

KEYNOTE SPEECH BY THE RT HON LORD OWEN AT A CONFERENCE ON
BREXIT AND THE NHS HELD BY THE UK IN A CHANGING EUROPE
WELLCOME CENTRE, 14 MARCH 2018

For what it is worth I cast my individual vote in the referendum to leave the EU. Why? Because I feared that the founding fathers' dream of a United States of Europe was slowly but surely becoming a reality. I still am a believer in a wider European unity. But ever since the summer of 1962, when I became the Labour Party candidate for Torrington in north Devon, I have been against a federal Europe, following the stand of the then leader of the Labour Party, Hugh Gaitskell.

In the referendum I argued the case for leaving primarily because of the threat of being sucked into a federal Europe. Federalism is a perfectly legitimate objective. But it has never been popular in the UK. We have, however, politicians who are 'closet federalists', people who want a federal Europe but dare not admit it publicly.

Everything has changed in relation to federalism since the referendum with Emmanuel Macron becoming President of France in 2017. To his credit Macron is an open and avowed advocate of a federal Europe. He does not say one thing in Paris and another in Berlin. The new grand coalition in Germany has shifted its position to accommodate Macron. It is, in my view, not credible to argue now that a federal Europe will never come. There is a greater than 50 per cent chance that it will.

I do not believe the British people will allow their government to follow the example of Denmark and the Republic of Ireland who, when their referendums voted against EU policy, their governments allowed themselves to be browbeaten by the EU to hold repeat referendums in order to comply with what the EU wanted. Many I accept are still anguished or angry, perhaps both at the referendum result. That debate will continue and tolerance is a vital aspect for any democracy. But MPs cannot run away from the fact that they legislated for a referendum by a large majority and thereby assented to giving up the power of Parliament to decide whether we should leave the EU and pass that decision to the people. Parliament did this on European membership in 1975 and after the 2015 General Election they did it again for the 2016 referendum. There is no democratic case whatever for MPs ducking out of that referendum decision.

This conference has before it a Report: Brexit and the NHS. I was the spokesman at the launch of the Vote Leave ‘Save our NHS Campaign’ on 6 April 2016. I explained in great detail that from 1973 the European Commission had, by and large, for twenty years stayed out of interfering in the UK NHS. Slowly, however, from 1990 in Brussels and in London it began to be accepted that for ‘patient’ the Commission could read ‘consumer’. They did not, however, do this in isolation, they did it because all three of the main political parties from 2002 to 2015 encouraged them to do so. The British people’s general disillusionment with this marketization of the NHS meant that the NHS was inevitably discussed in the referendum.

The EU’s progressive involvement in the NHS I explained in detail in the referendum had become sufficiently strong for the Labour government in 2006 to commission a legal opinion on the effect of EU legislation on the NHS. The English Health Department’s then commercial director, Ken Anderson told the *Financial Times* in January 2007: ‘My personal conviction is that once you open up NHS services to competition, the ability to shut that down or call it back passes out of your hands. At some point European law will take over and prevail ... In my opinion, we are at that stage now.’¹ Professor Menon in his introduction to ‘Brexit and the NHS’ writes “The EU has limited direct competence over health policy” but that has not stopped ever deeper EU involvement.

As if recognising the truth of Anderson’s interpretation on 13 December 2007, with not much publicity, the Department of Health issued a document titled *Principles and Rules for Cooperation and Competition*, running through this were EU legal positions which have since become the law that operates in the UK. The advisory Co-operation and Competition Panel was reported in the *Financial Times* in 2011 to have been applying its interpretation of the law since 2009 – by advising on NHS mergers and handling complaints about anti-competitive practices by hospitals and primary care trusts². In fairness to the Commission, since 2002 the then Labour government, then the Conservative/Liberal Democrat Coalition government from 2010-2015 and now the Conservative government on its own, not under EU pressure, established an external market in health with pressurised tendering and contracting with private companies in the UK, EU and the US eager and willing to participate. This went much further than the internal market of the 1990s and starting in 2002 with the so-called independent

¹ *Financial Times*, 16 January 2007.

² *Financial Times*, 27 and 29 July 2011.

hospital trust and has become a fully-fledged external market as the Health and Social Care Act heads towards full implementation.

Activity in this market for NHS contracts remains high today despite a signalled shift to the press about moving away from competition by the Chief Executive of the NHS, a person chosen because he had for ten years in the US supported a market in health care. Whole new layers of a time consuming market bureaucracy add huge costs. Over the last year (Apr 2016/17) £7.1 billion worth of NHS clinical contracts were awarded through the costly tendering process. This is on a par with the preceding year. £1.6bn worth of NHS contracts were advertised in the first quarter of the current financial year (2017/18); which brings the total value of contracts awarded through the market to around £25bn, since the Health and Social Care Act (2012) came into force. The private sector share of NHS contracts is rising, as they focus increasingly on growing opportunities to provide community health services. For-profit companies won £3.1 billion worth of new contracts in the last year (2016/17). This was 43% of the total value of awards advertised and their share has risen from 34% (2015/16).³

The NHS Operating Framework from the Department of Health for 2011 encouraged, for the first time, price competition below a maximum tariff. David Bennett, then chief executive of Monitor, who had been a senior partner at McKinsey and head of the Downing Street policy directorate and strategy unit under Tony Blair, gave an interview to *The Times* in February 2011 which described the regulator's new role in promoting competition. 'We did it in gas, we did it in power, we did it in telecoms,' he said. 'We've done it in rail, we've done it in water. So there is actually twenty years' experience of taking monopolistic, monolithic markets and providers and exposing them to economic regulation.' It was, he declared, 'too easy to say "How can you compare buying electricity with buying healthcare services?" Of course they are different. "I would say", he went on ... "there are important similarities and that's what convinces me that choice and competition will work in the NHS as they did in those other sectors'⁴. The European Commission were thereby encouraged from the UK to

³ NHS For Sale? Privatisation Report by NHS Support Federation, December 2017
http://www.nhsforsale.info/contract-alert/contract-report-dec-2017.html?utm_source=NHS+Supporters&utm_campaign=1c8217b680-EMAIL_CAMPAIGN_2018_01_22&utm_medium=email&utm_term=0_12b577a602-1c8217b680-710780425&mc_cid=1c8217b680&mc_eid=60b93444b0

⁴ *The Times*, 25 February 2011.

apply competition rules but once brought in they are difficult to change and bind us in the UK, but only while we are in the EU.

Nigel Edwards, the acting chief executive of the NHS Confederation, underlined the degree to which under the 2012 legislation it was intended that the state would I quote ‘be withdrawing from the day-to-day management of health care’, with the service becoming ‘like a regulated industry’ on the lines of telecommunications, water and the energy industries. It could, he warned, ‘trigger a major reshaping of the way care is delivered with services closing and changing’. ‘I do not think most people have grasped the scale of this change,’ he continued. ‘By 2014, the NHS will no longer be a system which still contains the characteristics of an organisation. Instead it will be a regulated industry in which that management chain no longer exists.’ Amid ‘any willing provider’, services would have to become more responsive to patients. But in a system with no real financial growth that would mean that new providers would have to replace existing ones. ‘There will have to be an element of Joseph Schumpeter’s “creative destruction”.’⁵

We are in the midst of that destruction and it is not creative, it has eroded the principles on which the NHS thrived in its first 50 years. I am genuinely puzzled why the main NHS charities that dominate discussion on the NHS – the King’s Fund and Nuffield Trust - continue to champion this external market? They have become not charities in the true sense of the term to serve those in need; but partisans fighting for a political view of the NHS held by a managerial class and MPs which poll after poll shows is not supported by public opinion. At last the Labour Party is changing its position and they know that to revert back to the principles of the 1948 Act will be much easier outside the EU legislative framework than inside.

An aspect of EU involvement in health in the Netherlands was described in 2011. The Dutch competition authority (the NMa) has had the effect of fragmenting service provision and impeding the provision of high-quality care.⁶ A €7.7 million euro fine was levied on the Dutch GP association for a ‘bad case of anti-competitive behaviour’, which was the association’s efforts to ensure that all areas of the country were

⁵ *Financial Times*, 16 January 2011.

⁶ Tony Sheldon, ‘Is Competition Law Bad for Patients?’, *British Medical Journal*, 20 July 2011; Tony Sheldon, ‘Dutch GP Association Is Fined €7.7m for Anticompetitive Behaviour’, *British Medical Journal*, 16 January 2012.

adequately provided with GP services. The Dutch Patients' and Consumers' Federation called for the involvement of competition in healthcare to be urgently reviewed. The outcome viewed from the UK appears to be a fudge.

It was no accident that the Vote Leave campaign wanting to take back control of many aspects of our life through the House of Commons focused on the NHS so I said at the launch of Vote Leave's 'Save our NHS campaign'.

“We are agreed in Vote Leave, that whatever our political views on the present marketization of the NHS, decisions on the NHS should for the future be for the UK Parliament and devolved administrations to take. It should not be for the European Commission nor the European Parliament.”

“Our longstanding democracy has hitherto for a century and more accepted as a principle that the people through their vote in national elections should decide the policy and direction of health care.”

“If people Vote to Leave on 23 June – as I hope they will – it will automatically follow that no British government can ratify the present TTIP. Thereafter, UK legislation will govern the NHS in future and as a consequence we can take back control and protect the NHS from the EU. The NHS will not have to be part of any new UK-EU free trade agreement. There will no longer be competition and market led interference from the European Commission.”

Barbara Castle predicted in the 1975 European Community referendum, against my views as her Minister of Health, when she was Secretary of State for Health and Social Security, that NHS principles would be challenged by Brussels. She has sadly been proven right and I was wrong.

During the referendum in another speech, this time on 19 May, I answered questions in some detail that had been coming up from the floor in campaign meetings across the country about the disgraceful Project Fear masterminded by the then Chancellor of the Exchequer about the effect of Brexit on the economy. In answer to:

Tell us the truth about the economics of remaining in or leaving the EU

I said, “There is no fine calculus that can weigh up the consequences of either. Economics is not a pure science, there are too many behavioural consequences to assess. Almost all the forecasts are ridiculously short-term – but became

equally ridiculous in extending projections of household income out as far as 2030 as in the Treasury's pure propaganda dossier."

In response to the predictions of a recession occurring because of Brexit during the referendum campaign I said:

"Technically anyone can always predict a short-term hit to the economy if one pre-supposes a big enough psychological or confidence set-back. But the possibility of a so-called 'technical recession', meaning two quarters of negative economic growth, is not what matters, when set against the basic course of the economy transcending short-term cycles. In or out of the EU is not going to make a huge difference to that, because it depends mainly on the pace of technical change and other influences on 'total factor productivity' which are far more important than the differences between EU trade access (single market) and UK WTO trade plus bilateral trading agreements (low tariffs)."

The Gravity Treasury model having been technically disparaged has now been abandoned after 2 years in which almost every prediction has been proven badly wrong. So by late 2017 we have the Treasury using a new Standard CGE model. We still have Treasury pessimism but less so than in 2016. Using a similar model, Global Trade Analysis Project, GTAP, four well regarded economists, Roger Bootle, Gerard Lyons, Julian Jessop and Patrick Mitford have made in 2018 a much more optimistic prediction. The *Sunday Times* puts the difference between the two predicted economies as 2.4% larger or 2.4% less by 2030. One thing is sure with a timescale of 12 years, neither will be correct. It is, I admit, very difficult for the lay person to know which forecast to trust. But a new study from Cambridge Centre for Business Research attacks the recent Treasury input data as flawed and thinks their results are too pessimistic. The Office of Budget Responsibility [OBR], which is quoted on pages on 6 and 7 in 'Brexit and the NHS', now has had to change its estimates of growth upwards which they put out in 2017 because of an increase in productivity.

I went on to say how much the NHS might be able to benefit from Brexit financially:

"The case for leaving the EU does not and should not depend on the 'nicely calculated less or more' of short-term economic forecasting, but on the broad

fundamentals. This must include budgetary questions which is a quagmire in the EU which I have tried to explain in detail in Annex B on the EU Budget. Budget pressure from the EU Commission is always onwards and upwards, away from grants from governments to introducing new taxes to be paid direct to the Commission. I have attached Annex B to the written version of this speech. It spells out in detail the facts as I saw them and indicated the amount we would have to spend as £10 billion after we left the EU and suggested £5 billion of that for the NHS. This was my figuring for the slogan on the bus. Incidentally the bus figure will soon reach £438 million a week and the British rebate, were we to remain, which we questioned in the referendum debate about net or gross figures, will no longer exist. I was also asked:

Tell us the truth about immigration

I said, “The total cost of the EU founding principle of free movement of labour and people is unknown. The already hard-pressed British taxpayer sees it as an additional cost and out of control cost. Instead of complaining about the past we must resolve to transform the future.”

I then spelt out what I could only describe then as a personal idea. It remains that today, but I stand by it in all its particulars and recommend them to this Conference; even if we have to pay some £35-40 billion (estimates vary) into the EU Budget for just short of two years while negotiating the Government’s proposed Bespoke Treaty outside the EU in the status quo transition period up until December 2020. After that on the EU plan there will only be legacy payments for long term schemes which we have previously supported. There will be therefore in 2021 a considerable reduction in public expenditure going to the EU, and I do not share the pessimism of the Brexit and the NHS Report. Even more so, I do not believe the political mood in Westminster will agree to a cutback in the growth of NHS expenditure. On the contrary, one of the political benefits of the NHS being discussed in the campaign was that a number of Cabinet Ministers, not least Boris Johnson and Michael Gove, are fully committed to putting a significant part of those savings into the NHS. I also in that speech during the referendum explicitly said what I thought the budget figures might be:

“Leaving the EU means that £10 billion a year - £50 billion over five years - can be invested from this Budget saving starting, say, on 1 July

2018.” [Now I would start it when we leave the EU on 1 April 2019] I went on to say, “This is our National Dividend like the so-called “Peace Dividend” we used to save money on the defence budget after the fall of the Berlin Wall. It would be a tragic lost opportunity if this was not spent creatively and just went into the normal Treasury pool. The National Dividend should be earmarked and put under the direct responsibility of a Cabinet Minister, preferably without a portfolio, to be used to restore the damage done by uncontrolled immigration to the fabric of British society over many years in specific parts of the country. It could be split into three broad categories – possibly 50% for elements in the NHS, 25% for education, mainly primary schools, and 25% for low cost housing. But only in these areas of the UK affected by immigration designed to help all those affected. Applications would be invited only from such areas. The Dividend would not be generally released to Whitehall departments though their assessment could be helpful as decisions are taken over the individual projects. But Whitehall must not spend the Dividend or offset it in their distribution of funding. Only those areas associated with high immigration past and present will gain. Labour must recognize that in the words of Jack Straw “a spectacular mistake” was made by Labour in 2004 when they produced a ridiculously low estimate for how many Eastern Europeans would take up unrestricted access. Those errors have been repeated by the Conservative/Liberal Democrat coalition and now the Conservative government. Today England is the most densely populated country in Europe except for Malta. We can live in harmony with immigration in the UK, of that I am confident. But only with the targeted resources which the British Parliament must control.”

The Report ‘Brexit and the NHS’ in its public health section should, in my view, have championed such a plan for a Brexit investment Dividend, a redistribution of resources predominantly, though not exclusively, to the north of England. I am strengthened in the belief that we can afford to do this £10 billion extra injection in the spring of 2019 by the recent *Financial Times* editorial “Britain has leeway to spend and should use it.”⁷ There is very little doubt after the Chancellor’s statement yesterday that there will be a

⁷ *Financial Times*, 6 March 2018.

percentage rise in NHS spending in the Chancellor's Autumn Budget. But that will not be enough. We will need the Brexit Investment Dividend I have suggested to start on 1 April 2019.

I also went on to warn in that same speech in the referendum campaign that Brexit would involve other expenditure besides the NHS, namely defence.

“There would be a special responsibility for the UK as an integral part of leaving the EU to devote more effort and more resources to NATO. We could use all our saving from EU defence in CSDP and from EU CFSP in the EEAS budget.”

We will need now, to deal with Russia, to raise our defence spending from 2% to 2.5% of GDP.

So I conclude ‘Brexit and the NHS’ does not give sufficient credit to the open discussions which were part of the Vote Leave campaign. Also the economic position outlined in this Report is clearly too pessimistic. The more realistic criticism is of the government from 2015-2016. That there was no Cabinet discussion on using the Vienna Convention disputes procedure rather than Article 50 for exiting and David Cameron just announced Article 50 in the Commons in advance of the referendum. Nor did the Prime Minister or the Cabinet Secretary ensure the Civil Service prepare plans in the event of a leave vote. When the Prime Minister resigned, despite saying he would stay, there were no plans for Brexit that accounts for much of the delay.

The Government's suggested Bespoke Treaty, to which I have referred, will include seeking continued application of the EEA Agreement for the duration of the implementation period to ensure continuity in crucial elements of our trading and non trading relationships with the three EEA EFTA states. Let us hope this Bespoke route first suggested by the Prime Minister in Florence and most recently elaborated on in the Mansion House will be accepted by the EU Commission negotiators. It depends on the UK accepting the present and future *acquis communautaire* up until at least the end of December 2020, though without either a UK vote or formal voice, and, as I said earlier, we have to be ready to pay into the EU Budget during this period provided we end up with an EU-UK Trade Agreement.

Other problems are already being addressed by the government. They want Associate membership of the European Medicines Agency and the European Chemicals Agency which makes sense. The EU negotiators may not accept this. In which case we can build on the medicines and health care products regulations, MHRA. We should not forget that the UK Medicines Commission worked very well and perhaps the UK can get closer to the US FDA (Food and Drugs Administration). Theresa May also called for close association with Euratom and a new science and innovation pact and continuation of the Erasmus students, all wise mechanisms for continuity and good neighbourliness under Article 8. But it is not yet clear if all this is acceptable to the EU. The EU-UK Joint Report accepts that the European Health Insurance card should still operate but the details need to be examined – the UK currently pays out £670 million far more than the £50 million NHS gets in return.

The Academy of Medical Royal Colleges believes the greatest challenge of Brexit will be the likely impact on the size and skills base in both health and social care. We should address this urgently but it is worth remembering well before Brexit there has been a long-held belief within the Colleges that the UK had to train far more doctors and healthcare staff within the UK. What is important for the NHS is that the Government has put on hold until at least 2021 introducing immigration controls covering both the EEA and the Commonwealth since the two henceforth must follow the same pattern. This decision has done much to eradicate fears in the NHS as have assurances of the rights of EEA citizens now in the UK. In my view those assurances should have been given immediately after the referendum result.

Following the referendum result, the need for the UK to train more health and social care staff in the UK has become very apparent. While no official data exists on the exact number of EEA (ie EU + Norway, Iceland and Liechtenstein) workers within the NHS, their roles and where they are. **(SLIDE 1)** In giving the Academy figures from various resources, I wish to stress again all who all admitted from overseas are welcome in the UK if they contribute to our economy or in terms of human rights are being persecuted and in real danger of life and limb. None will be more welcome than those who want to work in the NHS. They will have defined rights whereby they can stay in the UK and these will be honoured.

- Around 10% of doctors working in the NHS are from EEA countries and 6.8% are

citizens from the rest of the world

- 20% of surgeons working in NHS were trained in the EEA with a further 20% trained in the rest of the world
- 17% of dentists were trained outside the UK in the EEA and a further 11.4% in the rest of the world

Another set of figures relate to GPs and psychiatrists. **(SLIDE 2)** A decline in EEA health professions predated the EU referendum, but it is possible that the uncertainty relating to Brexit will worsen this situation as we approach full withdrawal but fortunately despite initial concerns being expressed there has been no Brexit. Nevertheless there is an urgent need both to keep the confidence of those who are in the NHS and to grow our supply of nurses and doctors from within the UK.

- The GMC estimates that around 24% of GPs practising in the UK were trained in the EEA. Using the GMC and their own data, the Royal College of General Practitioners estimates that approximately 2,137 GPs working in the UK trained in the EEA and are providing care to 3.5 million patients
- 53% of NHS psychiatrists working in hospital and community services are UK nationals. 41% of doctors who were awarded membership of the Royal College of Psychiatry (MRCPsych) obtained their primary medical qualification from outside the UK, and 28% of them are from the EEA.

Only a few weeks ago the Royal College of Nursing published a document ‘Left to Chance: the health and care nursing workforce supply in England’. The RCN do not have figures of nurses in the UK from the EEA countries and they appear not to be available. But key figures are shown in **(SLIDE 3)**. The population of England needs many more healthcare students to meet the growing healthcare workforce demand. It says that “after a significant growth in the number of European Union (EU) entrants to the workforce, we are experiencing a drastic reduction in EU entrants, with the number of EU-trained nurses and midwives joining the Nursing and Midwifery Council register for the first time dropping steeply since July 2016.”⁸

- Recent figures of all nurses, however, show approximately 40,000 unfilled nurse posts in England as of December 2016,⁹ with the NHS midwifery shortage in

⁸ Nursing and Midwifery Council, Report on EU nurses and midwives May 2017, <https://www.nmc.org.uk/globalassets/sitedocuments/special-reports/nmc-eu-report-june-2017.pdf>

⁹ The Royal College of Nursing (May 2016), *Safe and Effective Staffing: the Real Picture*, <https://www.rcn.org.uk/professional-development/publications/pub-006195>

England estimated at 3,500.¹⁰

- England is currently training around 20,000 nurses a year – this number will remain the same for 2017/18.¹¹
- Government intended this funding reform to enable the training of an additional 10,000 nurses, midwives and AHPs across the course of the previous Parliament.¹²

Since August 2017, funding that covered some of the university cost and provided a grant to a nursing student has been replaced with standard tuition fees. The Government claimed this policy decision which would save £1.2 billion would, because it was a market-led model, result in up to 10,000 more training places in pre-registration health care by 2020.¹³ In the first year after the reform, the number of nursing training applicants in England fell by 23% compared with 2016.¹⁴

It is successive governments who cut back on UK educational training costs for doctors and nurses with scant regard for a greater measure of self-sufficiency. The people of this country were largely unaware of this degree of dependence on EEA skilled doctors and nurses unless they found their sons and daughters or friends who had the necessary qualification to become doctors or nurses who were being turned down before their careers could even start. Parliament acquiesced in this for too long.

After the global economic crisis the NHS was hit by further cuts in the growth of expenditure like every other sector. The increase in health spending dropped considerably and will only average just 1.1% a year between 2009-10 and 2020-21. What is so irresponsible is that during this period politicians did not compensate the NHS for imposing PFI costs, marketisation costs, consultancy costs and extra management costs.

¹⁰ The Royal College of Midwives, *State of Maternity Services Report 2016*, https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf#page=6

¹¹ Health Education England, Commissioning and Investment Plan 2017/18, <https://www.hee.nhs.uk/sites/default/files/documents/Commissioning%20and%20Investment%20Plan%202017-18.pdf>

¹² Department of Health (July 2016), The case for health education funding reform, <https://www.gov.uk/government/consultations/changing-how-healthcare-education-is-funded/the-case-for-health-education-funding-reform>

¹³ Department of Health (2016) 'Healthcare student funding consultation', News story, 7 April, www.gov.uk/government/news/healthcare-student-funding-consultation-launched (accessed 25/01/18)

¹⁴ UCAS (2017) *Application rates by the January 2017 deadline*, www.ucas.com/corporate/news-and-key-documents/news/applicants-uk-higher-education-down-5-uk-students-and-7-eu-students (accessed 25/01/18)

What is inexplicable is why with health spending increases being reduced after the 2009 global economic crisis, as part of an overall public expenditure cutback, the Coalition Government went ahead in 2011 and introduced the most disastrous piece of legislation in the history of the NHS, far worse than Sir Keith Joseph's in the early 1970s. This Health and Social Care Act 2012 presents far more problems than Brexit. David Cameron has admitted it was the Coalition's greatest mistake and yet the government still shows no sign of recognizing that it is this external market which is bringing the NHS to its knees.

The most recent revelation is the ever greater use of management consultants. This has to be coupled with the recent headline in the *Times* that the hiring of NHS managers has soared by a quarter in only four years. The sharpest rise was in managers earning over £65,000 a year where in one year it rose by 7% to reach a present total of 10,300 people at a time when nurses and health visitors fell by 0.2%.

A recently published study by Bristol University showed NHS trusts that hire management consultants in order to cut costs end up spending more. Health service spending on such firms doubled between 2010 and 2014. Andrew Sturdy, professor in management at Bristol, said, "Our research has clearly shown management consultants are not only failing to improve efficiency in the NHS but, in most cases, making the situation worse." The average trust spent £1.2 million a year on management consultants and overall the NHS yearly expenditure on such consultants doubled from £313 million in 2010 to £640 million in 2014.

The Report 'Brexit and the NHS' virtually ignores all the evidence of an NHS market structure which is an integral part of the reason for the NHS being in such a desperate state. Its authors seem to assume that the current legislation and marketization should continue indefinitely. Whereas I argue that that very costly legislation has to be urgently revoked and the vocational, ethical and moral foundations of the 1948 legislation restored.¹⁵

END

¹⁵ David Owen, *The Health of the Nation. NHS in Peril* (Methuen, 2014).

Notes

David Owen resigned with Roy Jenkins in 1972 when Labour was in opposition because he wanted to enter the European Community. He espoused a thoughtful anti-federalist stance from 1977-79 as Foreign Secretary. He supported the British opt-out of the euro in the Maastricht Treaty of 1992. He was the Chairman of New Europe from 1999-2005, a cross party campaign to say No to Britain ever joining the euro. He opposed the Lisbon Treaty of 2009 without the referendum promised by Tony Blair in 2004 and rescinded in 2005.

Lord Owen, as Dr David Owen MP, was Minister of Health from 1974-76.

EU BUDGET

The first question is whether to take the Office of National Statistics figures or the Treasury's? The UK's gross contributions in 2014 were £19.107 billion, or £367.4 million per week comes from the ONS (ONS, Pink Book, 2015, tab 9.9: 'UK official transactions with institutions of the EU'). Forecasts for our gross contributions over the coming years are provided by the Treasury. The claim that the UK's gross contributions in 2015 were £17.8 billion is derived from from HM Treasury's 'European Union Finances 2015' (Cm 9167, December 2015). This figure is an 'estimated outturn', rather than an actual payment. The ONS figures are therefore preferable. The Treasury also wrongly deducts 25% of the traditional own resource (TOR), customs duties, from the gross contribution figure. According to the ONS, this was £741 million in 2014. However, the UK is permitted to retain this money 'by way of collection costs' for carrying out activities mandated by EU law, namely the collection of the common external tariff (Council Decision 2014/335/EU, art. 4(3)). Accordingly, it ought to be accounted for as money being paid to the UK by the EU, since the UK is being reimbursed for activities it might not carry out but for EU law. The ONS figures are right. Gross payments are therefore £19.107 million or £367.4 million per week. The £350 million figure Vote Leave has been using is therefore an underestimate.

The Head of the Statistics Authority, Sir Andrew Dilnot CBE, has said: 'Yes, the £19.1 billion figure is a legitimate figure for gross contributions... the official statistics are the £19.1 billion' (Evidence to Public Administration and Constitutional Affairs Committee, 26 April 2016).

The rebate was negotiated by Margaret Thatcher in 1984. Tony Blair decided to give away half of that rebate in 2005, for reasons explained at the time connected to the Government's wish to expand the EU more rapidly and therefore should accept a measure of the cost of such a policy. In retrospect it is considered more related to his personal reasons to become President of the European Council, a post for which he even lobbied Hillary Clinton when US Secretary of State when he was no longer an MP and even the White House. What this demonstrates is that the existing rebate remains highly political and very likely to be challenged and is in practice an effective discretionary grant. It is something that has to be constantly negotiated. The Chancellor told a parliamentary committee that: 'As I said to the House of Commons, it was not clear at all that the rebate would apply to the extent that it did.... It is not a unilateral decision of the British Treasury or the British Government to just say, "This is our rebate. We are entitled to it. Pay up". The way this works and has always worked is there is a negotiation with the European Commission' (Evidence to Treasury Select Committee, 17 December 2014). The rebate is deducted from the UK's GNI-based contribution a year in arrears (e.g. the rebate in 2015 relates to UK payments and receipts in 2014. The EU guidelines governing budget contributions states that the rebate is 'established by... calculating the difference, in the preceding financial year' between certain shares of unadjusted UK payments to the EU and EU payments to the UK (Council Decision 2014/335/EU, art. 4).

The EU is holding back until after the UK referendum the publication of the mid term

review of its Multiannual Financial Framework (MFF) or seven year budget. Several press outlets have already done a good job of writing this up (EurActiv, January 2016) and it looks as if after our referendum they will certainly utilize the €12 billion margin and they may raid the social funds already under pressure because of severe unemployment to pay for the additional cost of refugees. They are highly likely to point up the need for “new own resources” and the financial transaction tax (FTT) to which many in the UK financial services industry are bitterly opposed.

Vote Leave has always said that for every £2 we pay in we only get £1 back. According to the ONS, the rebate, or ‘Fontainebleau abatement’, was worth £4.416 billion in 2014 (ONS, Pink Book, 2015, tab 9.9: ‘UK official transactions with institutions of the EU’). Deducting the rebate and what we get from the EU in agriculture and scientific research the UK’s gross contribution is therefore £9.9 billion, in effect £10 billion a year.

NB We now know that the UK rebate was not applied during the seven year Budget written in February 2018 and due to start in January 2021 irrespective of whether we are still in a transitional period paying in to the EU Budget. So it was correct for Vote Leave to draw attention to the fact that the British rebate was “in practice an effective discretionary grant” (as now underlined in para three above)

The [Vienna Convention on the Law of Treaties](#) (23 May 1969) entered into force on 27 January 1980 and provides details regarding the termination of treaties. Please see ‘Part V: Invalidity, Termination and Suspension of the Operation of Treaties’ (Articles 42 – Article 72) pages 342–349.

Article 8

Article 8 of the Treaty on European Union states:

1. The Union shall develop a special relationship with neighbouring countries, aiming to establish an area of prosperity and good neighbourliness, founded on the values of the Union and characterised by close and peaceful relations based on cooperation.
2. For the purposes of paragraph 1, the Union may conclude specific agreements with the countries concerned. These agreements may contain reciprocal rights and obligations as well as the possibility of undertaking activities jointly. Their implementation shall be the subject of periodic consultation.

(Article 8, [Treaty on European Union](#), Official Journal c326, 26 October 2012)

Article 50

Article 50 of the Treaty on European states:

1. Any Member State may decide to withdraw from the Union in accordance with its own constitutional requirements.
2. A Member State which decides to withdraw shall notify the European Council of its intention. In the light of the guidelines provided by the European Council, the Union shall negotiate and conclude an agreement with that State, setting out the arrangements for its withdrawal, taking account of the framework for its future relationship with the Union. That agreement shall be negotiated in accordance with Article 218(3) of the Treaty on the Functioning of the European Union. It shall be concluded on behalf of the Union by the Council, acting by a qualified majority, after obtaining the consent of the European Parliament.
3. The Treaties shall cease to apply to the State in question from the date of entry into force of the withdrawal agreement or, failing that, two years after the notification referred to in paragraph 2, unless the European Council, in agreement with the Member State concerned, unanimously decides to extend this period.
4. For the purposes of paragraphs 2 and 3, the member of the European Council or of the Council representing the withdrawing Member State shall not participate in the discussions of the European Council or Council or in decisions concerning it.

A qualified majority shall be defined in accordance with Article 238(3)(b) of the Treaty on the Functioning of the European Union.

5. If a State which has withdrawn from the Union asks to rejoin, its request shall be subject to the procedure referred to in Article 49.

(Article 50, [Treaty on European Union](#), Official Journal c326, 26 October 2012)