An Alternative European Perspective

October 2021

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This regular monthly review of European healthcare issues has inevitably been biased towards reporting on Covid and the varying and common responses made across Europe in recent months. However, the UK Government announcements in early September on social care provision (which might more accurately be described as the increase in National Insurance payments) provide an opportunity to once again demonstrate how countries differ in managing the common human need of requiring care at some point in our lives.

This month alongside more discussion on the latest Covid trends and vaccinations, a comparison will be made of the differing systems for social care applying in Europe and what we may learn from them.

1 Social care in Europe

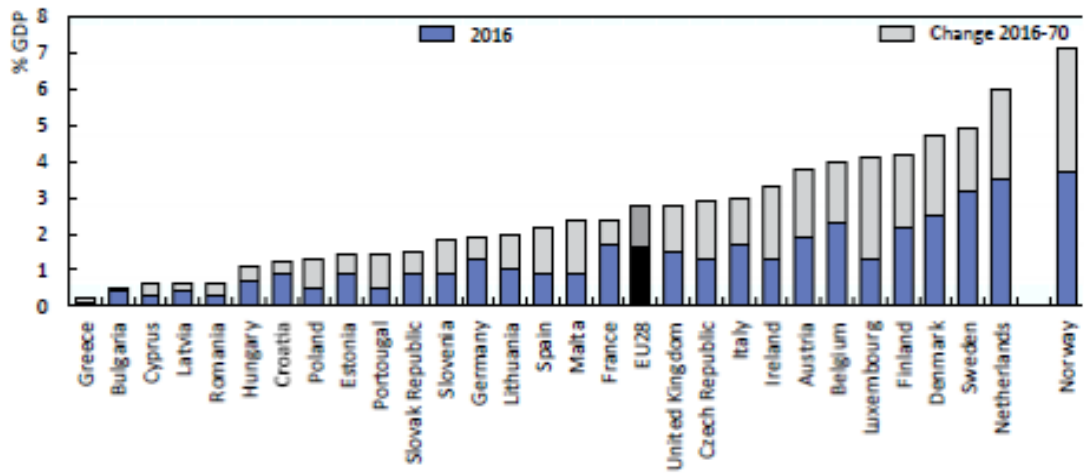
For the sake of brevity I borrow from an analysis from the European Social Care Network[1] who, in my view, have identified three issues that differentiate country responses to social care: absolute levels of public spending on long-term care; the size of the local workforce dedicated to health and care and finally the ownership structure of care providers.

Considering each in turn we see there are marked differences between countries in Europe[2]. At the lower end of public provision are the poorer countries in Eastern Europe and the Mediterranean, followed by a cluster of the larger countries who have limited public spending to c. 1.5-3% of GDP, and then a group of predominantly Nordic but also the three Benelux countries with universal systems of long-term care, ensuring higher levels of public support.

[1] https://www.esn-eu.org/sites/default/files/2021-02/Long%20Term%20Care_2021_Interactive.pdf

[2] https://www.oecd.org/els/health-systems/47884942.pdf

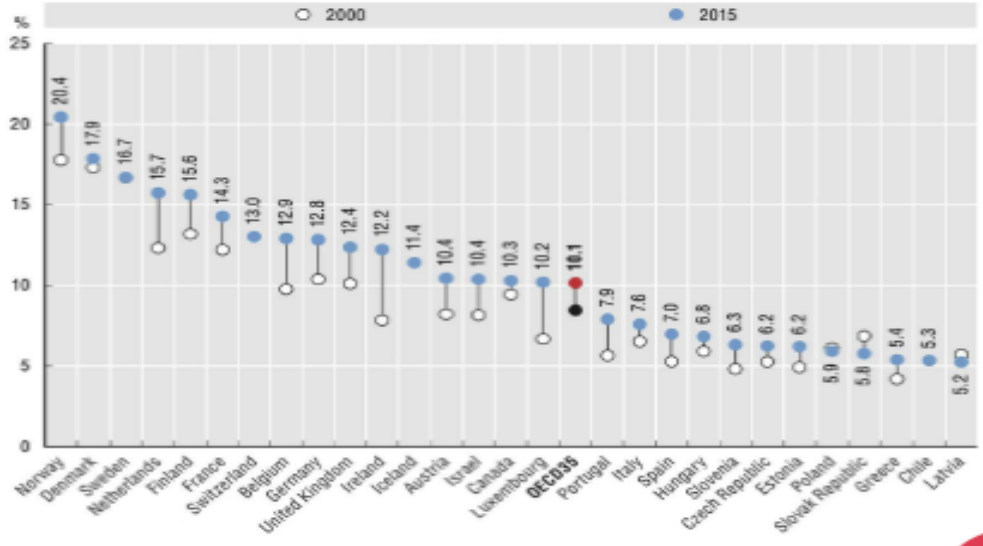
Figure 1 Public spending on long-term care as a percentage of GDP, 2016 to 2070 (estimation)



Source: EC and EPC, 2018.

More than a pinch of salt needs to be taken with long-term projections and attention must be paid to the fact that public spending does not equate with total spending on care. Most care is in fact self-funded or delivered at home by family or friends and a better guide to the burden placed on these informal systems is the relative sizes of the workforce dedicated to health and social care.

Figure 2 Growing share of social and health care professionals in the total labour force, 2000 to 20



Source: OECD, 2017

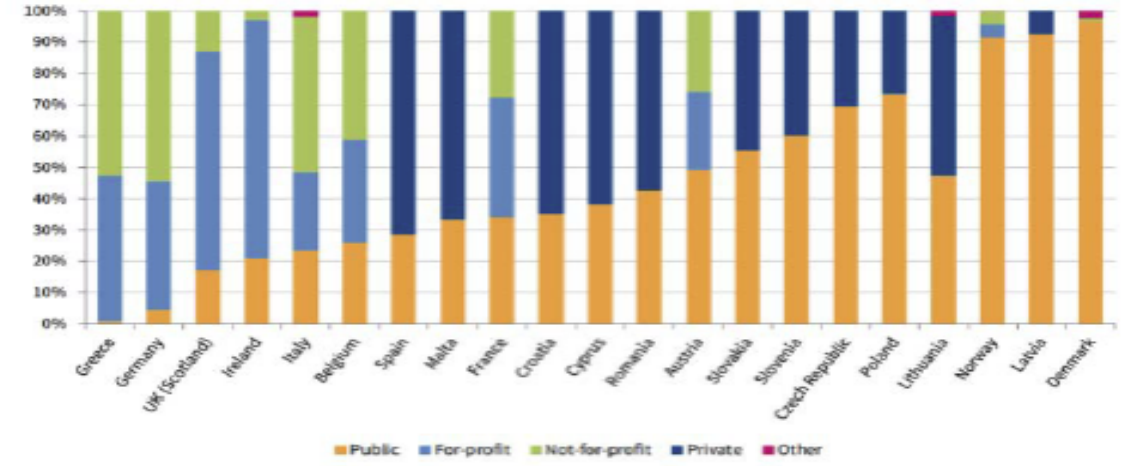
We see again the same earlier clustering of countries with differences in family and informal arrangements filling the gap (or not) between formal system provision and the actual need. The European Social Network report notes that,

The acknowledgement of (Long Term Care) LTC as a social risk has included an increasing awareness about the role of informal carers in providing unpaid support to people in need of LTC. Countries such as Sweden, Germany and Austria have identified this as an area of social intervention and each of those countries supports informal carers with specific services such as day-care for older adults and respite breaks for their carers. The German LTC insurance system compensates informal carers with a small allocation of cash payment, while in

Spain informal carers who receive an allowance also contribute to social security to build towards their pensions. Most countries offer special training courses for informal carers, e.g. in Finland or Slovenia (UNECE 2020). The extent to which such services are available is an important indicator for the quality of LTC.

The final category that differentiates care provided between countries is in the structure of provisions and, in particular, the level of private provision.

Figure 7 Market shares of different types of providers in residential care in selected Member States, around 2016



Source: Eurofound, 2017, 17.[2]

This clearly marks out the UK and Ireland as having a very high level of private provision. Allyson Pollock both in a recent Guardian article[3] and in an article in the BMJ calling for a National Care Service[4] identifies that,

Social services in the UK are among the most privatised and fragmented in the Western world. They have been underfunded for decades. Between 2010-11 and 2017-18 local authority spending on social care in England fell by 49% in real terms, while privatisation increased. The UK has 5500 providers operating 11 300 care homes for older people, and 83% of care home beds are provided by the for-profit sector. Responsibility for funding has been shifted to individuals, and there has been tightening of NHS and local authority eligibility criteria, as well as long delays in assessing eligibility and inconsistent and inequitable application of criteria. Care services in England employ roughly 1.6 million care staff (1.1 million full time equivalent), of which 78% are employed by the independent sector. Pay is low; 24% of people working in adult social care are on zero hour contracts, and in March 2019 around a quarter were being paid the national living wage of £7.83 an hour or less.

She also noted,

Care is highly labour-intensive and in NHS and local authority-provided care services around 80-90% of annual revenues were spent on staff costs. A recent National Audit Office report covering England shows how companies have slashed staff costs since then: more than half of the large for-profit care home providers surveyed spent considerably less than 60% of annual revenue on staff. Studies in the US show for-profit operators generally have the lowest staffing levels and consequently poorest quality of care and worse outcomes, including deaths.

My conclusion is that the UK cannot use the unaffordability of social care as an excuse for

[3] https://www.theguardian.com/commentisfree/2021/sep/14/multinational-care-companies-new-tax-privatised

[4] https://www.bmj.com/content/bmj/369/bmj.m1465.full.pdf

failing to ensure adequate public provision of care services, and thus relying on the NHS to act as a backstop for older people who have nowhere else to turn for care. Other comparable countries manage to fund this in absolute terms and manage to face the reality of planning additional provision as demographic pressures rise with an aging population. The UK's excuse that staff cannot be found to provide this care is belied by the success in other countries in funding a higher level of the workforce employed in health and care. The problem is that achieving higher employment levels will require higher pay which appears to be incompatible with a largely privately supplied service which prioritises profit, rental extraction and executive pay over wage levels.

This points to a separate conclusion that the solution to the social care problem has to be the re-nationalisation of social care in the form of a National Care Service. This has been advocated by Allyson Pollock (see footnote 4) and by Roy Lilley[5]. We will have to see what is in the Government's White Paper on reforming social care (later this year) announced as a part of government proposals for increasing National Insurance[6] (see p29). I suspect we will be underwhelmed but out of this debate may come a dawning of reality that existing systems are not working and will not work without more resources, more staff and a different delivery system. Others are coming to the same conclusion[7].

2 Latest on Covid

Those who stand back can see the bigger picture here in this telling table from the Health Foundation[8]

Country	Deaths	Expected deaths (5-year average deaths)	Excess deaths	Excess deaths as a share of expected deaths
US	3,566,645	2,845,479	721,166	25.3%
UK	735,854	613,484	122,370	19.9%
Italy	766,561	657,417	109,144	16.6%
France	679,538	601,380	78,158	13.0%
Canada*	312,700	280,174	32,526	11.6%
Germany**	1,025,105	949,820	75,285	7.9%

[5] See Roy Lilley Newsletter 26th August "Bevan Moment …"

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015736/Build_Back_Better-_Our_Plan_for_Health_and_Social_Care.pdf

[7] https://blogs.lse.ac.uk/politicsandpolicy/social-care-reforms-2021/

[8] https://www.health.org.uk/publications/long-reads/comparing-g7-countries-are-excess-deaths-an-objective-measure-of-pandemic-performance

The BMJ meanwhile is concerned at future projections[9] citing an intensive care doctor,

Dale Gardiner, an intensive care doctor in the English Midlands and a board member of the Faculty of Intensive Care Medicine, told The BMJ about the pressure he and other NHS doctors were currently facing with the level of covid on the wards. "People are worried about the winter, but, honestly, winter is already here for the NHS," he said.

"*We've got the highest number of covid patients in intensive care since March, and that's across the UK. In the Midlands, around 40% of intensive care beds are currently occupied by covid patients. That's 40% of beds where we can't provide care for other patients—for example, those needing cancer and time sensitive surgery."*

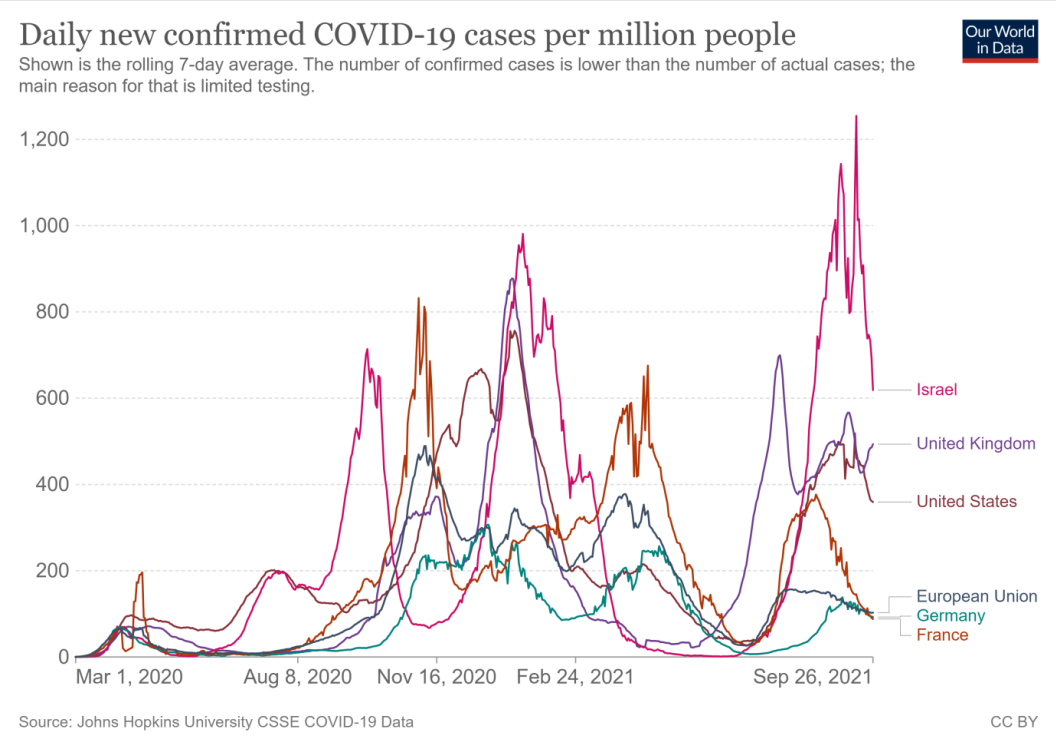
Gardiner added, "I think the situation in the NHS is in a worse state now than at the height of the pandemic. The covid numbers might have been higher in the past, but at the time hospitals were doing very little of the other vital work we normally do. Now we're trying to do both—there is a massive backlog."

Chaand Nagpaul, BMA council chair, urged ministers to "open their eyes and realise that now is the time to act."

He warned, "If left too late, we could find ourselves in a position where the NHS is dangerously overwhelmed, returning to a situation where ambulances were queuing round corners and hospitals had no choice but to pause all elective care, further increasing the already enormous backlog."

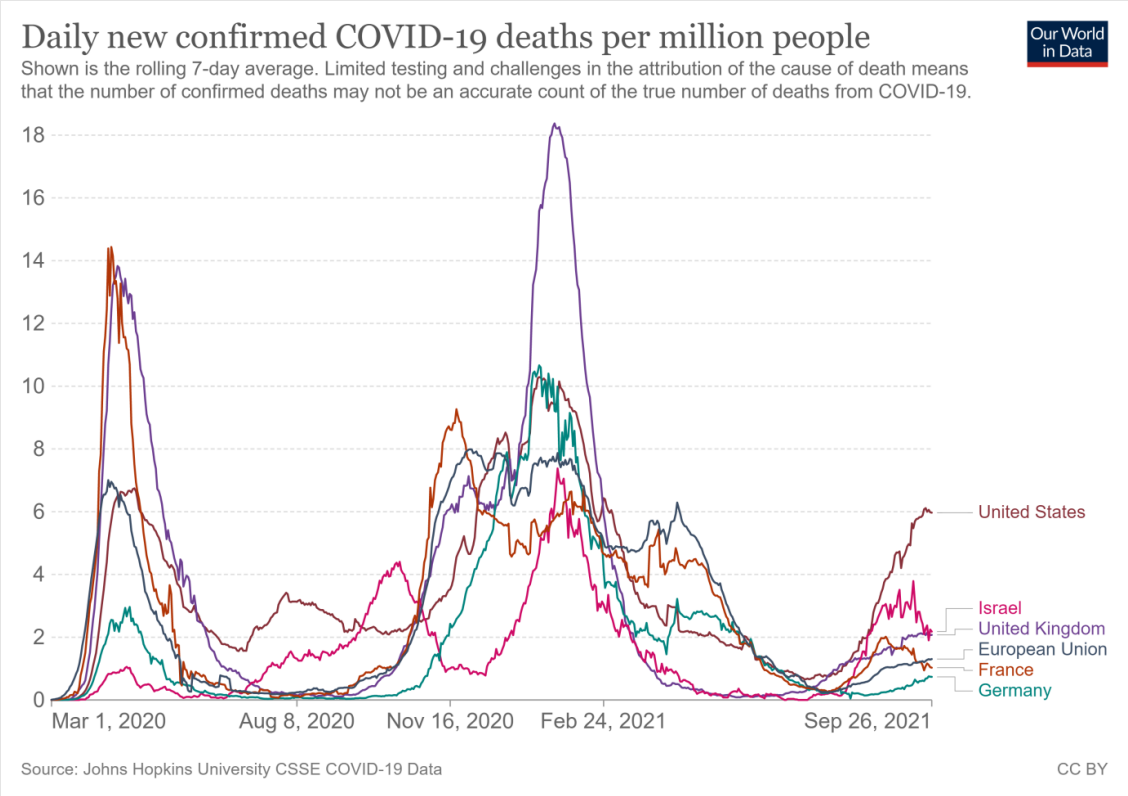
This acts as a background to the latest statistics provided in the graph below.

[9] Covid-19: Act now or hospital admissions could soar, experts tell government
BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n2285 (Published 16 September 2021)Cite this as: BMJ 2021;374:n2285

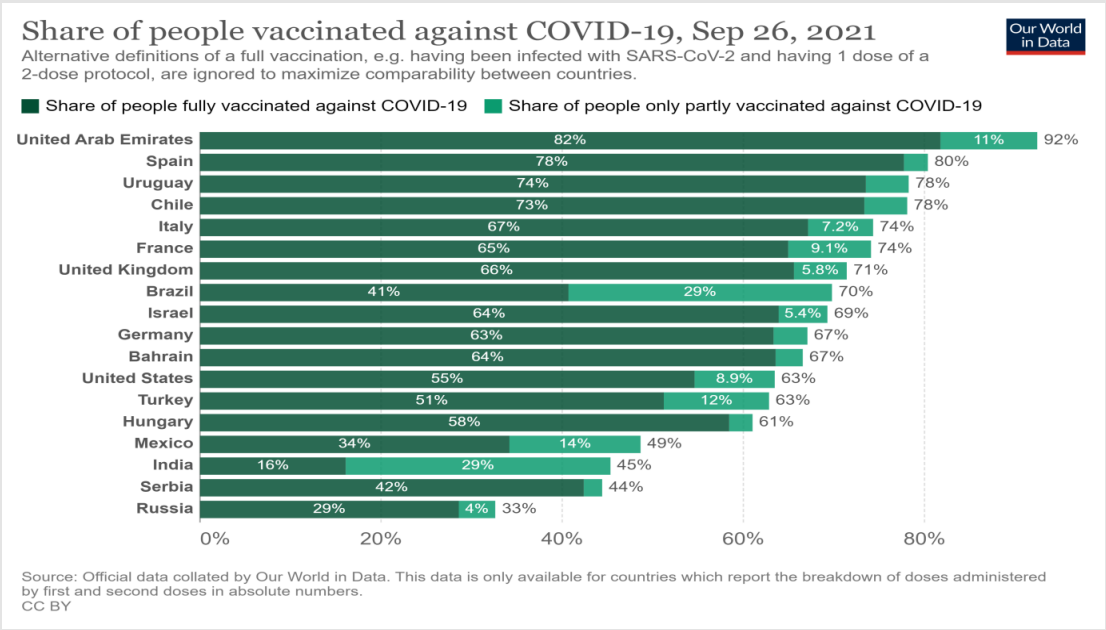


Figures for Israel are included as a key comparator for the UK and Europe as Israel has pursued a more aggressive vaccination strategy[10] as a substitute for other public health measures. These send a clear warning message to the UK if it thinks a vaccination strategy will be sufficient alone to manage the future months of the pandemic. The alarming graph for Covid cases is more muted in terms of deaths, but is not reassuring.

[10] https://www.theguardian.com/australia-news/2021/aug/24/why-is-covid-surging-in-highly-vaccinated-israel-and-what-can-australia-learn-from-it



Those that see in recent trends room for self-congratulation and complacency as winter approaches are running ahead of events and the facts. Europe continues to do better than the UK and the US and is now ahead of both in vaccinations.



3 Further reflections on vaccines

On one of my few forays into Nantes (for a celebratory meal at le Cigale) I was struck by the mixed messaging of a return to normal (the Nantes festival was in full swing with outdoor Opera, Roller Derby and an anti-Vaxx demonstration all taking place

in the Place Graslin simultaneously), strict controls (in my restaurant at least) and strident debate; but I have come across a few publications that make sense of this cacophony.

First I make no apologies for referring again to the book 'Pale Rider' by Laura Spinney[11]. This history of the Spanish Flu outbreak during and after the First World War makes it clear that the need for cures generates both partial and bogus solutions. Thus populations seized on and were sold all sorts of solutions that mostly were useless or of limited value. In turn this created both an ongoing market for self-cures, alternative medicine and natural remedies and a persistent distrust of vaccines that proved to be of little efficacy. This in turn has recently spawned another set of opportunists who see the potential for money-making.

The Anti Vaxx movement for example[12] has been whipped up by entrepreneurs tapping in to these long-standing controversies about vaccinations, their efficacy and side effects. But they are not entirely irrational as these references indicate[13]. Previously the UK's own Chief Medical Officer had drawn attention to the close run balance between the risks and rewards of vaccination for the young.

As the on-going debate about booster vaccines (to have or have not) shows, the need for balanced judgements and transparency about such decisions remains. In reading the Private Eye Compilation of 'Dr Hammonds Covid Casebook columns'[14] we are reminded that transparency remains something that does not come naturally to the UK government; or for that matter the EU decision-making structures[15].

4 Update on various European commentaries

Reuters reports that the UK is winning a place at the trough intended for the poorest nations[16]. This reflects badly on both COVAX and the UK.

The European Health Observatory is back from its summer holidays with a blockbuster edition of

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[11] https://www.amazon.co.uk/Pale-Rider-Spanish-Changed-World-ebook/dp/B01GH07CG6/ref=sr_1_3?dchild=1&keywords=pale+rider&qid=1632746746&sr=8-3

[12]The Anti-Vaxx Industry: How Big Tech powers and profits from vaccine misinformation https://252f2edd-1c8b-49f5-9bb2-cb57bb47e4ba.filesusr.com/ugd/f4d9b9_6910f8ab94a241cfa088953dd5e60968.pdf

[13] https://cancerres.aacrjournals.org/content/59/24/6103.long
https://www.jonathan-cook.net/blog/2021-09-18/debate-leaky-vaccines/

[14] https://www.amazon.co.uk/Hammonds-Covid-Casebook-PRIVATE-correspondent/dp/1901784711

[15]https://corporateeurope.org/en/2021/06/public-and-parliaments-kept-dark-eu-role-global-covid-patent-struggle

[16] https://www.reuters.com/business/healthcare-pharmaceuticals/global-vaccines-project-revamp-rules-after-britain-got-more-than-botswana-2021-09-27/

Eurohealth[17] devoted to governance of Covid management. It treads a fine line between stating the obvious and offending their funders but there is plenty here over 64 pages for study and reflection. The report concludes,

From the lessons learned through the WHO's work in the Region, it also becomes clear that universal health coverage is a precondition for the overall whole-of-society and whole-of-government preparedness. The pandemic has also amplified the need to take action to address the social and economic determinants of health and to develop pandemic preparedness and post-COVID recovery plans that link policy actions across sectors [see the article by Permanand and Azzopardi Muscat].

It is clear that effective governance strategies are fundamental for building health system resilience. The next emergency, whether it is the economic fall out of the pandemic, an environmental, cyber or refugee and migration crisis, or another virus, is just around the corner. We must not wait to prepare for it, but should rather draw on the lessons learned from this pandemic to help strengthen the governance of our health systems now to ensure better resilience and performance.

To those that point to Europe's relatively superior performance to the US, this salutary message is provided,

Written almost 25 years ago, the IOM (US Institute of Medicine) report expressed grave concern over the fact that: "… public health in the United States has been taken for granted, many public health issues have become inappropriately politicised, and public health responsibilities have become so fragmented that deliberate action is often difficult if not impossible". In looking at contemporary European responses to the COVID-19 pandemic, substitute 'Europe' in place of 'United States', or indeed any single European country, and it seems the reasons behind Europe's poor response and the solutions to them are encapsulated in that sentence.

Euronews is a useful source of keeping up with developments across Europe. Eggs are being thrown at Macron[18] and Grant Shapps is denying that there is a fuel shortage[19].

Politico reports on what the results of the German

[17] https://eurohealthobservatory.who.int/monitors/hsrm/

[18] https://www.euronews.com/2021/09/27/egg-thrown-at-french-president-emmanuel-macron-at-lyon-restaurant-trade-fair

[19] https://www.euronews.com/2021/09/27/uk-eases-competition-rules-for-fuel-industry-as-petrol-stations-run-dry

Elections may mean for EU health policy[20], suggesting there is hope for ending patent protection on vaccines together with a more euro-centric approach to pharmaceutical and medical supply lines.

The Lancet provides details of a study on the vaccination programme in Israel[21]. Good news overall but lots of loose ends on the durability of protection and new variants.

Medical News Today reports more fully on the early spread of Covid in 2019[22] and the intriguing question of whether it was circulating in Europe in 2019.

The BMJ reports on progress toward antiviral treatments for Covid[23]. It seems there is not much progress but research is not wasted.

The Kings Fund reports on the elective backlog[24] and tells us that this is weighted to the most deprived areas confirming the 'inverse care law'. No mention is made of whether this is a problem in Europe. The insularity of the Kings Fund knows no bounds.

Liberation[25] reports on the health budget deficit in France, which is 21.6bn euros apparently; but there is nothing to worry about as everyone knows the French Government will not cut spending with a presidential election looming.

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30.09.2021

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[20] https://www.politico.eu/article/germany-election-eu-health-policy/

[21] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00566-1/fulltext

[22] https://www.medicalnewstoday.com/articles/sars-cov-2s-spread-was-the-virus-circulating-in-europe-before-it-was-found-in-china#The-suggestion-of-earlier-circulation-is-not-far-fetched

[23] https://www.bmj.com/content/374/bmj.n2165

[24] https://www.kingsfund.org.uk/blog/2021/09/elective-backlog-deprivation-waiting-times

[25] https://www.liberation.fr/societe/sante/budget-de-la-secu-lexecutif-menage-la-branche-sante-20210924_DCJKRCOEFRGFFD47BDTOMGHG7M/