Department of Health & Social Care

From the Rt Hon James Murray MP
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Dear Chair,

Thank you for the opportunity to respond to the Committee's questions from 8 July on the costs and benefits of the UK-US Arrangement on Pharmaceutical Pricing and Tariffs (the Arrangement). Minister Gill will reply separately to update the Committee on the recommendations from the Joint Taskforce and will include responses to other queries raised in the Committee's letter of 28 April 2026 to her predecessor, Minister Ahmed.

The Arrangement aims to improve patient access to innovation and ensure that UK patients get the best new medicines fast, support the life sciences sector and contribute to economic growth through additional life sciences investment in the UK.

The pharmaceutical sector and the medicines it produces are essential to patient care, our NHS and the UK economy. Medicines bring major societal and economic benefits, helping people stay in work, reducing pressure on public services, and giving patients a second chance at life. That is why we must arrest the recent decline in the proportion of health spend dedicated to medicines – to enable more patients to access safe, cost-effective treatments that can transform outcomes and change lives.

Following changes to NICE's cost-effectiveness threshold in April for new medicines we have seen nine additional medicines approved for NHS patients in England and Wales that would have been unlikely to be recommended under the previous threshold. They include a treatment for a type of brain tumour affecting children as young as 12, a treatment for Duchenne muscular dystrophy and a treatment for patients with a rare and aggressive form of stomach cancer who have exhausted all other options.

The Arrangement also increases industry confidence and therefore supports innovative medicines being developed, manufactured and launched in the UK, where in addition to domestic policy change the UK has also secured mitigations under the US' 'Most Favoured Nation' (MFN) policy[1]; and to export pharmaceutical products to the United States, where the UK is the first and only country to secure a commitment of 0% tariffs for pharmaceutical exports for three years. Over £1 billion in industry investments have already been secured since the announcement of this arrangement in December last year.

[1] The Arrangement includes clarification of the US commitments on its Most Favoured Nation (MFN) pricing policy and supporting UK patient access; including outlining expectations from the US government that companies will continue to launch new medicines in the UK.

It is therefore important to recognise that the counterfactual - inaction – would almost certainly have led to significant tariffs on pharmaceutical exports to the US, potentially a further reduction in inward investment by life sciences companies in the UK, and fewer launches of new, innovative medicines. That would have had significant impacts on patients.

I recognise the strong public interest in transparency in relation to the Arrangement's impact on NHS spending, medicines access, the life sciences sector and future medicines pricing policy. I am therefore happy to respond to the Committee's request for a written summary of the costs and benefits.

UK/US Arrangement Costs

Over the short-term, our projections are more definite as the likely pipeline of innovative medicines is more visible. Whilst there is still uncertainty, we estimated at the time of finalisation that the Arrangement would cost approximately £1 billion in England over the current Spending Review period. This is expected to be primarily driven by implementation of EQ-5D-5L and the increase in the NICE QALY threshold. We expect this £1 billion to also cover the cost of the pilots developed through the Joint Taskforce with industry, which were announced recently. The Arrangement was finalised after the 2025 Spending Review settlement was agreed for DHSC. That settlement provided an average of 3.0% real terms growth in day-to-day spending for the NHS in England over the SR period, equivalent to a £29 billion real terms increase in annual resource budgets.

Future medicines spending depends on many factors that cannot be predicted with confidence over a ten-year period. These include which medicines are registered in the UK, whether/when they are recommended by NICE, and how quickly they are adopted by the NHS. Wider international pricing of new medicines is a further variable. As a result, sharing full modelling costs beyond the Spending Review - even on a confidential basis - would not provide the Committee with a more reliable picture. Internal modelling has been designed to support scenario-testing, rather than to provide a settled forecast.

We do know that it will be these future Spending Review periods where the additional costs of the Arrangement – including meeting the commitment to spend 0.6% of GDP on medicines – will be more significant compared to earlier years. However, agreeing the precise expected costs and the best approach to funding these costs will be for HM Treasury and DHSC to agree in the round through future Spending Reviews (including for the 2028/29 financial year).

Also, importantly, sharing of full modelling would risk prejudicing the commercial interests of the Government, leading to less favourable outcomes for patients from live discussions which make use of the sensitive analysis and assumptions. These include live domestic and international policy discussions, including preparations for future voluntary scheme negotiations, and the annual review process between HMG and the US Administration committed to as part of the Arrangement. Negotiations and implementation discussions are also ongoing on the wider UK-US Economic Prosperity Deal, including how the Pharmaceutical Arrangement interacts with the broader package across other sectors.

However, as set out in the Arrangement, we have committed to spend at least 0.6% of UK GDP on purchasing New Medicines by 2036, which provides a clear and transparent target for longer-term spend.

Response to External Analysis

The external cost estimates referred to by the Committee, including figures of £9 and £14 billion a year, are not recognised by DHSC. The BMJ analysis has assumed that if the US-UK arrangement had not been made, then newer medicine spending as a % GDP would stay at 0.3% until 2036.

Such analysis does not fully reflect the range of factors that will affect spending on innovative medicines over the next ten years. For example, we know that spending on innovative medicines has, historically, increased over time as more new treatments have launched in the UK and become available on the NHS, such as greater use of GLP-1s. We would expect that trend to continue as we move towards the medicines spending targets, even without the changes made through this Arrangement. It would therefore be misleading to attribute all spending above current levels to the Arrangement itself.

Recent analysis by outside organisations on excess deaths is also not recognised by DHSC. This analysis assumes any additional spending on innovative medicines would be funded directly from cuts to frontline services, when the Government has already secured record NHS funding and where future funding decisions will be taken at future Spending Reviews. While all spending will involve trade-offs, the exact impact will depend on future funding settlements and future policy decisions regarding the steps required to meet spending targets.

Crucially, this analysis does not factor in the benefits these reforms will have in supporting NHS patient access to life-changing medicines they would otherwise have been denied, like breakthrough cancer treatments, therapies for rare diseases, and innovative approaches to conditions that have long been difficult to treat. These medicines are an essential part of NHS frontline services, driving improvements in patient outcomes and transformation in care. Nor does it recognise the benefits resulting from a thriving UK life sciences sector. Nor does it recognise that under the counterfactual, where the Arrangement was not made, there would have been significantly heightened risk to patient access to medicines, likely seeing increasing delays to UK launch of innovations and the UK falling behind global comparators, as well as continued declined in industry investment in the UK, noted in further detail below.

I should also clarify that medicines already recommended by NICE cannot be resubmitted for consideration under the higher threshold. These will only be reconsidered if there is new evidence likely to have a material effect on the recommendation. This means the increased threshold does not mean higher prices for the medicines that are already available on the NHS.

Benefits to Patients

This arrangement is fundamentally about patients, ensuring they can benefit from life-changing medicines as they are developed, rather than the UK being left behind.

As noted above, the change to the cost-effectiveness threshold has already enabled NICE to recommend nine new medicines for NHS use that it would be unlikely to have been able to be recommend previously.

For patients accessing these medicines, the benefits are real and tangible. And this responds to long-standing concerns from patients and the voluntary sector that some promising medicines, particularly for cancer and rare diseases, were not reaching NHS patients quickly enough.

More broadly, innovative medicines are critical to the future success and sustainability of the NHS. In some cases, better access to effective medicines can reduce the need for other services because earlier access to innovative medicines can help prevent conditions from worsening, avoid complications, reduce hospital admissions, and support people to manage their health for longer. This is consistent with the wider shift from sickness to prevention, towards earlier intervention and treatment to help build an NHS fit for the future.

As set out above, without this Arrangement, in a challenging global environment, the alternative was to risk growing delays to innovative medicine launches in the UK and fewer patients benefiting

from clinical trial participation. With no mitigations secured regarding the US' MFN policy, such risks would be further increased.

With the changes agreed across NICE, the predictability of the remaining voluntary scheme and being the first and only country to secure 0% tariffs on pharmaceutical exports and MFN mitigations, we are giving a clear signal that we are willing and able to bring innovative medicines to NHS patients, encouraging the life sciences industry to prioritise the UK as an early launch market.

Economic Growth Supporting the NHS

The Arrangement also supports wider Government objectives by helping to make the UK a more attractive place for life sciences investment. Since the start of 2026 the Government has secured a series of major investments, including: AstraZeneca's £300 million investment in Cambridge and Macclesfield to expand R&D and establish a new digital drug development laboratory; UCB committing £500 million investment for a research hub in Surrey; a £45 million investment by Accord in its Barnstaple site; and Boehringer Ingelheim's £150 million AI/machine learning centre in Kings Cross. Such investments are creating jobs, driving growth and, critically, helping bring innovative treatments to patients faster.

Before the arrangement last year, the UK saw a number of pharmaceutical companies pause or withdraw investments totalling nearly £2bn – a trend that may have continued should the Arrangement not have been agreed. The life sciences sector is one of the most productive sectors in the economy, employing 360,000 people and providing £147bn revenue. Moreover, the NHS, as a publicly funded service, benefits from the economic growth and productivity improvement that this deal has already, and will continue, to enable.

I hope this summary is helpful. Please let me or my officials know if the Committee would find any further information useful.

With very best wishes,

RT HON JAMES MURRAY MP