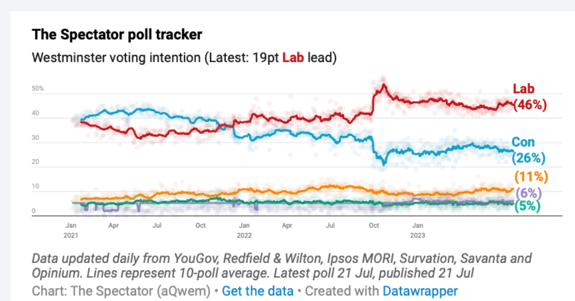
Alternative European Healthcare Perspective

August 2023, Roger Steer.

Political instability is sweeping across Europe. The Dutch Prime minister has resigned because of disagreements over immigration policies and announced his intention to retire from politics (there will be a caretaker government for a year before new elections). Frans Timmermans, the EU deputy President, is waiting in the wings.

A snap election was held in Spain resulting in a hung Parliament and the prospects of further elections. Macron in France has reshuffled his cabinet and replaced the Health Minister while planning his own new immigration policies. In Germany industrial production has collapsed but the political system cannot work out whether this is an opportunity or a threat (see article in Eurointelligence 19 July "Germany's toxic economic discourse". In the meantime Germany is planning to close many small hospitals with 20% deemed at risk.

In the UK the recent by-election results have confirmed the writing is on the wall for the Conservative government (and perhaps for Green policies as well).



All this spells trouble for the prospects for health and social care across Europe.

But as was identified last month all countries are not in the same place. These and other topics are discussed below.

France's new Health Minister

Macron has promoted eight new ministers noted for their closeness to Macronism. The new Health Minister means that Professor Braun can return to medicine having proved to be ineffectual (supposedly). The Times reported,

> *The health minister, François Braun, was replaced by Aurélien Rousseau, a former head of the Paris region health service who served until recently as Borne's (the French Prime Minister) chief of staff. Braun had made little impact handling troubles in the hospital system and hostility from medical professionals.*

Liberation was rather more forthcoming about the closeness of the Macron tribe and the significance of Rousseau's appointment.

And Ouest France discusses a 'very political family',

> *Aurélien Rousseau is married to Marguerite Cazeneuve, former advisor to Emmanuel Macron at the Élysée during the first five-year term and current deputy director (i.e. number 2) of the Health Insurance system.*
>
> *His family by marriage caught the political bug. There are two MPs. Aurélien Rousseau's father-in-law, Jean-René Cazeneuve, has been elected in the Gers since 2017. At the assembly, he held the strategic position of general rapporteur of the Finance Committee. While his brother-in-law, Pierre Cazeneuve, became deputy of Hauts-de-Seine last year, after having also*

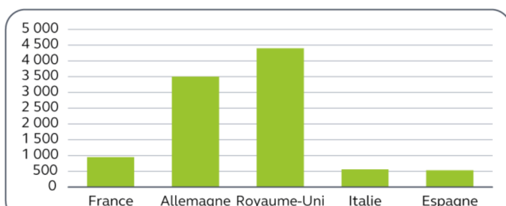
been an adviser to Emmanuel Macron at the Elysee.

Family ties already criticised by the opposition. "The Minister of Health is married to the director [deputy director in reality] of the CNAM [National Health Insurance Fund] whose father and brother are deputies. This reshuffle consecrates the monopolization of power by a small endogamous elite, "reacted for example on Twitter the deputy LR and Deputy Secretary General of the Republicans Pierre-Henri Dumont.

Not everyone is unhappy however as Rousseau, the new Minister, appears to have worked well with doctors in Paris during Covid when he was in charge of the Paris Regions healthcare system. Personally I am adverse to a man committed to *'in-depth transformations of the health system'.* Usually talk of transformation is a reliable indicator of talking too much to leading firms of management consultants.

The Cours des Comptes (the equivalent of the National Audit Office in France) are onto the issue however. There had been allegations that McKinsey worked for Macron's party free in return for favours; and more generally that the use of consultants was '*an expensive, easy way out for an administration with constrained means and deadlines*". The Cours des Comptes published its report on 10 July. The report however consoled the French Parliament with the fact that the problem was much greater in the UK and Germany and that spending had decreased since 2021.

Graphique n° 3 : dépenses de conseil du secteur public en 2021 (M€)



Source : Cour des comptes à partir des estimations de Syntec conseil, après consultation des structures homologues représentatives des entreprises de conseil

Nb The bars are the total level of spending in 2021 for management consultancy services provided for respective public sectors in selected European countries (Euros m).

As for Rousseau, I suspect it will not be too long before he finds another comfortable sinecure. It's not what you know but who you know.

The UK takes stock to mark 75th anniversary of the NHS

Amidst all the bogus self-congratulation at the survival of the NHS for 75 years I pick out two interventions.

Occasionally I watch Question Time, a popular BBC TV political programme. A week or two ago it was the 75th anniversary of the founding of the NHS and the BBC unfathomably invited Kate Andrews of the Spectator to provide balance by pointing out things people would rather not know.

> *The NHS is not the envy of the world, its performance lags other comparable countries in important respects, and respective governments have failed to do much about it, particularly in recent years.*

That Andrews is a hard and fast neo-liberal is well known but it was disappointing that fellow panel members did not put up a better defence.

The Labour Party representative was again vague, the Conservative willing to sacrifice patients to save tax payers, and the right-wing American was misleading about NHS spending and the reasons why the NHS performs poorly.

She was referring to recent NHS spending but included the extra c. £50bn wasted on PPE that wasn't and Test and Trace that didn't. She knows spending will fall back.

She also knows that the UK spends significantly less per capita than comparable Northern European nations. Southern Europeans benefit from sunshine and a better diet and because of the Catholic Church

exploit nurses and get away with it. But no one was able to put the finger on why the NHS performs less well than it should.

In my view the answer is:

1. Cash-limited budgets which provide perverse incentives to not provide healthcare: to delay, dilute and deny etc. in order to live within budgets. The thing about insurance funding is that it provides an incentive to providers as they get paid for activity. But you don't need an insurance system to introduce activity-based budgets.
2. HM Treasury control of capital expenditure on equipment and facilities, hospital capacity and doctor numbers trained. The comparison of healthcare systems presented by the Kings Fund last month demonstrates that NHS capacity has been deliberately capped by HM Treasury for decades. The results are inadequate facilities, beds, doctor numbers and staffing, diagnostic equipment etc. The dogs should be returned to their kennel.
3. The complicity of the medical profession to keep doctors in shortage in order to maintain demand for private care.
4. The timidity of politicians who, fearful of taxpayers, fail to acknowledge the need for defending the interests of the poor, sick, the very young and the very elderly: the predominant users of the NHS.

The solutions are therefore obvious and easily implemented.

The second intervention was a book review that appeared in the Times Literary Supplement of 9 July. The review in the TLS by Druin Burch, *Good in Parts*, considers *Fighting for Life* by Isabel Hardman; *Side Effect* by David Haslem; *What is a Doctor* by Phil Whitaker, and *Sick note* by Gareth Milward .

Burch is very critical of Whitaker for appearing to spurn the insights of modern medicine to instead hanker after a past era before effective management techniques were available. Burch by contrast sees the point of guidelines, early intervention, audit, targets and protocols. Haslem, an ex-Chair of NICE and the BMA, should have much to say but Burch pricks the potential by revealing that NICE spent most time reducing the use of drugs by those for which there remained a '*little doubt*' to '*beyond reasonable doubt*'.

Burch has a wider perspective and cites Milward's social history of the sick note as instructive of how the sick note has provided a bureaucratic solution to a problem: imperfect but effective. He has most time for Hardman however for what he describes as a '*chaotic and inconsistent history of modern British healthcare*' which is '*terrific, written with unfailing gusto and a joy to read*'.

Burch summarises ,

The NHS puts the government in a situation familiar to all parents: total responsibility and minimal control. The health service consumes over £200bn annually and employs two million staff, so government cannot sling off the need to exert influence. The danger, as each of these books makes clear is that attempts to influence slip too easily from demanding the reasonable but difficult, and into ordering the impossible. The latter creates a cadre of managers selected for their dishonesty in promising and pretending to deliver, the unachievable.

(Do I hear echoes of pretend and extend…? The description of the same phenomenon by an ex UK Director of Operation)

He goes on to criticise the American private system for over-treating, but also those who indulge in flag-waving when talking about the NHS. He sees that many other countries offer comprehensive healthcare without the complexities of the UK tax system and its bureaucracy. He obviously has never lived in France.

Why are doctors striking in France and the UK?

Industrial action by doctors (and other key workers) continues in France and the UK (and other countries

but it is extremely difficult to find details). Part of the problem is that within Europe freedom of movement makes it easier for professionals to arbitrage the system, or at least to indulge in comparisons of salaries. There is a surprising disparity of salaries. Not surprisingly UK doctors compare themselves to German and Dutch doctors rather than the French or Italian who appear to have widely differing salaries according to the linked charts.

There is every indication that unless ministers change their stance that these disputes will continue, waiting lists will rise and doctors' earnings will rise anyway. An astute minister would acknowledge the situation and respond accordingly. Unfortunately the UK has Stephen Barclay in charge of negotiations.

In France medical salaries lagged thanks to an element of oversupply of doctors in the past; but that was fixed by the medical profession with the numerus clausus which put a squeeze on numbers of doctors trained. They now recognise that they possess bargaining power. Don't be surprised if the French (and the UK) doctors' strikes persist.

Endocrine disrupting chemicals (EDCs)

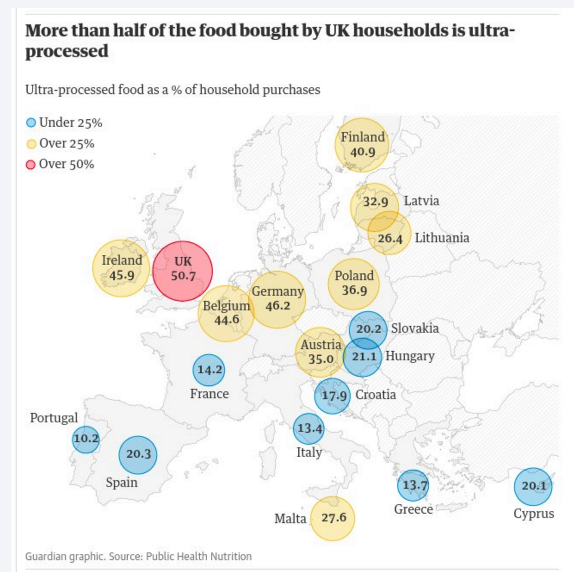
While parts of Europe are sweltering and burning, and preoccupied with the consequences of climate change, war and the potential for nuclear conflict, the Financial Times devoted a Big Read to the work of Shanna Swann in highlighting the dangers of EDCs found in many of today's plastic products. These dangers are not new and were the inspiration for Margaret Attwood's dystopian *The Handmaids Tale* . Sperm counts had decreased by 52% in 39 years, more couples are infertile and babies born have more abnormalities, resulting in more issues of gender assignment and coping with the issues this creates.

In a nutshell,

> *the innocuous products in your kitchen cupboard, bathroom cabinet or garden shed may be lowering sperm counts. They could also affect the reproductive systems of your unborn children. The implications of EDCs for human health don't stop there: they can disrupt thyroid function, trigger cancer and obesity*.

Other studies in the article point to *'the ultra-processed, high-fat western diet as the primary source of exposure to BPA and some phthalates'* further implicated in birth disorders.

Once again the UK seems particularly vulnerable:



Labour Party adds more content to its plans

More details have become available on Wes Streeting's Labour Party health policies in the form of a 23-page *Fit for the Future* health policy document. It is best read alongside the mission statement for public services. It's a hackneyed title and relies on regurgitated content based on faith in technology and prevention.

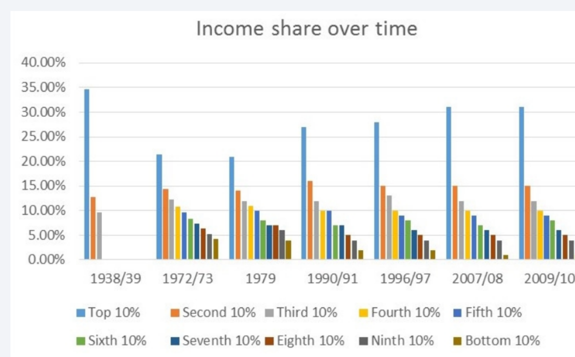
It reminds everyone that it will be subservient to Rachel Reeves iron grip on public finances. It will only excite those who see something in it for themselves: more for prevention, more for the private sector, more staff, more for the big pharma/ big tech industries.

Everyone is invited to comment. I suggest you take the opportunity but before you do, read **Durchin's *End Times***. As indicated in my introduction political turmoil seems to be rising everywhere. Although it is instructive to contrast and compare policies across

countries occasionally books and ideas come along that attempt to make more sense of seemingly chaotic events. This is one of them. Significantly it identifies health statistics as flagging key variables when examining the risk of turmoil. The main thesis is that the degree of immiseration amongst sections of the population and oversupply amongst the elites within society are identified as key factors in turmoil.

The book purports to have studied data accumulated on historical trends across centuries and across many countries. The author's credibility comes from having made predictions of the future that have come true. He also holds senior academic posts in several leading universities.

Thus when mortality rates start to increase, life spans shorten, and average heights reduce, he argues that alerts need to be raised on the risks of political turmoil to come. This chart identifies how the share of UK income accruing to the bottom 60% has been reducing since the seventies, more so for the bottom 30%.



Source: Equality Trust

The consequences are now showing up in mortality figures and average lifespans in the UK. The other side of the story is the increased number of potential holders of elite positions scrambling to get to the top. I haven't yet finished the book. I'll keep you posted.

Roundup of articles relating to healthcare across Europe

The European Health Observatory provided in July a review of the French healthcare system. Its overview includes,

The French health system is structurally based on a social health insurance approach, but it also shares National Health System goals reflected in the single public payer model, the importance of tax-based revenue for financing healthcare, strong state intervention and residency-based benefits. The Statutory Health Insurance currently covers almost 100% of the resident population under various schemes, but cost-sharing is required for all essential services. Coverage is also available to undocumented migrants under certain conditions.

While the number of most health workers has increased in the past decade, the number of general practitioners per capita in France has decreased, and this trend is expected to continue in the next years. Continued challenges in France include ensuring the sustainability of the health workforce, particularly to secure adequate numbers of health professionals in medically underserved areas, such as rural and less affluent communities, and improving working conditions, remuneration and career prospects, especially for nurses, to support retention. However, this is a slow process and progress has been incremental.

The national government has been playing an increasingly important role in managing health expenditure since 2010 through the introduction of spending targets and monitoring mechanisms for health insurance, reducing the initial independence of the Statutory Health Insurance in managing health expenditure. To ensure financial sustainability, sources of health funding have been extended beyond payroll contributions in the past decades to include a broader range of sources of income, including financial assets and

investments with a range of earmarked and value-added taxes.

As with many other health systems in Europe, the Covid-19 pandemic has brought to light some structural weaknesses within the French health system, but it has also provided opportunities for improving its sustainability. There has been a notable shift in the will to give more room to decision-making at the local level involving healthcare professionals and to find new ways of funding healthcare providers to encourage care coordination and integration. Future reforms target improving access to care and prevention as well as continuing the reform of primary care and provider payment to improve the equity in access and efficiency. Future challenges for the health system also include improving data availability for quality monitoring and regular evaluation of health system performance.

The Observatory also reports the Spanish election has blocked changes to co-payments in the Spanish Health Service. Further links are included in the article for those interested in the Spanish system.

The Health Foundation provides a useful evidence hub for sources of information on trends in factors contributing to health inequality:

Findings include

Money and resources: people on the lowest incomes (the bottom 40% of the income distribution) are more than twice as likely to say they have poor health than people on the highest incomes (the top 20%), and more than 5 times as likely to say they have bad or very bad health. Poverty in particular is associated with worse health, especially persistent poverty.

Employment: employment, or the lack of it, can have considerable influence on health and wellbeing. Poor health can limit people's ability to have and sustain work. The nature of people's work matters for health, but also impacts other factors that influence health, such as having sufficient income and forming social connections.

Housing: housing affordability matters for our health. Difficulty paying the rent or mortgage can cause stress, affecting our mental health, while spending a high proportion of our income on housing leaves less for other essentials that influence health, such as food and social participation. People on the lowest incomes are hit particularly hard – 26% of households on the lowest incomes spent more than a third of their income on housing costs in 2019/20, compared with only 3% on the highest incomes. Ending the freeze on housing benefit and increasing support would help people who rent their homes to meet their housing costs. Alongside this financial support, there needs to be an increase in the proportion of social homes and new affordable homes for the future.

Transport: increasing physical activity and minimising time spent sitting down helps to maintain a healthy weight and reduces the risk of cardiovascular disease, type 2 diabetes, cancer and depression. The NHS recommends that adults should do at least 150 minutes of moderate activity, or 75 minutes of vigorous activity, each week. Walking and cycling as part of one's travel routine – whether for an entire journey or to access public transport – can help meet these targets. There will be little benefit, however, if this means of exercise merely displaces the time for physical activity, or if the activity is not prolonged or intense enough to affect health outcomes.

It would be even more useful if the Health Foundation compared this wealth of statistics across European countries. **The Covid inquiry** has already

started this process and it tells a revealing story of huge differences in funding per head between the UK compared to France and Germany (not that readers of this newsletter need reminding).

An article in Nature on how the forthcoming Genomics revolution is being managed in different countries across Europe is worth a read. The article reveals tensions between the different approaches centred on managing the expectations of patients about what is legitimate to expect in terms of what use is made of the data. There is much dancing around the real issue that the value of data is in being able to target individuals for commercial marketing.

The American Journal of Economics and Sociology in its June 2023 edition reports that tax-funded primary care out-performs private models in the treatment of non-communicable diseases. Better quality is delivered and less admissions to hospital result. The conclusions are based on a very large study across 26 European nations.

A Nature scientific report Using Artificial intelligence to identify Subjective well-being factors (SWB)[1] across 17 European countries and Israel confirms that despite less sunshine Northern European countries people are happier.

This is attributed to levels of basic services, economic well-being, and better social cohesion and relationships. Avoiding loneliness is the biggest predictor of well-being.

If ever there was an excuse to go meet your mates in the pub this is it.

Cheers!

[1] Vera Cruz, G., Maurice, T., Moore, P., & Rohrbeck, C. (2023). Using artificial intelligence to identify the top 50 independent predictors of subjective well-being in a multinational sample of 37,991 older European & Israeli adults. Nature Scientific Reports, 13”