Global Counsel

UK-US Trade: Is the NHS 'on the table'?

Blog post by Senior Director Stephen Adams and Practice Lead Tom Smith, 6 June 2019

There are few UK political issues like the NHS – beloved, sacrosanct and elaborately celebrated and protected by politicians of almost any stripe. So it is inevitable that political alarm bells ring at the idea that the UK's national health service would be 'on the table' in a possible UK-US trade agreement – an idea that got some airplay during President Trump's visit to London this week. It's useful to be a bit clearer on what this might actually mean. We have been here before, during the TTIP negotiations, so it is also important to ask why and how a UK-US negotiation might be different.

Healthcare's status 'on the table' in a trade negotiation has a range of dimensions. Four probably matter most in terms of the anxieties in the UK debate. The first is the question of the ownership of NHS assets and the extent to which a trade deal could force privatisation. The second is access to NHS procurement markets. The third is the policy space of the UK to reshape the balance of public and private provision in the NHS in the future. The fourth are the protocols by which the NHS sets reference drug prices and uses its bulk purchasing power.

The first of these is basically a red herring. The UK's right to operate a centralised healthcare service with a large public core is not meaningfully on the table in a trade negotiation. The UK does not actually operate a pure public monopoly on healthcare – it has an active market for private healthcare and hospitals. That market is already open to US firms. The UK can and would use a range of general carve outs to clarify its right to keep large part of healthcare provision a public sector prerogative.

Access to public procurement markets for healthcare would be a more concrete issue. The US will want guarantees that US providers will have non-discriminatory access to NHS contracts placed on the private market – as many parts of the English NHS already does. The UK is already bound by a range of WTO obligations on how it manages procurement processes, and a trade agreement will probably augment these. But the UK will have to consider in what way it commits to make or keep areas of outsourcing open to private provision on a non-discriminatory basis and on what terms. In principle, it can carve this out from commitments if it wishes. The EU has routinely done this. This may prove harder in a more asymmetrical UK-US negotiation, but it does ultimately remain a UK right in any negotiation.

The question of whether the UK would be constrained on its capacity to reshape the operations of the NHS in the future is a mix of what it commits to in terms of outsourcing markets and the nature of investor protection commitments in an agreement. On the former it could be required to compensate the US for access committed and subsequently changed. But it is relatively free to define what it commits to in the first place. On the latter, the key constraint would be on taking physical assets like private hospitals into national ownership in a way that breached legal requirements and investment treaty obligations on private property and expropriation. Many of these constraints already exist.

The drug pricing question is probably the big one from the US perspective. US pharmaceutical companies have routinely expressed their frustration at the way in which NHS reference pricing can compress their prices – and set global benchmarks in doing so. The US has, in the past, pressured trading partners to choose ways of defining cost-effectiveness and reference pricing that have a better chance of boosting prices for US firms delivering new drugs, and to codify these in trade agreements. It would do the same with the UK.

This intersects with a sensitive policy question in the UK. Ultimately driven by the finite taxpayer-funded NHS budget, an independent regulator (NICE) determines whether a new treatment is cost-effective. This process has been augmented in recent years by direct negotiation between the central NHS and suppliers to strike even more favourable deals - to the NHS. This maximises the NHS's capacity to drive hard bargains. But it can have the effect of limiting or delaying UK patients' access to new and innovative medicines - a concern not unselfishly raised by US pharma companies.

British politicians have, on the whole, avoided confronting the trade-off between reimbursement prices and access to medicines. Trade negotiations with the US may have the effect of making the issue more salient. Ultimately, British policymakers will firmly resist any attempt to allow US drug companies to charge higher prices to the NHS than at present. What could transpire are British commitments to more systematic and transparent protocols for assessing and pricing new drugs, including scope for independent appeal and review. The NHS has made steps in this direction already in the latest Pharmaceutical Price Regulation Scheme, which covers reimbursement for on-patent drugs up to the mid-2020s, so this could be more a question of convergence rather than a clash of opposing views. Commitments to promote innovation in procurement would no doubt be a hook for US advocacy for further post-deal change.

Does this all mean the NHS is on the table in a trade agreement with the US? Clearly it is in some respects. It is the basic nature of a trade agreement that everything is on the table - until you take it off. That is what negotiations are about. The UK would be a junior partner in any negotiation, but it cannot be compelled to sign up to anything it firmly opposes. Nor are narrow US aims necessarily deal-breakers for Washington. Trade agreements have to be seen as a wider set of trade-offs in which the US will weigh this issue against many others.