Briefing
June 2020

Brexit Health Alliance
Supporting healthcare as the UK leaves the EU

# Negotiating a new relationship with the EU that safeguards patient access to medicines and medical technologies

The Brexit Health Alliance (BHA) is calling for the UK government to prioritise a deal with the European Union (EU) that delivers rapid access to medicines and medical technologies and ensures patient safety remains paramount.

## Key points

- On 31 January 2020, the UK left the EU and the Brexit transition period started. Between now and the end of the year, the UK will renegotiate its future relationship with the EU.
- The BHA believes that the UK's approach to the negotiations should provide patients and industry with as much clarity as early as possible, and prioritise:
  - guaranteeing patients uninterrupted supply of their current treatments and fast access to new medicines and medical devices
  - safeguarding high regulatory standards and public health protections for medicines and medical devices used to treat patients
  - promoting the UK's position as a global leader in life sciences innovation and international influence.
- This is important because after decades of cooperation across the complex regulatory systems that facilitate trade, supply chains and manage safety of products, there has been substantial growth in frictionless trade between the UK and EU. The future of this relies on the decisions that will be made in these negotiations.
- What the Brexit Health Alliance is calling for the UK government to agree with the EU:
  1. The maximum possible regulatory and customs cooperation for medicines and healthcare products.
  2. Patient safety and public health to be guaranteed by close cooperation and making UK and EU regulation as compatible as possible for medicines and medical devices.
  3. Maximum possible cooperation with the European regulatory network and collaboration with the European Medicines Agency; and UK participation in EU systems such as data sharing networks, pharmacovigilance and new clinical trials infrastructures.
  4. Active participation in future European-wide vigilance processes for medical devices to better understand post-marketing safety and performance.

# Safeguarding patient access to medicines and medical technologies

The Brexit process will impact patients' access to medicines and medical technologies in the UK. Ongoing future relationship negotiations between the UK and EU have the potential to shape what that will look like from the point of view of trade with the EU, the UK as a market for new products and location for clinical trials, and management of the safety of products made available in the UK. In this briefing, the BHA is calling for the UK government to prioritise agreeing a deal with the EU that delivers rapid access to medicines and medical technologies and ensures patient safety remains paramount.

## State of play – where we are now

The withdrawal agreement bill has been passed and the UK left the EU on 31 January 2020. This means that the Brexit transition period has started, during which the UK will renegotiate its future relationship with the EU. There are two possible outcomes at the end of the transition period. The first that an agreement is reached on the future relationship and the UK and EU put in place arrangements to move to a new way of working. The second that an agreement is not reached, and the UK moves to World Trade Organisation rules.

Until the end of the transition period in December 2020,* the regulation of medicines and medical technologies in the UK continues to be managed by EU-wide systems that facilitate patient safety, access and trade under the single market. These harmonised systems have meant that UK and EU patients have been guaranteed high safety standards through:

- shared information and surveillance of medicines
- rapid access to medicines, devices and new treatments through customs cooperation and alignment of regulatory standards, to avoid replication of authorisations or border controls
- options for new treatments through joint research, supported by shared regulatory frameworks.

The BHA believes that reaching a deal is critical, and that alignment with and continuation of the current integrated system is the best course of action. However, given the UK government's current parameters for a deal, we do not believe that the latter will be feasible. Therefore, we support the most recent government position, as set out in the UK's Approach to Negotiations[1] publication from February 2020, as the best way forward.

* The transition period ends by default on 31 December 2020. Alternatively, the UK and EU can jointly agree, on a one-off basis, to extend it by a further period of up to two-years.

This UK mandate document proposes an approach that prioritises the agreement of a deal over no deal, and advocates for tariff and quota-free trade. Although it proposes measures that reduce unnecessary barriers to trade, streamline practical processes and provide for appropriate regulatory cooperation, it is also clear that the UK will maintain its own rules and regulations. We recognise that agreeing to treaty-based rules tying the UK to future regulatory alignment to the EU and jurisdiction of the European Court of Justice is a red line for the UK government, but we also note that the UK has no intention to 'diverge for the sake of divergence' and that it does not envisage any reduction of the current high standards.

The mandate addresses technical barriers specific to medicinal products in order to facilitate trade. It suggests that an agreement should 'provide for mutual recognition of certificates of Good Manufacturing Practice compliance issued by the regulatory authority of either party, as well as acceptance of batch testing certificates issued by a manufacturer based in either party' and that it 'should include commitments to cooperate on pharmacovigilance and develop a comprehensive confidentiality agreement between regulators.'

## What agreements the Brexit Health Alliance is calling for

Recognising that the timetable for negotiations is ambitious, we urge for pragmatism and continued prioritisation of medicines, medical devices and health from both sides throughout the negotiations. The BHA asks that the UK government builds on what is proposed in the recently published mandate to secure agreements with the EU, to deliver the following:

1. The maximum possible regulatory and customs cooperation for medicines and healthcare products. Zero tariffs and compatible regulatory standards to avoid replication of marketing authorisations, border inspections, and protect 'just in time' supply chains.
2. Guaranteed patient safety and public health by making UK regulation as compatible as possible with that of the EU for medicines and medical devices, and by close cooperation, including:
    - a mutual recognition agreement that includes Good Manufacturing Practice compliance certification, inspections and batch testing for medicines
    - a mutual recognition agreement for all CE-marked medical technologies granted by a UK notified body (for EU27) or by EU27 based body (for UK).
3. Maximum possible cooperation within the European regulatory network and collaboration with the European Medicines Agency; and UK participation in EU systems such as data sharing networks, pharmacovigilance and new clinical trials infrastructures.
4. Active participation in future European-wide vigilance processes for medical devices to better understand post-marketing safety and performance.

## Benefits of clarity and cooperation

Implementation of the BHA recommendations will achieve as much cooperation across the complex regulatory systems as possible within the red lines set by both sides in order to facilitate trade, supply chains and manage the safety of products.

**Regulatory and customs cooperation**

By tabling an annex on medicinal products in the UK's mandate document,[2] the UK government implies that future cooperation on medical devices and medicines is a priority in the negotiations. The BHA welcomes this so that patients and the wider public are not negatively impacted by disruptions in the supply of medicines and health technologies, particularly due to the substantial scale of trade between the UK and EU. Around three-quarters of the medicines and more than half of the devices the NHS uses enter the UK via the EU.[3] For medicines, 45 million patient packs go to the EU from the UK every month, and products are often developed in complex supply chains from across Europe.

### Example: Emergency supplies

For both medicines and medical technologies, a crucial supply line is A&E trauma packs, which are flown from the EU to UK within hours of being ordered for unexpected large-scale emergencies such as terrorist attacks. Hospitals do not always stockpile these packs on a large enough scale to deal with extreme emergencies because the medicines and devices would risk being wasted.

A critical action on regulation to ensure uninterrupted supply of medicines to patients, is the establishment of a Mutual Recognition Agreement (MRA) that includes Good Manufacturing Practice compliance certification, inspections, and batch testing between the EU and UK. A suitable MRA would avoid the risk of significant supply chain disruptions by eliminating duplication and delays in conformity assessment. It would also remove re-testing requirements and reduce added complexity in medicine supply chains in the future.

Regulatory and customs cooperation will also support the continued availability of medical devices for both UK and EU patients. Many medical devices rely on international supply chains, both for finished products and components. Global companies' components can be sourced from across Europe and beyond and finished goods then exported globally. This often means that the company's entire global inventory is manufactured in one place, such as the international company that manufactures orthopaedic implants, but produces some of its products for the rest of the world in south Wales.

### Example: Availability of medicines for prostate cancer patients

There is a treatment used for prostate and breast cancer that is manufactured only in the UK but marketed in over 80 countries. This highly complex product is both manufactured and quality control tested at a state-of-the-art manufacturing facility with testing laboratories, equipment and 350 skilled staff required to assure product quality. Total manufacture lead time is 12 months from active pharmaceutical ingredient production to finished pack release. If the UK and EU can agree mutual recognition of the testing, it can avoid duplication of quality testing and release facilities in an EU27 location. The calculated duplication time for the manufacture and quality control testing is at least 42 months, with a risk of taking longer. This could affect the supply of this cancer treatment to patients, including up to 120,000 in Europe each year. implants, but produces some of its products for the rest of the world in south Wales.

**Cooperation with the European regulatory network and EU systems such as data sharing networks, pharmacovigilance and clinical trials infrastructures**

Alongside MRAs, while acknowledging the UK government's red lines and the timelines set out to complete negotiations, the BHA believes that both the UK and EU should be open to exploring ongoing regulatory cooperation. Cooperation such as input and access to patient safety databases like Eudravigilance, and cooperation through established EU-third country regulatory authority clusters, improves patient safety by ensuring that medicines available are of the highest standard.

For medical devices, active participation in future European-wide vigilance processes means better understanding of post-marketing safety and performance, particularly of long-term implants and high-risk products. An example of this is the UK's participation in EUDAMED,* the European database on medical devices that will support transparency and communications with the public, as well as clinical performance and risk management. This is crucial because the NHS would not function without medical devices. Hospitals and primary care organisations use a multitude of medical devices every day, from disposable syringes and surgical gloves, to surgical implants, diagnostic devices or MRI scanners.

Cooperation with European regulatory networks will allow patients to continue to benefit from early access to a wider range of innovative health technologies and take advantage of opportunities to access cutting-edge treatments. We would like to see the UK remain an attractive market for companies to choose to launch new products and a clear simple, system for companies to do so. Until

* EUDAMED is planned to be launched in 2022, as part of new EU regulations on medical and in vitro diagnostic medical devices.

now this has been achieved through participation in the European Medicines Agency (EMA) and European networks. If this is not possible in future, the priority for future arrangements should be to allow UK and EU patients to have timely, low-cost access to drugs and medical technologies.

Finally, the BHA would like to see the UK continue important work in pan-EU clinical trials. On rare diseases, the UK leads and participates in more than any other member state and ranks in the top four across the EU for clinical trials in mental health, cancer, cardiovascular disease and musculoskeletal disorders.[4] We urge that all possibilities are explored as part of negotiations to avoid costly and damaging disruption to the UK clinical research environment, and leave the door open to future collaboration.

Specifically, the BHA's ask is for the UK's future regime to be as compatible as possible with any future regulation, such as the new EU Clinical Trials Regulation (CTR), due to apply in member states after the Brexit transition period. Alongside aligning with the CTR, the UK should seek to negotiate continued participation in the underpinning EU-wide infrastructure and systems. These are time-sensitive considerations as the UK may not have the time to change domestic legislation before introduction of the EU CTR, in which case adoption could ensure the UK maintains global high standards.

The UK played a key role in shaping this regulation for the benefit of UK research, improved standards, greater transparency, and to promote academic-led clinical research. Further, it supports the recently introduced medicines and medical devices bill,[5] which aims to give patients faster access to innovative medicines and allow the UK to take a lead role in global research to find cures for rare diseases and improve treatments for patients around the world.

**Clarity on Northern Ireland Protocol**

Ahead of the potential no-deal Brexit, the UK government and the life sciences industry worked effectively together to establish measures to support the uninterrupted supply of medicines to patients. Despite this, we must continue to address all remaining risks in the EU-UK future partnership regarding the supply of medicines for patients. We understand that the Northern Ireland Protocol will come into force at the end of the transition period, but there are elements of the protocol that still require agreement with the EU, and which may or may not be superseded by provisions agreed in the future relationship negotiations.

The BHA believes the Northern Ireland Protocol will have implications across most areas of member activity in Northern Ireland, such as regulation, approval, packaging, commercialisation, supply and monitoring of medicines and devices, which may require re-design. Life sciences companies have advised that any adjustments to regulatory systems and supply chains can take more than a year to implement. The BHA asks that clarification on the interpretation of the Northern Ireland Protocol is provided urgently and that the UK is pragmatic in its implementation in relation to medicines and medical devices.

## What happens if agreements are not reached

After the end of the transition period, the UK will operate as a third country outside the EU's regulatory systems. If there is no future relationship agreement on the areas above, under a 'no deal' scenario, there will be barriers to cooperation with the EU, and certain medicines and medical technologies may be delayed in reaching patients or even become unavailable.

**Delayed access to new medicines and medical technologies**

The EMA currently represents 25 per cent of the global pharmaceutical sales market (representing some 500 million patients), compared with the UK's 3 per cent share.[6] There could be delays for UK patients in accessing new medicines and medical devices if its market is overlooked in favour of the EU's for the launch of new treatments; as well as a risk that they are offered at a higher price in the UK. Despite having a number of bilateral trade agreements with the EU, it is estimated that Switzerland, which is not an EMA member, gains access to new treatments on average 157 days later than the EU.[7] In Australia and Canada, new medicines come to market on average 6–12 months later than in the EU or USA.

This is particularly relevant in the context of the current COVID-19 pandemic. As highlighted in a recent article published by a group of leading academics and lawyers,[8] the UK now lies outside the EMA's rapid authorisation mechanism for pandemic vaccines and medicines for treatment. Consequently, the UK could have to wait longer for these than EU member states. The UK has also withdrawn from the EU's emergency bulk-buying mechanism for vaccines and medicines, which allows EU member states to increase their market power and speed up access to vaccines and medicines during a crisis. Its exclusion could mean the UK will have to pay more to acquire these pandemic countermeasures.

**Disruption in medical supply chains**

Divergence from well-established UK-EU harmonised standards, with no negotiated agreement around mutual recognition or cooperation with the EU on medicines and medical devices, will increase the risk associated with complex supply chains. Although immediate shortages are not anticipated, significant planning and preparations will be required to mitigate against the additional risk introduced by 'de-linking' current supply chains and the inevitable increase in the bureaucratic and regulatory requirements of importing goods.

For instance, new marketing authorisations for medicines by a UK company will no longer be valid to legally supply medicines into the EU after Brexit and vice versa, unless this is specifically agreed in the negotiations. Should the UK leave the EU without an agreement to continue as part of a regulatory system with the EMA or recognising its decisions, applications for marketing authorisation for new medicines would need to be submitted both to an EU approval route, and separately to the Medicines and Healthcare products Regulatory Agency (MHRA) for authorisation for use in the UK. This could lead to a greater administrative and cost burden. In addition, the MHRA, which benefits from the shared expertise and workloads of the distributed model of the EMA's approvals process, could see a significantly higher workload.[9]

## Example: Delays in access to radioactive isotopes

The UK uses medical radioactive isotopes, for example, in the diagnosis and treatment of cancer, and in 2018/19 the NHS performed more than 619,000 diagnostic procedures that rely on radioactive material.[10] The European Atomic Energy Community (Euratom) creates a single market for nuclear energy in Europe and is responsible for co-ordinating and regulating access to the materials. The government has stated that when the UK leaves the EU it will also leave Euratom, although it hopes to work closely with it in future.[11] Leaving Euratom's arrangements risks a series of time-sensitive supply chains that supply isotopes used in nuclear medicine. The UK does not have any reactors capable of producing these isotopes and because they decay rapidly, often within a matter of hours or days, hospitals in the UK must rely on a continuous supply from reactors in France, Belgium and the Netherlands.[12]

**Uncertainty for EU clinical trials in the UK**

If the UK falls outside the EU's regulatory system for clinical trials, UK-led trials will be more burdensome and are likely to be significantly more costly to set up, putting at jeopardy the UK's clinical research environment and patient access to cross-border trials. The UK will risk losing access to the crucial EU infrastructure that underpins the legislation, such as the clinical trials portal and database, which provide a centralised system for submission, assessment and approval of clinical trials.

Further, UK academic sponsors would require legal representation in an EU member state, which is administratively complicated and potentially prohibitively expensive, especially for non-industry sponsors of trials (currently 40 per cent). This would have a significant impact, because according to a 2019 report from the Association of the British Pharmaceutical Industry, over the last decade, an average of 28 per cent of EU clinical trial applications have come from the UK. The UK ranks first in Europe for the number of early clinical trials, with 4,800 UK-EU trials between 2004 and 2016,[13] and a further 147 phase 1 and 253 phase 2 clinical trials started in 2017.[14]

Changes could make the UK an unattractive proposition for many life sciences companies and limit the opportunities to undertake vital clinical trials. Other issues include the ability of the UK to be involved in multi-country international trials and patient access to trials moving forward, both of which are key areas to maintaining patient safety and the UK's role as a leader in innovation.

# Next steps

To maintain its own rules and regulations in the field after the end of the transition period, the UK government has introduced the medicines and medical devices bill,[15] which will allow regulation-making, delegated powers covering human medicines, clinical trials of human medicines, and medical devices. The bill will allow the UK to update frameworks derived from EU directives that have subsequently been implemented into domestic legislation, for example, to reflect changes in manufacturing methods or new types of product. It will also set out a framework enabling the introduction of UK measures to prevent falsified medicines. The bill represents the first step towards defining a sovereign regulatory regime in the UK after the Brexit transition period.

How the UK uses these new powers, and the impact on patients' access to medicines and medical devices, will depend on the outcomes of the future relationship negotiations. Whatever the outcomes, agreements and assurances around how any changes to regulation and management of medicines and medical technologies are required as quickly as possible to ensure that patients are guaranteed a high level of safety and rapid access to new treatments. It is essential that the government works with and supports industry during the transition period and ensures that patients are protected from January 2021 onwards.

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## Brexit Health Alliance

The Brexit Health Alliance was established to make sure that the interests of those who use health services, as well as healthcare commissioners and providers, educators, researchers and the healthcare industry are reflected in the Brexit negotiations. The alliance includes members from across the Devolved administrations and as such its work applies across the whole of the UK, including where health is a devolved matter.

For further information about the work of the Brexit Health Alliance, please visit:

www.nhsconfed.org/BrexitHealthAlliance

## Brexit Health Alliance members

Co-chairs: Niall Dickson CBE, Sir Hugh Taylor

Secretary: Kate Ling

Members: Academy of Medical Royal Colleges, Association of Medical Research Charities, Association of British HealthTech Industries, Association of the British Pharmaceutical Industry, Association of UK University Hospitals, BioIndustry Association, Faculty of Public Health, Medical Schools Council, National Voices, NHS Confederation (including the Mental Health Network, NHS Clinical Commissioners, NHS Employers), NHS Providers, Northern Ireland Confederation for Health and Social Care, Richmond Group of Charities and Scottish NHS Chief Executive Group, Welsh NHS Confederation.