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EU health law in the UK: From the past to the present, and towards the future

Interview with Tamara K. Hervey, by Aurélie Mahalatchimy

Résumé : Dans cet entretien, le Professeur Tamara K. Hervey, référence incontournable du droit de l'Union européenne de la santé, répond à diverses questions sur son expérience personnelle concernant l'enseignement et la recherche de cette branche du droit dans le seul pays ayant quitté l'Union européenne : le Royaume-Uni. Quelles différences y-a-t-il dans l'enseignement et la recherche en droit de l'Union européenne de la santé avant et après le Brexit ? Est-ce que le droit comparé et le droit international constituent un refuge intellectuel alternatif ? Qu'en est-il du financement de ses recherches depuis le Brexit ? Que pense-t-elle des influences et interactions actuelles entre le droit de l'Union européenne de la santé et le droit anglais de la santé ?

Abstract: In this interview, Professor Tamara K. Hervey, a leading academic scholar on European Union health law, answers a range of questions about her personal experience of teaching and researching this branch of law in the only country to have left the European Union: the United Kingdom. What differences are there in EU health law teaching and research before and after Brexit? Do comparative law and international law constitute an alternative intellectual home? What has happened to the funding of her research since Brexit? What does she think about the current influences and interactions between EU health law and English health law?

Mots-clés : Union Européenne, Droit européen de la santé, Brexit, Royaume-Uni, Enseignement, recherche.
Keywords: European Union, European Union health law, Brexit, United Kingdom, Teaching, Research.

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contact@confluencedesdroits-larevue.com

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Interview with Tamara K. Hervey
Jean Monnet Professor of EU law ad personam, The City Law School,
City University of London

1 | How did you first get interested in EU health law?

Originally, I was interested in how EU law might be used to pursue progressive social aims. Most substantive EU law is economic law, focused on creating and sustaining an internal market in which factors of production move with less hindrance than in ordinary international trade law, and where firms and governments are constrained in their anti-competitive behaviours. But EU law always included small 'social' elements, including coordination of social security protection for migrant workers, and some aspects of employee protection law. My PhD was on one part of the latter: a comparative law study of sex discrimination in employment law, and the EU was one of my comparator jurisdictions. That was published in 1993. Then in 1998, I published a small book on European Social Law and Policy. It looked at what social policy scholars call 'the Big Five': social security, social assistance, education, housing, and health, and asked to what extent – if at all – the EU's law and/or policy affected those areas. The chapter on health in that book was the first thing I wrote on EU health law. EU health law wasn't thought of as a discrete area of scholarship: if it was anything, it was a very small part of EU social law.

Several colleagues at the University of Manchester where I worked at that time, including Jean McHale, who later went on to be professor of health law at the University of Birmingham, were interested in medical and health law. We often talked about our work over lunch, and especially legal developments that were in the news. One such legal development was a case in which a woman, Diane Blood, was seeking to rely not on European human rights law (the usual 'European' aspect of medical

* Propos recueillis par Aurélie Mahalatchimy, Chargée de recherche CNRS, Aix Marseille Univ, CNRS, DICE, CERIC, Aix-en-Provence, France.

or health law), but on European Union law, to receive a medical service (fertility treatment involving her deceased husband's sperm) in another EU Member State, which was not permitted in her home Member State. Jean and I began to brainstorm all the ways in which EU law affected or could potentially affect national health law. We shared our emerging research agenda with a senior colleague. 'European Union health law, there isn't any', he originally remarked. Then he paused, and said, 'Actually, it's enormous, isn't it?'. Those conversations became first of all *Health Law and the European Union* (the 'and' signifying that we were interested in the interface), published by Cambridge University Press in 2004; and then subsequently *European Union Health Law: Themes and Implications*, published, also by Cambridge University Press, in 2015. By 2015, we were confident that EU health law is a subject in its own right, worthy of study, and that our thematic approach is the best way to study it.

2 | The UK has always been, in some ways, a reluctant EU Member State: it was never a member of Schengen, it had special budget arrangements, it did not fully participate in many EU laws and policies. What difference did that make in researching and teaching EU health law before 2016?

To be honest, the vast majority of the areas of EU law that I was interested in were areas where the UK was fully committed, and in many cases, the UK had been an important player in Council when EU legislation was adopted. The EU's clinical trials law, for example, is an area where the UK had a significant influence, partly because of the UK's significant experience in the field of biomedicine. So, of course, I was aware of the areas where the UK had formally opted out of EU law (Schengen, aspects of the EU Charter of Fundamental Rights). But I didn't tend to focus on those aspects where the UK had a 'special deal'.

3 | What did you feel on the day the referendum's result was announced?

Although I work in London, I live in Sheffield, in the North of England. So I wasn't living in a 'London bubble' – I knew quite a lot of people who were planning to vote Leave – the security guard at my partner's work, the person who looks after our garden, several people who were parents of children in my children's school – and I'd heard a lot of discussion about why people were thinking of voting that way. Often, it was nothing to do with the EU, and everything to do with domestic politics.

There's a story I tell about this, in *Not What The Bus Promised* (Bloomsbury, 2023). It goes like this:

> "It is Saturday 4 June 2016. [Shortly before the referendum date on 23 June.] I am strolling in the sunshine to the concourse outside Sheffield railway station. The concourse is sheltered from a four-lane road by a 'wall of steel' sculpture, fitting for a city with a proud history of steel-building. But the sculpture is also controversial,

as the steel used to build this civic monument comes from China, not from Sheffield. I spot a 'Leave UK' campaigner: an earnest and acne-adorned young white man giving out leaflets and engaging passers-by in conversation. The leaflet includes the now infamous picture of the bus: 'We send the EU £350 million a week', it proclaims (falsely). 'Let's fund our NHS instead'.

As I approach, I overhear a middle-aged man interacting with the young Leave campaigner. The middle-aged man is becoming increasingly frustrated and irate. He has worked in the NHS in Sheffield for over 30 years, and now he's a manager in a local hospital. 'I've seen what the Tories [UK Conservative Party, in government at the time] have done to it. Do you really think they [in government] would give more money to the NHS? Do you really believe those lies? Those people [in London] don't care what happens to Sheffield or its NHS'. I watch the interaction as I approach, and I think that I can help.

'He's right', I interject, joining the conversation with the aim of seeking to defuse its increasingly heated nature. After all, everyone present agrees that Sheffield and its NHS are what is important here.

'Being in the EU isn't harmful to the NHS. In fact, it's beneficial'.

The information that I feel I need for this conversation comes easily to my mind. I've been researching the effects of EU law on health for three decades. These effects are not always as good for health as they could be, but there is no doubt that they help, especially in the context of the UK, which is not in the Eurozone and has not experienced EU- or IMF [International Monetary Fund]-imposed austerity. I have just finished a live interview on BBC Radio 4's Moneybox. The BBC had finally woken up to some of the health-related aspects of Brexit, and the Moneybox production team wanted to know more from a legal expert. Technical legal questions such as 'how does the EHIC [European Health Insurance Card-] work?, what about UK pensioners who have retired to Spain and access clinics there?' segued into more esoteric interpretative questions such as 'Does being in the EU mean that we cannot renationalise the NHS?'. All of these matters are topics in which I am a technical expert, and I have also been practising making my answers intelligible to a BBC audience.

My knowledge lands with the middle-aged hospital manager.

But it makes no sense at all to the young Leaver. As he struggles to parry our accounts – at least in my case, delivered as calmly and pleasantly as I can muster – a much older 'minder' from the Leave UK campaign comes to his rescue. I do not recall exactly what he said, but I do know that both the middle-aged NHS manager and I retreat almost immediately. I am not sure about the manager's views, but my sense is that there was no point whatsoever in civil engagement with this individual. He seemed quite simply impervious to fact-based or logical argument."

So the Referendum result in June 2016 was not a surprise to me. But it was a nonetheless a shock: I knew immediately that this would be a terrible act of national economic self-sabotage; and that it would unleash all sorts of damaging social responses, especially to anyone who seemed 'foreign'. I also knew that my own life was going to change in a way that I hadn't planned, and that the professional future that I'd imagined for myself would not come to pass.

If people would like to know more about how I felt in the run-up to, and on the day after, the EU referendum, they could read my blog about it.

4 | As a recognized expert in EU health law, were you consulted by various actors in England in order to prepare the country for the changes that were coming?

The answer to this question is 'yes', but not all the actors who really needed to listen to this kind of advice. In particular, I was never able to advise anyone in any of the relevant governments.

In some ways, the most interesting work I did was for the House of Commons and the House of Lords. I was the Specialist Adviser to the House of Lords EU Home Affairs Sub-Committee Inquiry into Brexit and Reciprocal Healthcare, August 2017-March 2018. Being Specialist Adviser means providing technical advice to the members of the Committee for when they ask questions of ministers (and others) in their Inquiries. This Inquiry was on the legally complex area of cross-border healthcare, covered by the Regulation on the coordination of social security systems and the Patients' Rights Directive, and a host of case law and implementing legislation. The UK was able to negotiate some ongoing reciprocal healthcare, and although we all lost our precious EHIC cards, we do now have UK Global Health Insurance Cards which do almost (but not quite) the same.

It was even more exciting (although always with underlying feelings of sadness) to be appointed one of two Specialist Advisers to the House of Commons Health Committee. I undertook that role twice, for two consecutive Parliaments: November 2016-May 2017 and then again from October 2017. I was working for Dr Sarah Wollaston, a Conservative MP who famously changed from Leave to Remain during the referendum campaign. When the vote was announced, she realised that she herself, and the members of the Parliamentary Committee she chaired, didn't know enough about the effects of EU law on health and the NHS, to be able to effectively hold the government to account the way a Parliamentary Committee is supposed to do. So she recruited two Specialist Advisers to help with that. I was one of the two: the other was Dr Nick Fahy, who had been a UK Civil Servant, and worked for the European Commission, and was then at the University of Oxford. We assisted with first of all thinking through what the Committee should look into; and then a major enquiry on the Brexit process, people and NHS staffing; and one on healthcare products: medicines, devices and equipment. There were genuine concerns about what would happen if the UK left the EU without a Withdrawal Agreement: almost no planning had been done for this, which would have left patients in dangerous positions because supplies of certain products, such as radioisotopes, would have been severely disrupted. In February 2019, Dr Wollaston took the view that she could not remain in the Conservative party, because of the government's reckless approach to Brexit. There would have been

a third Committee enquiry, on public health, but Dr Wollaston lost her seat in the 2019 election, and was replaced by Jeremy Hunt in the Chair. He did not undertake any Brexit inquiries.

In addition to this work, the major collaborative ESRC-funded project I did on Brexit, with Mark Flear (QUB); Matthew Wood (Sheffield, Politics) and Ivanka Antova (now, Northern Ireland Human Rights Commission), involved working closely with several bodies in the health policy domain. The first work we did was with the Faculty of Public Health, helping them to define their own Brexit work and position; and with an attempt to embed a 'Brexit should do no harm to health' clause in a major piece of Brexit legislation. This was ultimately unsuccessful, but it raised the profile and awareness of the many problems Brexit raised for health in the public domain, especially the House of Lords of the UK Parliament.

We worked with a small and a large health-focused charity. With Kidney Care UK, a charity which helps dialysis patients to go abroad to see family or have a holiday, we helped determine the unfolding legal position so that they could give robust advice on their website – even if the advice was 'we don't know yet'. Cancer Research UK was concerned not only about effects on patients of Brexit, but also effects on clinical research and access to new health technologies. We helped them understand the EU's external relations with non-EU countries in this field, looking at the EU's various international agreements, and showing how none gives anything like the easy access to collaboration that Single Market membership gives. We also helped them to understand what legal steps would be necessary for exchange of data in clinical trials, if the EU were not to decide that the UK is a safe country with which to share data post-Brexit. Fortunately the EU Commission has taken a data adequacy decision with respect to the UK. This is up for review in June 2025, and there is always the possibility that the UK will diverge from the EU such that the adequacy decision cannot be renewed in the future. This would be highly problematic in the health and biosciences domain.

One of the biggest areas of concern is – and remains – health and social care staffing across the UK. We worked with the NHS Confederation (an umbrella organisation for NHS employers) and also the British Medical Association on this aspect of Brexit. Fortunately, the Withdrawal Agreement secured quite a lot of continuity for people who were already in the UK, but the cultural and psychological damage of Brexit (and the concurrent 'hostile environment' immigration policies that followed) has been done. Our ongoing work, with the Nuffield Trust and funded by the Health Foundation, shows that the UK is more reliant than ever on migration for its health and social care staffing, but that this is now mainly from countries outside of the EU, including, controversially, countries on the WHO 'red list' where the UK has agreed not to 'actively recruit'.

Leaving the EU is particularly challenging for Northern Ireland. We worked with several organisations there, to help advise on the unfolding and complex legal position. Cooperation and Working Together, set up under the Good Friday Agreement, works on projects across the border on the island of Ireland. Many of these concern health: a shared children's heart hospital in Dublin; a cancer centre in Altnagelvin in the north of the island; young people's mental health services operating across the border. We also worked with the Royal College of Midwives in Northern Ireland and the Health and Social Care Professional Regulators in Dublin, who were concerned about mutual recognition of training and qualifications on an island which in many respects has one healthcare workforce working across two countries. People's lives work as if there is no border, and EU law helped to make that legally practical.

5 | In terms of teaching of EU law in England, what has changed since 2016? Do colleagues or students now respond to you differently?

This is an area that I began thinking about and working on almost immediately after the referendum result was announced. On a personal level, I knew my whole career was going to be forced in a different direction. Logically, I knew that while – on balance – most of the Leave vote was older people, a not-insignificant proportion of my (then) students must have voted Leave. I also knew that my then Dean had voted Leave. I was aware that the place of my subject – European Union Law – could no longer be assumed to be secure in every law school across the whole of the UK. In Scotland and Northern Ireland, there has been a firm commitment to continuing to teach and research EU law. In England, it's not so clear.

What has been wonderful is the response from my colleagues within the EU. Very shortly after the vote, I gave a talk on EU patient mobility in the Netherlands. I concluded by saying 'I will always be a European', and that elicited a spontaneous round of applause. I can feel myself becoming emotional thinking about it even now! Everyone with whom I was working then is still interested in future collaboration, and I've met new people too, for example, through the EAHL interest group on supranational biolaw; the I-Biolex project; and, during the pandemic, through the regular online work-in-progress webinars that are now EUHealthGov. It is so heartening that everyone has patiently waited while I did so much 'Brexit law'. Now they are fully embracing me as an EU lawyer again: one who is employed outside the EU but nevertheless continues to be a scholar of the EU.

On a professional level, I have also been – and continue – working to sustain the network of EU academic lawyers in the UK. Many of my colleagues from across the UK have now left for the EU: Ireland in particular, but also many people went to their home Member State or that of their parents. I co-organised a project about Brexit and the Law School, which included a workshop with papers also from colleagues in Norway, Iceland and Switzerland, and culminated in

a special issue of The Law Teacher, an internationally-recognised legal pedagogy journal. And I am one of four co-leaders of the *EU Academic Lawyers Assembly*, which runs workshops twice a year, aimed to provide support and collaborative encouragement, especially for early career EU academic lawyers who are based in the UK.

6 | In terms of research in EU law in England, what has changed since 2016? Does comparative law or international law provide an alternative intellectual home?

It is quite difficult to answer this question, because no one is studying it methodically. I have an impression, especially from colleagues in the *EU Academic Lawyers Assembly*. There seems to be a continued place for EU law as a subject, especially as I said in Northern Ireland (where much of EU law continues to apply under the Withdrawal Agreement's Protocol); Scotland; Cardiff in Wales; Oxford and Cambridge; and many – though not all – London law schools. My own law school, in City, University of London, has five full professors, and several other colleagues, who work in the field of EU law. But I have heard of several law schools where EU law is no longer a compulsory subject on the undergraduate curriculum, and it may already be the case that there are UK law schools without a single EU lawyer in them.

In terms of alternative 'intellectual homes', some colleagues focused more on the substantive legal topic of their interest. So, for instance, EU environmental lawyers became environmental lawyers; EU labour lawyers became labour lawyers. I don't know of anyone who became a 'pure' public international lawyer, but some people now focus more on broader trade law rather than just EU trade law.

7 | What does the research funding landscape look like now?

In the short term, there was a significant investment in EU law and policy research, both from the main funding council, the Economic and Social Research Council, and from smaller funding opportunities. I benefited hugely from that investment, securing a large inter-disciplinary grant which involved collaborating with two co-investigators (Mark Flear and Matthew Wood), a post-doc (Ivanka Antova), and eight student short-term research assistants. That was a big, and complex, project to run, and it would have been really fun, if the topic had not been so sad. I nearly didn't manage to finish the final deliverable – a book – because every time I sat down to write it, I was overwhelmed with the sadness of it all. I wrote a blog about that, too, which seemed to help.

But now I have the impression that it is extremely difficult – though not impossible – to get national funding for EU law work. The one major project I know of that has been successful in doing that recently is based in Edinburgh, and is led by Niamh Nic Shuibne. It is called 'Taming the Dark Energy of EU law' and is about 'the principles of EU law that are not written into the EU Treaties yet anchor

and propel the Union's constitutional development in very significant ways.' I do currently have some very small funding as a co-investigator for a British Council Springboard project, led by Professor Mark Flear in Belfast, Northern Ireland. This is for (re)building links with colleagues in France.

The UK has now – finally – rejoined Horizon Europe as a 'third country'. My sense is that, for humanities, social science or law projects anyway, it will be very difficult for UK-based academics to lead projects, but we should be able to participate, going forward. I'm hoping to be recruited to at least one such project in the future. And I'm also still being co-opted into projects funded by national entities in the Member States, and indeed beyond. I'm currently on the Scientific Advisory Group and very involved in the EU case-law analysis in the I-BioLex project funded by the French National Agency for Research; on the Advisory Board for a project funded by the independent Research Fund Denmark, on investigating how EU health legislation has accumulated over time and the implications; and a co-investigator on a small European-Commission funded project on EU pharmaceutical regulation, led from Canada.

8 | After EU law stopped applying in England, how would you describe the interactions and influences between EU health law and English health law?

As part of my work with the Nuffield Trust, colleagues and I wrote a paper on this which is published in the 2023 *Journal of European Public Policy*. We considered three broad approaches, all present in the context of contemporary health law in England. In the first approach, English health law and policy moves in parallel with the EU. Law and policy makers in England, perhaps quietly because of the ideology of 'freedom' that is associated with leaving the EU, deliberately make sure that English law and policy stays similar to EU law, or at least compatible with it, as EU health law changes. This is currently the dominant position, applying to data adequacy; clinical trials; medicines authorisations (where the UK tries to apply EU standards quicker and more efficiently – with success only in specific areas); good manufacturing practice; batch testing; and CE marking of medical devices. In several of these areas, there are small 'tweaks' to English law and policy, but the essence is to remain aligned.

The second approach is active divergence, where English law and policy-makers deliberately make different regulatory choices to the EU's. The most obvious example of this is the UK's Innovative Licensing and Access Pathway (ILAP), introduced in March 2021. Aimed to speed up access to medicines, the pathway brings together the UK's Medicines and Healthcare products Regulatory Authority (MHRA) which licences/authorises medicines, and its National Institute for Health and Care Excellence (NICE), which conducts health technology assessment on the cost-effectiveness of new medicines. The EU is pursuing a similar agenda, but rather more slowly. Some proposed areas of clinical trials regulation and some proposed

aspects of medical devices regulation would also involve active divergence: we will have to see whether these are pursued under the next UK government after 4 July 2024. A new Procurement Act 2023 (enacted after we'd submitted our journal article) will significantly change the landscape for health products and services purchasing in England: it's now an academic question whether the UK could have pursued this agenda as an EU Member State anyway. But this is probably the only major area where there are potentially discernible 'Brexit benefits' for health and the NHS in England; an outcome we predicted in our first major paper on the effects of Brexit on health and the NHS, published in the Lancet in 2017. And of course, those 'benefits' have to be balanced against the very significant detriments, discussed in detail in several journal articles, and our book *Not What the Bus Promised*.

Third, we found that in a lot of areas, health law and policy in England is actually drifting. No active decisions are being taken, resulting in initial alignment with the EU, because of the way the UK's EU Withdrawal Act 2018 operates, providing vital legal continuity for what is now called 'assimilated EU law'. But then, when the EU updates or replaces its regulatory content or standards, its institutional structures, or its processes and practices, in practice English health law and policy drifts into divergence.

9 | What do you feel now about the future of EU law in the UK?

What do I *feel* is an interesting question. I think my main and overall feeling is one of sadness, with a bit of exhaustion. I was never – and I still am not – uncritical of the EU. There are many aspects of EU (health) law and policy that could be better. The Eurozone austerity policies and the harm they did to healthcare systems is a major example. But in health, as in every other law and policy area, I feel that we are better together. The world has to face up to climate crisis; to ageing populations (in the global North); to ongoing extreme poverty (in the global South); to conflict leading to mass human migration and displacement: all have health dimensions. The scale of these, and other challenges, call for some involvement of a supranational organisation like the European Union.

And there are of course many tangible benefits to health from EU membership: economic development from being part of a larger market engenders better health outcomes; infrastructure development, especially in roads, has a major positive effect on health; and so on. So I feel that all the energy that went into the Brexit process was a terrible waste: we have so many other problems we need to tackle, and responding to the EU referendum vote was a major distraction from them. I would like to see the EU continue to succeed as a place where differences can be overcome towards a greater good. In the health law and policy space, I would like the EU to undertake a greater role in developing solidarity and equality, and to develop the trust from its people that would be needed to do that.