billion generated from private dentistry (37%).[7]

19. Data from the General Dental Council gives an indication of the types and volume of employment within the dental practices sector as registered by 31 December 2016.

Type	Count
Dentist	41,483
Clinical dental technician	351
Dental hygienist	6,931
Dental nurse	55,525
Dental technician	6,188
Dental therapist	2,897
Orthodontic therapist	522

Source: 'Annual report 2016', General Dental council, 2017

20. Not all 41,483 dentists will be actively practicing. Some will have retired, for example, but maintain their registration.

Pharmacy

21. Community pharmacies are almost entirely private businesses that provide state-funded NHS pharmaceutical services, supplying over 90% of NHS prescription items dispensed in the community[8]. Almost all pharmacies in England provide NHS prescriptions. Only a handful of pharmacies provide only private prescription services.

22. Community pharmacies broadly provide four categories of medical service:

- Dispensing of prescription drugs and appliances;
- Provision of over-the-counter (OTC) medicines, specifically P-medicines, (i.e. those which do not require a prescription but do require a pharmacist on-site to be dispensed – these are privately purchased medicines not paid for by the NHS);
- Advice and guidance associated with medicines and appliances; and
- Clinical and public health related services (e.g. cholesterol testing).

[7] Dentistry UK Summary Market Report 2014, LaingBuisson, October 2014
[8] 'General Pharmaceutical Services: England 2007/08 to 16/17'

23. In addition to providing these services to patients, most pharmacies also generate income from retail sales of health and beauty goods. Information is not held on the proportion of total pharmacy revenue that comes from the NHS against retail income. Some pharmacies also provide private medical services such as blood pressure measurement, cholesterol testing and smoking cessation services. No information is held on the extent of such service provision.

24. Pharmaceutical services are rarely traded but supply chains for medicines are crucial to their business model. Pharmacies generally purchase medicines from wholesalers. For some specific medicines, manufacturers provide medicines directly to pharmacies.

25. Private pharmacy service provision is relatively small compared with NHS pharmaceutical service provision. It would include services offered by wholly private pharmacies (including on-line businesses) and private prescription services offered by community pharmacies.

26. GVA data for the pharmacy sub-sector is unavailable. There has been a growth in the number of pharmacies, increasing by 15% since 2006/7.[9] There are also growing levels of market concentration in the community pharmacy sector. The large firms with multiple retail outlets and supermarkets now hold over half of the total market share.

27. The General Pharmaceutical Council indicates that there were 53,967 pharmacists on the register as at 31 March 2017.[10] The proportion of registered pharmacists from the EEA route is 6.5% (3,529) compared to 4.7% for the same date the previous year.

28. For registered Pharmacy Technicians, there is no breakdown available by nationality. However, analysis of the GPhC Pharmacy Technician Register indicates that 0.7% of technicians had a registered address outside Great Britain in 2012.[11] No information is held for Northern Ireland.

Care Services

29. Social care[12] GVA was around £32 billion in 2016,[13] and there were around 1.8 million employed and self-employed jobs in the sector as at March 2017.[14] Skills for Care also estimate that about 95,000 workers across all adult care services in England are citizens of other EU countries.[15]

[9] https://digital.nhs.uk/catalogue/PUB22317 pg 1
[10] 'Annual Report, 2016-17', General Pharmaceutical Council, 2017
[11] Pharmacy Technician Register Analysis 2012, GPhC
[12] Social care is captured within the SIC divisions '87 - Residential care activities" and "88 - Social work activities without accommodation". These SIC divisions (and therefore all associated GVA and employment estimates) include non-market social care
[13] 'UK GDP(O) low level aggregates', ONS, November 2017
[14] 'JOBS03: Employee jobs by industry' & 'JOBS04: Self-employment jobs by industry', ONS, September 2017
[15] 'The state of the adult social care sector and workforce in England, 2017', Skills for Care, September 2017

30. Local authority social care is heavily means tested and local authorities now have little in-house provision. The vast majority of provision (whether commissioned by local authorities, by the NHS or by individuals who do not meet the means test) is therefore by the independent sector (i.e. private companies or charities).

31. Social care provision takes many forms, but largely constitutes residential/nursing homes, home care or live-in carers. The market is not consolidated and has many small and medium sized firms. The ten largest providers have just 15-20% total market share in each part of the market. According to the NAO definition, adult care services cover care for older people, and adults with physical disabilities, learning disabilities, mental health needs and "other" social care needs. Staff costs are the largest input in both care homes and (especially) home care.

32. The ONS does not produce trade data for social care, but it is sparsely traded.

33. Health is an area of devolved competence in line with the Scottish, Welsh and Northern Irish devolution settlements. Health services are also devolved to the Crown Dependencies and Overseas Territories through individual legislative and constitutional arrangements.

34. Each of the UK's nations has its own advisory, planning and monitoring framework for its health system and its own public health to tackle health protection and inequalities.

The current EU regulatory regime

35. The protection and improvement of human health is an area in which the EU is generally limited to supporting competence. Article 168(7) in the treaties of the European Union expressly recognises that Member States are responsible for their definition of health policy, management of health services and medical care and the allocation of the resources assigned to them.[16]

36. In certain aspects relevant to health, the EU shares competence with the Member States. A group of shared competences relating to common safety concerns was introduced in the Treaty of Amsterdam and extended by the Treaty of Lisbon. Article 168(4) makes provision for the Union to adopt measures relating to: the quality and safety of organs and blood; certain measures in the veterinary and phytosanitary fields and medicinal products and medical devices. Similarly, Article 168(5), which was extended in scope by the Treaty of Lisbon, provides EU competence to adopt certain incentive measures designed to protect and improve human health.[17]

37. EU public health bodies contribute to our ability to share data, expertise, exchange information and collaborate closely. These include the European Centre for Disease

[16] Report on the Balance of Competence of the European Union. Health, July 2013
[17] *Ibid.*

Prevention and Control (ECDC), agreed under Article 30 of Regulation (EC) 851/2004 and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), agreed under Article 21 of Regulation (EC) No 1920/2006.

38. The International Health Regulations 2005 (IHR) require all countries to report cases of disease and other health threats. The UK also participates in World Health Organisation (WHO) public health activity, both through WHO-Europe and directly with WHO headquarters in Geneva, and is a member, along with other G7 countries, of the Global Health Security Initiative (GHSI) and associated Global Health Security Action Group (GHSAG).

39. This means that in terms of the provision of medical services there is little direct regulation from the EU that has an impact on this sector.

40. Given that the provision of medical services and social care cuts across a number of areas of the economy, the medical services sector is impacted less directly by other aspects of the EU regulatory regime. Most notably:

    - The Mutual Recognition of Professional Qualifications (MRPQ) Directive enables qualifications in regulated professions in one Member State to be recognised in all others. Professions that fall under the automatic recognition system, such as dental practitioners and pharmacists, have harmonised training conditions and are therefore able to practice across EU Member States without meeting additional conditions. For other regulated professions, including social workers, EU Member States may impose proportional measures, such as an adaptation period of up to three years or an aptitude test;

    - The training of medical services providers – general considerations on training in the higher education sector are set out in the Higher Education Sector Report; and

    - The regulation of medicines, medical devices and clinical trials, which is set out in the Life Sciences Sector Report.

Existing frameworks for how trade is facilitated between countries in this sector

41. The arrangements described in this section are examples of existing arrangements between countries. They should not be taken to represent the options being considered by the Government for the future economic relationship between the UK and the EU. The Government has been clear that it is seeking pragmatic and innovative solutions to issues related to the future deep and special partnership that we want with the EU.

42. As noted above medical services are sparsely traded and consequently it is the general provisions on services trade that provide the framework for trade in these services outside of the EU.

43. There are a number of existing arrangements that govern the way in which other countries trade with each other in this sector.

44. The baseline for trade in services is the WTO's General Agreement on Trade in Services (GATS). All WTO Members are parties to GATS which sets out general rules, principles and obligations as a framework for trade in services; plus a schedule of commitments which set out how open and non-discriminatory parties commit to be across the service sectors covered.[18] GATS also sets out 'how' parties will allow services to be traded and this is split into four principal 'modes': where a product rather than a service supplier/consumer crosses a border (e.g. an architect sending architectural drawings to a client overseas); where the consumer of the service crosses a border (e.g. tourism); where the company crosses a border (e.g. a retail chain opening a new establishment in another country); and where the service provider moves (e.g. a lawyer spends nine months working in her firm's office in another country). Commitments taken by parties vary and parties can unilaterally choose to improve their GATS offers at any point (subject to a certification procedure) or lower the level of their commitments, but in order to do so they will be expected to offer compensatory concessions.

Sector Views

[This information was provided by the Government to the Committee, but the Committee has decided not to publish this section]

[18] The UK is a member of the WTO in its own right, but its current commitments are listed in wider EU schedules