Evidence from the NHS Confederation to the House of Commons European Scrutiny Committee inquiry into the institutional framework of the UK-EU Trade and Co-operation agreement (TCA)

Who we are

1. The NHS Confederation is the membership body that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

2. The NHS is the largest employer in the UK and is therefore important not only because of the services our members provide but also as a major economic player and catalyst for employment, economic growth and regeneration across the UK's regions. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure.

Our reasons for submitting evidence

3. We have been actively engaged since the Brexit referendum in assessing the implications of exiting the EU on the NHS, and in advocating for an agreement that promotes the interests of patients and the healthcare systems on which they rely. We continue to work closely with the DHSC and NHS England/Improvement to support our members in implementing the necessary changes "on the ground".

4. Our members in the NHS tell us what is really happening on the frontline in hospitals, community and primary healthcare settings, on the practical impact of the TCA's provisions, and how implementation might be improved. This feedback and experience from the "coalface" is an invaluable resource for Government to harness constructively in shaping policy and strategy.

5. We co-ordinate the Brexit Health Alliance, a coalition of organisations across the four UK countries, to promote a future relationship with the EU that protects patients and maximises opportunity for the health sector. The Alliance continues to press for resolution of ongoing healthcare-related issues arising from the TCA and its implementation.

6. We also have strong and demonstrable links with our counterparts in the European union, and through these influencing channels we can indirectly reach the European Commission, members of the European Parliament and politicians in EU member states who cannot be reached through the formal EU structures now that the UK has exited the EU.

Responses to the Committee's questions

What are the most important powers of the Partnership Council and the different Specialised Committees and what could the practical impact of the exercise of these powers be?

7. The powers of the Partnership Council and its committees are set out in Title III, Part One of the Agreement. Chief among these are the Council's power to adopt binding decisions by mutual consent where the TCA or its supplementary agreements so provide, and to make non-binding recommendations to the Parties regarding implementation and application of the TCA or its supplementary agreements.

8. On a practical level, there are issues concerning the NHS such as the regulation of medicinal products where the TCA's provisions fall short of the measures needed to facilitate supply of these products with the minimum of bureaucratic barriers. Here, the Working Group on medicinal products (which sits under the Trade Specialised Committee on Technical Barriers to Trade) could play an important role in making proposals to recommend solutions to the practical problems being encountered, and could deepen and extend the provisions of the TCA in the longer term. The group's role is to monitor and review implementation and ensure the proper functioning of the relevant Annex. The TCA states that the EU and the UK should work together to implement agreed international guidelines and that any changes to either the UK or the EU's regulation regime should be subject to notice and discussion by this Working Group. It is disappointing that this group has not yet met.

9. Other issues that could be raised through the Council and its committees are the lack of mutual recognition of conformity assessment of medical devices (ranging from MRI scanners to pipettes), which will require duplicate testing and authorising for marketing in the UK and EU respectively, and the requirement for clinical trial sponsors based in the UK to have legal representation in the EU. This incurs considerable additional costs for the sponsoring research institutions and does nothing to benefit the patients for whose sake the trials are being conducted.

How could the implementation of the TCA and the actions of the UK/EU joint bodies impact the operation of the Northern Ireland Protocol annexed to the UK/EU Withdrawal Agreement?

10. Solutions relating to the rules on regulation of medicinal products could, if adopted by the Council, ease the obstacles anticipated for supply of medicines in Northern Ireland after the current "grace period" expires. The reverse applies: the relationship between the Withdrawal Agreement (WA) and the TCA is such that it is possible for retaliatory measures related to implementation of the NI Protocol/WA to include suspension of obligations under the TCA, but these measures must be "appropriate".

11. Future divergence by the UK from the existing "acquis" of EU rules, and/or updated or new EU legislation with which Northern Ireland (but not Great Britain) must continue to align, may provide fertile ground for this kind of rift.

12. A further significant concern for our members is the possibility that the UK's accession to the EU's Horizon Europe programme (2021-2027) that funds medical and scientific research, envisaged in Part Five of the TCA, may fall foul of the ongoing dissent between the UK and EU over the operation of the Protocol. Refusal to allow UK association to Horizon Europe would significantly reduce funding for medical research collaborations and hamper the search for innovative treatments offering hope to patients both in the UK and EU.

What structures does the TCA provide to develop or deepen areas of cooperation such as mutual recognition of professional qualifications?

13. The TCA contains various "framework" provisions on which subsequent agreements could be built if the Parties so desire. Annex SERVIN-6 sets out a possible mechanism for agreeing mutual recognition for professions, based on a "bottom up" approach from professional bodies and regulators who would present proposals to the Council for agreement. Early indicators are that UK national regulators for the health professions are concluding bilateral

agreements with their counterparts in EU countries as a swifter, more straightforward procedure that also preserves the autonomy of regulators, in line with UK domestic legislation on the reform of professional regulation.

14. Part Four, Title 1 of the TCA includes provisions on health security to the effect that the European Centre for Disease Prevention and Control (ECDC) and UK's Health Security Agency (UKHSA) "shall cooperate on technical and scientific matters of mutual interest to the Parties and, to that end, may conclude a memorandum of understanding" covering, for example, co-operation tackling cross-border health threats such as Covid-19. This would be a useful and desirable supplementary agreement that we urge the EU and UK to progress.

What are the key features of the dispute resolution procedures provided for in the TCA, and what are the likely legal and policy implications of these for the UK? How closely do they follow precedent in other trade agreements and do they raise any concerns with respect to the UK's regulatory autonomy?

15. The TCA envisages dispute resolution procedures whereby a tribunal of independent arbitrators would make decisions that would be binding on both parties. Proceedings would be confidential and there is no appeal mechanism, unlike WTO procedures which provide for appeals to a body of legal experts. Also unlike the WTO rules, the TCA allows NGOs or civil society bodies to make representations to the arbitration tribunal, though the tribunal is not obliged to take their views into account. We welcome this as it provides the opportunity for organisations such as the NHS Confederation to draw to the tribunal's attention relevant issues that may impact on public health and wellbeing.

16. An important feature of the TCA, which the UK has also followed in other FTAs such as the agreement with New Zealand, is that there is no investor-state dispute settlement system (ISDS) – so a business/corporation cannot use the TCA's dispute settlement provisions as a method of challenging measures taken by parties to the agreement. This is welcome news to the health sector, as it means that whilst companies may make representations to the arbitration tribunal, they cannot challenge a State for (e.g.) taking public health measures that they regard as detrimental to trade (this can happen under WTO rules).

17. The TCA contains the reservations included by the UK in other TCAs reserving the right to regulate in the interest of public health and to determine how to fund, organise and deliver national health services, thereby safeguarding regulatory autonomy. However differences in the UK and EU's regulatory regimes, for example technical barriers to trade (TBT) in respect of medicines and medical devices, or sanitary-phytosanitary (SBS) rules, could cause operational issues "on the ground" and discourage UK divergence from EU regulatory "norms".

How, ideally, should the transparency requirements around the meetings of UK/EU joint bodies, as set out in the TCA, be implemented both ahead of meetings and afterwards? How satisfactory are the requirements as currently set out in the Agreement?

18. The transparency requirements in the TCA's rules of procedure for the Council and its committees are rather weak. Whilst the agendas and minutes should be made public, there is no requirement for the meetings themselves to be held in public (though the co-chairs can agree to do so). This lack of transparency is understandable where there is a high degree of political sensitivity around negotiations. The TCA goes into considerable detail about

timescales to be observed, which imposes a reasonable discipline on the conduct of proceedings.

How could the UK/EU TCA institutions be utilised by the UK and EU to raise and, where possible, address, concerns about legal and policy developments on the other side which are of importance to them respectively (e.g. for the UK, changes in EU regulation in key areas like financial services, pharmaceuticals and energy)?

19. The Partnership Council and its committees could perform an extremely useful function "horizon scanning" upcoming EU (and UK) legislation now that the UK is no longer represented either as a Member State in the European Council or by MEPs in the European Parliament, and has lost these formal routes for influencing EU policy direction or legislative proposals. The provisions in Title 10 of the agreement, in particular GRP6 (early information on planned regulatory measures) and GRP 12 and 13 on regulatory co-operation, could provide a useful vehicle for this, especially through the Trade Specialised Committee on Regulatory Co-operation.

20. The dispute resolution procedures do not apply to Title 10 which helpfully means that the parties must proceed by consensus.

21. The provision that such committees "may invite interested persons to participate in these meetings" also offers the opportunity for business or legal experts from affected sectors, or organisations representing consumers or end users, to contribute their expertise. We envisage this could be extremely valuable in the specialised committees and working groups – for example, the working group on medicinal products – where technical experts can work together to propose practical solutions to problems arising from implementation of the TCA.

What should the Government's approach to representing the UK in meetings of the TCA's joint bodies be? Should the Devolved Administrations be involved in discussions that relate to devolved competences? How should the Government ensure cross-departmental and cross-sectoral coordination of its positions in the various bodies established by the TCA?

22. Government benefits from the expertise of public and private sector business and of civil society organisations in informing the UK's positions. The NHS Confederation's response in September to the Cabinet Office consultation on engagement with business and civil society groups on implementation of the TCA argued that, if appropriately constituted and meaningfully consulted (not mere "window dressing" or talking shops), the Domestic Advisory Group and Civil Society Forum to be set up under the provisions of the TCA could add significant value to the Government's approach. We have also responded to the call for expressions of interest and put the NHS Confederation forward for a "seat at the table", given the size and political, social and economic importance of the NHS.

23. We have also argued for a co-ordinating committee that could bring together the health-related elements of the TCA for consideration "in the round", as unlike (for example) the aviation or fishing sector there is no dedicated chapter on health issues. Provisions which impact significantly on the NHS and the wider health sector are scattered throughout the TCA and the health impact may be overlooked or sidelined as a result.

24. The devolved administrations should certainly be involved in discussions that relate to devolved competences, for example health. The architecture of the TCA's institutional framework is complex and requires good domestic co-ordination across UK Government

departments, in order to secure comprehensive and balanced representation on the appropriate Partnership Council bodies and committees.

How is the EU approaching the implementation of the TCA and the work of the joint UK/EU bodies, and what are the potential implications of its approach?

25. This is not a question on which we can shed more light than the Inquiry can obtain from the EU's own communications and from the experience of those (on both "sides") who are closely involved and attend the meetings.

26. However we do have a rich conduit for information and influencing through the European health stakeholder group of pan-EU healthcare organisations that we convene, consisting of a wide range of member organisations such as patient groups, medical research charities, academies of medicine, associations of professional bodies, and industry (pharma/med tech/life sciences). All of these have access to politicians in their own Member States, to EU Commissioners and officials. and to MEPs. This group has supported us by lobbying for mutually beneficial outcomes, for example such as campaigning for UK/EU data adequacy agreement and is currently campaigning for the UK to participate in Horizon Europe funded research programmes.

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