Alternative European Healthcare Perspective

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Following a request from a reader for a copy of the archive of previous monthly newsletters it seems only reasonable, after making the effort to compile the archive, to make it available to other people as a resource.

It is here…

… it prompts the question: after three years of producing these newsletters have we learnt anything? If so, can it be expressed in a relatively concise and digestible way?

That therefore, is the task undertaken this month. At the end I also present the usual highlights of articles drawn from across Europe.

It was Covid that triggered this newsletter. There had to be a better way than the seemingly inept responses of the Johnson Government; that is, compared to the more businesslike approach of Macron in France.

There had to be ways of ensuring better resilience and governance of the UK health system compared to other countries in Europe.

Once you start unpicking the thread of why the UK is different it leads in unexpected directions and to darker places that you had suspected but had not sought out before.

What did we discover?

What have we learnt?

It is more than the width of the Channel that divides us from other European countries and the EU.

There is a different mindset, a different set of values, legal frameworks and gut instincts that gives us the differences in healthcare systems today.

It does not have to be this way. We all bleed when pricked and medical science is not a nationalistic enterprise but a human enterprise.

There should be common scientific approaches available that would represent the most economical and effective way of making improvements and progress rather than continuing to bathe in the illusion that the UK leads, or is the envy of, the world.

Or that the UK uniquely amongst leading nations cannot afford better health and social care and has nothing to learn from other European nations.

I was encouraged in adopting a cross-country perspective by Thomas Piketty who in his book, Capital and Ideology, identifies and dissects the various ideologies and discourses that compete to justify the current state of the world.

In this way he had claimed in his 2020 book we are better able to understand the weaknesses of the stories being told to us and to construct alternatives.

However, what emerged was that the UK has recently been going out of its way to ally itself with the US in hostility to multilateral co-operation (WHO, UN, WTO, EU); whereby any different approach from the US/UK nationalistic response is identified as a threat.

Thus, attempts during Covid to organise joint procurement of PPE and vaccines and to internationalise and defeat patent laws that would undermine efforts to manufacture and distribute sufficient vaccines for the world were baulked by first the US and the UK but then France and Germany who saw vaccine production and pharmaceutical patent protection as key to their own economic models.

The UK has looked to US models for the development of its own healthcare systems rather than to any of the various European models available to it; and the EU direction of travel towards a European Health Union with common healthcare strategies is clearly out of the question. This odd choice exists despite the failure of managed care and accountable care systems in the US to provide either an efficient or effective healthcare system in the US itself. Why this outcome should be different in the UK, or in other countries where it is being promoted is never made clear.

What are the consequences of a US-centric focus in the UK?

Again this is never made explicit and would be denied if challenged, but it can be argued strongly that it contains the implicit acceptance of privatised healthcare as legitimate; that private provision and management is superior in efficiency and customer satisfaction; and that models based in the US (managed care, accountable care etc) of a commodified healthcare market set to be dominated by large private organisations is the way forward rather than a model based on a 'Social Europe' sensibility.

There is a marked reluctance in the UK and in Europe to recognise the Americanisation of healthcare.

Rather, throughout Europe, health and social care are still seen as national responsibilities with the role for each country to determine the healthcare systems and policies in operation within national territories as an aspect of devolved responsibility and national sovereignty.

This despite policies of harmonisation and convergence marked by plans for a European Health Union and for global health strategies.

No such reluctance applies to the American-dominated World Economic Forum (Davos) and the output from the world's largest consultancies: Mckinseys; Bain; PWC; KPMG; etc. who all see the global healthcare market as an entity driven by common approaches, which in a nutshell can be described as access regulated by membership of a funded insurance contract scheme; personalised medicine; and, digital transformation.

I am clarifying this at the outset as it can guide readers in determining the key differences in approach that divides European nations currently.

How does this affect the UK?

In the UK hitherto access was provided to all citizens who were entitled as a right to register with their GP to gain access to healthcare. The UK is now moving away from such a system to one where membership of the 'scheme' depends on proof of right of residency and potentially a national insurance payments record.

This moves the UK closer to the social insurance and private insurance models used in many European countries. It makes life more difficult for immigrants and is a key element of the 'hostile environment' policies adopted by

successive Home Secretaries since Theresa May. But it marks a move away from a socially liberal approach of treating all citizens alike, free of the need to present ID credentials etc in order to get access to care.

Similarly in the UK access to healthcare was nominally open to all, only regulated by the GP, acting as gatekeeper to the rest of the NHS.

Rationing was by waiting list rather than ability to pay.

In Europe there are complicated pricing and access rules meaning the payment of personal contributions is necessary, either out of pocket or via contributions to additional insurance schemes on top of state-sponsored schemes for most major life-threatening conditions.

Paradoxically the UK has a relatively high current out-of-pocket payments rate for healthcare as a result of high prescription charges and the rise in pay-as-you-go schemes for access to private healthcare (in order to avoid rising NHS waiting lists).

The promotion of personalised medicine therefore is a euphemism for the requirement for individuals to make personal contributions for access to healthcare and for targeted marketing direct to the consumer rather than via GPs or hospital doctors.

Digital transformation is linked to this latter development.

Traditionally in the UK, access to healthcare has been negotiated via medical professionals, via the GP; in Europe direct access has been possible to specialists.

Professionals would be directly employed by clinical centres (hospitals); these in turn are managed on a geographic basis.

Digital transformation threatens this by creating a financial intermediary, aided by digital technology, responsible for administering the membership scheme; negotiating contracts with suppliers and directing flows of patients to where the intermediary chooses.

This is the essence of accountable care devised by the American HMOs (health maintenance organisations)/managed care organisations. It promises more scientific management but in practice it has consolidated an expensive and inequitable system, rationed by price. In the UK the links to accountable care have been disguised by referring to integrated care; so far in Europe progress in developing the role of the intermediary has been limited to isolated experiments where the positive outcomes are disputed.

For those that think it an unrealistic fear, the privatisation of the NHS was a topic of conversation between President Trump and Boris Johnson according to the recent biography of Johnson.

While Johnson is now outside of public life the threat of a return to a Trump presidency has not disappeared.

What have also increased are the negative noises around the NHS and the plethora of organisations promoting a rethink: Reform, The Royal Scottish Geographical Society, LSE/Lancet Commission, The Times Health Commission, are only a few of the organisations pushing for radical reform, a call reinforced by Wes Streeting the Labour Party health spokesperson.

With this in mind therefore I offer up what has struck me in highlighting data, information, graphs and reports on health and social care across Europe over the last three years:

Comparing the UK with its neighbours

The UK compares poorly not only in terms of inputs devoted to health and social care (budgets, staff, beds, diagnostic facilities and equipment, investment , IT) but , not surprisingly:

- in performance (waiting times, access, emergency care, cancer treatment, social care provision);
- in outputs (life expectancy, years of good health),
- in public health (living conditions, morbidity, environmental hazards),
- in quality of life (self-reported, rates of mental illness, leisure time, childcare facilities, etc).

Despite claims of improvement (in absolute terms), in relative terms compared to the richer European nations the UK continues to lag, and to lag badly.

I refer you to my previous newsletters for the chapter and verse but take it from me and the host of others who point this out on a regular basis, it is true. The NHS is certainly **not the envy of the world**.

Reasons for the lack of response from the UK Government

The Government blames the NHS itself. It constantly cites the extra money provided, the problems with mismanagement, declining NHS productivity (this is recent mind, NHS productivity had been better than the UK average for a long time). Commentators call for the NHS to fix itself before it gets any more money.

The view is often expressed that the NHS is unsustainable, unaffordable and out of date in a more consumer-orientated society, used to the principle that you get what you pay for and can afford.

In looking at the evidence for this however experts agree that the provision of high-quality healthcare for all is deliverable, desirable and affordable.

As Covid demonstrated, when push comes to shove, resources can be found.

Other countries manage the task with only modest increases in expenditure, and achieve better provision and better outcomes and performance.

The UK Government however avoids comparisons with other governments and instead is prone to Anglo-Saxon exceptionalism or a God-given sense of a unique mission for the US, UK and the five eyes (the members of the Anglosphere intelligence community).

How does the UK Government get away with it?

It seems it is not just the Government suffering from insularity, groupthink and immodesty.

Often the UK's own healthcare think-tanks do not draw upon international perspectives in their reports.

For example, a recent report on dentistry looked only at dentistry in the UK rather than across Europe.

Similarly, the media are not used to presenting Europe in a better light than the UK, have not explored in depth the obviously poorer performance of health services in the UK, and where they have, have tended to side with those that attribute this to the NHS itself rather than government.

In addition, many champions of the NHS and its supporters are reluctant to admit its failings and thus increase the pressure on the current Government to act.

There is a tendency to wait for the next Labour Government's time in office rather than press for immediate improvement.

However, Labour in opposition does not seem to be prioritising health and social care.

Instead, the economy is being prioritised above all else. Increasingly Labour ministers in waiting are repeating the lines of current Conservative ministers concerning affordability, prioritisation of the economy and the prior needs of taxpayers.

Pressure from independent regulators, supposedly installed to ensure improvement and that standards are kept, has been easily swatted aside on the grounds of affordability.

Regulators are denied intervention powers and increasingly are being muzzled. (see the discussion in my March 2024 newsletter).

The courts, only too aware of the cases identifying negligence and poor care, are biased in favour of attributing blame to individuals rather than systems.

Senior figures in the medical profession have a conflict of interest in that most benefit from the failures of the NHS.

Historically they opposed the formation of the NHS and have ensured that the numbers of doctors in training are insufficient to improve the NHS.

This is also an issue in other European countries (see the discussion on Numerus Clausus in my August 2022 newsletter).

In the end it seems the UK is a victim of its own history and values.

It is a society based on preserving privilege, that unlike the France does not promote equality in its national story and has not suffered civil wars in living memory with the consequences of savage suppression of minorities and political representatives of the poorer classes (the consequence being that European elites are more nervous of unleashing reckless political forces with legitimate grievances).

UK elites have not suffered from recent political turmoil in the same way therefore; they have managed to preserve their dominance of wealth and land ownership, access to privileged education and disproportionate political influence via control of Parliament, Civil Service, the armed forces, the judiciary and the media.

The net result is the inequity we see in health and social care compared to Europe, a legacy of the Poor Law in the UK, and of continual efforts to identify the undeserving poor to excuse therefore poor provision and lack of access.

Round-up of stories from across Europe

The European Health Observatory reviews the Belgian Healthcare system. It reveals,

> *Compulsory social health insurance covers most Belgian residents (99%), who are affiliated to a sickness fund of their choice or to the public auxiliary fund. T*
>
> *he provision of care is based on the principles of independent medical practice, direct access (no gatekeeping), free choice of physician and of health care facility, and predominantly fee-for-service payment.*

Current health expenditure per capita in Belgium in 2021 was 11.0% of GDP. Public expenditure on health was 77.6%, while out-of-pocket payments and voluntary health insurance were 17.9% and 4.5%, respectively.

The Observatory also advertises its Summer School in Venice 'Navigating the health workforce crisis: health care innovations and transformation'. It is open to UK applicants. I wonder how many NHS applicants there will be. Will anyone from NHS England be going?

Euronews features a scandal that Nestlé puts more sugar in its baby products sold to low income countries. The article explains that not all babies are equal.

Worldwide obesity has more than doubled since 1990. Within that same time frame, the percentage of obese children and adolescents has multiplied four-fold, reaching 8 per cent of 5-19 year-olds. Once associated with high-income countries, obesity has now become an issue in low and middle-income countries.

"The reason why European products don't have added sugar, isn't because there are tougher legislations," Laurent Gaberell, Agriculture and Food Expert at Public Eye told Euronews Health.

"It's because Nestlé decided not to add sugar in its baby food in European markets. The company knows what consumers here expect".

Euronews also report that sugary drinks increase the risk of cancer by 18%. However '*the scientists tempered their findings by highlighting the study was "observational" and that although the results had also taken into account sociodemographic factors — age, gender, education — as well as lifestyle choices such as whether the participants smoked or exercised, further research is needed to properly establish a causal link.*'

Nestlé are let off the hook again.

The **EUobserver** reveals that EU schemes allowing young UK people better access to Europe is going nowhere in the face of stiff resistance form the UK Government, which is probably worried about young people not coming back, thereby contributing to the healthcare drain. The UK is now getting a taste of the medicine it has been dishing out to other countries with the UK filling a very large percentage (one in five according to the Guardian) of its NHS vacancies with immigrants and now facing the prospect of many UK trained staff emigrating for better prospects overseas.

The **EUobserver** also reports on the Nuffield Trust report on increased drug shortages in the UK as a direct result of Brexit.

Copilot, the latest updated Microsoft AI assistant, discusses the costs and benefits of Brexit and provides this analysis:

"Since the UK left the EU, businesses have faced challenges related to trade. New customs procedures, paperwork, and delays at borders have affected both imports and exports.. Customers also face additional costs, including VAT on delivery, which makes accessing EU markets less attractive for some businesses. In addition, post-Brexit devaluation of the pound has led to higher import costs. Finally, according to a report by Cambridge Econometrics, Britain's economy is around 6% smaller than it would have been if the UK had remained in the EU. The overall cost of leaving the EU is estimated to reach £311 billion by 2035.

Supporters of Brexit still argue that leaving the EU allows the UK to regain control over its laws, borders, and regulations, and that the UK now has the flexibility to negotiate its own trade deals with countries outside the EU; that Brexit provides an opportunity for the UK to shape its own policies independently. "

Copilot concludes that Brexit has had both costs and benefits; that businesses and individuals continue to adapt to the new landscape, that the long-term impact remains an ongoing area of study

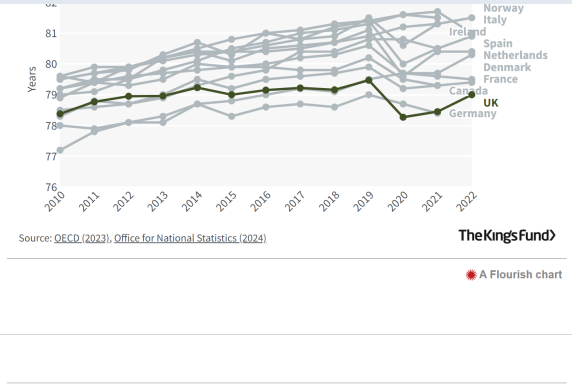
Tell that to the people running out of drugs.

The Health Foundation reports on levels of English health inequality projected to 2040. As I keep saying, I would be grateful if the Health Foundation could provide an international perspective on such matters: it would add a great deal. As it is the reader has no idea whether English levels of inequality are good or bad or getting better or worse compared to European neighbours: surely a pertinent question.

The Kings Fund report on changing life expectancy in the UK is a model of how to present international comparisons.

This is the picture of changing men's life expectancy:

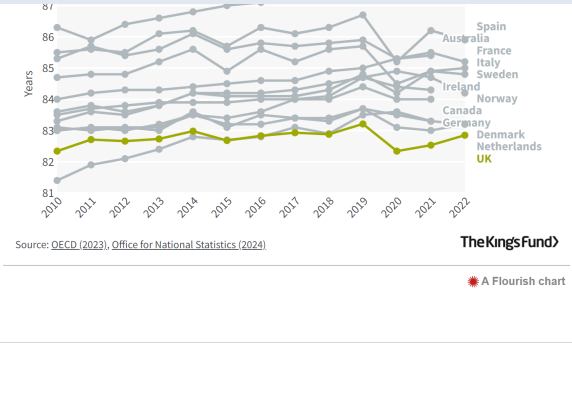
How does the UK compare with other European countries? : Men



I don't know whether we should be pleased or not that UK life expectancy is now improving again after Covid: it has a way to go to match European levels.

In passing we should note that levels in Germany are depressed because of the unification of West and East Germany.Or that the deficit in men's life expectancy is less than for women. This is the picture of changing life expectancy for women:

How does the UK compare with other European countries?: Women



I cannot argue with the Kings Fund conclusions, which are as a clear a reflection of years of government failure to take care of the health and wellbeing of its own population as there is:

> *The fall in life expectancy in England resulting from the Covid-19 pandemic was unprecedented in recent decades, and life expectancy has not yet recovered to pre-pandemic levels.*
>
> *Future improvements in life expectancy depend on many factors. However, the outlook for England is not promising given the deterioration in population health. The poor health of children, the huge and growing backlog of unmet health care needs (pre-dating the pandemic but exacerbated by it), the almost 3 million – and rising – working-age adults unable to work because of long-term sickness, the persistent constraints on NHS capacity and widening health inequalities illustrate the scale of the challenges that need to be addressed. Added to these are the unpredictable risks of, for example, periodic resurgences in Covid-19, flu or other viral infections, and extreme climate change events such as the heatwaves in 2022.*
>
> *Life expectancy in the UK compared poorly with most comparator countries before the Covid-19 pandemic; higher excess mortality during the pandemic has resulted in the UK's further downward slide in international life expectancy tables, with female life expectancy now the lowest among comparator countries (with the exception of the US).Meaningful long-term gains in reducing health inequalities and improving population health and the UK's life expectancy relative to comparator countries have never been more urgent and yet also more challenging."*

At least the UK is faring better than the USA…