HOUSE OF COMMONS

Health Committee

Oral evidence: Impact of membership of the EU on health policy in the UK, HC 949

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Watch the meeting

Members present: Sarah Wollaston (Chair); Mr Ben Bradshaw; Julie Cooper; Dr James Davies; Andrew Percy; Emma Reynolds; Helen Whately; Dr Philippa Whitford

Questions 1-113

Witnesses: **Professor Martin McKee CBE**, President, European Public Health Association, gave evidence. *[This evidence was taken by video conference]*

Q1 Chair: Good afternoon. Welcome to this afternoon's session. Welcome to Professor Martin McKee and thank you for joining us by video link. It is rather a refreshing change for those watching in the gallery as they can actually see you, whereas normally they just see the back of our witnesses. Thank you for joining us. Would you like to start the session by introducing yourself to those who are following from home?

Professor McKee: Of course. My name is Martin McKee. I am a professor of European public health with the London School of Hygiene & Tropical Medicine, but I am also the president of the European Public Health Association, with the current two-year period ending in November.

Q2 Mr Bradshaw: Professor McKee, thank you very much indeed for fitting this in at such short notice from Copenhagen. We are having three half-hour sessions, so this is inevitably going to be quite broad brush. To start with, could you spell out for us your view about the relevance/impact of our membership of the European Union on health and the potential consequences were we to leave?

Professor McKee: On health, there are many implications. I have written several books on European law and our policies, so it is difficult to know where to start, but maybe I can divide them up into the impact on health services, the impact on public health and the impact on the broader determinants of health, including the environment.

As to what leaving the EU would mean, we are in the area of speculation. I have been struggling to discover what Brexit would actually mean and, as I am sure you are aware, there have been as many different scenarios as there are almost countries in the world. Is it the Norwegian model, the Swiss model or even the Peruvian model—or, more recently, the Albanian model? Given that, I will maybe generalise and say that there are inevitably

trade-offs. The more closely integrated we are with the single market, the more we will have to accept in terms of rules and freedom of movement; the further we are from the single market, the more we will be able to isolate ourselves in terms of mobility, to the extent that, as I am sure you all heard yesterday, it was even suggested by one campaigner for leaving—I am not sure if he was really serious—that we might at some stage introduce visas to go between here and France. I suspect that is not going to happen because there would be similar—

Q3 Chair: Professor McKee, we are asking you to set out what you see the benefits to be, and then we are going to come on to some other aspects about the complications later. We are really asking you to set out the benefits as you see them at this stage.

Professor McKee: Maybe I could start with health services. There, we have the movement of people and the movement of things like pharmaceuticals and technology. As to the movement of people, on the one hand, of course, we have the ability for UK citizens and UK residents to get treatment when they go abroad, but, more importantly for the NHS, given the shortages we are facing, we have the ability to recruit from the rest of Europe. You could say that we could recruit from anywhere in the world, but the big advantage of recruiting within Europe is that now, under the professional directives, we have agreed standards on continuing professional development. We have an alert mechanism so that we can never again have the situation we had with Dr Ubani, the German doctor, who came and killed a patient. All those issues have been addressed because we have those mechanisms.

We have the European Medicines Agency based in London. There is a common standardised process for approving medicines across Europe, which means that the pharmaceutical industry, which is very important to the UK, can go through one process and we have faster access to drugs as a result.

Maybe I could link research to that. This is obviously a huge benefit for research, and you know that over 90% of academics are in favour of staying in. All the vice-chancellors are in favour of staying in, and that is because we have the common protocols of the clinical trials regulation, which is vastly improved from what it was, described by some people as fantastic, which allows us to have the sharing of knowledge and experience.

Medical technology would be the same, particularly given that over 90% of the British medical technology industry are small and medium enterprises. They have common standards and common rules. That is health services, to some extent.

There is more I could say, but maybe we should move on to public health. In public health, we have the environment. Our environmental regulations are largely driven by European laws. We see the impact of that with clean beaches, water and air pollution. Traditionally, the UK has lagged behind much of the rest of Europe, or at least western Europe, and it has been the environmental standards set at a European level that we have had to aspire to that have taken us up. We see that with the air quality in London, for example, where we are still failing to meet these standards. The European Food Safety Authority in Parma provides expertise on all sorts of areas.

If we were outside the EU, we could do these things ourselves and reinvent all these agencies, but we would have to pay for it; there are economies of scale. The major

problem is the shortage of expertise. If we take the work that the Food Safety Authority is doing now on neonicotinoids and bees, there is a limited amount of expertise in Europe—even in the world—to do this work, so we would have to compete with other countries to do our own thing. Then there is the European Centre for Disease Prevention and Control with its rapid alert process, which is very important with the Zika virus. They issued a statement a week ago looking at the situation and the risk to Europe, and, although the risk is mainly to southern Europe, none of us is immune because infectious diseases cross borders. Then there is the work that the chief medical officer has been doing on antimicrobial resistance, with the UK playing a leadership role but within Europe.

There are other areas, and I give one example that one of my colleagues came up with. I am just taking this right out from left field because it illustrates the benefits. One of my colleagues has been leading the campaign to prevent the use of drugs for executions in the United States. He makes it very clear that it was only by working with colleagues across Europe through the European Union mechanisms that that was able to happen. I could go on, but maybe I should stop at that stage. I am happy to answer any further questions.

Q4 Emma Reynolds: Thank you, Professor McKee, for that answer. Could you say whether you think the balance of competences that we have at the moment between the UK and the rest of the UK, being a member of the European Union, is right? Would you like us to have more European co-operation, would you like to reform the way we work together, or would you like us to have less co-operation?

Professor McKee: I would refer you, as you know, to the British Government's own report on that, which concluded that the balance of competences was about right. We all have our own different personal views. I tend to be more integrationalist than some, and that is perfectly fine. I would really rest on that. If we look at the academic research and the UK's influence, it is very clear that, in the Commission and the Council, the UK, partly because of the academic input, pushes very far above its weight and we have a very high level of influence. The area where we do not do so well is in the Parliament, and that is because we send Members to the European Parliament who do not attend. We have a problem there. The UK could engage more there if the British public decided to elect people who would actually participate in the debate, but that is democracy.

Q5 Emma Reynolds: What do you think the implications for health policy more generally would be if we were to vote to leave?

Professor McKee: It comes back to the point that I have no idea what voting to leave would actually look like because we would have to continue to have some sort of relationship. If you look at agreements such as the EU-Vietnam and EU-Peru agreements, in the elements of those that cover trade with the European Union they have to accept labour standards and health and safety standards. As we hear about tearing up the red tape and being free of all that, even Peru and Vietnam have to adhere to that if they want to trade. As we go from that model to the Norwegian model, which is essentially inside the EU but not having a voice—or not much of a voice, in practice, but they do have some voice—and paying more per head than we do into the EU budget, there is an enormous spectrum with everything in between. The difficulty is that when one hears the case being made, there is a picking and choosing to say that we should co-operate when we want to, but co-operation requires two sides to agree to that.

I genuinely struggle to know what a vote to leave is. Frankly, if you want my personal opinion—you may or may not—if we did vote to leave, we would want to come back in again fairly soon afterwards because we would realise the consequences. I think that for health, almost certainly—I can speak maybe for health research better than anything else—it would be devastating, and we saw that with the Swiss referendum on free movement. For universities, it would be catastrophic, albeit not for the funding, because that perhaps could be replaced—although how much money would be there to replace it is another question—but in terms of our ability to recruit talent, have exchanges and to co-operate we would have real problems.

Q6 Chair: Could I perhaps ask for your opinion on a few areas where some concerns have been raised? You may be aware of the issues that have been raised about the European professional card. The Nursing & Midwifery Council has raised some concerns about the role of regulators and whether or not this means that particularly those who are coming to do temporary work will be registered with bodies overseas. Although you have mentioned that there will be an alert system, effectively this will reduce the power of regulators in Britain to make decisions and regulate health professionals, so it will be a considerable watering down. Also, you may be aware that concerns have been raised by the GMC potentially where, in other countries, the degree of training is not considered to be equivalent to what is achieved by training in the UK. In other words, do you have any concerns that that may lead to a watering down of the ability to control who works as a professional in the UK?

Professor McKee: This is very much work in progress, and, as I think you know, I have done quite a lot of research on this in the framework of European Union-funded projects. For example, some years ago we took case studies of doctors as a little vignette, where a doctor does something in the clinical area or in the personal area—sexual or whatever—and we sent it to regulators in different European countries to see how they would respond to it. We were working with the GMC in doing that, and you are absolutely right that there are differences. There are differences not just in the threshold but in the nature of who does what. But we have made enormous progress from the early days. The medical professions in each country guarded very jealously their right to self-regulate; we have moved a long way from that, particularly because of things going wrong, like the Dr Ubani case. The fact that that has happened—

Q7 Chair: Indeed, but do you think there is possibly an issue? Are the Nursing & Midwifery Council and the General Medical Council right to be concerned, and do you think that this should be changed further?

Professor McKee: They are changing it further. They are engaged in a continuing dialogue on this with the other regulators, which we have been feeding into. So yes, there are genuine concerns. There are concerns about the level of competence of medical students coming out across Europe, including the UK, it should be said, not least with problems of training. We now see that we have a mechanism to discuss these things. There is widespread consensus, but there are differences—differences not just, as I say, up and down, but differences in the bits that people stress; but that dialogue is now taking place, which it was not before. Yes, we have a problem in the same way that we have had problems in the past with the clinical trials regulation and data protection. The direction of travel is that if we work together, we can overcome them, but we have not overcome them yet, I agree.

Q8 Chair: Do any other members want to come in on specific points on that? You mentioned earlier that public health is your area of expertise. As you know, there has been a judgment in the European courts on the ability of the Scottish Government to introduce minimum pricing. Clearly, their opinion is that this is going to impact on the Scottish whisky market. They have expressed an opinion that their preference would be for it not to be minimum pricing. Do you think that is excessive interference? Should Governments not be able to set what they see to be evidence-based, sensible public health measures without interference from the court?

Professor McKee: Of course. First of all, the ruling does not say they cannot do it. They have to make the case that it is proportionate, because, like all these things, they come under European competition law. I have a couple of points.

First, the Scottish situation is very unusual because Scotland introduced minimum unit pricing, not because it necessarily would have been its first choice but because it does not have tax-raising power in that area. But then it can make the case, and the Scottish Government seem to think they can introduce it by making the case. I think they will introduce it.

The court has consistently taken the side of public health, and that is one of the concerns that has arisen in other trade agreements, in particular some of the WTO deals where public health has not been prioritised. If we look back at judgments such as Kohll and Decker and the free movement of patients—all the stuff on the free movement of our patients and services—the court has consistently taken as its principle the part of the treaty that says that a high level of health shall form a part of the European Union's policies. So it is there, but it is up to the Scottish Government to make the case that this is proportionate and there is not another way to do it. I do not see that they have a problem there. As far as I understand it, the Scottish First Minister does not see that it will be a problem either, but you have an SNP Member on your Committee, so I will be advised by that.

Q9 Chair: Yes. I think it is a concern. "The Court of Justice considers that the effect of the Scottish legislation is significantly to restrict the market…" is the exact wording of the judgment.

Professor McKee: That is right, yes, but you can restrict the market on public health grounds, and we do it in many areas. It is not unusual that that would be the case, but the point has to be made that this is the best way of doing it. You will remember that this goes back to earlier somewhat spurious cases that were taken. The classic one is the Cassis de Dijon case. I am not sure if any of your Committee drinks kir or kir royale.

Chair: Actually, yes.

Professor McKee: There was an attempt by the German Government to restrict the sale of crème de cassis in Germany because it did not meet with the particular standards for alcohol there. The Germans were saying there is a health argument here, and so on and so forth, and the court said that crème de cassis is perfectly safe and it was marketed in France. This was a non-tariff barrier to trade. There is a balance.

Q10 Chair: You think there is a balance, but you are saying you are confident that they will be able to introduce it if they can show it is proportionate.

Professor McKee: I think they will.

Chair: Thank you.

Professor McKee: Yes, and I believe that they think that too.

Q11 Dr Davies: Could I ask about the priorities of the current presidency of the European Union, which I believe are healthy foodstuffs, antimicrobial resistance and innovation in the pharmaceutical system? Do you agree that these are the appropriate priorities for the current time, and why are they best dealt with at the European level?

Professor McKee: I will take them in turn. As to healthy food, because the European Union is a major player in agricultural policy and food crosses borders, there is clearly a transnational dimension to that.

As to antimicrobial resistance, the English Chief Medical Officer has been at the forefront internationally on this and, in fact, has been very heavily engaged with the European Union and during the Dutch presidency. There is no way in which we could possibly deal with antimicrobial resistance on our own. We have examples of pneumococci that are resistant to antibiotics being brought back from Spain to Iceland by people on holiday. Unless we are going to seal our borders completely, this has to have an international response, and from the European Union as well as internationally, because this is a matter for the G7 as well and for the World Health Organisation. Within the European Union there is a clear need. Why the Dutch presidency? It is because the Dutch presidency has a lot of use of antibiotics in agriculture, and there are issues on which we need to get a discussion between Ministries of Agriculture and Ministries of Health.

As to innovation, a key issue for the European Union is economic growth. Innovation is important. Just look at the pharmaceutical work there, and the innovative medicines initiative too, where the European countries are coming together to help to produce new antibiotics in particular. The areas in which there is a marked failure, for all sorts of reasons that you are familiar with and I will not go into them, are about patent life and so on, where we need a concerted international response. The EU has stepped up to the challenge there and is leading on that. I think those are all perfectly justifiable at a European level, but maybe you have another view.

Q12 Dr Davies: Can you identify any further priorities that you think the EU should focus on in future years?

Professor McKee: There is still an issue around regional development policy. That is an issue of bringing everybody up to the same level, and that would obviously have an impact on migration, which I know is a concern for a lot of people too. We are now moving into the common agricultural policy reform, and there is a lot of work to be done on that to balance these competing objectives in environmental sustainability, food production and the problem with depopulation of rural areas. There are health dimensions to all of those, including the area we overlook—the population of rural areas when we want to get GPs and others out into those areas. If there is nothing else to keep people there, we are going to have a problem.

There is an awful lot to do, but that would be a good start. There is clearly more to be done, as your Chair pointed out, on the health professionals. That is work in progress, but there are an awful lot of challenges to which we need to respond. My own view is that we do it far better by discussing it together.

Q13 Dr Whitford: I would like to pick up on what the day-to-day benefits of being part of the EU are for the ordinary person in the street.

Professor McKee: If I could put myself in the position of an ordinary person in the street, I was on holiday over the Christmas period and I needed treatment at a French hospital. I was able to use my EHIC and get the treatment rapidly without any problems whatsoever; so that is one immediate benefit.

In terms of health, the fact that when you go into a hospital so many of the people who treat you will be from other European Union countries shows that you have a very tangible benefit in front of you there. When we have been talking to people about what the EU means to them, we have had countless examples of people saying how their elderly relative was cared for by a very kind and caring Romanian, Bulgarian, Hungarian or whoever, who really made a difference to their final days. Those are some of the tangible issues that people might see.

Every time they take a deep breath of air, they know the air they are breathing is cleaner because of the European Union. There is the fact that they can drink water out of the taps that is not going to give them gastroenteritis. I remember that, when I was a junior doctor, the hospital wards were full of kids with viral hepatitis and gastroenteritis. The European Union is not the only factor there, but it has certainly helped to improve the environment. There are a lot of different ways in which I think the EU has made a difference.

Q14 Dr Whitford: What about the actual clinical outcomes for patients? Where do you think the EU has contributed to that, in actual treatment of illnesses?

Professor McKee: In research, I look at projects such as the HANDOVER project—a European collaboration to look at the issue of handover of patients at the end of a shift, where they really moved that forward. There is the role of nursing, for example, in the RN4CAST project, which looked at the way in which nurses really do make a difference and, without getting into the current issues, the way in which well-trained nurses are good at spotting people becoming ill and addressing the "failure to rescue" problem. There are a whole lot of areas in which the research has allowed us to compare policies across countries in this tremendously rich natural laboratory in which we live. Then I could go into public health and the benefits of the Mediterranean diet that we might not have known about if we did not have comparisons. We also have the key issue of—

Q15 Dr Whitford: Do you not think that we would still have known, in that we are aware of research from the States and other places in the world, and, therefore, we would be aware of research from Europe? As to things like how nurses and doctors work, we work a lot of those out within the NHS and within the different nations of the UK—things like handovers and information.

Professor McKee: Sure, but whenever we are involved in these projects people challenge your preconceived notions. You think you know a thing—I speak for myself here—or I

think I know something and then I find that somebody does it in a different way. The richness of the interaction, the engagement, is tremendously important. I would not lose sight of that. Of course we can read what happens elsewhere, but there is always a tendency when you read about what is going on elsewhere to misinterpret it.

Q16 Dr Whitford: Talking about the benefits and the public health side, as other people are picking up, there is a lot of concern regarding TTIP here, both in its impact on the NHS—the potential for that to enshrine outsourcing of services—and the more direct public health measures.

Professor McKee: Yes. I will start with the first part of that. Some of you might know that I have written extensively about TTIP. In the past I have been one of its strongest critics because I have been very concerned particularly about the investor-state dispute settlement process. However, I have been quite amazed by this debate. Some people are arguing that it is opaque—you cannot find out what is happening—and yet all the negotiating documents are on the internet. The EU TTIP panel is a paragon of transparency; it has a Twitter account and is fully engaging. Cecilia Malmström, the Commissioner, has been really open about what is happening.

As I say, as someone who was very concerned about it—I reviewed other cases, and there was a case in Slovakia that gave us real problems, which I wrote about in the *British Medical Journal*—I am now quite happy that those issues are being taken on board and, crucially, it has been made very clear that the instructions given to the Commission by the Council of Ministers have been that, if you leave the social side in this and open it up to competition, that is not what you are to do. Martin Schulz, the President of the Parliament, has been absolutely clear that this will not pass if it comes back in that way. The negotiating team have been very open, and I really would encourage people to look at their website and follow their Twitter feed. In public health, I think we have won the battle but we do not realise it; but they are being misrepresented in an absolutely disgraceful way as being closed and secretive, which is certainly not the case. There has been a huge change.

Q17 Dr Whitford: Do you not think that the investor-state dispute settlement is a real concern? I note there is a suggestion of moving to an investment court system. I am not sure in what way that would be different because the ISDS is one-sided. The businesses can take a Government to court. The Government cannot actually take the businesses to court.

Professor McKee: We were concerned about this, so we did a systematic review of all cases in the world where the tobacco industry had taken national Governments to court. We published this paper about a year ago. We found that when they went to court, as opposed to tribunals like the WTO, in court they almost invariably lost, and in the two cases when they did not lose—in the Canadian Supreme Court and the European Court of Justice—the court gave the Governments enough instruction to reframe the legislation so that the tobacco industry lost the second time round. The new mechanism that is being proposed will, as you say, be judge-led. The judges will be selected at random and not by the corporations. It will be transparent; it will be open; other people can act as amici curiae. They can bring evidence before the court. As I say, that is completely different from the tribunals, which are secretive, with negotiators appointed. That is why we are content. We have looked systematically at the experience of taking these disputes before a court, and we have found that in every single case the Government won, with the exception of two, where they changed the law and then won the second time.

Q18 Dr Whitford: At the moment this is just a proposal. How do we make sure that that is what it is? That is probably one of the aspects of TTIP that people are most frightened about.

Professor McKee: First of all, we need unanimity in the Council of Ministers to get through. As we have seen with the Canadian trade deal, it is quite difficult to get; Romania is currently objecting to that because of the issue of visas for Romanian citizens. The UK Government, or any other Government, can block it if they wish, but, secondly, the European Parliament, the President of the Parliament and the parliamentarians in the debates have made it abundantly clear that, if it does not provide the protections, then it will not get through. That does not stop national Governments. If they want to open up to competition, they can do that, but it is not required.

Q19 Dr Whitford: What about the actual barriers? We know that the monetary trade barriers between the EU and America are quite low and that this is more about regulation. Does that not open up public health concerns around growth hormone-fed beef, GM crops and additives—things that we do not allow? The idea that the US will give in on everything and come to an EU level just does not seem likely.

Professor McKee: You are absolutely right on that, and that is something that we are aware of. The thing is that, now we know this is a risk, it is very clear that the mood of the Parliament, the mood of the Council, is not to allow these things to happen. You could have added food irradiation, for example, as well. I have mentioned neonicotinoids, where there is a ban in Europe on those and the industry would like that not to be the case, but at the minute that is holding. I think within Europe there is a clear recognition that we do things differently here and this should not be an excuse to undermine public health. Of course, within the treaty, there is the treaty obligation that a high level of health should be part of all of the European Union's policies, so we can simply use that to go to the European Court of Justice and uphold the treaty. It is there.

Q20 Dr Whitford: Do you think the US on their side of this negotiation will actually move and expect their industry to change if they want to sell products in Europe?

Professor McKee: If they would want to sell those products, but there are many other products they can sell without getting into that. They already have irradiated food—meat—which we do not buy from them. There are lots of things that we do not buy from the US. We do not have to include absolutely everything in it.

Q21 Dr Whitford: Do you not think they will automatically get swept in if the whole point is an open trade agreement—TTIP?

Professor McKee: That is why there is a dispute resolution court involved in it, because it cannot do that. For example, would we allow internet sales of automatic weapons? I don't think so.

Q22 Chair: Is there not a genuine concern that if we move even to a court system, away from a tribunal system, that the level of the fines involved can have a chilling effect and lead people to accept things that they would not otherwise accept because they are worried about the penalties involved?

Professor McKee: Where it becomes important is that we act as a European Union on that. It becomes an issue particularly when they try to pick off small countries. For example, we

know at the minute—it is not so much in terms of fines—that the tobacco industry tries to pick off these small individual countries. I wrote a piece for the Slovenian papers the other day. We work very closely with our colleagues, and we know that Malta, the Baltic states and some of these smaller ones are picked on. Their Health Ministries talk to us so that we can provide them with support when that happens. But then they can Europeanise it, and it makes it much more difficult for some of these corporations to do exactly what we are saying. We are not that small, of course, so we are never going to be in the position of Slovenia, but they certainly want to try to break things up so they can pick them off one at a time. Malta has a really big problem with this.

Q23 Julie Cooper: You mentioned the importance of the research and the attitudes of the universities. How would the UK be affected and how effectively would we be able to collaborate in research projects with other states if we come out of Europe?

Professor McKee: We do know what would happen, because the Swiss were fully integrated and then they had a referendum on free movement; they were excluded from a number of elements. First of all, if we wanted to participate, we would have to pay; we would have to contribute in the way we do at the minute—the way in which Canada, Norway, Switzerland and Israel do, for example. Lots of countries do buy into the system. In a way, we would not necessarily save any money, and in fact it might be more expensive. It would be problematic in taking leadership of the projects because the UK has been very much in the position of research leadership in Europe. That is not possible for the Swiss.

Of course we collaborate with other countries. I have just received a very large grant from CIHR, the Canadian research funder; I have previously held an American National Institutes of Health grant. But we are very much subsidiary parties in that; we cannot lead them and we collaborate; we have issues around overheads, indirect costs recovery, and so on and so forth.

I am quite confident that we could find ways of doing that if the UK Government paid into the system, but it would be much more difficult. The real problem would be free movement of researchers—both the more senior researchers, with the issue of work permits and so on, and the exchange that we have in the Copernicus scheme and others, where we have junior researchers coming backwards and forwards. This tremendously enriches our team, both by our people getting experience elsewhere, and really very much from my teamwork I have a very broad mix of people coming to us.

Q24 Julie Cooper: Thank you for that. Are there not circumstances, though, when the directives and the regulations hamper effective research happening?

Professor McKee: We have to remember that there is a balance in all these things. Maybe I could pick up particularly on the clinical trials regulation, because I am conscious that the Vote Leave campaign has used that as an example in a way that is totally misleading. We know, for example, from the episode in France a year ago, when one person died and a number were injured, that medical research has significant risks attached to it. Similarly, in the use of data, where you have unauthorised disclosures of data, there are significant risks attached. You are always trying to balance the interests of the researcher to get the work done easily and quickly—and, as a researcher, I am in favour of that—but also the interests of the subject to be protected from the harms of other things.

In both those cases—data protection and the clinical trials regulation—by common consent, the first time round the European Commission did not get it right. However, it has listened and there is a very active process of engagement. I have been involved through the Academy of Medical Sciences in the UK, the Federation of European Academies of Medicine and my colleagues in the Council registration too, and we now have results in both cases that we think get the balance right and encourage innovation. You might want to look at what Cancer Research UK has written about the clinical trials regulation as unleashing the potential of the NHS. There is AllTrials, the group that has been set up by Ben Goldacre and others to get greater transparency. One of the big achievements has been the transparency in the new regulation so that you cannot hide falsified results. They described it as fantastic. Of course, there is a balance to be had on all these, but I am afraid the representation by some people of the clinical trials regulation is a total travesty in terms of what it really did. It was a success for the medical research community but balancing it with the interests of the research subjects.

Q25 Dr Whitford: I want to pick up on the issue of health research and new medicines. The European Medicines Agency is based in London, so I am sure we would still be able, as you say, to pay to be part of that. I would imagine the chance of it actually being based here, if we were outside Europe, would be unlikely. I do not know whether you have had any dealings with it.

Professor McKee: I would say the chances are zero, to be perfectly honest. It would be a bit like putting a major European agency in Toronto. It is just not going to happen; it would be moved. That would have a major impact, given the importance of pharmaceuticals in the UK economy. We should not underestimate that. The UK has played a very significant role there. That would significantly diminish our engagement, not just within Europe but with the FDA and regulators elsewhere.

Q26 Chair: Thank you very much. Thank you for joining us.

Professor McKee: Thank you very much indeed.

Examination of Witness

Witness: **Professor John Ashton CBE**, President, Faculty of Public Health, gave evidence.

Q27 Chair: Thank you very much for joining us for the second part of our session, Professor Ashton. I think this is going to be the last time you appear before the Committee; is that right? Are you moving?

Professor Ashton: It is the last time in this capacity. I finish my presidential role in June, so, yes, thank you for inviting me. The paper that you have, which I will speak to, is work in progress of the Faculty of Public Health. I will pull out the highlights to give some shape to this discussion. I suspect everyone would agree that the referendum debate so far has been a lot of heat and not much light. We are trying to produce a paper before the referendum that will have a factual and evidential basis to it.

Q28 Chair: Is this online at the moment so that people who are interested can follow it?

Professor Ashton: No. This is going to go out to our members tomorrow as an interim paper to ask their views on whether they think we should take a position on this as a college, to encourage us on whether or not to go forward and produce a substantive paper.

Q29 Chair: In that case, could we publish that tomorrow as well on our website, if you could let us have a copy?

Professor Ashton: That is absolutely fine.

Q30 Chair: If you could very quickly sketch over the main issues that you feel need to be addressed, that would be a helpful introduction.

Professor Ashton: That is what I thought I should do, to remind ourselves that the European third health programme, which runs from 2014 to 2020, has four big strategic things. One is promoting health, preventing diseases and fostering healthy lifestyles in "health in all policy" areas, which you are familiar with; secondly, protecting EU citizens from serious cross-border threats to health; thirdly, contributing to innovative, efficient and sustainable health systems; and then, finally, facilitating better and safer healthcare. They are pretty high-level things.

We are trying to pull out here the main thematic areas that really need to be thought about in trying to form a judgment. If you go on to the second page—I think I have a different printout from you—clearly there is quite a lot on the environment and health protection that needs to be considered. If you consider the origins of the European Union after the war, with the British Iron and Steel Federation and so on, the aftermath of the war and the desire to create structures and governance arrangements to mitigate against future conflict, which was very much part and parcel of it, but also the origins with iron, steel, industry and work, it perhaps is not surprising that the early competences were very much about the workplace, workers' safety, health and safety, and so on. In a way, things have incrementally moved out from that over the intervening 50 years. Another John Ashton was Edward Heath's adviser in Brussels at the time, but I should not have said that probably.

Environmental legislation, quality standards, air and drinking, and these kinds of things, are very much bread and butter to the public health contribution, and I think Professor McKee touched on that. Communicable disease surveillance and control—diseases which know no boundaries but where it is important to know what is going on and to be able to collaborate and intervene effectively and early—are very important things to consider, and whether—you are going to ask me something—

Q31 Mr Bradshaw: No; I was going to interrupt to say that we can read the document in our own time. Could you give us your view, if it is possible, without inviting you to pre-empt you consulting your members, as a public health expert about the benefits or disbenefits of our membership of the European Union when it comes to the public's health? What is interesting is that you have broadened the public health remit, even further than Professor McKee has, to include all of the Marmot points, such as health and safety at work, work conditions and so forth, but is it possible for you to quantify whether, over all, this has been good or bad and what the potential implications of Brexit would be?

Professor Ashton: That is what we are trying to solicit from our membership in offering them this tomorrow. We are trying to draw together evidence that fleshes out these big themes. If you ask me my personal view, I have found very little to convince me that getting out of the European Union would be a good idea from a public health point of view, a quality of life point of view, and thinking about that nexus. If you take a contemporary view of public health, it is indivisible from economic development, questions of environmental sustainability, questions of equity and so on. It is indivisible from that. One can get into a very big picture where it becomes quite difficult to get hold of it. What we have tried to do here is give a skeleton and a framework that is a bit more tangible to think about. If you do not want me to talk through it, that is fine.

Q32 Chair: We only have a short period of time, so I guess what we are interested in teasing out is what are the things that the EU is doing well and what are the things it needs to do better or does, frankly, badly—that kind of discussion. As you said, we have lots of heat and not a lot of light.

Professor Ashton: I know.

Q33 Mr Bradshaw: Also, I would imagine there must be some national, domestic or international data on health and health outcomes post-membership, not just for us, but for some of the other accession countries as well, and whether membership has acted as an improver of the kind of broader aspects of public health that you have just described.

Professor Ashton: The person you should have asked about that, of course, was Professor McKee—

Mr Bradshaw: We did not have time.

Professor Ashton—because that is what he has been publishing on for the last 30 years, and certainly he has monitored the impact of the decline of the Soviet Union, of the incorporation of eastern bloc countries; he has monitored all that data over the years. I am not the one to speak to his data.

Q34 Mr Bradshaw: You are aware of its findings, are you, sort of second hand?

Professor Ashton: I am aware that things were very dire at the end of the Soviet Union, with phenomenally terrible statistics compared with western Europe and that since then there has been a levelling up certainly in east Germany and so on. That impact has to be considered as quite important. From my own areas of research, there are other things on which I would say—Martin McKee talked about research and the education sector—there is no doubt that British public health has provided a leadership role in Europe. It is generally acknowledged that the academic side, the education and training side, our own faculty's accreditation processes and so on, are highly regarded as to what to aim for. On the other hand, some of the experiences of interventions in Europe, which we have learned from and followed, looking, for example, at the teenage pregnancy story over the last 40 years and the dramatic reductions we have seen in teenage pregnancy with the programme that we developed over the last 20 years, are very much based on the learning from Scandinavia and the Netherlands about how to go about doing sex education, providing the wherewithal for young people to be in charge of their destiny as young adolescents and so on. There is that two-way flow.

I have been part of a network for 25 years of academics who run a summer school in different places each year. We have had between 1,000 and 2,000 people going through that. As to generating understanding, collaboration and so on, it has been quite remarkable. There is a lot of that soft infrastructure stuff, which is quite important, which has gone on, on the research side, the education side and so on, which did not happen before, when you used to hitchhike round Europe.

Q35 Dr Whitford: Do you not think, as I mentioned to Professor McKee, that the actual sharing of knowledge would still go ahead and that we share knowledge with the States? Knowledge is not locked in by borders. We would go to conferences. We go to conferences all over the world as medics. Is it not just a better awareness of each other that has been happening as the world has got smaller anyway?

Professor Ashton: That is an interesting observation, which we could talk about and I do not know quite what we would conclude. Take something apparently not relevant, such as Scandinavian noir and the way in which all that literature from Scandinavia is now freely available in English. I have been going to Scandinavia for many years, and a medical colleague of mine 35 years ago said to me, "Do you know, we publish the most amazing stuff here, but you lot have never heard about it because we don't translate it." What applies to literature also applies to medical matters. They have had in the past their own medical journals in Swedish, Norwegian, Danish and so on, which we never get to read, but to the extent to which there has been a mixing and a crossover, I think there is much more influence of different parts of the region now than was the case when I started out.

Q36 Dr Whitford: But do you not think that would have happened anyway with the internet and English becoming de facto an international language?

Professor Ashton: I am saying it is a question that I cannot see how one can answer, but one has a sense that there is a much greater sense of Europeanness now than there was before. With the internet, many people would feel that they are global citizens in the way that many people would now feel European—comfortable and so on.

Q37 Chair: The question is: would those things come to a grinding halt if Britain were to leave the European Union?

Professor Ashton: The answer with so many of the arguments for leaving is that we just do not know. In the paper, as you will see when you look at it, we have tried to find out. We have invited people to tell us what they think are the impacts of coming out. It is quite difficult to find tangible things. By listing the things that go on at the moment and where there are benefits, we are trying to get to a position where people can form their own judgment about whether it is a good idea or not.

Q38 Dr Whitford: Do you not think from that point of view that there is a benefit in you as an organisation not taking a side but putting the data up? Sometimes the problem is that when organisations say, "We are leavers," or, "We are remainers," then other people say, "There is no point in reading that because they have already made their mind up." Therefore, having this might be a benefit.

Professor Ashton: That is what we are trying to do. At this stage it is work in progress. We do not know whether we are going to take a view and what view. We are trying to paint a picture.

Q39 Mr Bradshaw: When do you think you might be able to express a view, because you are leaving it quite late?

Professor Ashton: I know; I realise that. I intend us to do that before the referendum.

Mr Bradshaw: Before the postal votes go out.

Q40 Chair: This Committee is not going to take a view because there are a range of views, but in a similar way we would like to host people's opinions so that anybody who wants to write in to us who has an expert opinion on the EU can do so. We will host a range of views on our website, so we would be very happy to link to yours.

Professor Ashton: If you wish, I will see if we can add that addendum to the document that is going out to all our members tomorrow to say that you would be happy to hear from them as well.

Chair: We are interested to act as a source for people to look at a range of views from organisations that wish to do so.

Q41 Emma Reynolds: Do you think that the balance as it is at the moment, and the co-operation that we have with our European partners as a member of the EU, is about right, or do you think there are areas where we could co-operate even more closely—not just in public health in the narrow sense, but in the wider sense that you have set out in this paper with regard to environmental protection and all the other benefits that we derive from our membership? Do you think we should be doing more? Is there scope for doing more, do you think we have it about right, or do you think we should be doing less?

Professor Ashton: The competences of the European Union have grown incrementally in response to challenges that have emerged over the years. I do not see the European thing as having been a centrally determined effort to create a United States of Europe at all. It has been very incremental. There is very little competence with regard to health services. It is really about the things that relate to that initial impulse. It is about movement of labour and so on, from which we benefit. But I think part of the problem we have is that, because we are so ambivalent about Europe in this country, we have never optimised the opportunities that are there. Martin McKee mentioned European Members of Parliament not attending and not participating and so on. I see that as a missed opportunity.

One thing I organised in the late 1970s with the healthy cities programme, which is a WHO thing, was to bring together children from different countries for summer camp. We could have been doing a lot more of that. When we think about some of the problems of communal misunderstanding, religious groups and so on, we could have been using this vehicle to create much more of the understanding of cultural difference and so on, and build solidarity at a continent-wide level than we have done, because people have not been engaged with the opportunities. I know from my work with WHO that when you have contacts in different countries, different cities and different places, it is so easy to do things. What you really need is a catalyst for that. You need people to be interested in

doing it, to make it happen. We just have not optimised that opportunity because we are so half-hearted about it.

Q42 Chair: What do you think the EU should do more of? If people do vote to stay, what would you like to see the future direction being as to active engagement?

Professor Ashton: The very basis of public health is always data and intelligence, so I would say making more of an effort to communicate differences between different parts of Europe so that people can see what the benefits of the Scandinavian approach to life are and the disadvantages—and the same with the Mediterranean diet. Martin McKee again pointed out that the Mediterranean diet, in scientific circles, is largely credited with this big difference in life expectancy between northern parts of Europe and the Mediterranean region. I do not expect most British citizens would know anything about that really. I think there is something about sharing the knowledge better. I would think more on that.

I do not suppose anyone here would disagree with feeling that the way the European Union works is very bureaucratic and it somehow needs to become much less so. It is a bit like saying that the United Nations has failed. We are not going to scrap the United Nations. What it needs is to be made relevant.

Q43 Chair: Can I give you an example that we came across in our last Committee? We wanted to recommend having teaspoon labelling, for example, for sugar content, but one issue we are up against is that that is a European competency. Do you think that is an example of how it takes a long time to see progress on that kind of thing through Europe, whereas we would perhaps have greater flexibility to introduce those kinds of measures ourselves directly—just to give you an example?

Professor Ashton: I am with you. I am impatient. I am getting towards the end of my professional career, so I am getting more impatient probably. But something like that, which is part of an international problem of obesity, is the sort of thing where it would be very beneficial if there was a level playing field between food manufacturers, processors, confectionery and so on across all the European countries. One would have thought that a good public health campaign supported by Government would be helpful.

There is a body called the European Public Health Alliance, which sits in Brussels and which represents something like 70 public health organisations in Europe and has access to the European Health Ministers. I think twice a year they have a big meeting where they are able to lobby for health things. That is a very influential group as an umbrella and presumably we would be out of that if we left.

Q44 Chair: I am trying to get at the balance here. You have set out some very obvious benefits in communication, but do you think there is also a downside in that you have to reach agreement with so many other countries if you want to change something relatively straightforward like the labels on your packaging?

Professor Ashton: It seems to me that in some ways the European Union has been more committed to the environmental and protection measures. We seem to have made more progress in some areas, surprisingly enough, on the health improvement measures, some of these behavioural sorts of things. So it is not "either/or"; we need "both and". If we can

make progress on one thing while Europe is going slower on others, then maybe they add up.

Q45 Chair: Except you sometimes cannot make progress because you cannot introduce compulsory changes to labelling without it being agreed by so many other states. That is what I am getting at. Do you think there is any prospect for those kinds of things being streamlined more effectively?

Professor Ashton: We have to keep lobbying, arguing and campaigning on these things, making more use of our colleagues and networks that we have to mobilise. The European Public Health Association is an important body. Martin McKee is president of that at the moment. That brings together people who are policy people and activists and so on from all over Europe. It is those kinds of bodies that can begin to bear influence.

Q46 Julie Cooper: If the approach of Britain or the UK was less half-hearted, do you think that with the good work that has gone on here, looking at child obesity and sugar levels, we could be influential in Europe? Is that what you are saying—that we do good work here and Europe is better on the environment, tending to look at more environmental concerns? Is there a role for us to lead on this with a more committed attitude?

Professor Ashton: Definitely. When I was here last time, I talked about the way in which different cities in this country moved much faster than others in the 19th century. My own city, Liverpool, passed an Act of Parliament in 1846 to appoint a medical officer of health. The rest of the country did not do that until later. In the same way, if different countries are progressing different parts of the overall agenda at different speeds, there is no reason why, in due course, the European level cannot get behind something and try to roll it out across the whole continent.

Q47 Dr Davies: We heard Professor McKee's views in terms of the priorities of the current presidency of the European Union. Just to recap, those are healthy foodstuffs, antimicrobial resistance and innovation. Do you think that those are the correct priorities to be focusing on and at the right level, and what would you like to see being looked at in the future?

Professor Ashton: That is a good question, is it not? Antimicrobial resistance is very important and has come to the surface. If you twin that with—what was the other one about research and development?

Q48 Dr Davies: It was innovation in terms of the pharmaceutical system.

Professor Ashton: One competency of the European Union is rare conditions, which strays over into the medical area, away from where it does not normally have competences. The thing about rare conditions is that, usually, the pharmaceutical industry has no interest in them because they are not money-spinners. You need a big enough population of sick people with a rare condition to make it worth the while of the pharmaceutical industry to invest in the research and development. With a population of 600 million, you can begin to make a business case for doing the research and development, particularly if Governments are prepared to get into bed with them and do it as a co-investment. That was discussed during the Ebola situation, a rare condition, which had been ignored from when it was first noticed 30 years ago to getting round to

developing a vaccine. There are quite a lot of rare conditions for which there is nothing at the moment and about which Europe could, if it so willed, do something.

Your question was whether they have the right priorities. You will always get disagreement when you ask people to have three priorities. I am saying that, of those three, a couple seem to be eminently sensible for this kind of bloc. The economic development side and the way it impacts on social inequality and differences in life expectancy are very important.

I am from Liverpool. Liverpool got £1 billion out of Europe Objective 1 money in the 1980s, which was very important in pulling Liverpool back from the dead in regenerating the city. It was terribly important to enable young people to have job prospects and all the rest of it. You cannot talk about this without making the connections to these other policy areas, I think.

Q49 Dr Davies: Is not the difficulty how much of the prioritisation of certain issues could be dealt with through intergovernmental co-operation as an alternative and how the UK Government would spend their own money if it were from Westminster, Edinburgh, Cardiff or Belfast, rather than from Brussels?

Professor Ashton: We will all have our views on that, won't we, but in a global world of 8 billion or 9 billion people, a population of 60 million is quite small when it comes to having an impact. Being part of a bigger family in many ways becomes important, does it not?

Q50 Dr Whitford: My question is about thinking about how membership of the EU impacts on patients, on ordinary people who are not doing research directly, and other aspects. What does the person in the street gain health-wise?

Professor Ashton: What does the person in the street gain? A comparison point has already been made, and there has been some fairly small experience of people going abroad for treatment, has there not? The "not invented here" syndrome bedevils innovation and diffusion of innovation in this country. The more people are familiar with other countries that are nearby and the more they travel to and have exchange with them and the rest of it, the more likely they are to be open to copying innovation and best practice, I would suggest. We are more likely to do that with Europe than any other part of the world, except probably America because of the Americanisation of television. But as to practices such as the way the Dutch run their operating theatres, with several theatres going at the same time and a senior doctor, nurse and anaesthetist and so on, these kinds of innovations have a chance when people get exposed to them, but they have no chance if they do not.

Chair: I am conscious that we only have a few more minutes. I am wondering whether Julie or Andrew might want to ask a question.

Q51 Julie Cooper: Very quickly, because you have made some excellent points on the research, which was what I was going to ask about. What the UK receives from the research deal at the moment seems to me to be entirely positive.

Professor Ashton: We get more back, yes.

Q52 Julie Cooper: We get more back and we get to lead the research. Is there any downside at all? It looks entirely like it is a case for us to remain, to me, in terms of research. Is there anything else that you would like to add? Is there a downside to this deal that we currently enjoy?

Professor Ashton: There may be, but not that I am aware of at this point.

Julie Cooper: Thank you very much; it is very full.

Q53 Andrew Percy: I have listened to and been following the debate on health outside of this place, and even within. One thing that strikes me as odd about the whole debate is that it is framed in a way that, if we leave, which I personally hope we do, suddenly all of these relationships end and none of this sharing of best practice and pooling of research resources continues. There are plenty of countries around the world that are not a part of the European Union with which we are intimately involved.

Is not the truth of it that, ultimately, it is up to professionals to determine with whom they work, how they work and how they share their experience? That does not end if you leave the European Union. I used to live in Canada, which has some of the best health outcomes in the west. It is not in the European Union and is not in an equivalent of the European Union with the US or anything like that. It has excellent medical research and excellent drug research, and it shares that practice around the world. It does not end if we leave the European Union. Those relationships continue, do they not? That is the question to my statement.

Professor Ashton: I think, though, it is like all the arguments for coming out: it is conjectural; we do not know. We have had 40 or 50 years of experience of being part of the European project.

Andrew Percy: It is 40 years.

Professor Ashton: It has put down some roots, some networks and so on. The question is whether individuals could replicate the benefits if we just turned our back on it. I do not know.

Q54 Andrew Percy: But you could choose to be a part of that network even outside the European Union.

Professor Ashton: Yes, you could be. Things like the programmes that Europe has always run to support twinning arrangements between universities, exchanges, conferences and things like that, have built up very dynamic, organic links—I mentioned one before—that mean that people travel readily between places and get to know people.

Q55 Andrew Percy: But the facts are that you do not need the European Union for that because the bigger proportion of twinning and research arrangements that we have in the UK between universities is with universities in the United States. I am a trade envoy to Canada. We have tied up an MOU between two universities just recently and there are other universities hoping to do the same. So actually, yes, it is great, and perhaps Europe helps to facilitate some of that, but those arrangements happen and the No. 1 twinning arrangement and sharing of research is between British universities and American universities. I think we

obsess about the structure. Researchers will work together whether or not we are members of the European Union.

Professor Ashton: We are trying to stick to the evidence, so I would not be drawn on that. What you have quoted is anecdotes.

Q56 Andrew Percy: It is evidence. It is very clear that the largest amount of pooling of academic research and joint projects is between the United States and the US. That is a fact. The figures support that, followed by—I cannot remember but I think it is—Germany.

Professor Ashton: That may be the case, but the point that "If the European project is abandoned, it would be possible to do the same thing with Europe" is a hypothesis.

Q57 Andrew Percy: I do not think anyone is arguing—we are getting into a debate—about abandoning the European project, or even European co-operation; it is about abandoning the current governance mechanisms around that, which makes all the difference.

Professor Ashton: I have an open mind. I am just waiting for the evidence.

Andrew Percy: I am waiting for it the other way as well.

Q58 Chair: We will get an answer to this question and explore it depending on the result of the referendum, but thank you very much—

Andrew Percy: The people are never wrong.

Professor Ashton: Thank you for asking me.

Chair—for attending the hearing again this afternoon and for all your evidence over the year to the Committee. Thank you.

Examination of Witnesses

Witnesses: **Jane Ellison MP**, Parliamentary Under-Secretary of State for Public Health, **Dr Felicity Harvey CBE**, Director General, Public and International Health, Department of Health, and **Kathryn Tyson**, Director, International Health and Public Health Delivery, Department of Health, gave evidence.

Q59 Chair: Good afternoon. Thank you for coming. It would be very helpful if we could spend a few minutes with you introducing yourselves and your roles to those following from outside this room and maybe you could give us any opening thoughts before we are called for a Division.

Jane Ellison: Let us do introductions. I have brought a brains trust because I want to make sure the Committee gets really good answers across a broad range of topics. I have been the public health Minister since October 2013. You, in particular, Chair, are very familiar, and most people are, with my domestic remit, which, since the election, has included dementia and children's policy as well as the core public health I had in the last Parliament in the same job. I also act as the Department's EU and international Minister, but that means that I do talk on everybody's portfolio when we are doing European negotiation and so on. Part of the reason I have brought my colleagues is because we then have that

depth of knowledge across areas that are not necessarily my domestic portfolio but which we might be able to expand on.

This is Dr Felicity Harvey, who is director general of public and international health, and Kathryn Tyson, who is director, international, in the EU branch within DH.

Chair: That is very kind. Ben, do you want to open?

Q60 Mr Bradshaw: Minister, I do not think you followed the earlier evidence. We have asked each of our witnesses to give us a broad summary of what they see is the impact of our EU membership on our health and the potential consequences of a Brexit on that as well. You may be aware that the previous two witnesses talked about public health in the very broadest sense as well.

Jane Ellison: Thank you for that. It would be useful if I could share a few opening thoughts covering public health but also beyond that. There are the obvious points that have been made by the Chancellor and the Secretary of State about the possibility of the rocking of our economy by a Brexit vote and the impact that that would have on public services more generally and the workforce issues. Over 100,000 EU citizens work in our health and social care system. Those two are hugely important areas, but below that there are some areas I want to shine more of a spotlight on for the Committee that I think are important. One is health protection. Our EU membership has made a real contribution to our health protection efforts. As somebody very pithily put it to me in our briefing discussion, "Bugs don't respect borders." From our point of view, one thing that underpins the point the Government make about security is around health protection, and a good example of an EU-level initiative around that on cross-border health is AMR and its long-term threat.

Q61 Chair: Can you say what AMR is for those outside this room?

Jane Ellison: Antimicrobial resistance. Very recently, you will all remember the Ebola outbreak and there was a lot of European co-ordination there. Access to treatments and medicines is another area that is really important, and that was touched on in your previous witness session. There are some real benefits to UK patients in the greater range and quality of treatments, and there was a good point made about rare diseases in the previous session. The shared quality and safety standards across the EU benefit patients because we can import safely from other countries. There is also something, which you might want to explore a bit more, around UK patients benefiting from faster access to innovative pharmaceuticals because of shared authorisation standards and processes, which, incidentally, have a real impact in lifting the bureaucratic burden on UK businesses.

In public health, health systems and public health are a member state competence, but, for example, a single EU regulatory framework for food safety not only helps UK firms trade with Europe but gives our consumers real confidence abroad around that. In a common action in an area like tobacco, which some of us are very experienced in, there is a mutually reinforcing relationship with some of the work that is done at an EU level.

The last broad area I would point to as a real strength of our membership of the EU is the life sciences and research area. Other Committees have taken evidence from my colleague

George Freeman on this, but we have an extremely vibrant UK life sciences industry, which has access to an important single market, has significant bases in the UK and there are real benefits to patients in the area of research. Again, that was touched on in your previous session.

There is also the broader point about the exchange and analysis of comparable health data, which helps us to improve our own health system and helps us to lead within Europe. There are some areas where the UK does punch above its weight and gives important leadership on health matters. In all these areas they reinforce the central point of the Government's case for remaining in the EU, which is around influence in the EU and, beyond that, globally, but also in terms of the security of our citizens and the prosperity of our industries.

Q62 Mr Bradshaw: We are going to come on later to Britain's potential leadership role, and perhaps some of the examples you could give us of what you as a Minister have done at the Health Council, but I was interested that the areas you touched on in public health were what I could call the relatively narrow ones of EU competence on health, when it comes to the Health Council, but of course Professor McKee and others have talked about the much wider public health impacts of things like health and work, conditions at work, environmental legislation, clean air and clean water. Is there anything you want to add about that or do you think that is a bit too off your portfolio?

Jane Ellison: Certainly as to the latter point about clean air and those points, you are right that it is not strictly within my portfolio, but it goes to the point I was making about some of the issues that essentially cross borders that you cannot tackle effectively without international co-operation. Our equivalent of that would be something like antimicrobial resistance where, while it is important that we have a robust single country policy—and we do for this country—tackling a problem of that scale and international nature has to be done in a multinational way, we think.

Kathryn Tyson: Is it helpful if I add that the Chief Medical Officer—this is a quote widely reported the other day—highlighted in particular those two issues of clean air and clean beaches, I think she talked about, as being very important EU interventions in the public health sphere that have improved the public's health?

Q63 Mr Bradshaw: Is it your intention to publish any sort of document? I do not think we have had anything from you in writing. I know you have had quite short notice about this hearing, but it would be incredibly helpful to us as a Committee if perhaps after this session—

Jane Ellison: Yes, we would be delighted to.

Mr Bradshaw—you could get together some material and send it to us as your statement position, including as much as you can about what the chief medical officer has said and so forth.

Jane Ellison: Obviously, the chief medical officer is independent, but she has expressed her view, and it has to be said it is a view that I think represents a broad consensus among a lot of experts in the health field about some of the benefits. We are not dewy-eyed about it—we are always realistic about these things—but it is certainly the case that we have

identified a great many benefits, as I say, particularly underlining the points about security and influence. We would be delighted to follow up this session with a statement perhaps covering some of the points that I have particularly highlighted. Do you want me to come back?

Mr Bradshaw: Yes, please; we have only just started.

Sitting suspended for Divisions in the House.

On resuming—

Chair: Many apologies for the delay and thank you for coming back, Minister, to join us. Ben, you were just completing your questions.

Q64 Mr Bradshaw: Yes. I would like to ask Dr Harvey and Kathryn Tyson whether they have anything to add to what the Minister said about public health in a broader sense.

Dr Harvey: The other thing I might add in terms of this information sharing and the EU giving a framework, which helps us protect patients, is particularly the health security point. As we went through Ebola, one example where we were using that framework was through ECDC and the Health Security Committee meetings.

Q65 Chair: Because there are some people who might not know what that means, could you clarify the acronym?

Dr Harvey: ECDC is basically the organisation across Europe that looks at communicable diseases and surveillance of those communicable diseases. As we were going through the Ebola issues, they were incredibly helpful in bringing together the member states. We had a particular issue about how we were managing medevac of patients back from Sierra Leone, and through their co-ordination function they were able to set up a mechanism that did not enforce us but enabled all member states to say, "We have a patient coming back. Who can do the medevac for us?"; and they financed that. In terms of benefits for patients, having that framework enables the exchange of information and enables us to work very closely together. It can also help where you have a health emergency in bringing together co-operation and, indeed, financing from the Commission.

Q66 Mr Bradshaw: Minister, do you have a clear picture at all of the challenge that we would face as a country in the event of a Brexit in renegotiating and rewriting a lot of this legislation?

Jane Ellison: The Government's position, as you know—and I very much agree with this—is that we are much stronger in; we want to remain in the EU. As you would expect, that is the focus of my efforts. It is a leap in the dark if the country were to leave the European Union, and, to that extent, there are things that are just unknowable; so it is difficult to speculate. We have to assume, for example, that where we have European institutions based here—the European Medicines Agency is based here—they would want to base that in a member state.

Q67 Mr Bradshaw: We would lose that, in your view.

Jane Ellison: I would assume they would want that to be based in a member state, as a European institution, to give one example.

Kathryn Tyson: There are no other European institutions based in non-EU member states.

Q68 Emma Reynolds: Minister, in the last Parliament there was a very comprehensive study of balance of competences, but could I press you further on that and whether you feel, in your view and your experience in this Parliament and over the last Parliament, that the balance of competence in this area is about right, or whether there are areas where we could co-operate more closely as member states or where, indeed, we should co-operate less closely?

Jane Ellison: As you say, there was a comprehensive review of the balance of competences. I would say, yes, it is broadly right, but that does not mean to say that, for example, as a Minister, one does not have to be extremely vigilant and cautious to make sure that there is, for example, no competence creep. We are very clear about member state competence on health systems and on those areas of public health that we have identified that are member state-competent. One has to be wary of that and make sure that we continue to deal in those terms. Equally, there are emerging areas, such as antimicrobial resistance, where it is obvious that having those mechanisms for co-operation are very important. I have not seen any reason to extend competence. The way it is set up at the moment allows us to act perfectly effectively on that, but certainly having a seat at that table of influence means that we can really advance some of those agendas that are very important to the UK and where clearly only international action can make sufficient progress. The balance is about right, but we are always vigilant for competence creep in areas where it would not be appropriate.

Q69 Emma Reynolds: Obviously you attend the Council of Ministers on a regular basis. What is the UK's level of influence in those meetings?

Jane Ellison: From my experience, which is the last couple of years or so, it is good. We are recognised in the area of health internationally for our clinical expertise and for the lead that we have taken on some of the really big health threats, such as dementia and antimicrobial resistance. We played a key role in Ebola. Where we are very rich in the UK in expertise in some of the institutions of our health system, that is also respected, and in particular that gives us good levels of influence within technical discussions and negotiations where some of our technical expertise is brought to bear to make sure that what comes out of the negotiations at European level is enabling, workable and practical. I do not know, Felicity, if you want to give an example of that.

Dr Harvey: Certainly, and I think it is very much the expertise. As Professor McKee was saying, there is a limited pool of experts internationally. We are rated very highly in those, and the MHRA—the Medicines and Healthcare products Regulatory Authority—is one of those organisations that is thought of extraordinarily highly. If we take the example of the clinical trials directive, back in 2001, which the Committee might remember, one area of balance of competences where there was some challenge was how that clinical trials directive had been implemented. In fact, the MHRA worked very carefully, very thoroughly, with colleagues, and the clinical trials regulation that we now have, again which Professor McKee noted earlier, is a very good regulation. It has a hugely positive impact on the UK as somewhere to do research and has a very good impact across the European Union and member states. So there are examples like that. For the MHRA, it is not just the clinical trials directive; there are a number of examples, like the medical devices regulation, which at the moment is in its final stages. They and we have been able

to have a huge impact in Europe about making sure that that regulation is something that is proportionate to patient risk, on the one hand, but enabling us to have a very strong life sciences industry. For medical devices, that is particularly important. We have life cycles of those products over about two years, so it is quite important that we get them into practice if they are safe and have patient benefit. That is where the medical devices regulation that is near finalisation is at the moment. We and the MHRA will stay very closely engaged with that, but that is another example where we have been able, through our influence, to move something to a position where it has huge benefit for both us as the UK but also across Europe.

Kathryn Tyson: I would say that not only is it the voice from the expertise that is respected but the reputation of the UK for that proportionality and a pragmatic approach to discussions and to pursuing legislation. I see it in one of my particular areas of interest when we are at the World Health Organisation negotiating on a number of possible co-ordinated EU statements. The voice from the UK, which is usually not mine, is always in favour of, "Can we please be clear that we want to do something that has impact? We are not going to snow this area and say something on every single matter, but let's use our voice to make an impact on this global stage."

Q70 Emma Reynolds: Minister, could I have your reaction to those who say that, even if we were to leave the EU, surely these experts in public health or health more widely would share expertise and co-operate? What would your reaction be to that? Obviously the big advantage of being within the EU is that we provide a leadership role, and if we were in the situation of Norway, for example, and accepted some of these regulations, we would not have any say in formulating them. I would be interested in your reaction to that.

Jane Ellison: I will come back to the point about Norway. The Prime Minister has been quite clear. No one is saying that Britain would not exist outside the EU. We are a great country; we will be a great country whatever. The question is: do we have more influence? Are we more secure? Are we better off in the EU? I believe we are. I believe, in my particular area of interest in health, we can demonstrate that.

For those who make the other argument, in a way it is for people to demonstrate that; it is a leap in the dark. If people think there is a better future outside the EU, I feel the onus is on them to prove that in a way, because we are trying to illustrate where we do gain, as I say, in influence, which I think in the health area is considerable in a way that benefits patients, our businesses and everyone who lives in the UK. Retaining access to the single market of 500 million people is, for example, a huge part of the benefits of being in the EU, but you have to be in it.

Coming back to your point about Norway, I was at an informal health council last week, and my colleague—a lovely person whom I like very much and we have met on a number of things—was present at the discussions at an informal council, but at a formal health council, when it comes to negotiations and decision making, he is not present and voting.

Q71 Emma Reynolds: This is your Norwegian counterpart.

Jane Ellison: This is my Norwegian equivalent. That neatly illustrates the fact that, yes, Norway is part of the wider family, if you like, and part of those general discussions and a friendly relationship, but at the key moment of influence of voting in a negotiation on

regulations that do affect Norway in many cases, they are not able to exert their influence at that moment. That is not a position in which I would wish to see the UK.

Q72 Dr Davies: As a Minister, what is your experience of the health priorities of the Netherlands presidency or, indeed, those preceding it? Do you feel that the issues they concentrate on are appropriate and dealt with at the right level? Are there any examples of issues that have not been dealt with at the right level or ones that you would like to see addressed?

Jane Ellison: The issue of what individual countries choose for their presidency priorities is a member state competence; that is for them. As it happens, we have huge common interest with the Dutch on antimicrobial resistance. We are particularly supportive of their agenda, often helping with leading discussions or informal meetings inside of formal meetings. That is something where we have made very good common cause and it is of great interest.

Previously, Luxembourg had a real interest in dementia policy, which obviously had a great overlap, and there were a number of very good conversations there with the previous head of the health presidency, again with overlap. It is ultimately for member states, and it has the benefit of rotating the things that the EU looks at, but, because it is only six months in rotating, you tend to find that there is often quite a common thread and, when you have something that is looming large on all our agendas, often thoughts will turn to that; but I am quite clear that it should be for member states to set that. My experience is that people discuss it and they look at what is current and what needs addressing at that moment. That does tend to be reflected in the decisions they make. I do not know, Kathryn, if you want to add to that from your experience.

Kathryn Tyson: Sure. The expectation would be that forthcoming presidencies would discuss with other members of their presidency trio, with the immediately preceding presidency, to see if there are continuing themes that can be taken forward. They would have an eye to any legislation that would need to be taken forward during the presidency and whether that might influence a theme or it is just a separate piece of negotiation. Then, of course, as the Minister said, it is member state choice on what priorities they want to take forward. Again, it is helpful, because it is only a six-month slot, if somebody further down the line in your presidency trio, or further down the line still, is going to pick it up again, because six months is not very long to develop some of these big public health themes.

Q73 Dr Davies: Thank you. As a Welsh MP, my constituents are subject to Welsh health policy, of course, for better or worse. How do you ensure that the Ministers of the devolved nations are involved in what goes on in Europe? I understand that sometimes they act as a substitute for the UK Minister at the Council of the European Union.

Jane Ellison: I do not think they have in the time I have been, no.

Dr Harvey: They can, but I think they have not very recently.

Q74 Dr Davies: But what about in this whole debate about Europe and in general?

Jane Ellison: Let me tell you how we incorporate the views of devolved Administrations. In addition to the regular contact that my Department has with the DAs, which is very

substantial—recently, for example, we were able to say in a debate on contaminated blood, which is not an EU issue but just to give an example—

Q75 Dr Davies: About what?

Jane Ellison: On contaminated blood, for example. It is not an EU issue, but, to give an example of the very regular contact, officials in the Department had led a workshop with their counterparts in all the DAs to make sure there was some common understanding and knowledge. In addition to that regular contact, when we are developing the UK negotiating position on EU legislation, views are sought from the devolved Administrations, both at official and ministerial levels. For example, before we finalise a position, I will write to my equivalents in the devolved Administrations and say, "This is the position the UK is planning to take," and we invite that comment; but almost certainly leading up to that point there will have been lots of official level contact. Felicity, I do not know if you want to give an example of where we have done this.

Dr Harvey: One example is around emergency care. If we go back to Ebola, that was an area where we were working very closely in Europe with our European counterparts and seamlessly with our devolved Administration colleagues. In any of the emergency scenarios we were testing, we were testing that with them; so we do have that very close working. Particularly if you think about health security, the bugs know no borders, so it is very important that we have that very close working relationship and that feeds into discussions that we are having not just in Europe but in WHO as well.

Jane Ellison: There is a particular interest, clearly, for all the countries of the UK—going back to this point about the very pragmatic view and the technically competent view, which the UK provides in a lot of negotiations—to make sure that patients across the UK benefit but also that companies in the different parts of the United Kingdom benefit from sensible, proportionate regulation.

Q76 Helen Whately: I have some questions about workforce, starting off first with the EU working time directive, which has clearly generated some controversy. On the one hand, the balance of competences said that the working time directive can provide benefits, and, on the other hand, there has been much criticism even among healthcare professionals themselves of the impact of the working time directive, for instance, on the experience of junior doctors in training, whether they still get the competences they would have got before—that they do not get the same experience of following a patient journey; there is not the same team experience, which some would say has some implications now for the strike that is going on even; and some criticism that it may be detrimental to the continuity of care for patients. I would be very interested to hear your views on the benefits and the drawbacks of the EU working time directive and specifically what difference might leaving make to having the EU working time directive in the UK healthcare system.

Jane Ellison: Can I make a more general comment about workforce and then ask Felicity, who has particular expertise in this area, to talk about that because there are areas that are particularly relevant? For example, the mutual recognition of professional qualifications is also quite an important factor. As to workforce, it is worth getting on the record that the free movement of labour allows the NHS to recruit very highly skilled and qualified health professionals from across Europe. In September 2015, the numbers were 9.4% of NHS doctors, so just over 10,000, and 6.3% of NHS nurses, 20,500, were from an EU country.

That varies around the country in terms of where there is most reliance on them, but that is a very important resource for the national health service. Felicity, do you want to comment on the working time directive particularly?

Dr Harvey: Yes, absolutely. As to the working time directive, as you say, the balance of competences review that we did in 2013 was one of the areas, as well as the clinical trials directive that we have just commented on. It was another one of the areas where concerns were flagged, not necessarily overtly that it was a problem with the directive itself, but there was concern about the interplay between the directive and how we were doing contracts in this country. As you probably know, we had a review done in 2010, just before the balance of competences review, by Professor Sir John Temple—particularly around how, within the working time directive, you would do medical education and how you would manage to take that forward. Then in 2013, after the publication of the balance of competences review, we had a review by Professor Sir Norman Williams of the Royal College of Surgeons, again looking at the interplay between the working time directive and contracts. In terms of a contract, we now think that, because there is a particular issue around making sure for the UK Government that we do not have tired doctors providing healthcare services, or indeed any professional group, that you can manage a contract within the working time directive without needing to have an opt-out. Certainly, in the current contract, that is possible, not only within the working time directive but it even goes further than the working time directive. We are very much of the view that it is possible and you can do a contract within that directive but also ensure that you are doing safe medical education.

To come back to the point that the Minister just raised, in this country we do have up to 10% of the NHS as healthcare professionals from European countries. One other area that was flagged within the balance of competences review was indeed the mutual recognition of professional qualifications.

Q77 Helen Whately: Can I come to that in a minute, because it was a topic I certainly wanted to raise? While we are talking about the working time directive, from the work that you refer to about the UK contract and making sure our doctors and healthcare professionals are working a safe number of hours, in the event that the UK were to leave the EU, and in the event if this was negotiated through our future relationship with the EU that you no longer have an obligation to comply with the EU working time directive, would that mean that there would be knock-on consequences for contracts for healthcare professionals, or has the work gone beyond that? Are you saying that we would still probably work around those terms anyway because of the work that has been done since then on what is the safe way of working?

Dr Harvey: I might just remind the Committee that the working time directive came from health and safety regulations, so it was around making sure that you had a safe environment and people were not working too many hours. It is in that context that the contracts have moved over time in making sure that we did not have to have people working very long hours, lots of consecutive nights, and so on. I cannot comment on exactly what would happen in the future. I could say that what the contract currently looks like is not just to meet the working time directive hours: it goes beyond that. I cannot comment on what may happen in the future. I can say that it is not just to meet the working time directive hours, if that helps.

Q78 Helen Whately: That is helpful; thank you very much.

I would now like to talk about workforce supply, Minister, on which you brought some points in just now. Earlier you said that about 100,000 EU citizens are part of the health and social care workforce in this country, so clearly they are a substantial part of the supply of the workforce. Could you talk about whether there are implications for workforce supply of the UK leaving the EU?

Jane Ellison: Again, it is a question of speculation, I suppose, in a way for those advocating that position to say how they would handle that. We have identified that those highly skilled professionals are very important to our healthcare system. I suppose there has been some broader public discussion around the referendum about whether people would require visas and whether there would be other barriers. I suppose that any of that would be potentially difficult and off-putting for some people. Until those advocating for the country to leave the EU are able to give some detail about how they would handle that workforce issue, it is very difficult to respond to it. We have just identified that we think it is very important and one would not want to put patients at risk by losing access to that skill. It goes into other areas as well. Many UK professionals have benefited from working elsewhere in the European Union too, and in earlier sessions we talked about research-level co-operation, for example, where there is great mutual benefit there too.

Q79 Helen Whately: Thank you. Then I go to the point about qualifications, which Dr Harvey just referred to. If I understand it right, the qualifications in any EEA country are automatically recognised here. For instance, doctors can register with the General Medical Council without additional checks. Could you talk about how we can be confident in the quality of doctors who have been trained overseas and then can practise—and other healthcare professionals, in fact, practising in this country?

Jane Ellison: Do you want to come in on this? There was a comprehensive revision of this in 2013.

Dr Harvey: There was indeed. If I can comment, the regulator in this country does not have to accept what it has from another country and definitively put somebody on the register. They are able to look at the information they are getting from the regulator and they will take a view. We are in a much better position with the mutual recognition of the professional qualifications directive. We had some concerns when we were doing the balance of competences review because it was not yet finalised, but we have managed to get amended minimum requirements so that, for example, for the medical profession it is a minimum of five years and at least 5,500 hours of training. Also, we have new language controls—and that was one concern, as you will remember particularly from an incident a couple of years ago—as part of MRPQ, which have now been taken into the legislation here for all our regulators: the GMC, GDC, GPhC, and so on. We have also been able to bring in to fitness to practise an impediment around language as well as the EU-wide alert mechanism. The regulator takes the information it has, but it does not mean it definitively has to let everybody on to the register. It can seek further information; it can also seek additional information or, indeed, have some assessment of language skills before somebody comes on to the register. That is registration with our regulators.

The second issue, of course, is that it is up to the employer. The employer, very importantly, for anyone they take on, either on a short-term or longer-term contract, needs

to assure themselves that that person has the prerequisite skills, competences, training, and registration and language skills to be able to carry out that role. That is really important. We have brought in regulations so that the responsible officers in every NHS trust now have a responsibility around the language skills of the doctors that have been taken on as well. We are in a much better position and do not share some of the earlier concerns that we had about MRPQ, as it was being developed, in the same way that we did before. It is much stronger, again because of a lot of intervention.

Q80 Helen Whately: That is helpful and I think makes clear that part of the onus is on employers, and you say that employers are able, for instance, to assess language skills. I have a couple of follow-up questions. The first is: is it not a problem that, if I understand right, it is not legal to systematically test language skills? The other thing is that although large employers may be able to do all those assessments, is it really possible for smaller employers to make the kind of assessments that would be necessary, and do they not look to organisations like the GMC and if somebody is registered think that, therefore, that is a person who is fit to practise in their profession?

Dr Harvey: Yes, they will. There is guidance now to the NHS from the GMC and other regulators to support them in their role in ensuring that people do have the skills and competences, but it is the responsibility of an NHS trust, or any employer, to ensure that the people they are taking on to do a role do have the prerequisite skills to carry that role out safely.

Q81 Helen Whately: Then on the point that they cannot systematically test on languages, why is that not a problem? If you were recruiting somebody from overseas, it sounds as if it would make sense for it to be a normal thing to check their language competence.

Jane Ellison: I think it is about proportionality. That is the question.

Dr Harvey: Exactly.

Q82 Chair: On that point, you can come to the UK from a country like Australia and have to sit a formal language test, but you can come from somewhere else in the EU and not have to sit a formal language test. It is a kind of workaround, is it not, Minister?

Emma Reynolds: But you have to register with the regulator—

Dr Harvey: You do indeed have to register with the regulator.

Q83 Chair: It is a bit of a workaround, though, is it not?

Jane Ellison: As Felicity has explained, as an employer, you have to ensure that your patients are going to be safe and the people you take on are fit to do the job, and you have now the tools to be able to ask the right questions and make that right balance of judgment.

Q84 Chair: With respect, is not one of the issues that has been raised the issue to do with temporary staff, and that has been raised by the NMC? Their regulator will remain the regulator of their home state rather than over here, as I understand it. That is the concern they have expressed. Is that correct?

Dr Harvey: They have a responsibility if they are temporary. If they are going to be temporarily working in another member state, the onus is on them with their home regulator to get together the dossier of information that they will bring to the other country. My understanding, however, is that they still have to be registered with the regulator in the country even though they are only temporary. They will be getting the dossier of information, which comes from the regulator from the home state. That does not mean they cannot question it; they can question it. Clearly they are taking a dossier that is from a country if it is for a temporary worker for up to a 12-month period.

Jane Ellison: If this is an area of particular interest to the Committee, we can include that, if you would like, in our written submission.

Q85 Chair: That would be helpful because it is a concern that has been raised by the GMC and the NMC. The other issue, just to play devil's advocate here, is the whole clunkiness of the process. Having sat on the previous Committee, you will be aware how long it took to come to a workaround. Is that one of the issues that you feel Europe needs to address if the country votes to stay? Do we need to have much more streamlined processes?

Jane Ellison: My experience is that in any negotiation you would always wish for it to be as smooth and effective as possible, to reach sound conclusions as quickly as you can. My view, Chair, is that in any discussion, whether it is multilateral or bilateral, and whether it is inside or outside the EU, you will always get some people with whom you will have a good and swift negotiation that comes to a rapid conclusion and sometimes you will not. The idea that you might have to have a great deal more bilateral negotiations and discussions if we were outside the EU seems to me to be not a recipe for speeding up conclusions but rather for slowing them down.

Q86 Chair: There is an argument made by some people about having the flexibility to be able to set what you feel is the right regulation and to do so swiftly rather than having to agree it with 28 other nations. It is a point about which a lot of people raise concerns with these kinds of procedures.

Jane Ellison: It is a fair point. We will certainly reflect on that and, as I say, write a bit more in our written submission. The broad point is that, inevitably, it can take some time to get agreement in all sorts of areas right across a number of nation states, where everyone is perfectly reasonably making sure they are putting forward a country position and so on. Having got that agreement, it then creates a level playing field that disproportionately benefits you in the years going forward. If you take something like the work that went into both the clinical trials directive negotiations—mark 1 we would all say was not brilliant and perfect, but mark 2 is a considerable improvement—that time invested opens up a great deal more capacity in what you can do across the single market of over 500 million people.

Dr Harvey: May I add one point, though? It is not true to say that the European Union is always very slow. If we take the PIP example—the breast implants—I would start by saying that that was fraudulent; it was not an issue that the regulations necessarily could have dealt with. However, as a result of that, there was an EU joint action. One issue they were concerned about at the time was that there were a lot of notified bodies, which were the competent authorities[1] for devices across member states. As a result of something that

[1] Note from the Department of Health: Notified Bodies are the private organisations that certify medical devices.

the MHRA, again, took a lead on in working with other member states, they increased the level of scrutiny of the inspections that were carried out of all the notified bodies such that we moved from 80 notified bodies to 60. Some of them just fell out. After that, they also decided that those notified bodies would split themselves into some that specialised in particularly high-end medical devices, and that now happens. That was an issue that you might say could have taken a long time. Actually, it did not, as a result of that.

Jane Ellison: It is a good example of where the EU working ended up with a more streamlined process where people were using their particular competences in the most effective way. I think it runs counter to the argument that everything always ends up breeding more and more institutions. It is a good example of where the number was smaller and people were playing to their strengths in terms of what they were good at.

Q87 Chair: Indeed, but one concern has been that you could have a product certified by a certified body somewhere in Europe that we would not choose to certify ourselves and we would have no choice but to allow it to come into the UK. Could you say that that has now definitely been dealt with and that will not happen in the future?

Dr Harvey: With the medical devices regulation, as it is—clearly it is not totally finalised, but we are in the last stages of that and the UK will stay close to that until it is—we are now much happier that that is far less likely to happen. The notified bodies are much more robust. All of that has been taken into the regulation as well and we are doing this on a basis of risk, patient safety, but at the same time making sure that we do not end up with stopping having an innovative environment, which is really important to us, both for patients and life sciences in general.

Jane Ellison: It comes back to that word "proportionate", and it is exactly right to take a risk-based approach. We absolutely want patient safety to be key, but, equally, one criticism made often of health systems around the world is that they are too slow to innovate. We want to make sure, where possible, we can speed important innovations to market.

Q88 Chair: Indeed, everyone understands the principle about innovation, but the concern is where there are substandard products that have been certified elsewhere. If such a product was identified, how would the UK be able to respond to that if it had concerns?

Dr Harvey: Could I comment? That is why the inspections of the notified bodies, and again the MHRA is playing a very leading role in these, are very important in ensuring that all notified bodies have the skills and competences to carry forward the assessment of the products. That is not an area about which we are currently concerned.

Chair: Thank you for clarifying that. Julie, you want to follow on that about research.

Q89 Julie Cooper: That is right, yes. We have heard quite a bit about what a leading role the UK plays in the research programme in collaboration with its European partners. I would be interested to see what you think about how that would be post-Europe if the decision was made for us to leave Europe. Where would we be left with our research programme? What would be the impact on us?

Competent Authorities, such as the MHRA in the UK, are government regulators that oversee and designate Notified Bodies to operate in their Member State.

Jane Ellison: I will make a general comment and then perhaps we could illustrate. I go back to the point I made earlier. Clearly there are collaborations beyond the EU and with other countries—and Britain is a leading force in this area—of research generally but health research in particular. No one is saying that some of these things would not happen if we were outside the EU. The question is whether being in the EU makes them stronger, and I believe that the evidence suggests it does. We very much punch above our weight in European research funding and, in particular, in the strength we have in health research. I know that the Minister for Universities and Science, Jo Johnson, has given evidence on this to the Lords Science and Technology Committee. We particularly feel the UK strength in life sciences is very important when looking at funding in some of the kinds of things coming up on the horizon in terms of health science. Do you want to comment further?

Dr Harvey: If I could also come back to the free movement of professionals as well, this was an area that Professor McKee alluded to earlier. Not only do we attract a lot of clinicians, although we also enable a lot of our clinicians to go to other European countries, but we attract a lot of scientists. We know at the moment, particularly with things like the clinical trials regulation, which is about to come in, that we are punching above our weight. We get more in funding; we have more funding per capita on health research than any other member in the European Union. As you know, in general research we have managed to have €7 billion—£5 billion, roughly, depending on the exchange rate—of funding through Framework 7 for all research, and normally about 15% of that funding comes to the UK.

As a member of the European Union, we are able to get that. We benefit hugely from the amount of research funding that we get in, and that research funding is for the UK, but it is also for collaborations with the UK, with other member states, with innovative companies, and so on. It is actually us working also in collaboration with other members. Clearly, if we were not in the European Union, we would not be able to apply for those sorts of amounts of funding in the way that we can now.

The other issue would be how freely you could get scientists to move between member states. We know that at the moment, not being able to comment on what could happen in the future, we have a very thriving university sector and academic sector with researchers coming in from across Europe.

Q90 Julie Cooper: You cannot think of any instances when the clinical trials directive restricts us and stifles research possibilities for us.

Dr Harvey: There was quite a lot of criticism of the clinical trials directive initially—the directive from 2001. One issue, and again that was raised in the balance of competences review, was that there was a concern that different countries had implemented it in different ways. The UK was also said to have gold-plated it and, as a result, we did not get the benefits that the clinical trials directive was attempting to get.

As Professor McKee said earlier, in the revised directive, which is for implementation by 2018, but which was completed in 2014, many people—scientists, the innovative industries and indeed Governments—feel this has the potential to unlock clinical trials. Where we saw Europe taking a lesser proportion of clinical trials, the early signs look as though that is getting better. We do not have the clinical trials regulation yet fully

implemented. However, the MHRA, for over five years now, with other member states has spearheaded the clinical trials facilitation group, which we have chaired, and one initiative has been the voluntary harmonisation procedure to authorise clinical trials in multiple member states. That has already had a substantial impact and is now in the new regulation that is being implemented. We think it will have a benefit for the UK but also for the rest of Europe. Enabling more patients to have access to clinical trials means they have access to innovative medicines earlier.

Q91 Mr Bradshaw: Very quickly, on reciprocity, at the moment I have this wonderful card that I can use when I go to the continent and, if something should befall me, get health treatment. Is there any guarantee that I would be able to do that in the event of Brexit?

Jane Ellison: It is a function of us being in the European Union, so I would imagine that, no, there is no guarantee. Again, it is one of those things that is a question for those who envisage a future outside the European Union to explain how UK citizens travelling in the European Union would get that healthcare.

Q92 Mr Bradshaw: Do you have any figures or data as to the number of British citizens who use—

Kathryn Tyson: To be clear, it is EEA, not just EU—and Switzerland has the EHIC card also for its nationals. In return, the countries that have access to the EEA buy into free movement of citizens and pay into the system as well, to be clear on that. Did you ask about numbers of tourists?

Q93 Mr Bradshaw: It was the number of British citizens who benefit from this reciprocity.

Kathryn Tyson: There are several categories. The two most important ones are tourists and temporary visitors who use the blue card. As is the case in many of these situations, we do not exactly count how many people use the card, but we know there were about 44 million visits for the purposes of tourism by UK nationals to other EEA member states in, I think it was, 2014, as opposed to about 24 million back from EEA member states into the UK. That is a bit of a no-brainer: there are far more EEA countries for us to visit than vice versa. There would be an imbalance there.

The second large proportion of healthcare costs that the UK pays in respect of its membership of the EEA is in respect of our pensioners—people in receipt of a UK pension who choose to live elsewhere in the EEA, largely speaking in the south of Spain. It is a little bit warmer there than it is here.

Q94 Mr Bradshaw: Have those people been given any clarity as to what their status would be in the event of our leaving the European Union?

Kathryn Tyson: No.

Q95 Chair: Can I ask you to clarify this? The evidence that we have received is that £220 million of costs is potentially recoverable through EHIC, but we only recover about £50 million. Can you set out why we are so bad at recovering costs?

Kathryn Tyson: Largely speaking, this goes to the non-paying-on-entry basis of the NHS, so the NHS does not have a habit of identifying people's eligibility for treatment before

setting out to treat. That is entirely understandable. There has been a programme of work in place for the last two or three years now to try to improve that, through using behaviour change and more information, including information to potential patients, and workshops with staff and some incentives to health trusts as well to better identify and bring forward for potential recharging to member states. There have been some improvements in systems to close loopholes that were potential loopholes leading to fraud and error, although no positive evidence of fraudulent use of EHIC cards has ever come to light.

More broadly, because we have a residence-based system and our qualifying criterion for that is something called ordinary residence, that can be presumed on production of a large number of things. For instance, evidence that one is registered with a GP is often taken as proof of being ordinarily resident. There is some work going ahead at the moment following a consultation earlier on this year to try to make it clear that further evidence of being ordinarily resident is going to be required. You are quite right: there is a cost-recovery programme in train that aims to recover nearer to that £200 million than the current £50 million approximately that is recovered.

Q96 Chair: I think everyone would accept that you would not reclaim every penny, but it does seem a huge discrepancy and something that is causing a lot of concern.

Jane Ellison: Yes. It is something the Department takes very seriously. This piece of work has been ongoing for some time and is, as I say, something that a lot of thought and effort has gone into, particularly working close with the front line to make sure that it is something that we do, but in a way that ensures that health professionals can carry out their No. 1 role without additional burdens.

Q97 Emma Reynolds: To clarify a point that came up in the earlier discussion, if you are a nurse or doctor who comes from New Zealand or a French-speaking African country and you come to register here with the Nursing & Midwifery Council, as I understand it, if you could just clarify this, Minister, you are subject to the same language tests as if you were a Romanian or Portuguese nurse coming to the UK. That is now the case. We had a discussion of this earlier on and that is my understanding, but could you clarify that?

Dr Harvey: If you are from the EU or the EEA, under the mutual recognition of professional qualifications, the regulators can indeed assess language skills. They will not give the same test that they would give to others from other countries, but from any other country they would give you a language test. They have to assess language. There is guidance in how they might do that. It is not exactly the same test, but they have the requirement to do that. For anyone who is not within the EEA it is a specified test that is given to assess language skills, but could I just reiterate that, now that we have within MRPQ the ability to test for language and assess language skills, the regulators can indeed do that?

Q98 Chair: It is not formalised.

Dr Harvey: It is the ability to.

Q99 Chair: That is the difference, as I understand it.

Dr Harvey: They will have guidance as to how they will do that. If it is not EEA, then there is a specified test that they will do. We need clarity from the regulators as to how

they make that assessment for EEA citizens, and, to remind you, in terms of fitness to practise language skills is there. If somebody is found lacking, they then will do a test.

Q100 Chair: If they are found lacking, they will do a test.

Dr Harvey: They will have guidance as to what they will do ordinarily, but if somebody is found lacking and is on the register, they will indeed make a formal assessment.

Q101 Chair: One frustration is that there is not a parity of having to sit a formal language test, so you cannot ask somebody to sit a PLAB test if they are from the European Union.

Dr Harvey: But perhaps we could give further information to the Committee on exactly what the GMC, the NMC and so on would do in those specific contexts.

Q102 Emma Reynolds: I happened to meet the NMC yesterday and they told me that they are testing nurses that are coming to register.

Dr Harvey: They certainly can.

Q103 Emma Reynolds: They have failed some nurses for not meeting a language standard.

Jane Ellison: The one thing this Government and the Secretary of State could not have been clearer about is that patient safety is absolutely key, and for all employers it is essential that they have patient safety at the forefront of their mind in everything they do, including recruitment. Clearly language is key to that, but we can supply more information.

Dr Harvey: Exactly, but I would maybe come back to the fact that, just because somebody is from the EEA and provides their dossier of information, the NMC, GMC and the GDC do not need to put them on the register. The decision is theirs, not the individual coming to this country. They can turn somebody down on any of the criteria.

Q104 Chair: Thank you for clarifying that. It is an important point. Can we turn now to the subject of TTIP?

Jane Ellison: Before you go into the next questions, could you give us some sense of timing because, obviously, we have had three votes and—

Q105 Chair: I am aware of that, Minister. Are you able to stay for a little bit about TTIP, because it is something that all members are concerned about—

Jane Ellison: I know it is really important.

Chair—as it relates to the NHS and health, but that would probably be the end of our session.

Jane Ellison: Thank you. That is a helpful steer.

Q106 Chair: As you will know, there has been widespread concern expressed about whether or not, if TTIP goes ahead, we would be in a position where the NHS would then be opened up to the full force of the market forces. We received a letter in this Committee from the directorate-general for trade in the European Commission in December 2014, from which it

appeared to me to be clear that health would be exempted. I see that Cecilia Malmström has also written in a similar vein.

I want to clarify with you, Minister, whether or not you are clear that the NHS would be exempted and to address the point a lot of people have made to me, which is: why do we not specifically say we are going to exempt the NHS, because other countries, as I understand it, have said they are going to specifically exempt the NHS, in which case what would be the harm in just going ahead and saying that, to put people's minds at rest, because they are not currently always reassured?

Jane Ellison: I know. I might ask Kathryn to comment in a moment on that more specific point. The Government are really clear: we take the protection of our public services, and that includes the NHS, in trade deals very seriously. We have protected the NHS in all trade deals and we will continue to do so, so it is very much the Government's view that the NHS is under no threat from TTIP. As you say, the commissioner has reinforced that. Both sides of the negotiation have reinforced that. For us, the NHS will be protected and it is non-negotiable.

Q107 Chair: Why not specify that to put people's minds at rest, because it is something that we are repeatedly contacted about as a Committee?

Jane Ellison: Kathryn, do you want to comment in more detail on that?

Kathryn Tyson: On the specifics of why we have not sought a specific carve-out for health.

Jane Ellison: It might be something we have to come back on with further thoughts.

Kathryn Tyson: We did not seek a carve-out for health as a broad sector, because the disadvantage to our life sciences and pharma industries from such a carve-out, excluding them from the open trade routes, would have been more disadvantageous than the perceived threat to the NHS. Could we write with whether we know about the other countries excluding their health systems?

Q108 Chair: It is a matter that is extremely important to people from outside this place. There is grave concern, as you will know, from people that somehow we will be opened up to American corporations. It seemed to me in the letter that we received that there was reassurance on that part, but it has not necessarily reassured the public.

Kathryn Tyson: The joint statement from Commissioner Malmström and Ambassador Froman from the US in March 2015 went further than the letter and made it extremely clear that there was no threat.

Jane Ellison: I think, Chair, some of the comments made, as we both know as veterans of various debates, have been mischievous. Some people have sought to see threat where there is none present. We could not have been clearer; the Government could not have been clearer; and the Prime Minister, the European Commissioner and the US Government have been very clear on this point. The NHS is not threatened by TTIP. We are very happy to come back and write perhaps on the specific point with regard to what other countries have done and perhaps supply some more information.

Kathryn Tyson: Would TTIP make it easier for a US private health provider to come and open a hospital in the UK? Perhaps. Would TTIP require any local health commissioner to send its patients to that hospital or to procure the healthcare specifically from that hospital rather than from a public provider? Absolutely not.

Dr Harvey: The other important thing is how the Government choose to provide their health services. Whether they choose to contract some of those out or not is an issue for the Government of the day. As to how that message is being reinforced, it is very clear that, if one Government take one position and another Government take another position, through TTIP, it is absolutely the Government of the day that have the choice as to how they do it and it does not mean, through TTIP, that they are forced to continue down a route—for example, privatisation. That is not what would happen through TTIP. There are quite a number of guarantees and we can certainly write to the Committee to clarify those even further. We do not see TTIP as a threat to the NHS.

Q109 Chair: Thank you for clarifying your position on that and we look forward to seeing your letter. The other issue raised by Dr Whitford earlier is the issue around whether we would be obliged to have hormone-treated beef, for example, or products that we would not wish to have if we were setting the rules entirely ourselves. Are you able to address that point?

Jane Ellison: Yes. We were talking about this earlier.

Dr Harvey: In fact, no, we would not, and the European Commission has been very clear on that. There would be no reduction in regulatory standards, the meat from animals reared using hormones would not be allowed, and on GM food already subject to science-based approvals there would be no change. We would not, within the European Union, need to accept anything that is less than the standards that we currently have. Obviously, as to antibiotics in food, as you know, for growth promotion, the European Union has said, since 2006, that we would have no antimicrobials used for growth promotion. Those rules, in terms of food safety, would still apply within TTIP. We would not be reducing the level of our standards in that regard.

Kathryn Tyson: We are absolutely not the only country in the EU that wants to make sure the negotiating team keeps that in their minds.

Q110 Chair: Thank you. The final issue is the area of investor-state dispute settlements. I know that is now being modified to go to a system of courts, but, again, a lot of people have expressed concern that just the presence of those courts and the levels of the fines that they would have the power to impose could have a chilling effect on the Government's ability to set their own public health policy up against big corporations, such as big tobacco.

Jane Ellison: Again, this is something we have discussed. It is fair comment to say that the history of how tobacco companies have conducted their business with any Governments has meant that, wherever there is a forum in which to press a dispute, they have tended to take that opportunity. In constructs of the nature that you are describing, where equivalents exist elsewhere, they have never been successful in those forums and we see no reason why they would be successful in this context.

Q111 Chair: Finally, as to the stabilisation clauses that would be introduced that would bind for 20 years ahead, is that something that concerns you at all?

Jane Ellison: Could we write to you on that?

Q112 Chair: Yes; thank you. I do not know whether any other colleagues have points they want to make. We look forward to hearing from you further on that issue, and thank you for your patience and for coming along.

Jane Ellison: It was a pleasure. We look forward to reading the Committee's report.

Q113 Chair: We are not going to produce a report. We felt we wanted to—

Mr Bradshaw: We are a repository for all of your evidence.

Jane Ellison: Jolly good. We will send you lots. Thank you very much.

Chair: Thank you.