

Alternative European Healthcare Perspective

June 2023

[Roger Steer](#)

In the last month the World Health Organisation has withdrawn its alert on the Covid pandemic. It's over. Official . But we are warned to remain alert for new variants. The mopping up afterwards though continues.

In the UK the ex-Prime Minister faces new charges of violating his own rules. And progress to dent waiting lists remains slow.

In Europe each country faces its own problems but in their own way, healthcare being firmly a local responsibility despite the existence of a 672 billion euros Covid Recovery Fund.

More on both these issues below together with a roundup of other reports on healthcare across Europe.

The end of Covid

On the 5 May the Director-General of the World Health Organization tweeted,

"Yesterday, the #COVID19 Emergency Committee met for the 15th time and recommended to me that I declare an end to the public health emergency of international concern. I have accepted that advice.

With great hope I declare COVID-19 over as a global health emergency."

Which is good, but somehow I am not reassured by that word 'hope'.

Which is presumably why the rest of the [WHO is continuing to produce weekly updates, is monitoring new variants closely, and would intervene again if needed.](#)

In the meantime the extremely vulnerable are still receiving updates to their vaccines; the rest of us can presumably just get on with it.

But the Covid story hasn't gone away

Europe and the UK both have healthcare backlogs, disaffected workforces and questions remain about why so many people died, why preparedness was insufficient and whether the management of the crisis was optimal.

In the UK the Independent Inquiry [is facing obstruction](#) in getting to the bottom of things. It seems that the use of Whatsapp was cruelly misunderstood inside No10 as creating a private means of exchange, escaping public scrutiny. Wrong.

Boris Johnston has sacked his legal team, not a good look, and is appealing for more time on the basis he is not represented. Desperate. Rivka Gottlieb, a spokesperson for Covid-19 Bereaved Families for Justice

UK, said it was 'outrageous' for the Government to *“think they can dictate to an independent inquiry which of Boris Johnson’s WhatsApp messages they can see”*.

She added:

“With the revelations that have come out yesterday about him breaking lockdown rules, you really do fear the worst about what they’re hiding.”

Labour’s deputy leader, Angela Rayner, said:

“The fact the Covid Inquiry has had to invoke legal powers to compel the handover of crucial documents suggests that this is a government with much to hide.”

The urge to delay any publication of findings until after the next election seems as strong as ever.

As it is the NHS are reporting steady progress in [managing long waiters](#) but without it being obvious how (apart from tail-gunning), whether enough is being done, and what the costs of prioritising one group of patients over others is.

It seems that the overall number of patients waiting is around 7.3m (although attention is not drawn to these figures on the NHS website).

As it is the number waiting is very high compared to historic levels, although the number of long waiters is back to the levels when the conservatives were last in power.

It is not a good sign that [the BBC is 'helping' by publishing its own Health tracker](#) showing the local waiting times for an individual’s postcode.

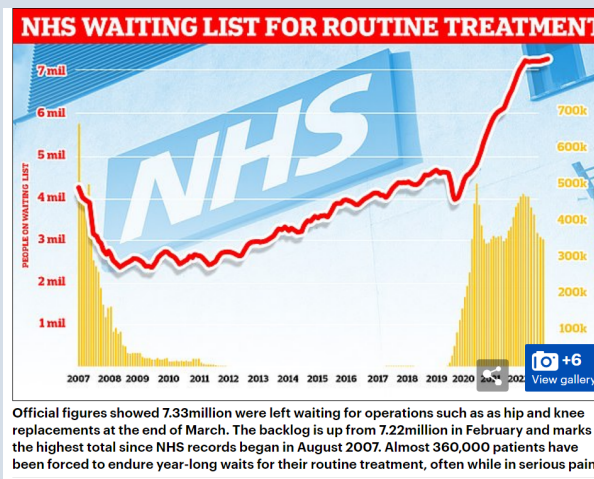
In Europe it’s a mixed bag. [This article](#) from the Health Economics review in 2022 attempts to identify winners and losers in the Covid

management stakes but more importantly they conclude,

“The best country in terms of the efficiency of its response was Norway; followed by a group of countries Cyprus, Denmark, Estonia,

Finland, Iceland, Ireland and Luxembourg. Surprisingly there was a large group of countries deemed to have managed COVID with less efficiency (including France Germany, UK, Italy, Spain and the Netherlands)”.

The authors claim health systems need to go through a deep restructuring (strengthening), both of management and medical infrastructure. They cite the large number of fires in intensive care units



caused by overheating equipment to support this argument.

They also identify the need to regain trust through communication¹, transparency and openness to all elements likely to induce a rapid recovery. They claim restoring confidence in institutions will help to induce acceptance to changes in rules/ pathways to fight a future pandemic. They also concluded,

“The efficiency of the public health sector is less determined by resources, but rather, in the current use of resources.”

And called for more proactive management, not just reactive management.

But this article from [the Lancet in May](#) aptly entitled *No time for complacency on COVID-19 in Europe* tells a more up-to-date story.

“None of the waves of COVID-19 since the spring of 2022 overwhelmed health-care systems in Europe, or warranted new restrictions from December, 2022. Yet, excess mortality, although not only attributable to COVID-19, has been and remains unacceptably high. COVID-19 claimed the lives of 467 921 people in Europe during 2022. Hospital admissions of

new patients with COVID-19 continue; infections persist in immunocompromised people; and vulnerable individuals with comorbidities remain at high risk of severe COVID-19. Persisting symptoms are also associated with 3–20% of affected people suffering from Long Covid. Persisting absenteeism from work linked to COVID-19 and to other circulating respiratory viruses since the lifting of public health measures has had negative effects on European economies.

Much more strategic attention and investments are needed now to more effectively manage COVID-19 and develop greater resilience to future respiratory pathogens.”

Lest anyone be in doubt the authors call for action,

“Governments must improve protection of vulnerable people, urgently invest in improving ventilation and indoor air quality in health-care and other settings, and revisit surveillance and monitoring systems to ensure that we are prepared to respond to future pandemics. Longer-term strategies are also needed, such as developing pandemic prevention and preparedness plans, strengthening health systems, including public health functions, improving risk communication and community engagement, and ensuring adequate human resources planning and training to counteract staff shortages across social and health systems. Europe needs to develop resilience in our public health systems for

¹ Readers are asked to study this excellent article from the Glasgow Media group looking at how Covid communications happened in the UK. <https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-4446.13010>
More evidence for the prosecution

future emerging pathogens and get better prepared for other potential future health hazards responsible for public health crisis. Failure to take these steps now will result in more deaths due to COVID-19 and other respiratory pathogens and mean that we are not well prepared to respond to future public health threats”.

Talking of Staff Shortages

One of the biggest problems emerging is how to address the clamour for counter inflationary pay awards. Again each country is different. In the UK the doctors and nurses haven't settled (although the NHS Staff Council has); in Germany they have settled at around 11% (as I reported last month), in France they haven't, and the AI chat function on Bing summarises thus,

“In the first year of the covid-19 pandemic, there were at least 6500 protests by healthcare workers globally, a 62% increase from 2019-20 in countries where continuous protest activity data are available.

In the UK, nurses, ambulance workers, and other NHS staff staged a series of strikes in 2022-23, and consultants have voted to follow junior doctors in taking strike action. Junior doctors have had a 26 per cent real terms pay cut since 2008 and earn less than a barista at coffee shop chain Pret-a-manger.

In Spain, more than 700,000 people were waiting for surgery, and 5,000 frontline GPs and paediatricians in Madrid have been on strike for nearly a month in protest at years of underfunding and overwork.

In France, there are fewer doctors now than in 2012 and more than 6 million people do

not have a regular GP. Doctors have also protested against privatisation, staffing shortages and difficult working conditions.

In Germany, 35,000 care sector posts were vacant last year, 40% more than a decade ago. Doctors have also demanded higher pay and better working conditions.

There is no clear evidence of any agreements being made between the doctors and the governments in these countries. The strikes and protests are likely to continue unless urgent action is taken to address the issues facing the health and care workforce in Europe. “

Which only goes to prove that AI will not completely replace the need for this newsletter... although their heart in is the right place, an emphasis on the latest news, is what I believe is required.

In that respect in France Macron appears to be trying divide and rule by [promoting the interests of the 'second line' of employees.](#)

That is, “the head of state quoted “our farmers, our teachers, our truck drivers, delivery people, electricians, handlers, cashiers, our garbage collectors, security and cleaning personnel...”, and promised: “We will have to remember that our country, today, is entirely about women and men that our economies recognise and pay so badly.” A year later, a mission commissioned by the Ministry of Labour confirmed the diagnosis: the “second lines”

are indeed underpaid and poorly recognised.”

The French Health Minister has been [talking about prevention](#) (he obviously expects to stay in post for some time, something democracy cannot guarantee).

The article linked from Connexion, the French magazine for English people, is startling to an English person because it states boldly certain things not often said.

François Braun, the French Health Minister, said France is "probably behind Anglo-Saxon countries when it comes to prevention, and certainly behind northern Europe"².

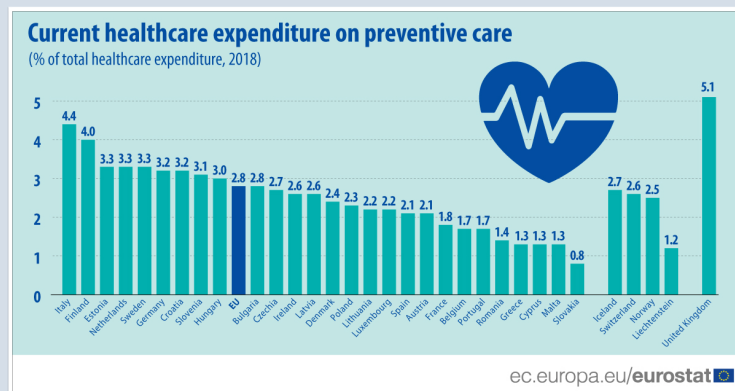
“Prevention is not really part of the French culture.”
“Coming out of the Covid crisis, health systems across the world are struggling”.

The crisis has been particularly visible in France, where many areas are suffering from a shortage of doctors, while GPs have recently been on strike demanding an increase in consultation fees. Prevention is seen as a way to reduce strain on the system, while also saving public money.

Braun claims, “Through physical activity, we can reduce the number of people who require treatment for high blood pressure, for example, by 70%. These treatments cost €1billion per year.”

The French are thus looking to link their hosting of the Olympic Games in 2024 with public health initiatives. I wonder if they consulted a [report from the Scottish government](#) looking to identify the legacy from large sporting events which concluded,

“The area of physical activity and sport has received a lot of attention over recent years. However, the empirical evidence base assessing participation levels is small, as a number of review papers have noted. The evidence that exists is variable in quality and shows mixed results. It is therefore too early to say whether hosting multi-sport events can increase participation levels”.



This presumably is why other measures are being taken to encourage exercise, as well as vaccines for HPV for

boys and girls and free condoms for those aged under 26.

But also the Minister intends to “transform the way healthcare is organised”. He believes systems built in the post-war period are no longer adapted to contemporary challenges, with supply failing to rise in line with demand.

“Competition no longer has its place, between clinics and hospitals, public and private. More cooperation is necessary.”

Mr Braun admitted that the numerus clausus – the strict limit on the number of medical students, abolished in 2021 – had been a 'catastrophic' idea, stating *“the idea in the 1970s was that the fewer doctors there were, the fewer medical procedures there would be, allowing us to balance the books. Today, that idea seems totally absurd.”* But not alas to the UK Treasury.

The reforms will not have an immediate impact, however.

“It takes 10 years to train a doctor. While we wait to see the effects, the system will be on its knees if we do nothing.”

(Which is the policy of Steven Barclay.)

“In areas where there are no private GPs, the state must take on this responsibility.”

GPs and other primary care providers will be encouraged to work in groups, with a more global view of patients' needs and a greater focus on prevention.

Mr Braun also highlighted the need to reform the T2A funding model, which allocates money to hospitals based on productivity, and which doctors say, fails to account for chronic illnesses.

This is something President Macron already promised when addressing healthcare professionals at the beginning of the year.

In terms of nursing, lack of personnel is also an issue.

“We are already training 30% more nurses. The main problem is 20% drop out during

their studies or their first year on the job,” Mr Braun said.

He blames this on the financial pressures student nurses face, as well as their training, which is ill-adapted to the professional environment.

“We train professionals who are completely lost once they are in the field. We are working to totally revamp these three years of studies.”

Mr Braun also defended Assurance Maladie's proposal to raise consultation fees from €25 to €26.50, while GPs have been asking for €50.

“A €1.50 increase would mean an extra €7,000 on average per doctor per year.”

Authorities have offered to increase the fee to €30, but only for doctors who agree to take on extra responsibilities to combat so-called medical deserts, by taking on new patients or seeing patients outside normal working hours, for example.

“When I speak to former colleagues who left public hospitals to go private, most do not leave for financial reasons, but due to a particular problem: out-of-hours service,” Mr Braun said.

“The burden of working at night and on weekends falls almost exclusively on the public sector.

“It's important that in a given area, everybody participates in overnight and weekend work.

“Our system is supported by two legs – one public and one private – and it is important that each leg is just as strong as the other.”

The attitude of Dr Braun, an ex-head of Emergency care, stands in contrast with the UK's own Steven Barclay who believes in the market to provide solutions, who has cut trainee numbers, and is saying the NHS has enough resources. Both however are struggling to settle the [wave of strikes](#) and continuing staff shortages.

In Germany they are paying up and adjusting tariff levels.

Policy-making Issues

The discussion of prevention in France and as a panacea by Patricia Hewitt (discussed last month) and the [Labour Party](#), has stimulated

some commentary in the policy making community.

[Sam Freedman](#) and [Steve Black](#) have both

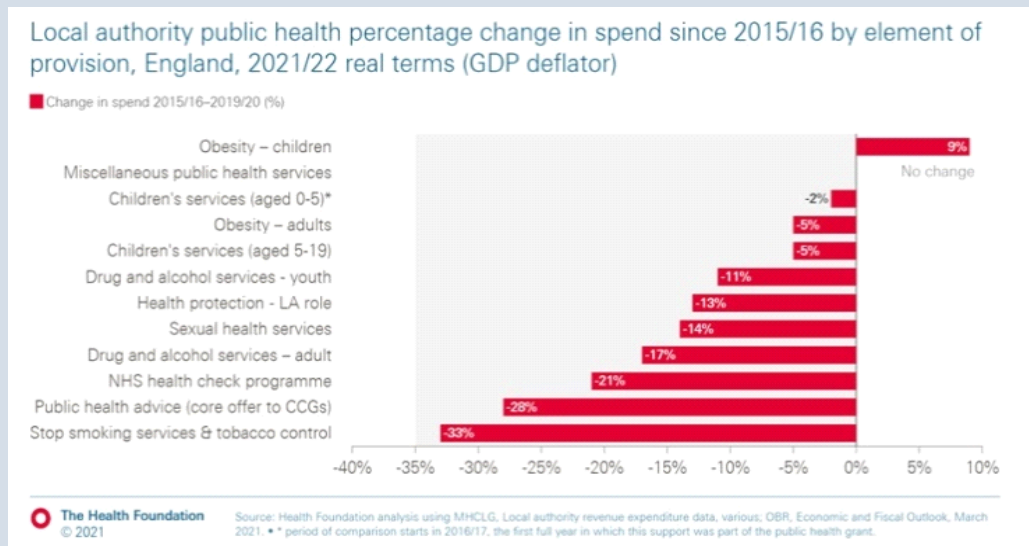
grappled with policy paradoxes

and conundrums as they apply to health services everywhere.

Freedman points to the seeming 'common sense' and 'obvious' support for the idea of investing in preventative care, which while being supported by politicians in theory, is persistently ignored in practice. He cites the above table which shows that funding for obvious public health measures has been cut drastically over the last five years.

He identifies three barriers that prevent the obvious ideas happening: spending rules; misdiagnosis; and fear of the electorate. He seems surprised by these. As though spending good money on the latest whim, which will only make problems worse, and will not solve the manifest problems was an obvious way forward. He concludes,

"It's taken me a long time to realise it but ideas are overrated in policy. The real skill is figuring out how to make the ideas we already have happen. Finding ways round the structural barriers to good policy; correcting misperceptions about the causes of widely accepted problems; devising



cunning ways to make unpopular but necessary policies palatable. It sounds less exciting than coming up with a big new idea, but it's a lot more useful."

I disagree. There are too many ideas and not enough science. If the real skill is in figuring out how to make the ideas we already have happen this rather pre-supposes that the unscientific ideas possessed are likely to have the effects desired, be achievable, or even be costed

correctly and be consistent with the plan presented. All too often this is not the case.

Correcting mis-conceptions about the causes of widely accepted problems, cited by Freedman above as an imperative, is often conflicted to meeting the path of least resistance to politically acceptable short term fixes.

The best example being that funding the NHS properly is unaffordable. Which to my and many others' eyes is a belief that causes problems but which continues to hold sway despite all the evidence to the contrary.

As for *“devising cunning ways to make unpopular but necessary policies palatable”* this is the easy resort of scoundrels. One man's necessity is another man's poison.

Honest debate informed by the facts, decided after sufficient time and study, fully involving those most affected, and with decision-makers, not driven by ulterior motives and vested interests, is the better way. HS2 springs to mind.

The conclusions fit into a current planning vogue focussed on project management and a focus on implementation. The use of the word agile is liberally sprinkled into these discussions. The problem is that methodologies devised in real war time, or, in near war conditions of coming up with software solutions before the competition

who would wipe you out, are not analogous to tackling ageing as an issue within health and social care.

The big money may be in policy advice to politicians in a hurry, but rushing to implement their barmy (new or old) ideas is a recipe for disaster. Talk to Andrew Lansley, if you don't believe me.

Steve Black by comparison attacks the one-legged or one-eyed approach of policy-makers who take 'obvious' ideas, like prioritising front line staffing (or prevention), to their logical conclusion and seek to prioritise them above all else.

“The relentless advocacy of “more resources to the front line” (not just from politicians but from NHS England) has led to NHS policy that compromises investment in other factors that also matter for outcomes. Higher staff numbers are preferred to teams with the right mix of experience to be productive. Management and administration are being cut to pay for more doctors and nurses. So is spending on more modern computers and diagnostic kit. Capital spend and management costs are low to start with and continue to be cut to fund more front line staff.

Front line staff in the NHS can't get more, higher quality work done unless they have quality space to work in (but the NHS has hospitals where the roof leaks, the ceilings are falling down and the space was due a major redesign two decades ago). Their work is often compromised by chunky IT that wastes their time and fails to support quality improvement. They are short of diagnostic equipment and the kit they have is old and slow. There are too few

operational managers to support process redesign or to coordinate work so the system functions well. Cuts in admin staff leave doctors and nurses with less time to spend with patients.

It is as if the NHS tried to build a three-legged stool but focussed on the “staffing” leg while stealing wood from the other two legs, delivering a stool that breaks as soon as anyone tries to sit on it.

Sometimes it looks like the NHS is managed like a car owner who cuts the cost of running their car by focussing on the cost of fuel, eliminating maintenance and never topping up the engine oil and then wonders why the vehicle stops working.

Complex systems like the NHS can't be improved with a blinkered approach that only pays attention to one input. All the inputs interact, sometimes in complex ways.”

Policy wonks don't want to hear this; nor ministers. As if to prove a point [the Government announced this week a revision to its new hospital spending programme](#). Less a revision, more a '[rapid unscheduled disassembly](#)' (as Elon Musk would call it).

The Government has suddenly realised (or more likely finally plucked up the courage

to admit) that they cannot afford to build new hospitals without paying attention to those falling down first.

And, that because they cannot afford more new hospitals they now have to get round this by promising to delay projects rather than cancel them.

This leaves a lot of people clutching at straws. Particularly as the Government says that all building projects still require a business case approved by the Treasury before a brick is laid.

This is a problem because new hospitals cost more than old ones and the scope for downsizing hospitals further to pay the extra costs has been reduced because Covid has shown the NHS needs more, not less capacity.

All the evidence of reduced capacity being possible as community care and primary care expand their scope has been exposed as a hoax (see below in the European Journal of Health Economics).

As are claims that [local government has the money to finance the extra social care required to stop hospitals filling up](#) with people unable to be discharged into the community.

Plus many of the savings schemes that had been identified to fund the new hospitals are being brought forward now, thus showing new hospitals were never necessary to making savings (restoring Sustainability) in the first place.

This may be obvious to some people but it's not obvious to the Government's policy advisers.

Round up from Europe

[The European Journal of Health Economics](#) [had already published this article](#) pointing out the inconvenient truth that community care cannot act as a substitute for acute care. In its understated way it says;

“Expansion of community-based services may not generate reductions in hospital activity and expenditure.”

Of course this has been known for many years and I can refer anyone who is interested to an extensive literature over the last 20 years.

One of the authors is Matt Sutton who proved that the argument being used to close A&E departments as they were unsafe at the weekend and '500 patients would die' in London alone was bogus.

You don't hear that argument anymore because it didn't factor in the different case mix at the weekend. But policy wonks don't want science; they want 'cunning ways to make unpopular but necessary policies palatable'.

[This article in the May edition of the Journal of European Social Policy](#) looks at the different attitudes to healthcare across Europe.

Not surprisingly it identifies higher satisfaction linked to higher spending but it throws up some anomalies. The Irish (and Germans) are more dissatisfied than expected; and northern European citizens are less positive about their healthcare than countries such as, France Belgium, Israel, Austria, Spain, UK and Switzerland.

Apparently the cultural climate towards public institutions counts for a lot and varies across Europe.

[The Journal of International Migration and Integration](#) looks at differential unmet health needs amongst four European nations (France, Germany, Spain and Greece) migrant communities. It reminds us that these four countries were the four largest recipients of migrants requesting international protection in 2020.

Germany had 102,500, France 81,800, Spain 86,400 and Greece 37,900. The UK had 9,936 in that same period. All four countries had unmet health needs in these communities but it was greater in countries relying more on out-of-pocket payments (Greece in particular).

The authors call on countries to give exemptions to migrants in negotiating healthcare systems.

[The European Journal of Health Economics](#) looks at refinements to the methodology for calculating Qualys or the costs in differing countries for extending lives. The article shows that the costs vary substantially across countries and according to age.

It's not clear what the implications are: perhaps to send our old people to Greece?

[Eurointelligence](#) brings its insights to bear in an article of 24 May 2023 marking the death of Bob Lucas the inventor of the dynamic stochastic equilibrium model in macroeconomics.

He was wrong but it was convenient for a lot of people to believe that he was correct. Think how that mind-set affects health policy and the planning of new hospitals.

[European Health Observatory](#) always has things of interest. This month I draw attention to the sensible way the Germans go about healthcare reforms.

The article discusses plans for changes to the hospital remuneration system . In particular the system is moving to a fixed fee element in

remuneration shifting from 40-60%, a fee structure linked to the type of hospital within which it applies, and a five year implementation period.

The [Kings Fund](#) are always worth checking out but I am as confused as ever on Integration of primary and community care and where it is going. Chris Ham's account of [the last 20 years](#) is probably required reading. I interpret it as a bid to the next government for influence.

Judging by [this](#) the next Labour government will need all the advice they can get. Although [Eurointelligence](#) highlight in their article of 30 May, the 'Value of Hope', that Labour have some new ideas.

Meanwhile perhaps [the people have already decided.](#)

