Alternative European Healthcare Perspective

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February 2024

2024 has arrived with a bang. In France a new Prime Minister and Health Minister were appointed on 11 January. The new French Health Minister is Catherine Vautrin, an experienced right-wing politician who worked for the Cigna Group in France/Europe, a private health insurance provider. Only a relatively bland case of corruption blots her copybook (taking a benign view). She was the Treasurer of President Sarkozy's re-election slush-fund and was indicted before charges were dropped.

In the UK the new Health Minister, Victoria Atkins, has failed to solve the junior doctors pay dispute, the consultants are threatening to continue their own dispute, and there is as yet no coherent plan to address an overheating system now running at over 95% capacity, facing widespread financial deficits, staff shortages and serial blockages…

… not least on new capital projects rendered uneconomic and unaffordable by price increases and the untenability of continuing to plan for further bed reductions as the 'saving ' assumed to balance the books.

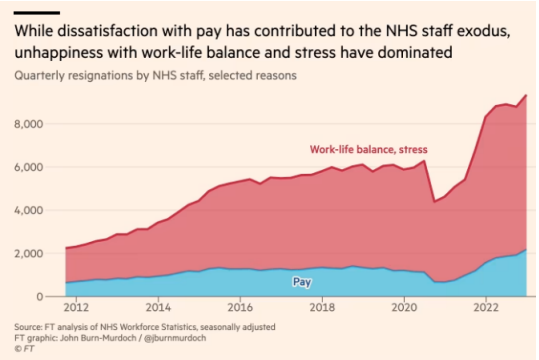
The French population is revolting against issues in agriculture. Farmers were blockading Paris as I write, and bonfires were set alight at strategic roundabouts locally in the Vendee. The reason for the protest is the impact of Ukrainian wheat imports on the EU grain market and the collapse in French farmers income.

The new 34 year old Prime Minister faces a baptism of fire (literally) but if nothing else he is good at facing the press and saying all the right things. He has been handpicked by Macron in an effort to rejuvenate the failing efforts of Macron to deliver on his vague promises. If the experience in other European countries is any guide however he will find his work cut out. Eurointelligence gives good coverage of the major political winds blowing across Europe.

These include the rise of right-wing populist nationalism; the collapse of the German economic model and thus the reduction of strength of the motor driving European integration; the fostering of further anti EU sentiments and thus a reduction of the pressure to improve equality and the social wage across Europe.

This all paints a bleak backdrop for the discussion of European healthcare issues.

It's not just about pay by the way as the FT pointed out in 2023.



Work-life balance and stress have dominated pay as the issue leading to NHS staff exodus.

This month I discuss the statement from Hans Kluge, the Director of the WHO European Region, on the effectiveness of vaccines, and the latest trends and issues

across Europe. In this context I also discuss the latest edition of the Annual Report of the DHSC for 2022/23; and contrast this with the latest annual report from France.

As usual, I draw attention to a miscellany of reports and issues that have taken my eye in the last month; notably from another recent visit to the UK where it appears the battle to prevent ill health is facing an uphill battle.

The effectiveness of vaccines

The European Regional Director of the WHO, Hans Kluge, highlights the success of European co-ordinated action on Covid to provide vaccines and support, and claims a saving of 1.4 million lives across Europe.

He claims, the European Region's cumulative death toll could have been around 4 million, Overall, COVID-19 vaccines reduced death by 57% across the WHO European Region, between December 2020, when the vaccine rollouts began, and March 2023.

He goes on however to discuss the circulation of respiratory viruses more generally. Thus,

> *WHO's recommendation is for persons at highest risk from COVID-19 to continue to be re-vaccinated 6 to 12 months after their most recent dose. This includes the elderly, pregnant women, the immunocompromised and those with significant chronic medical conditions, and frontline health workers.*
>
> *Besides COVID-19, the European Region is seeing widespread circulation of respiratory viruses like influenza, respiratory syncytial virus (RSV) and measles.*
>
> *When looking overall at the Region, we can see that RSV rates peaked before the new year and are now declining, COVID-19 rates remain elevated but are decreasing, and influenza rates are now rapidly increasing.*
>
> *As we speak, we are seeing a high intensity of influenza infections in several countries across the Region. Health systems should be ready to see a likely surge in influenza cases over the coming weeks. Across the Region, the past 2 weeks have seen a 58% increase in reported hospitalisations for influenza, and a 21% increase in intensive care admissions, compared to the previous 2 weeks. Influenza cases increased 4-fold between November and December, with 38 countries in our region reporting the start of the seasonal influenza epidemic.*

Kluge also warns against complacency when it comes to Covid. Thus,

> *Also, while COVID-19 infection rates are broadly decreasing across our region, this can rapidly change. A new SARS-CoV-2 variant of interest – known as JN.1 – is fast replacing other known variants. It's now the most common variant being reported globally and is the dominant variant circulating in our region, accounting for 79% of sequenced variants.*
>
> *Though there's no current evidence to suggest the JN.1 variant is more severe, the unpredictable nature of this virus shows how vital it is that countries continue to monitor for any new variants.*
>
> *Many countries have reduced or stopped reporting on COVID-19 to WHO. I cannot stress enough how important continued COVID-19*

surveillance is, alongside other circulating respiratory viruses.

The UK of course, in its efforts to justify Brexit, denies that European coordination need play a role; that ongoing vaccination continues to be necessary or important; or that there is any threat requiring continuing vigilance and preparation.

This seems to be the wrong lesson to have learnt from the Covid Inquiry to date.

Kluge's final words sum up the feeling of many of us,

As we put a difficult 2023 behind us and look forward to 2024, I am deeply concerned that health is slipping from the political agenda and that we are failing to address the ticking time bomb facing our health and care workforce.

As health systems come under strain, we are reminded that we may be unprepared for anything out of the ordinary, such as the emergence of a new, more severe COVID-19 variant or a yet unknown pathogen.

I ask policy-makers and health-care leaders to show demonstrable support for the health workforce; not with words but with action.

A comparison of French and UK health expenditure

In this section I use the DHSC Annual report 2022/23 and the French equivalent for 2022 to consider health expenditure across the two countries.

By the way, for those who do not read French, there are translation facilities on the web.

The French report provides an international perspective which clearly explains the blip in expenditure in 2021 and 2022; and compares to other countries in Europe as well as in other countries around the world, including the USA and Japan.

The report on France's health expenditure is produced by an independent body whereas the English version is produced by the DHSC as part of the parliamentary accountability process. The French report contains this table showing how Covid impacted expenditure increases across a range of countries. It shows that the COVID shock to health finances was much greater in the United Kingdon (Royaume-Uni) at 15.1% than in France at 3.4% or Germany (6.2%). In Japan expenditure actually fell in 2020 (-3.1%). We have Matt Hancock (and Baroness Mone) to thank for that.

See link https://data.drees.solidarites-sante.gouv.fr/explore/dataset/306_les-comptes-de-la-sante/information/

Graphique 1. Évolution de la DCSi en valeur

En %

Pays	Évolution en 2020	Évolution en 2021	Évolution en 2022	Évolution moyenne entre 2010 et 2019
Pologne	2.7	11.8	21.3	5.3
Lettonie	8.1	38.5	13.7	7.0
Lituanie	9.0	17.8	13.5	6.7
Hongrie	17.8	15.5	10.1	4.3
Belgique	-0.4	7.8	8.3	3.8
Pays-Bas	8.4	8.9	7.9	2.7
Norvège	3.7	7.3	7.3	5.6
Grèce	4.6	6.0	7.2	-3.9
Espagne	5.5	7.9	7.1	1.7
Slovaquie	1.9	16.8	6.7	2.4
Islande	10.8	8.0	6.6	3.5
Portugal	3.7	13.1	6.3	1.4
Tchéquie	19.5	10.2	6.2	4.2
Estonie	10.0	13.5	5.9	7.7
Finlande	4.2	12.0	5.7	2.8
Slovénie	7.3	11.9	5.3	3.2
Allemagne	6.2	7.8	5.0	4.1
Etats-Unis	10.9	2.5	4.6	4.3
Luxembourg	8.6	10.6	4.0	2.1
Autriche	4.2	13.2	3.4	3.6
Japon	-3.1	4.6	3.1	3.3
Suède	4.4	7.6	2.9	7.0
Italie	2.8	4.9	2.4	0.9
France	3.4	9.9	2.0	2.1
Suisse	2.8	5.9	1.3	2.8
Royaume-Uni	15.1	9.4	0.7	3.7
Canada	13.1	7.5	0.4	4.1
Danemark	4.6	10.4	-2.0	2.3
Chypre	12.4	23.0		2.9
Croatie	4.6	20.9		0.6
Bulgarie	19.7	18.4		5.4
Roumanie	9.3	15.8		8.0
Malte	9.1			10.2

Lecture > En France, la DCSi en valeur augmente de 9,9 % en 2021 et de 2,0 % en 2022. Elle avait augmenté en moyenne de 2,1 % par an entre 2010 et 2019.
Sources > DREES, comptes de la santé (pour la France) ; OCDE, Eurostat, OMS, Système international des comptes de la santé (SHA).

The DHSC annual report is 340 pages in length and is clearly not intended to be read .

The attention span of most journalists being that of a gnat, the DHSC has got away with it as far as I can tell. On the other hand, the French expenditure report alone is 275 pages but there is an 18 page overview.

Tableau 1 Consommation de soins et de biens médicaux (CSBM) et dépense courante de santé au sens international (DCSi) par poste

Montants en milliards d'euros

	2019	2020	2021	2022	Évolution 2021/2022 (en %)	Contribution à la croissance de la CSBM (en pp)
Soins hospitaliers	97,2	103,3	110,2	114,9	4,3	2,1
Hôpitaux du secteur public	74,5	79,8	84,9	88,7	4,5	1,7
Hôpitaux du secteur privé	22,7	23,5	25,2	26,2	3,6	0,4
Soins ambulatoires	109,9	107,2	116,8	120,9	3,6	1,8
Soins de ville[2]	56,6	54,8	60,3	62,2	3,1	0,8
Soins de médecins et de sages-femmes	23,7	23,0	24,6	25,6	4,1	0,4
Soins d'auxiliaires médicaux	15,9	15,7	17,3	17,8	3,0	0,2
Soins de dentistes	12,0	11,4	13,5	13,8	2,6	0,2
Laboratoires d'analyses	4,5	4,5	4,7	4,6	-1,6	0,0
Cures thermales	0,4	0,1	0,2	0,3	34,7	0,0
Médicaments	30,7	29,8	31,1	32,8	5,3	0,7
Biens médicaux[2]	17,6	17,8	19,8	20,0	1,0	0,1
Transports sanitaires	5,1	4,7	5,6	6,0	7,7	0,2
Consommation de soins et de biens médicaux (CSBM)	207,1	210,4	226,9	235,8	3,9	3,9
Part en % du PIB	8,5	9,1	9,1	8,9		
Dépenses hors CSBM	63,4	69,4	80,6	77,8	-3,5	
Soins de longue durée	42,7	45,5	47,7	49,5	3,8	
Soins de prévention	5,5	8,7	17,5	12,7	-27,9	
Gouvernance	15,2	15,2	15,4	15,7	1,7	
Dépense courante de santé au sens international (DCSi)	270,6	279,8	307,6	313,6	2,0	
Part en % du PIB	11,1	12,1	12,3	11,9		

pp : point de pourcentage.
1. Dans les comptes de la santé, les soins de ville ne comprennent ni les honoraires en clinique privée, ni les dépenses de médicaments et biens médicaux et de transports sanitaires habituellement inclus dans le périmètre des soins de ville des régimes d'assurance maladie.
2. Optique, orthèses, prothèses, audioprothèses, véhicules pour personnes handicapées physiques (VHP), aliments diététiques, masques FFP2 et chirurgicaux, matériels et pansements.
Source > DREES, comptes de la santé.

Annex A – Regulatory Reporting – Government Core Tables

The figures in **Core Tables 1** and **2** are from HM Treasury's public expenditure database OSCAR. This is consistent with HM Treasury publications.

Core Table 1: Public Spending

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Plans
Resource DEL							
A	NHS England	16,598,249	17,186,308	25,597,500	23,371,789	**14,524,033**	29,683,055
B	NHS Providers	75,607,340	81,526,454	93,119,985	99,849,097	**107,932,134**	108,811,192
C	DHSC Programme and Administration	1,107,488	856,606	26,540,107	13,268,380	**5,065,263**	3,893,798
D	Local Authorities (Public Health)	3,011,064	2,931,555	4,205,920	4,217,325	**3,195,761**	3,370,210
E	Executive Agencies	1,026,301	923,546	1,480,833	10,181,091	**3,737,212**	2,010,366
F	Health Education England (footnote)	1,819,177	1,444,495	1,448,640	1,595,487	**1,789,611**	
G	Special Health Authorities	2,718,887	2,743,281	2,650,888	2,868,350	**2,969,741**	2,992,296
H	Non Departmental Public Bodies	624,829	628,293	723,579	875,334	**769,729**	108,321
I	Arm's Length Bodies [1]	838,583	2,981,221	2,849,887	2,124,627	**844,324**	148,274
J	NHS Commissioning Board financed from National Insurance contributions (non voted)	21,926,343	22,961,639	22,823,176	25,196,757	**36,266,858**	27,560,297
Total Resource DEL		**125,278,261**	**134,183,398**	**181,440,515**	**183,548,237**	**177,094,666**	**178,577,809**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Plans
Capital DEL							
A	NHS England	221,233	265,530	330,577	291,416	**238,684**	444,137
B	NHS Providers	3,928,404	4,498,029	7,281,187	6,833,740	**7,537,572**	8,297,926
C	DHSC Programme and Administration	1,658,348	1,811,114	4,677,582	1,795,522	**1,987,401**	2,841,061
D	Local Authorities (Public Health)	-	0	0	0	**0**	0
E	Executive Agencies	(70,475)	140,735	21,022	(221,171)	**(274,232)**	156,600
F	Health Education England	467	1,557	532	1,119	**1,889**	
G	Special Health Authorities	(49,815)	24,172	47,320	30,623	**23,715**	40,312
H	Non Departmental Public Bodies	95,246	118,533	156,325	187,746	**129,542**	20,264
I	Arm's Length Bodies [1]	157,836	155,574	189,762	200,041	**203,379**	287,501
Total Capital DEL		**5,941,244**	**7,015,244**	**12,704,307**	**9,119,036**	**9,847,950**	**12,087,801**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Plans
Resource AME							
K	NHS England	(19,733)	294,489	86,125	119,445	**10,693**	250,000
L	NHS Providers	1,134,119	1,070,401	1,978,051	1,100,553	**962,326**	2,000,000
M	DHSC Programme and Administration	(437,113)	785,506	1,997,564	3,115,133	**(3,519,936)**	645,000
N	Executive Agencies	(2,181)	(2,033)	13,831	269,629	**(483,838)**	0
O	Health Education England	(44)	68	159	596	**(856)**	
P	Special Health Authorities	6,405,024	675,203	(1,266,873)	43,308,197	**(58,933,071)**	7,882,000
Q	Non Departmental Public Bodies	6,373	3,536	23,207	25,429	**16,508**	2,000
R	Arm's Length Bodies [1]	(72,480)	20,839	49,696	31,745	**(23,742)**	101,000
Total Resource AME		**7,013,965**	**2,848,009**	**2,881,760**	**47,970,727**	**-61,971,916**	**10,880,000**

		2018-19 Outturn	2019-20 Outturn	2020-21 Outturn	2021-22 Outturn	2022-23 Outturn	2023-24 Plans
Capital AME							
K	NHS England	0	0	0	0	**0**	0
L	NHS Providers	0	0	0	0	**16,807**	13,378
M	DHSC Programme and Administration	(4,801)	(5,563)	(7,355)	0	**2,654**	92,222
N	Executive Agencies	0	0	0	0	**0**	0
O	Health Education England	0	0	0	0	**0**	
P	Special Health Authorities	0	0	0	0	**0**	0
Q	Non Departmental Public Bodies	0	0	0	0	**868**	0
R	Arm's Length Bodies [1]	-	-	0	0	**0**	0
Total Capital AME		(4,801)	(5,563)	(7,355)	0	**20,329**	**105,600**

1.The structure of the Estimate changed in 2018-19 with the creation of an additional line in order to provide greater transparency for its reader.

315

The overview reveals that expenditure trends in France were significantly more muted than in the UK, as provided by the DHSC report.

The lurch in spending at the DHSC from 2019/20 to 2022/23 was of the order of £125bn over three years; this hasn't been fully and satisfactorily accounted for. It seems to have been masked by our old friend AME (Annually Managed expenditure) that is kept outside the normally reported spending channels, coming up with a £58bn contribution from a review of discount factors applying to medical negligence provisions. In other words the full impact of Covid has been masked by fortuitous factors.

All this requires further scrutiny. I will come back to this and the European perspective in future months.

As an aside however, on a recent trip to England I was surprised by the continuing faith shown by the Labour Party's Wes Streeting in the magical powers of spending on prevention of ill health.

It is incongruous that the DHSC report records in Annex A, copied (line D) that spending on public health has fallen back (in 2022/23) to exactly the same levels as in 2018/19 despite Covid and despite faith that prevention holds the key to improved health.

From my own observations of a rash of Vape products in shops everywhere across the UK (designed to hook young people onto nicotine); offers of beer at £1.50 a pint for breakfast in a pub in Sheffield; and an early morning encounter with a young lady weighed down with armfuls of cans of beer on offer at her local Tesco; and the continual promotion everywhere of betting as a lifestyle choice: all I can say is that Wes Streeting needs to broaden his attacks beyond the NHS itself.

A friend in the prevention industry points out that everyone will have to play their part: the NHS, local authorities and schools, supermarkets and retail, the food, tobacco, betting and drinks industries: but there is scant sign of this happening.

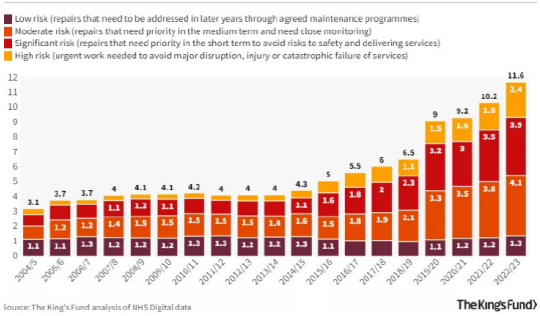
It is simply not good enough for the focus of the NHS Prevention Programme's to be to support individuals in taking action to reduce risks to their health. A much broader strategy placing responsibility on those with the most power to change public health is required.

Roundup of articles relating to healthcare across Europe

The Kings Fund produced a good set of numbers detailing the rising backlog maintenance in the latest NHS estates returns.

Figure 1 The cost and severity of maintenance issues with NHS buildings and equipment is still growing

Cost to eradicate backlog (£ billions, cash terms)



This is set against the context of several years of capital underfunding, and the lengthening list of priorities competing for NHS funding, including pressure to reallocate capital funding to support NHS operational spending.

But as usual the Kings Fund fails to offer solutions.

The Kings Fund's plea in their associated response to the Chancellor's Autumn Statement for,

> *the government ..to… build on its proposals to make England smoke-free and take further bold action to make working in health and care a more attractive career option, bolster out-of-hospital care such as primary, community and social care services, and help people live healthier lives through a focus on prevention'*

comes across as missing the point and avoiding the issue.

Anyone with bright ideas should respond to this consultation ending on 16 February. It's obvious that the Treasury has none nor the DHSC. The NHS does not manage its assets as a whole; reporting is misleading and complacent; resulting in overvalued assets, underinvestment in assets, assets subsidising existing operational activity rather than boosting productivity: it lacks a coherent path to improving matters.

This is another theme that will need revisiting.

The latest edition of Eurohealth from the **European Health Observatory** promotes the idea of a European Health Union.

Contents includes:

- Foreword
- Editorial
- The promise of a European Health Union
- Ensuring the availability of a sufficient health and care workforce
- Financial access to healthcare
- Comprehensive approach to health and wellbeing
- Towards needs-driven innovation and healthcare policies
- European health investment hub
- What could the EU do to build resilient health systems and resilient, healthy societies?
- Tackling the health workforce crisis: Towards a European health workforce strategy
- Ensuring affordable access to healthcare for everyone in the European Union

- How can the European Union scale-up action on non-communicable disease prevention?
- Identifying disease-specific patient and societal needs to foster needs-driven healthcare
- Revamping the EU's health security framework to manage future health crises
- Building capacity and identifying appropriate support
- EU joint actions 2.0: A booster for health in the EU?

Articles discuss the development of European healthcare over the next five years, from 2024 to 2029.

It's good that someone is doing this; it often looks like ministers in the UK and elsewhere only think in terms of the next election. Now that the Hungarian Prime Minister Victor Orban has been forced to back down, it may be time for Europe to take the offensive on co-operative measures on healthcare and other matters.

We'll see.

For those interested in Europe's contribution to Global healthcare this online seminar on 7th February looks interesting :

It will discuss "Europe in the world: Viewing health challenges through a global lens" .

It offers:

"The third webinar of the series will deal with the following three themes:

- *Enhancing health security*
- *Addressing long term challenges, such as population ageing or climate change*
- *Strengthening the EU's global voice and leadership*

This will be a highly interactive format, to allow for debate, comments and suggestions.

Speakers and facilitators include:
Caroline Costongs, EuroHealthNet (Keynote)
Isabel de la Mata, DG SANTE, European Commission
Nicole Mauer, European Observatory on Health Systems and Policies
Matthias Wismar, European Observatory on Health Systems and Policies"

The **ECDC Communicable Diseases Threats weekly bulletin** suggest the situation is under control across Europe despite respiratory disease being slightly elevated.

The Health Foundation produced a report Is the grass really greener? Comparing how social insurance and tax-funded systems raise revenue: an explainer.

The report examines how other European countries raise revenue for publicly funded health care services.

It compares the social health insurance (SHI) systems of France, Germany, and the Netherlands with the tax-based systems of Italy, Spain, Sweden and the UK.

It concludes that different funding models each have their merits, but ultimately there is no perfect system, and no strong evidence that any country's funding system is superior to others.

Overall levels of health care funding are the product of political choices, with no simple relationship between the model used and the overall amounts raised.

It goes on to say all seven countries will have to grapple with the common challenge of ageing populations, needing more health care as they grow older.

UK policymakers should recognise the strengths of the current model and focus on improving the current funding system for the NHS, rather than embarking on a wholesale switch to another funding model.

Its messages seem sensible but will not answer the need of the hour, which is to shift politicians' thinking. Ultimately it appears as a cop out because other countries do not have the angst and frustrations of the UK funding system despite spending similar or higher amounts.

This must be a function of the system and the report should be more creative in providing workable recommendations. Personally I favour hypothecated funding linked to activity-based funding triggers. People do not object to paying health taxes; it's the other stuff they object to.

Deepdyve offers a comparison between Norwegian and German stress levels and satisfaction amongst clinicians. The article gives the gold medal to Norway but only just. It commends interventions to foster physician wellbeing, job satisfaction and high-quality patient care in Germany.

I doubt whether anyone would commission comparisons between Norway and the UK.

As I write news flashes remind me that two thirds of voters want a new government and that one in four MEPs are involved in scandals or breaking the law.

It seems across Europe that 2024 will continue to contain controversy and political debate for healthcare. I will continue to watch this space for you.