

Science, Innovation and Technology Committee

Oral evidence: Life sciences investment, HC 1331

Tuesday 16 September 2025

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[Watch the meeting](#)

Members present: Dame Chi Onwurah (Chair); Emily Darlington; George Freeman; Tom Gordon; Kit Malthouse; Dr Lauren Sullivan; Adam Thompson; Martin Wrigley.

Health and Social Care Committee member present: Andrew George.

Questions 28 - 70

Witnesses

[II](#): Lord Patrick Vallance, Minister for Science, Research and Innovation, Department for Science, Innovation and Technology; Rosalind Campion, Director, Office for Life Sciences (OLS); Dr Zubir Ahmed, Parliamentary Under-Secretary of State, Department of Health and Social Care.

Examination of witnesses

Witnesses: Lord Patrick Vallance, Rosalind Campion and Dr Zubir Ahmed.

Q28 **Chair:** Good afternoon and welcome to the second panel of this Committee's one-off evidence session exploring the investment issues facing the UK's life sciences. I would very much like to welcome our ministerial and governmental panel. I shall ask you each to introduce yourself the first time I ask you a question. We have had a very interesting session with industry, and that has given us messages that I know the Committee members want to share with you.

I am going to start by asking a question of the Minister for Science, Research and Innovation, Lord Patrick Vallance. I want to point out that Lord Vallance needs to leave at 4.15 pm, so if he stands up and leaves, that is not being rude to the Committee; it is prearranged that he needs to leave us. Lord Vallance, as I said, we have heard very clear messages from the industry witnesses, which we will be sharing with you. You are uniquely placed: you were president of research and development for GSK until 2018, the chief scientist during the highly successful public-private development of the covid vaccine, and are now responsible for UK research and development. Could you give a quick summary of the issues that you see regarding the UK life sciences sector, particularly with regard to government-funded research and pharma pricing regimes?

Lord Vallance: I am pleased to have the opportunity to do this. If you read the ABPI report, it does contain a lot of things that are correct—not everything, but a lot is correct. It points out that we are very good at basic research and aspects of clinical research. We have some work to do on clinical trials to get them in the right place. There has been a 10-year decrease in performance there, which we have a clear ambition to reverse. We have some opportunities around things like health data, which is all laid out very clearly in the Life Sciences Sector Plan.

The real crunch issue is the appropriate uptake, access and payment on medicines, which is causing an environment that the industry is finding difficult in the UK and is leading to many of the reactions we are seeing. That is where the fundamental issue lies at the moment and where we need to make sure that we get into the right place.

I am not saying there are not more things we could do on research and development; there are. We also have to do a lot on data; in particular, the Health Data Research Service needs to get up and running and into the right place, and we need to get better at clinical trials. The problem that we are facing now is one that is to do with pricing, access and uptake, and I will add to that the possibility of tariffs from the US.

Q29 **Chair:** Just to clarify, are you saying that we need to pay more in terms of pricing to support innovation?

Lord Vallance: If you look at what has happened to the overall NHS spend on medicines, it has been in decline as a percentage of total NHS



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spend since about 2015, and the reason that we need to reverse that direction is not just price. I do not think this is just about saying, "We're going to pay you more." It is about saying, "We need to make sure that we get rapid uptake of the best new medicines and we have equitable access right the way across the UK." There is probably a price issue for some medicines as well. All those things need to be looked at. It would be a big mistake to say that the only thing we need to do is put up prices; it is more than that, and the ultimate beneficiary of this needs to be patients on the one hand and the economy on the other.

Q30 **Chair:** Just to clarify, could you tell us when you first heard that Merck was withdrawing its investment?

Lord Vallance: In July, when it had its quarterly results and said that it was going to cut its annual running costs by \$3 billion a year by 2027 and make 6,000 redundancies across the world, one had to assume that some of that might hit the UK. I did not hear about the actual proposals around its withdrawal until the day before or possibly the same day, which is not surprising, because these things are commercially sensitive and they do not tend to tell us about them until they happen.

Q31 **Chair:** Did you engage with Merck in the intervening time?

Lord Vallance: I have had many meetings with industry throughout this. It is perhaps just worth saying—one of the things about being old is you can remember these things—not that long ago in 2007, almost exactly the same thing happened with Merck. It had built a brand-new research centre in Terlings Park, then never actually filled it and suddenly withdrew altogether, so it is not the first time this has happened.

Q32 **Kit Malthouse:** Patrick, you seem remarkably relaxed about this announcement. I have to say, the reason we are having this emergency meeting is that we all think this seems to be part of a trend and pattern of decline of the industry. Given that your provenance is from the industry, I am surprised that you seem so relaxed about it.

Lord Vallance: No, I am not relaxed in the slightest bit about it. I am not running up and down screaming, because that does not help, but I am deeply concerned that there has been a 10-year decrease in the investment and support for an industry that is vital for the economy, patients and the NHS, and at a time when medicines are making a bigger impact on health than ever.

Q33 **Kit Malthouse:** I understand all that, but off the back of Speke and now this, we have the Lilly freeze, AZ in Cambridge: it is looking like there is a contagion, and I guess we were hoping you would come with a, "Here's what we're going to do to sort it out." We heard in the previous session that the timing of this is disappointment following a Prime Minister promise made in February to sort out the VPAG—the pricing mechanism—that has just not transpired.

During the months since then, you must have known that the industry



was extremely unhappy and therefore there were likely to be consequences. What has actually happened? We understand there is no conversation going on at the moment because there is a standoff.

Lord Vallance: I am sorry, that is not correct. There are regular conversations going on all the time and I am in touch with many people in industry; I spoke to various CEOs very recently about all these things. This has been an ongoing discussion and is not an easy one to solve.

It is worth saying that there has been some mechanism like VPAG for a very long time in the UK, and it has always been a bone of contention between Governments and industry. The last scheme got stopped when the rate went up to 25%, so VPAG was brought in—negotiated by the previous Government together with industry—to try to come up with a solution. Unexpectedly—against everyone’s expectation—it came up with a figure of 23%, which was clearly not what anyone expected; they thought it would be something closer to 15%.

Reversing that costs money, and what was put on the table—despite the fact that this was the one that was agreed by both sides—was for the Government to help to bring that rate down to below 20%, make changes in the way that we value medicines via a change in the NICE discount rate, which actually represents a double-digit average increase in the price of new medicines, and introduce incentives for companies to get even more preferential treatment if they invest in the UK. So there was an offer put on the table in the end that was not voted on by the companies, probably also mired with discussions going on with the US.

It is a very complicated current picture, but we are determined to solve this. This is not something where we are sitting saying, “Let’s watch the decline of the industry.” That is what has happened for the past 10 years: people have sat there watching a decline over 10 years. We must not do that; we have to act. It is going to require solutions in all these areas, and there are ongoing discussions with the US about this. Now is a pivotal moment, and that is why this is an important session today to try to get this right.

Q34 **Kit Malthouse:** During those months of discussion, was it made clear to you that if there was not a resolution in a timeframe that was short enough, some investments might be under threat?

Lord Vallance: Industry has been clear that the ongoing investment in the UK is dependent on having a commercial environment that is conducive to them doing business. If you look at the difference in different stages of companies, it is quite interesting. Where we are doing really well is in companies that are not the big, mature companies that are growing. Moderna has invested £1 billion in the UK. BioNTech has committed to invest £2 billion in the UK and is growing.¹

¹ Correction requested by witness: BioNTech has committed to invest £1 billion in the UK, not £2 billion as stated in the evidence session.



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We have a series of investments in companies that are on the way up with new technologies. Isomorphic in the UK is probably the leading AI drug discovery company. There are things that are going very well. The bit that needs attention is this question of the big companies and the pricing, and that is where we know that, if we do not get that right, the investment will not be there.

Q35 Kit Malthouse: If you knew they were unhappy and the pricing mechanism was a problem, you have obviously had quite a lot of time since February to try to get it sorted. You accepted that the equation—the formula—had come up with an unexpectedly large amount. Who is stopping you from correcting it?

Lord Vallance: The offer that was put on the table by the Government was equivalent to £1 billion.

Q36 Kit Malthouse: Who is making the decision about that offer? Is it you?

Lord Vallance: No, it is not me. There are a lot of people involved in it: Treasury, DHSC, and so on.

Kit Malthouse: Minister, there will be one person who is making the decision, "This is the offer we're going to give."

Lord Vallance: This is clearly a major area for the UK and a £1 billion offer was put on the table that has not been voted on.

Q37 Kit Malthouse: I understand that; you have explained that already. Who said, "We are going to make a £1 billion offer?" Who said, "We'll make an offer that is not going to be accepted?" Was it the Chancellor? Was it the Secretary of State for Health? I guess what we are trying to do is find the person who has the levers they can pull to try to change what looks like a disastrous trajectory for life sciences in the UK.

Lord Vallance: That offer was made by the Secretary of State for Health and Social Care.

Q38 Kit Malthouse: So in theory, we should have the Secretary of State for Health and Social Care in front of us at some point to talk about the pricing mechanism, why he is not making an offer that the industry can accept, and whether he is willing to see the industry decline.

Lord Vallance: Nobody is prepared to see the industry decline. There is a question of how much money the NHS can put into this, how much goes on price, access and distribution, and what the mechanism is to get that into the right place. Everybody is focused on trying to make that happen. Plus of course we have the question of potential tariffs that are being talked about at the moment, where we also need to make offers in this direction to try to get things working properly. It is a very live debate at the moment with people trying to fix it. We have Dr Ahmed here from the Department of Health and Social Care and he may want to say more.



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Dr Ahmed: Madam Chair, if you will allow me, I can pick up on some of Mr Malthouse's points. The offer was on the table for eight weeks. There was an opportunity to dissect it, digest it and vote on it, and that opportunity was not taken. At that point—for the sake of operational reasons and certainty as much as anything else—we had to make a decision as to whether we continue to have that offer open-ended or stick to the current offer that was—again, as Lord Vallance says—negotiated only 18 months ago with industry.

Our door is still open, not only in terms of VPAG, but on a wider discussion about how we use pricing mechanisms that are evidence-based, for clinical benefit, that benefit patients but also make this a mature and welcoming environment for investment for all these companies. That is the basis upon which we are working.

Q39 **Kit Malthouse:** Final two questions from me. Was there agreement between the Departments about the level of the offer or did the Department of Health and Social Care overrule your Department, Patrick? Secondly, what was the explanation for the offer not being voted on?

Lord Vallance: Who do you want to answer those questions?

Kit Malthouse: Either of you.

Lord Vallance: As you know very well, that was the agreed offer that went in from the Government.

Kit Malthouse: It does not have to be agreed. If it is the Department of Health and Social Care's budget, it gets a say, even if you say, "We don't think that's enough."

Lord Vallance: There is collective accountability for things. But in terms of why they did not vote on it, that is a question for industry; you have to ask it that question. We were very disappointed they chose not to vote on it. The timing got very mixed up with US negotiations as well.

Chair: Certainly the impression I got from that previous panel was that they could not agree. That is why the ABPI said that effectively it could not agree what its position was and that is why it did not choose to vote on it, but we will come back to that. I am now going to ask Emily to pursue questions.

Q40 **Emily Darlington:** First, welcome to your new role, Dr Zubir Ahmed. I am very happy to see that we have a life sciences Minister at the Department of Health and Social Care in that role. We have heard from industry that there has been a credibility gap between what we say—our life sciences strategy—what the Prime Minister said at the conference and what actually happens. The actual wording was, "credibility problem". How do you see yourself in your new role actually fixing and squaring that circle and making sure that what we are promising at ministerial level is being delivered to these companies in the way that it has been promised and committed to?



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Dr Ahmed: By way of introduction, I am an MP for Glasgow South West. By trade, I am a surgeon and medical researcher. I am delighted to be in this role.

Chair: We have a vote so I will suspend the sitting.

Sitting suspended for a Division in the House.

On resuming—

Chair: Welcome back to this session of the Committee. We had a brief interlude for a vote and have decided to continue. Emily was in the midst of asking Dr Ahmed a question.

Q41 **Emily Darlington:** We heard from industry that there was a credibility problem. I was welcoming you to your new role and wanted to understand how you saw your new role fixing between what we say in our life sciences strategy and what we are able to deliver in terms of everything from clinical trials through to potential negotiations on pricing.

Dr Ahmed: I would divide up my new role both in terms of what I am going to do in the Department of Health and Social Care and then how I partner with Lord Vallance. What is really important and comes out of the Prime Minister's, the Secretary of State's and the Government's ambitions is that we have had a National Health Service for a long time—70-odd years—with varying degrees of satisfaction, but it has never been hand in glove as a national research service.

There is now a dawning realisation that those two components need to come together in a way that benefits not only patients, but our economy. For that to happen, we need to make certain decisions that give certainty to industry in terms of longevity. We can only do that if we cross the traditional boundaries of Government Departments because the science does not simply stop at the door of 39 Victoria Street or an NHS hospital. For instance, Dr Sullivan knows exactly where science starts.

To bridge that gap, it is really important that we work cross-departmentally and that is why—probably for the first time ever—you have two Ministers in the Department for Science, Innovation and Technology and the Department of Health and Social Care who have a clinical and research background, a deep understanding of what is under the bonnet of medical research, and in Lord Vallance's case also a deep understanding of the industry requirements. It is a really exciting partnership.

Q42 **Emily Darlington:** I agree. I have spoken a lot to you both about my worries about where we were going on life sciences and how we needed to up our game in this. It is clear that, as we and the industry recognise, the ideas and the reality are there. Do you think the two of you together can make that case to Treasury to make sure the investment is there—on the science and R&D side through to the NHS—to make sure that we see the changes that the industry is talking about and stop losing out to



Belgium and Ireland?

Lord Vallance: The short answer is yes. We have to make that happen. We cannot afford to lose this industry from the UK. It is very important that we have two global companies; it matters that it is two. It is very important that we have a very thriving start-up and SME sector here as well, and that is not only important for the economy; it is important for health. We must come to an agreement on the right way forward, from all the other things that are really good and that they like. We have to fix this problem in one way or another.

Q43 **Emily Darlington:** My final question—just because you have raised it as an issue—is around the tariff discussions. President Trump is landing tonight. Are the two of you going to be involved in any discussions with US officials around the tariff arrangements over the next few days during the visit?

Lord Vallance: I spoke to a colleague who has been leading on the negotiations and flew back from Washington this morning, having held constructive talks.

Q44 **Emily Darlington:** Can we maybe hear something from the outcome of this visit that may improve the landscape in terms of tariffs?

Lord Vallance: It is unlikely over the course of this visit.

Dr Ahmed: I would add that trade discussions at that level are probably above certainly my pay grade. I would also just add that you make a very compelling point about how multilayered these issues actually are. They are not simply about pharmaceutical pricing in the NHS or our relationship with the commercial sector; they are actually about relationships between two Governments and quite significantly shifting geopolitical tectonic plates. So it is very multilayered.

Q45 **Dr Sullivan:** We heard from the previous panel about the long-term certainty and commitment to medicine innovation, and there is a little bit about reward for innovation and that side of things. Dr Ahmed, you mentioned that there would be this long-term plan coming, so I just wondered when we might see the crystallisation of that long-term commitment and investment. They also said the life science strategy was brilliant and well-regarded, but what is the longer-term commitment? If you are able to give us a when, that would be lovely.

Dr Ahmed: Dr Sullivan, always a pleasure. The long-term plan is the Life Sciences Sector Plan, and it has been road-tested to make sure it is working hand in glove with the 10-year NHS plan. We have the firm commitments of where we want to be in 2030 in terms of being the leading life sciences economy in Europe, and certainly by 2035 the third most important life sciences economy globally behind the US and China. With my appointment, and Patrick and I working very closely together, it is really about delivery, delivery, delivery on those components.



The proof points of some of those ambitions are already here in terms of the multi-million-pound deals we have done to fund Genomics England and get a Health Data Research Service up and running; £350 million also went to Our Future Health, which is a phenomenal project run by some world-class clinicians. So the cogs are turning, and Lord Vallance and I have to make sure they turn as fast as possible.

Q46 Dr Sullivan: We talk about 10-year and 30-year plans. Obviously it is all dictated by the Governments of the day, but to give that confidence to the wider sector that we actually share their ambition, what more do you think we can offer them in that commitment?

Dr Ahmed: We have one of the richest datasets anywhere in the world in terms of its comprehensiveness, and that intrinsically attracts some of the highest investment in the world to the UK. One part of my job is to unlock that in a meaningful fashion. I do not think we have got that right yet, but I am optimistic that, once the Health Data Research Service partnership is set up, that is the vehicle through which we do that. That in itself will be hugely attractive to inward investment.

Lord Vallance: Can I just add one other thing? The fact that we continue to fund basic R&D, train great people and have all those things in-house is very attractive to industry. All those bits remain really attractive and we must continue doing that. We must get better at the clinical trial bit for the reasons I have said. The long-term security that industry is now looking for is a pricing and commercial environment that they actually think meets their needs and meets the current political environment, where the US is also looking at reference pricing—in essence, what happens in other countries. That is the thing that we need to fix now.

The other things are in a good place, and the Life Sciences Sector Plan is a very good road map that we should deal with quickly, but it should actually be sustainable and not party political.

Q47 Andrew George: To a certain extent, we are going over the same theme time and again. My question really is for Zubir. You have arrived shortly after the car crash that was the VPAG negotiations. What we hear from the industry is that the UK is full of potential—the words that it uses are talent and fertile ground—but we are losing market share globally. Companies are moving out stage left, as it were, negotiations have failed, and you are no longer talking. You are saying the door is open, they are saying the door is open, but you are still not talking. If you both want this to work, how are you going to get back to the negotiation table?

Dr Ahmed: As I was saying when you were away, this is a very multilayered discussion. It is no longer about pricing and what the NHS pays for medicines. It is not even wholly about the commercial conversation any more. There are geopolitical overtones, here so it has to be managed at multiple levels, and that is what this Government are trying to do.



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Specifically to your point, if this is a car crash, then the car probably started moving in about 2014. To use some medical terminology, this is a long-standing, chronic illness, not an acute illness. The conversations continue and we have healthy relationships with a number of large pharmaceutical companies, and some smaller ones, as mentioned, such as Moderna and BioNTech. AstraZeneca, Merck and all these companies still have large footprints in this country, employing thousands of people, and we have healthy relationships at the university, hospital and NHS level.

To characterise this as us somehow haemorrhaging lots of talent and as contagion is misrepresentative because, in each case that we have highlighted recently, there have been specific issues with their financial flows, their planning of where they want to have their operations, and how they want to cut their own cost bases, contingent upon their own revenue streams with their own specific headline drugs and how they want to market them.

Q48 Andrew George: Are you not overcomplicating it really? They are saying the door is open, you are saying the door is open, but you are not talking. It is as simple as that, is it not? You just need to be around the same table.

Dr Ahmed: There are conversations happening. It is my second week in the job and I am very keen to engage with industry and pharmaceutical commercial partners on a face-to-face basis; it is important for me as the Minister to show them the whites of my eyes, as someone new in the role. To characterise this as being simple is not fair. It is intrinsically complex, because this is about getting the best value for money for patients with specific illnesses in terms of what benefit a medicine gives them, and to do it in an accessible and equitable fashion across the country.

Q49 Chair: Lord Vallance said earlier that it was basically about money and pricing. You are saying that it is not simple; it is multilayered and not so much about pricing. The key issue we have been told is that the UK spends less of its healthcare spend is on medicines, 9%, while the average is 13%. If we raise that by 4 percentage points to the average, it would be £12 billion. Can you say what impact it might have on the NHS if that money were to move into pharma spending rather than wherever it is going now?

Dr Ahmed: The UK's health ecosystem is difficult to compare with other health systems because of its universality. Patrick and I are in agreement that pricing is an issue. What I am saying is that how we deal with pricing is multilayered in terms of how we demonstrate clinical benefit as we change prices.

In terms of a direction of travel, it is reasonable to say—in this Committee and to industry—that we want to see a direction of travel where we spend more money on novel medicines, medicines that are



disease-modifying and that prevent disease. At the end of the day, if we are going to get a left shift from sickness to prevention, medicines are a core component of that. The medicines of today that cure hepatitis C, turn HIV into a chronic disease, and prevent you from having heart attacks and strokes are not the same medicines that we were talking about from 20 or 30 years ago, which were treating symptoms. We now have to look at medicines in a different light from how we are perhaps looking at them, and therefore calculate their economic and clinical benefit on that basis.

Chair: I think you are saying that we need to spend more on innovative medicines, but you are not telling me where that money would or could come from. Let us move on.

Q50 **Dr Sullivan:** Briefly on that point, the DALY formula was last updated in 1999. Is that what you are talking about—that you may be looking at how we look at the formula for assessing the impact of medicines in life?

Lord Vallance: Are you talking about QALYs?

Dr Sullivan: Yes.

Dr Ahmed: Quality-adjusted life years was a mechanism that was brought into being in 1999 by the National Institute for Clinical Excellence. It was actually the year I started medical school. NICE was and is a world-leading organisation that can quantify clinical benefit. In 2025, there is an argument that we re-examine certain components of how we quantify benefit—not only clinical, but economic benefit—from medicines.

Q51 **George Freeman:** Having been in the industry 30 years, we would agree on a lot of things, not least that this sector has come and gone and had its highs and lows. Having been in your position—we were here back in 2010: pharma was closing and biotech was on its knees—this happens. Not every Government get it absolutely right, but in that period we did some big things. One was to create an integrated life science portfolio where the Office for Life Sciences was set up and we were working across Government. I was lucky enough to hold that first portfolio. I am very struck—perhaps we can come to this in a minute—by how fragmented the portfolio has become.

Patrick, you made a really interesting comment earlier. We heard in the first session, unequivocally, from industry that the core problem here is NHS procurement and pricing. I am not suggesting it is easy, but that is what the witnesses said: it is not skills or research; it is that. Is it not time that we really change the NICE model? It was put in place by Ministers to protect themselves from having to make horrible decisions to say no.

Should we now be looking at a much more adaptive system that says, "Pathway 1, it'll save money and lives; fast track it. Pathway 2, it'll save lives and could save money; we should test it quickly. Pathway 3, it'll



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probably save you money, but you need to change your care pathway; we recommend it's implemented quickly and we give approval based on evidence." Is this binary yes/no based on an arbitrary QALY set in the '90s not ridiculous? Should we not be setting out a much more modern, open, international framework for real clinical health economic excellence? Patrick, you touched on this earlier and it feels to me like the big intellectual challenge.

Lord Vallance: It is a very important one and the foundation is this move up from 9% of NHS spend, which will happen. There will be an increase in percentage spend in the NHS on medicines, and that then raises the question of how best to allocate that money. NICE has been an extremely good way of making sure we get an evidence-based assessment of medicines against cost; as with all methodology, it is worth looking at it and asking, "What needs to happen going forward?" It is important to look at that in the context of a percentage increase as we go on; otherwise, you are really stuck because, if it is really constrained, you cannot do very much. That is the problem that we have been living with for over a decade: we have just watched it go down. It was 12% in 2015; it is now 9%. It has just gone down steadily and that has to be reversed.

Q52 **George Freeman:** I suppose my key point—you and I both come from industry—is from my experience having been there, DH undervalues time; industry would take price reductions in return for speed of validation, data and, "This drug works with these patients, not with those." That was the promise of our 2010 coalition strategy, but we never broke that. It feels to me as though this is a moment to try to give that offer: "We are never going to pay the highest prices in the NHS, nor should we, but we should use it as a research engine to give you better data, quicker access and better accuracy on who your drugs or devices will work with."

Lord Vallance: That is exactly what the Life Sciences Sector Plan says: that regulation needs to be faster, and I am pleased to say MHRA is really rising to that challenge and doing it. MHRA and NICE need to be linked so there is not this, "We do one, stop, wait, then do the other," but we try to do things together. That speed point is important. The second point that is important is speed of access into the NHS. The third point that is important is equity of access, because at the moment we have patchy access across the UK. All those things lead to an increase in medicine spend.

Chair: I am going to have to move on now to Tom because we only have five more minutes of Lord Vallance's time.

Q53 **Tom Gordon:** One of my first jobs after graduating was working at York Health Economics Consortium. When we talk about QALYs and DALYs, one of my frustrations is that we only ever tend to look at a five or 10-year cost-saving period. We know that that is quite frankly bonkers.



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If I just take the quick example of my mum, she had breast cancer, had a left side mastectomy, then chemotherapy and went through a whole thing. At the time, she had two different types of breast cancer in the same breast. She was told that they did genetic testing and it was not going to be the case that it was BRCA, so they could not do a preventative mastectomy on the remaining breast, but that she is almost certainly likely to end up developing breast cancer again because of the fact she had two separate independent tumours at that time.

While she was under the knife, she sensibly asked, "Can you not do two for the price of one?" to put it bluntly, and she was told, "We can't do that; it wouldn't be within the scope of the NHS." But she almost certainly faces the possibility of having to now go through that entire process—the trauma and recovery process—again.

Rather than just arbitrarily trying to increase the threshold of a QALY, why do we not take into account the broader economic impact when we look at that? Is that something that the Department, DHSE and NICE might look at and consider? Probably one for you, Dr Ahmed.

Dr Ahmed: Sorry to hear about your specific case. To be honest, as a surgeon myself in situations like that, when it comes to that level of clinical decision-making, I do not think we need to get so micromanaging that we take away clinical discretion from the individual clinician. There should always be operational and financial scope in the system to be able to have bespoke decision-making. At the end of the day, what are we doing, if we are not able to have at least some level of personalised decision-making? In any future articulation or formulation of economic benefit analyses, I would certainly think there needs to be some level of personalisation, certainly for decisions like that.

Q54 **Tom Gordon:** That pivots onto the next question I had, which is for Rosalind. Spending on medicine and healthcare has been falling in the UK. Obviously what we have heard from industry earlier is that that is having a profound impact on their ability to invest in the UK and the life sciences sector as a whole. What are the plans to address that?

Rosalind Champion: We have covered that already. We have a really clear set of interventions set out in the Life Sciences Sector Plan, and then there is the conversation about what price we are paying for medicines, which the two Ministers are very heavily involved with, alongside other Ministers across Government. We have not only a plan for ensuring that the sector thrives, but a specific set of interventions that need to happen in medicine pricing.

Q55 **Tom Gordon:** We saw the plan earlier this year, and we have heard from industry today that there is no confidence about some decisions that have been taken as a result of VPAG and various other things. Is there any review or update about strategy? Is there going to be any further input from industry to try to make sure that the life sciences sector gets the support that it needs to do its job as well as we know it can?



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Rosalind Campion: If you look at the sector plan, it says very clearly that we want to make sure that we have the right commercial environment. As you have heard from the Ministers, we are keen and open to a further conversation about making sure that we have that. The conversation is ongoing with industry and will continue to be so, so we will get there. We see absolute clarity across Government that we cannot let the life sciences sector fail.

Q56 **Chair:** What we have not had is any clarity about where the money would come from.

Lord Vallance: I have just said that there will be an increased percentage of NHS spend on medicines.

Q57 **Chair:** That means the money will come from somewhere else in the NHS, from knee operations or cancer treatment.

Lord Vallance: As you know, there is a fixed budget and these are all trade-offs. The trade-off that has been made for the past decade is a lower percentage on medicines. We are reaping the consequences of that now in a very urgent way, and that is what we now need to address.

Dr Ahmed: It also depends on how you do it and what gradient you use. There is a possibility that, as medicine spend increases, you are going to be spending less on other things such as admissions for heart attacks and strokes, and so on. There is a way of offsetting your spend that is positive and invests in the health service and in wellbeing.

Lord Vallance: Just one other thing to add to that is we are in an extraordinary era of new medicines, both for prevention on the one hand and cures on the other, and that is really a dramatically different position.

Chair: That is very true. What we would be pleased to see—as I am sure industry would, as we heard that it is not confident in the credibility—is a plan that reflects that, so that we can have confidence that that is what the future is going to bring.

Q58 **Kit Malthouse:** We are here because promises were made in February that have not been fulfilled. The Prime Minister promised to sort the system, and it has not happened. I guess what we heard from the industry was that it has reached a point where it does not have confidence that all the stuff you have talked about is necessarily going to come to fruition. I guess the question that we are asking is: how are you going to change their minds in the short term?

Lord Vallance: A deal was put on the table that was £1 billion being transferred to them from the NHS. Clearly, we are not there, so we need to keep talking and get to the right position on this.

Q59 **Chair:** Lord Vallance, I have asked this question twice already. If that will give credibility, could you say when the Life Sciences Sector Plan is going to be updated to reflect the current commercial conditions? That will give

it credibility.

Lord Vallance: The only thing that is going to give credibility is a financial settlement.

Q60 **Chair:** When might we expect to see that?

Lord Vallance: There are all sorts of ongoing discussions.

Kit Malthouse: You said there are not.

Lord Vallance: Hang on, I want to be clear about this. The VPAG is one part of this process. Those discussions stopped. There are still many discussions going on with industry about the overall commercial environment, and the VPAG is a very specific UK general manager issue.

Q61 **Chair:** I am sure you are going to say you cannot give a running commentary on it, but we would expect to see the outputs of those decisions and discussions in an updated Life Sciences Sector Plan at some point.

Dr Ahmed: The Life Sciences Sector Plan is the Life Sciences Sector Plan. Obviously the VPAG in negotiations affect it in some way, which is why we are here having this discussion about it, but I do not think how we negotiate with industry over medicine pricing necessarily would mandate—in fact I would be confident it would not—changes to our overall strategy and aims in the Life Sciences Sector Plan. It is with the Life Sciences Sector Plan in full view that we are engaging with industry, because we know it is an integral partner in us achieving these goals. We would be very happy to come back to this Committee once those negotiations have concluded and update you.

Rosalind Champion: If I might add on that, the single message that I have had from industry over the course of the last few years that I have been doing this job is about the importance of stability, having a plan, sticking to it and then delivering on it. I have a very strong sense from industry that it likes the Life Sciences Sector Plan; it would like the commercial issues that we have discussed today to be fixed, but is content with the plan.

Lord Vallance: I agree, but in a sense what we have to do is fix one thing that is said in the plan, not rewrite the plan. I do not think we need a new plan.

Q62 **George Freeman:** I have one last question about ministerial responsibilities. We used to have one Minister for life science who did the DH, Business and Office for Investment bits. Dr Ahmed, do you have responsibility in DH for all the life sciences? Are you the life science Minister?

Dr Ahmed: I am.

George Freeman: Do you have responsibility for the NIHR?



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Dr Ahmed: I do.

George Freeman: For the drugs budget?

Dr Ahmed: For the medicines budget, yes, and MHRA.

George Freeman: For NICE?

Dr Ahmed: For NICE.

George Freeman: So you are the key man in the Department of Health and Social Care.

Chair: I know that Lord Vallance needs to go.

Dr Ahmed: We both have to go, I am afraid.

Chair: I understood that you were staying until 4.30. I know Lord Vallance needs to go.

Lord Vallance: I am really sorry; I do need to go.

Chair: Yes, I would like to release Lord Vallance and keep Dr Ahmed. We have a further question for you.

Dr Ahmed: I can do one more question, and then I am afraid I have a constituent that I could not move.

Q63 **Martin Wrigley:** I am sorry, I am confused. This is not my area of speciality, but I am missing something. You are saying everything is fine and that you are having conversations, but there are a couple of things you need to fix. I am hearing from industry that it is pulling out from investment. These are two very different pictures. What am I missing?

Lord Vallance: I am not saying everything is fine at all; I am saying things are in a very bad position. They have got very bad over 10 years, and we need to come to a solution with industry. That is what I am saying and that is what they are saying.

Q64 **Martin Wrigley:** They are saying you are not talking and you are saying you are talking.

Lord Vallance: At the moment, we are not formally reopening the VPAG negotiations. We are having lots of discussions around commercial environment in the UK, of which VPAG is a small part.

Dr Ahmed: We are very happy to come back on that.

Chair: Thank you very much. I know that you have to run, Lord Vallance.

Dr Ahmed: Apologies. I am very happy to come back after recess.

Chair: I know that Dr Ahmed and Rosalind Campion can stay for a few minutes.



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Q65 Emily Darlington: This is specifically in your role. A big issue that we have is innovation take-up. I did a project with Nesta looking at prescriptions and how long it takes GPs to start actually prescribing new drugs. That challenge is obviously amplified with GPs, because they are contractors into the NHS, but we could talk about NHS trusts having exactly the same issues. What exactly are we doing to make sure that even if we fix the pricing, there is a proper market here for those innovative medicines?

Dr Ahmed: What you are rightly pointing at is what I would call the heterogeneity of variation of practice across the country when it comes to approaching the same conditions, and why there is so much variation in what drugs are prescribed. What we are going to do to tackle that is really to drive forward our ambitions for a single national formula for England. As a Scottish MP, I can tell you that that has had many benefits in Scotland, and I want to see those benefits extended to England so that there is more equitable access to medicines across the board, because we can give more uniform prescribing tramlines for clinicians.

Q66 Chair: Dr Ahmed, can I just confirm that you agree with Lord Vallance that spending on medicines needs to rise?

Dr Ahmed: There is an inevitability about it over the course of the next decade in our 10-year plan, because the 10-year plan is predicated on prevention, community care and hospital care. All these things need us in Government to empower clinicians to bend the arc of demand and disease progression, and medicines are a critical part of that.

Q67 Chair: Your view is that it is possible to do that without taking funding away from other areas of the NHS?

Dr Ahmed: If you do it in a proper strategic way and have a prevention and disease-modifying lens on your medicine spending, that is possible to do.

Q68 Chair: Rosalind Champion, you spoke about the life sciences sector's confidence in the Life Sciences Sector Plan. As we have said, we heard a sense of a lack of credibility. How do you resolve those two?

Rosalind Champion: The Life Sciences Sector Plan was developed in partnership with industry and the NHS; more than 250 organisations were involved in its co-creation. What we heard today in the first session, which I was able to listen to, was a strong sense that the Life Sciences Sector Plan sets out the right interventions. Where industry has had some questions, they are about delivery. Those questions are ones that we have heard for the last decade or more and are based on some concerns around sector plans in the past.

As we developed the sector plan, we put in place clear metrics and SROs, and a real sense of how we would know if we had done what we said we would. These things have made it different. We have a Life Sciences Sector Plan that is clear about who is going to do it and is clear in its



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oversight. Those things will help us to fix the challenges we have had over the course of the last few years on delivery.

Q69 **Chair:** Are you saying to the Committee that the clearer metrics will enable delivery and the lack of credibility that we have heard about this afternoon will be fixed by that?

Rosalind Campion: By that, but also by accountability. In the Life Sciences Sector Plan, you will see I joined Mr Malthouse's APPG at one point to discuss this. Many of our sector plans in the past have not been really clear about individual responsibility for interventions, and that is something that is very different in this Life Sciences Sector Plan.

Chair: Thank you very much to all our witnesses.

Dr Ahmed: Could I just say in closing, Madam Chair, I am very happy to come back. I appreciate that there is a level of uncertainty across the Committee, which you want to rightly probe, and I am very happy to try to come back and furnish you with more answers as we have them on negotiations on medicines pricing.

But I would just end by saying the volatility that you see in the pharmaceutical sector right now is multifactorial. I am not denying that pricing is not one factor, but personal commercial decisions of those companies at a global level are also impacting the decisions they are taking in the United Kingdom.

Q70 **George Freeman:** I know there has just been a reshuffle, but when it is clear, perhaps you, Ros, as the OLS could let the Committee have a breakdown of all the ministerial portfolios that relate to life science? The Department of Health says that Baroness Merron is also involved.

Chair: Excellent question, George.

George Freeman: We would just like to know who is responsible.

Rosalind Campion: We already have it clear, so we are really happy to do that.

George Freeman: Thank you very much.

Chair: Thank you very much.