Memorandum of evidence from the British Medical Association to the Business, Energy and Industrial Strategy Committee inquiry on the implications of leaving the European Union for British business: pharmaceuticals

The British Medical Association (BMA) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. The BMA is committed to safeguarding the future of the profession and the patients we serve and it is essential we are consulted and involved in consultations to inform negotiations to leave the European Union (EU) which would affect the medical profession and patients.

We welcome the opportunity to provide evidence to the Committee on the implications of leaving the EU for British business and hope our submission is informative for decision makers during the negotiation process.

Executive summary

- The UK government must seek to negotiate a formal agreement with the EU on the EMA (European Medicines Agency) and the regulation of medicines, medical devices and medical products after the UK leaves the EU.
- Should the UK develop a significantly different regulatory process to the EMA over time, there is a risk that the increased time and cost burden the pharmaceutical industry would incur through the duplication of processes, may lead to the industry prioritising the launch of new medicines sales in the significantly larger European market over the UK.
- An agreement between the UK and EU on the mutual recognition of the CE marking scheme for medical devices and technology would help manufacturers to avoid having to satisfy different safety, health and environmental protection standards. This would reduce delays in devices and technology developed in other countries reaching the UK market and vice versa.
- Should the UK become a second-tier market, this could lead to delays of up to 24 months in new drugs and devices being made available to patients in the UK.
- Establishing a regulatory regime for clinical trials that diverges significantly from EU standards would increase the burden on UK researchers and pharmaceutical companies. This would make the UK a less appealing destination to conduct trials, particularly for rare diseases, while also creating barriers to collaborating and sharing expertise and facilities.
- EU nationals make a significant contribution to the UK pharmaceutical, biotechnology, medical research and university sectors. The highly specialized nature of medical research means it can be difficult to sustain research projects employing solely UK nationals. Consequently, any future immigration system for EU nationals must consider the impact and implications for the clinical academic medical workforce.
- It is crucial that the UK continues to work collaboratively with the EU on research to develop new medicines and medical devices. Reduced collaboration risks not only having a significant adverse impact on the UK’s capacity to develop new products for the benefit of patients, but also limiting training and career opportunities for medical researchers and making the UK a less attractive destination for key talent and expertise.

What are the opportunities and potential disadvantages of seeking regulatory divergence from EU product, safety and other standards?

1. Seeking regulatory divergence from the EU on product, safety and other standards will be a major disadvantage in ensuring timely access to medicines, medical devices and biotechnology, maintaining high standards of pharmacovigilance and facilitating high-quality clinical trials. Non-
trade tariffs such as tighter border checks with the EU, may also increase the burden of trading with the UK. This is particularly important as the UK has a well-established and growing import and export market for pharmaceuticals and biotechnology. Increased lead times and additional paperwork could affect service levels and margins, and cause the UK to be viewed as a second-tier country for importing pharmaceuticals and medical devices.1,2

1.1 Setting alternative licensing requirements and customs requirements, would increase the regulatory and administrative burden on pharmaceutical companies incurred by duplication of processes. The industry has stated that associated increased investment in time and costs would cause them to prioritise the much larger EU market over the UK3 — the EU accounts for 25% of world sales of medicines, second only to the United States, while the UK accounts for only 3%.4 This would potentially cause delays in new drugs being made available for patients in the UK. It has been suggested a separate regulatory system to the EMA could lead to delays of 12 to 24 months for UK patients being able to access life-saving cancer drugs.5,6

1.2 A separate system for the accreditation of medical devices and technology - such as software and data - in the UK (diverging from the CE (“Conformité Européene”)) scheme, would increase the burden on biotechnology firms through the need to satisfy different safety, health and environmental protection requirements.2 Removing this frictionless trade would lead to delays in devices and biotechnology developed in other countries reaching the UK market, and vice versa.6 This would be particularly detrimental for the UK, as most medical devices are imported.7

1.3 A divergent regulatory approach would also increase the regulatory burden for companies conducting clinical trials. As a member of the EU, the UK adopts a range of regulations on clinical trials – the Clinical Trials Directive (2001/20/EC) and the Good Clinical Practice Directive (2005/28/EC), which will be replaced by the Clinical Trials Regulation (536/2014) during 2019. Outside of this system of regulation, pharmaceutical and biotechnology companies would need to provide different datasets to the MHRA (Medicines and Healthcare products Regulatory Agency) and EMA, and researchers would need to seek individual permissions for trials in the UK, as well as the EU.

1.4 This increased burden would make the UK a less appealing destination to conduct clinical trials by creating barriers to working collaboratively and sharing expertise and facilities and limiting access to datasets from other EU countries.8,9 This would ultimately reduce collaboration between the UK and EU and therefore delay the development of and access to new medicines and devices across Europe.

3 Association of British Pharmaceutical Industry press release (01.04.2017) New medicines to be prioritised in Europe over Britain, warn leading pharmaceutical companies
5 www.bbc.co.uk/news/health-38922366 (last accessed on 10.10.2017)
1.5 Regulatory divergence from the EMA would also weaken pharmacovigilance processes. The EMA coordinates a large network of pharmacovigilance, including post-approval regulation, surveillance and information sharing of medicines and medical devices across their life-cycle. The specific advantage of this collaboration at an EU level is the wider coverage area for surveillance and reporting, as there are a greater number of patients using a drug, compared to within an individual country, which increases the accuracy of data and helps pick up concerns at an earlier stage. Should the UK reduce its involvement in this network, and adopt a more selective approach to pharmacovigilance data and information sharing, it would significantly lessen the capacity to manage and detect issues such as adverse drug reactions.8

1.6 The UK has had particular prominence in setting standards in genomics and precision medicine. The NISBC (National Institute for Biological Standards and Control) is responsible for developing and producing over 90% of the international standards in use around the world to assure the quality of biological medicines. This has been achieved through globally leading initiatives such as UK Biobank and work by Genomics England on healthcare genomic data in rare diseases, and increasingly in cancer. These initiatives rely on EU infrastructures such as ELIXIR (the European Life-science Infrastructure for Biological Information) – a pan European initiative to coordinate, sustain and integrate Europe’s life science bioinformatics resources. Failing to continue to work with the EU on bioinformatics would risk reducing the UK’s influence in these areas.

1.7 While there may be opportunities – for example, streamlining approval processes, this would fail to mitigate against the delays incurred by a divergent approach to licensing decisions and clinical trials and the risks to patient safety of weaker pharmacovigilance. Failure to agree a withdrawal arrangement by March 2019, would increase the likelihood of regulatory divergence. This would in turn create considerable uncertainty about the UK’s approach to medicines and medical devices regulation, which would lead to a shift away from products being developed for the UK market and delayed access to new medicines and medical devices.6 While it is vital that the UK should negotiate a withdrawal deal that works for the ongoing supply of medicines and medical devices, we also believe that it is vital that the Government puts in place contingency plans if no deal can be agreed by March 2019.

To what extent should the UK seek to retain influence on these standards? Is it preferable for the UK to: establish an EU association agreement (or equivalent); replicate EU regulation; diverge from EU rules and standards?

2. We believe it is vital for the UK Government to continue to work closely with the EMA after the UK leaves the EU by negotiating a formal agreement – for example, the Swiss model of an MRA (mutual recognition agreement)10 - to continue to support and participate in EMA assessments, and approval of licensing decisions domestically. A number of non-EU countries have set a precedent for working on an individual basis on medicines licensing with the EMA – either through an MRA to align regulatory processes,11 or through membership of the centralised authorised medicines procedure, as is the case with EEA countries.12

2.1 Ensuring close collaboration will also require the UK to replicate the new EU Clinical Trials Regulation so there is alignment, as well as an agreement as to how the UK (through the MHRA)
participates in the operation of pan-European clinical trials. This will maximise opportunities for the UK to retain influence on clinical trials standards, which has also previously been valuable to the EU, for example the UK playing a key role in developing the new Clinical Trials Regulations.

2.2 To prevent delays in medical devices and technology reaching the UK and EU markets, and facilitate coordinated post-approval surveillance, the UK Government should also seek to agree mutual recognition of the CE-mark between the UK and the EU. This is in line with the arrangements in place for several non-EU countries for regulating and then importing medical devices into the single market. For example, Australia, New Zealand and Switzerland have MRAs with the EU to promote trade by providing easier access to conformity assessments.

How dependent is the sector on workers from EU countries, at all skill levels? What is the potential impact of restrictions on freedom of movement? How far can gaps be filled by UK workers?

3. EU nationals make a valuable contribution to the UK pharmaceutical and biotechnology sectors, particularly in medical research. There are around 900 medical academics working in the UK from EEA countries – around 2% of the total workforce.13 This group provides world-leading expertise. For example, 46% of Cancer Research UK PhD students and around half their research fellows are from outside the UK.14 The employment of world class researchers helps to ensure that UK universities and companies involved in medical research maintain an internationally competitive edge. The highly specialised nature of many aspects of medical research means that it can be difficult to sustain research projects employing solely UK nationals. Experts within a specific field may be so few that there are none available domestically.

3.1 If the UK failed to negotiate a withdrawal agreement by March 2019, this would compound significant distress and uncertainty for EU nationals working in the UK, and may lead to expertise relocating. In the long term, if companies carrying out medical research find that in the UK they are unable to employ the best medical researchers from around the world, then they may move their operations to countries where this is possible. The needs of the clinical academic medicine workforce must be considered in any future review of the immigration system facing workers from EU countries.

How significant are EU-dependent R&D activities within the sector’s broader research landscape? What R&D collaboration, funding and access to facilities and resources is the UK in danger of losing as a result of Brexit?

4. The EU is a very significant partner in international medical research and provides a vital platform for collaboration between EU countries. It provides funding, through the Horizon 2020 programme and the EIB (European Investment Bank), facilitates sharing of research staff and expertise, supports cross-border clinical trials and data sharing, helps develop world-class facilities and provide a high-quality training environment.

4.1 The level of EU funding the UK receives for health-related research projects is substantial and underpins collaboration, which in turn increases the impact of research.14 Between January 2007 and March 2017, the UK received the highest level of funding (£1.2 billion) among all EU countries for health-related research projects from EU funding programmes FP7 (Framework Programme 7) (2007-2013) and Horizon 2020 (2014-2020).14 This investment stimulates further significant

13 Higher Education Statistics Agency, 2015-16
industry funding (£1.6 billion in 2015-16) from bodies such as Cancer Research UK, the British Heart Foundation and the Wellcome Trust.9

4.2 Beyond providing financial resources, a key feature of these programmes is how they facilitate and actively promote international collaboration between researchers and research institutions. For example, between January 2007 and March 2017, the UK was actively involved in 1,000 health-related research projects, involving over 2,300 UK participations – the act of involvement of a legal entity in any number of projects - and delivering health-related research work worth €4,800 per researcher.14

4.3 Should the UK cease to work collaboratively with the EU on research, it would create uncertainty for future funding and opportunities for researchers, and, therefore, damage the UK’s scientific appeal, as well as creating psychological barriers to cross-border collaboration and cross-fertilisation of ideas.15 For example, collaboration across the EU on research into diabetes has led to the sharing of expertise, and Horizon 2020 funds, to develop of community-based approaches to prevention and management of the disease across Europe and more widely.16 Research carried out in isolation would have a limited impact17 and this would in turn limit the UK’s ability to translate research into products in the market – the UK currently has the largest pipeline of therapeutic treatments in Europe17, while 25% of the world’s top prescription medicines were discovered in the UK.14

4.4 The UK also risks reducing training and career opportunities. Researchers across the UK and EU are able to train and develop in world-class research networks and facilities offered by all Member States, with the UK seen as a highly attractive destination (eg between 2007 and 2013, the UK was the top destination for the EU’s Marie Sklodowska-Curie action fellowships, with five UK institutions among the top ten organisations).14 Attracting these skills to the UK has significant benefits to the research sector and wider economy.18 The EIB also invests substantially in UK research facilities – for example, at universities in Oxford, Edinburgh, Swansea, Bangor, Newcastle and UCL in 2016 – which makes a significant contribution to ensuring UK facilities are world leading.19

How can future collaboration, funding and resource/facility access with EU countries be best secured? How can the UK best retain influence in EU and international research programmes?

5. To ensure researchers and research institutions across the UK and EU continue to collaborate closely, the UK Government should, at a minimum, negotiate a formal agreement to maintain access to EU research funding programmes. This could be similar to the arrangements that several non-EU countries have for participation in Horizon 2020, known as Association Agreements20 – for example, Switzerland, Norway and Israel are among the highest net recipients of funding from the programme.21

5.1 A formal agreement would support access to expertise, knowledge and capability with the EU, while tapping into and maintaining influence in international research. This will ensure

---

13 European Investment Bank (24.01.2017) EIB confirms GBP 5.5 billion backing for investment across the UK in 2016
international partners continue to seek access to UK infrastructure and collaboration with UK researchers.

5.2 The European Commission has recently announced that, after March 2019 should the UK leave the EU without negotiating an exit deal, UK researchers collaborating on existing EU funded projects will lose access to EU funding from that point onwards and may be required to leave ongoing projects. The potential impact of this is already causing the research community significant uncertainty in terms of future funding sources and opportunities for collaboration. This must be addressed urgently to prevent the UK losing academic expertise and to ensure future demand for researchers to work in the UK. Failure to do so would ultimately damage the UK’s research outputs and reputation.

What opportunities are there for the UK to improve exports to countries outside the EU?

6. The strength of UK manufacturing lies in orthopaedics, health-related wearable devices, imaging, diagnostics and a number of other areas. As well as agreeing mutual recognition of the CE marking scheme, leaving the EU may create opportunities for the UK to increase exports of medical devices and biotechnology in these specialties and more widely. This would require the UK to negotiate bilateral deals, such as MRAs with non-EU countries and membership of MDSAP (medical device single audit programme).