An Alternative European Perspective

December 2022 Roger Steer

As the French say there is a sense of déjà vu about the UK just now. Old faces (*or not so old in the case of Rishi Sunak*) have returned to the helm as Prime Minister, Chancellor of the Exchequer and as Health Secretary. It also looks like the tired old policies of Austerity and Efficiency savings will be tried again. There is even talk of further "reform" of the NHS.

The advice to healthcare managers is to keep your heads down and trust the next election is sooner rather than later.

My newsletter this month will take an outsiders view of the UK scene and bring you more news and references to articles and studies on how other countries face the common problems all countries confront , but with more or less success.
But first I cannot but help to reflect on my recent trip to the UK…

New team in charge , same old policies

The new Prime minister is Rishi Sunak. He is a 42 year old who only joined the conservative party in 2010, being elected an MP in 2015 and only took up office as Chief Secretary to the Treasury in July 2019, after, allegedly, as a reward for, supporting Boris Johnson in his bid to overturn Theresa May.

He is on a steep learning curve. As Chancellor from February 2020 he opened the floodgates to Covid spending and now as Prime Minister he is charged with recovering the mess, not wholly of his own making but as no innocent bystander either.

The new Chancellor of the Exchequer is Jeremy Hunt. His claim to fame is as the longest serving Health secretary (2012-2018). He was the Chair of the Health and Social Care Select Committee from 2020 to 2022. So he is no innocent bystander to the current state of the NHS either. Remarkably as the new Chancellor he has seen fit to cut the £7bn of extra funding he claimed the NHS needed in his role as Chair of the Health Select committee to £3bn in his most recent role.

The new Health team is:

Steve Barclay, Secretary of State for Health and Social Care. Apart from earning the epithet as "the NHS's worst nightmare" he brings baggage both as a graduate from Sandhurst military academy and as a short lived junior Health minister in 2018 under Theresa May before being asked to become "Brexit" secretary.

Will Quince , Minister of State for Health is another new boy only being elected to parliament in 2015. His claim to fame is having lost six and a half stone recently.

Helen Whately , Minister for Social Care, is on the other hand a well known quantity with eight years experience as engagement manager at MacKinsey's to boast of along with previous experience as the minister for social care in 2020 and 2021. Nothing much has been achieved yet but she can handle a horse, according to wikipedia.

Neil O'Brien is Minister for Primary care and Public Health , with the Covid brief. Never done a proper job in his life but seems opinionated.

Maria Caulfield is Minister for Mental Health and Women's Health Strategy. An ex-nurse and shepherdess. Came into politics to defend Brighton hospitals. Continues in politics to give a job to her husband, per her wiki.

Nick Markham, is Parliamentary Under Secretary of State (Minister for the Lords) responsible for :

NHS capital, land and estates:

- new hospital programme
- reinforced autoclaved aerated concrete (RAAC)
- energy resilience and Net Zero strategy
- NHS Property Services
- car parking
- data and technology:
- NHS IT and data to support innovation
- security management and cyber security
- departmental management and business
- lead statutory instrument (SI) minister, including retained EU laws

NHS finance:

- procurement
- cost recovery and immigration health surcharge

Lords' business, sponsorship of:

- NHS England
- NHS Counter Fraud Authority
- NHS Digital

It is somewhat concerning that a man who has made money out of Covid testing is now the minister in charge of procurement, and counter fraud. What could possibly go wrong? Whatever happened to division of responsibilities?

The new team have been given their marching orders as per the latest Autumn Statement.
The relevant words on the NHS were:

"Protecting vital public services
2.33 In ensuring sustainable public spending, the government's focus is on protecting vital public services, prioritising the needs of low-income households and levelling up the country.
2.34 The government recognises that the NHS is under significant pressure, including from the ongoing recovery from the impact of the pandemic. The Autumn Statement therefore makes up to £8 billion of funding available for the NHS and adult social care in England in 2024-25. As part of this, the government is investing an additional £3.3 billion in each of 2023-24 and 2024-25 to support the NHS in England, enabling rapid action to improve emergency, elective and primary care performance towards pre-pandemic levels.
2.35 The NHS will publish full recovery plans for the urgent and emergency care and primary care systems including interim milestones in the new year. These plans will set out detailed ambitions for recovery to deliver:
• improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023-24, with further improvement towards pre-pandemic levels in 2024-25
• year-on-year improvements in A&E waiting times over 2023-24 and 2024-25
• improved access to general practice, so that everyone who needs an appointment with their GP practice can get one within two weeks, and those who need an urgent appointment can get one on the same day
2.36 The NHS will continue to deliver the Elective Recovery plan published in February, and will explore further options to enable patients to make genuine choices about where to access their care from any provider - private sector or NHS - which meets NHS standards and NHS prices at both the point of GP referral and later in the pathway. This choice will be supported by radically increasing patient information, data transparency and regular monitoring of patient choice uptake.
2.37 The government will continue with the New Hospital Programme to deliver healthcare more efficiently, and will introduce measures to support and grow the workforce and improve performance across the health system, including:
• ensuring the NHS has the workforce it needs for the future, including publishing a comprehensive workforce plan next year. This will include independently-verified forecasts for the number of doctors, nurses and other professionals that will be needed in 5, 10 and 15 years' time, taking full account of improvements in retention and productivity
• further measures to support greater local decision making and freedom for healthcare professionals to do their job. This will include commissioning an independent review by Patricia Hewitt into how best the new Integrated Care Boards can work with appropriate autonomy and accountability
2.38 The NHS performance also relies on the adult social care system, so the government will make available up to £2.8 billion in 2023-2024 in England and £4.7 billion in 2024-2025 to help support adult social care and discharge. This includes £1 billion of new grant funding in

2023-24 and £1.7 billion in 2024-25, further flexibility for local authorities on council tax and,
having heard the concerns of local government, delaying the rollout of adult social care charging
reform from October 2023 to October 2025.
• £600 million will be distributed in 2023-24 and £1 billion in 2024-25 through the Better
Care Fund to get people out of hospital on time into care settings, freeing up NHS beds for
those that need them
• £1.3 billion in 2023-24 and £1.9 billion in 2024-25 will be distributed to local authorities
through the Social Care Grant for adult and children's social care
• £400 million in 2023-24 and £680 million in 2024-25 will be distributed through a grant
ringfenced for adult social care which will also help to support discharge
2.39 Together with continued investment across the sector, including in training and
technology, this will put the adult social care system on a stronger financial footing and improve
the quality of and access to care for many of the most vulnerable in our society."

This needs to be read alongside the text of the Chancellor's statement to Parliament:

"The NHS budget has been increased to record levels to deal with the pandemic and today I am asking it to join all public services in tackling waste and inefficiency.
We want Scandinavian quality alongside Singaporean efficiency, both better outcomes for citizens and better value for taxpayers.
That does not mean asking people on the frontline, often exhausted and burned out, to work harder, which would not be fair.
But it does mean asking challenging questions about how to reform all our public services for the better.
With respect to the NHS I have asked former Health Secretary and Chair of the Norfolk and Waveney Integrated Care System Patricia Hewitt to help me and the Health Secretary achieve that by advising us on how to make sure the new Integrated Care Boards operates efficiently with appropriate autonomy and accountability.
I have also had discussions with NHS England about the inflationary pressures on their budget.
I recognise that efficiency savings alone will not be enough to deliver the services we all need.
So because of difficult decisions taken elsewhere today I will increase the NHS budget, in each of the next two years, by an extra £3.3 billion.
The Chief Executive of the NHS, Amanda Pritchard, has said this should provide sufficient funding for the NHS to fulfil its key priorities and shows the government is serious about its commitment to prioritise the NHS.
That is why today we commit to a record £8 billion package for our health and social care system – a government putting the NHS first."

The meat is contained in the following two tables.

Table 2.1: Resource DEL (RDEL) excluding depreciation

£ billion (current prices)	Outturn[1] 2021-22	Plans 2022-23	Plans 2023-24	Plans 2024-25
Resource DEL excluding depreciation				
Health and Social Care	144.1	168.2	176.2	180.4
of which: NHS England	*133.7*	*152.6*	*160.4*	*165.9*
Education	70.1	77.1	81.2	82.6
of which: core schools	*49.8*	*53.8*	*57.3*	*58.8*
Home Office	14.4	14.6	15.4	15.5
Justice	8.5	9.4	9.8	10.0
Law Officers' Departments	0.7	0.8	0.8	0.8
Defence	31.7	32.1	31.9	32.0
Single Intelligence Account	2.5	2.6	2.3	2.4
Foreign, Commonwealth and Development Office	7.5	8.2	7.8	7.7
DLUHC Local Government	10.7	11.8	15.7	15.3
DLUHC Levelling Up, Housing and Communities	2.6	3.1	2.1	2.1
Transport	3.2	8.3	6.8	5.7
Business, Energy and Industrial Strategy[2]	2.4	2.6	2.7	2.6
Digital, Culture, Media and Sport	1.6	2.0	1.6	1.6
Environment, Food and Rural Affairs	4.1	4.5	4.3	4.2
International Trade	0.5	0.6	0.5	0.5
Work and Pensions	5.7	8.4	8.0	7.1
HM Revenue and Customs	4.6	5.9	5.6	4.6
HM Treasury	0.4	0.4	0.3	0.3
Cabinet Office	0.9	0.7	0.5	0.4
Scotland[3]	32.5	35.3	36.5	36.9
Wales[4]	13.7	15.2	15.9	15.6
Northern Ireland	12.5	13.4	13.5	13.6
Small and Independent Bodies	2.4	2.4	2.4	2.4
UK Shared Prosperity Fund	-	-	0.6	1.3
Reserves	-	10.7	13.9	12.9
Total Resource DEL excluding depreciation, ringfenced COVID-19 and energy support funding in DEL	**377.2**	**438.3**	**456.2**	**458.6**
Ringfenced COVID-19 funding	74.6	-	-	-
Energy support funding in DEL[2]	-	13.9	-	-
Total Resource DEL excluding depreciation	**451.8**	**452.2**	**456.2**	**458.6**
Allowance for Shortfall	-	-2.4	-3.7	-3.6
Total Resource DEL excluding depreciation, post allowance for shortfall	**451.8**	**449.8**	**452.6**	**455.0**

[1] 2021-22 figures reflect outturn in Public Expenditure Statistical Analysis (PESA), adjusted for provisional estimates of core spending. For devolved administrations, figures represent the Barnett consequentials of departmental COVID-19 funding less the element they carried forward from 2021-22 into 2022-23.
[2] The Department for Business, Energy and Industrial Strategy plans in 2022-23 exclude £11.8 billion of funding for Energy Bills Support Scheme, £2.0 billion of funding for the Expected Credit Loss from the Bulb Special Administration Regime, and £79 million of funding for Alternative Fuel Payments for businesses.
[3] Resource DEL excluding depreciation is before adjustments for tax and welfare devolution.
[4] Resource DEL excluding depreciation is after adjustments for tax devolution.

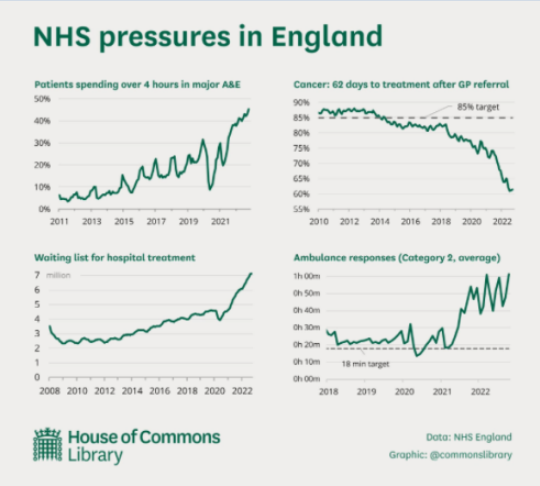
Table 2.3: Total Managed Expenditure (TME)

£ billion (current prices)	Outturn 2021-22	Plans 2022-23	Plans 2023-24	Plans 2024-25	Plans 2025-26	Plans 2026-27	Plans 2027-28
Current Expenditure							
Resource AME	461.7	581.3	578.3	559.4	570.7	600.6	617.6
Resource DEL excluding depreciation[1]	451.8	452.2	456.2	458.6	466.5	476.6	490.1
of which: COVID-19 funding	*74.6*	-	-	-	-	-	-
Ringfenced depreciation	24.4	28.6	29.2	29.6	30.0	30.7	31.5
Total Public Sector Current Expenditure	**937.9**	**1062.1**	**1063.6**	**1047.6**	**1067.1**	**1107.8**	**1139.2**
Capital Expenditure							
Capital AME	16.6	1.5	21.6	17.5	16.5	16.3	16.7
Capital DEL[1]	93.0	118.3	113.6	115.2	115.6	115.6	115.2
Total Public Sector Gross Investment	**109.6**	**119.8**	**135.1**	**132.8**	**132.1**	**131.9**	**131.9**
Total Managed Expenditure	**1047.5**	**1181.9**	**1198.8**	**1180.3**	**1199.2**	**1239.7**	**1271.1**
Total Managed Expenditure % of GDP	*44.7%*	*47.3%*	*47.2%*	*44.9%*	*44.2%*	*44.0%*	*43.4%*
of which Total DEL	*544.8*	*570.5*	*569.8*	*573.8*	*582.1*	*592.2*	*605.3*

[1] Resource DEL excluding ringfenced depreciation is the Treasury's primary control within resource budgets. Capital DEL is the Treasury's primary control within capital budgets. The Office for Budget Responsibility (OBR) publishes Public Sector Current Expenditure in DEL and AME, and Public Sector Gross Investment in DEL and AME. A reconciliation is published by the OBR.

Source: HM Treasury Calculations and Office for Budget Responsibility EFO.

As commentary on this, I can only pay tribute to the drafters of these examples of wish-think. It masks of course an inflation rate of 11.1%; an accelerating crisis in the NHS (See graphs below);



And wilful blindness to a workforce crisis about to be made far worse by a bitter pay dispute, industrial action and a re-run of the seventies with governments determined to take on the workers to prove who really runs the country.

NB *The answer to that question was not the government as the governments of Wilson, Heath and Callaghan found out.*

> (For an alternative view on the Autumn Statement I commend again Richard Murphy who sums things up nicely.)

It raises the question as to whether Scandinavian quality and Singaporean efficiency is real and attainable.

Unfortunately the European Health observatory only has a 2012 Country review for Sweden. But the wiki page seems more up to date and a useful summary.

It describes a system governed by localities with very high levels of public provision, funded by local councils able to levy local income taxes.

That might stick in the gullet of Westminster politicians. Plus it needs be noted there is a very high level of public provision of social care which I discussed in my October 21 newsletter, with a higher number of people employed in health and social care in a better funded system. Norway and Denmark offer even less to conservatives.

As for Singapore…All roads for conservative Brexiteers seem to lead to Singapore-on-Thames as the preferred economic and social model.

Be careful of what you wish for would be my advice.

The wiki page for Singapore and for the Singaporean Health system make it quite clear that there is a two tier citizenship meaning only c60% of the 5.7m population are classed as full citizens; almost 80% of the population are housed in publicly owned tower blocks with poorer migrant workers housed in little more than barracks.

There are a host of health and care providers competing for customers with workers obliged by law to compulsorily save (Medisave) for treatment costs.

Emergency care is fully funded and partly provided by Medi-bikers (surely something that could be further adopted in the UK).

Otherwise there is a complex and shifting web of insurance schemes and government subsidies that both oblige Medisave account holders over the age of forty to pay for their future social care needs and helps those in financial difficulties.

> *7 private insurers - AIA, Aviva, AXA, Great Eastern, NTUC Income, Prudential and Raffles Health have the rights to provide insurance with just three providing social care insurance.*
>
> *You can see what forces may be at work pushing such models in the UK.*

Be sure to ask for vested interests to be declared by people pushing such ideas. Overall health and life spans are good but that may be attributed to only having 10% obesity (compared to 30% of adults in the UK and 20% of children); and access to good

food and sunshine. Plus it is much easier to plan and provide healthcare for a relatively small number of people on a congested island, rather than over a geographically and socially diverse area such as the UK.

NB *Singapore is not even twice the size of the Isle of Wight or 1/109th the size of Scotland despite having a similar population to Scotland.*

The answer to the question of whether Scandinavian quality and Singaporean efficiency is possible in the UK of course exists only in the minds of "cakeists" in the conservative party. They who cruise the policy bars from around the world and try to pick up something that may look good when presented to colleagues as a bright new idea.

> *You know the sort: the ones who gave us Brexit, "world-class commissioning" and the digital revolution.*

I note in passing that Rishi Sunak has taken to boosting the idea of Silicon Valley - on- Thames. This only goes to prove that the boy can leave California but you cannot take California out of the boy.

This recent Times article reminds us that the idea has been around for some time and faces an uphill struggle. Tech City in Shoreditch was its forerunner and never got beyond Tech roundabout.

So much for the context , what about the debate?

Framing the narrative and what my friends think.

The battle is on, to frame the debate on the future of the NHS. We all have our own opinions and experiences and my recent experience was in touring the UK and having the debate with my friends and colleagues.

These are my findings:

1. Many people are thankful and grateful to the NHS. Including the widow of my friend in Chichester who died almost a year ago. Incidentally she thanked me for my role in helping to prevent the closure of the A&E in Chichester hospital. I was once seated next to Harriet Harman at a dinner and she asked me what I did. I said I helped Conservative councils stop her Labour government closing A&E departments. Subsequently we moved on to help Labour councils stop Conservative governments close A&E departments just to show no political bias. As a further aside I keep having these awful feelings of Déjà vu for what might happen under a future Labour government still apparently wedded to the un-sustainability /integration/ modernisation/prevention/digitisation mythology.
2. Many people are fearful and filled with low expectations of the NHS fuelled by relentless negative press coverage but also by evidence on the ground as people talk to one another.
3. Many people were also angry and determined to resist cuts in services, closures to services and to fight for increased funding and better pay. These people had been attending the SOS NHS Conference on 12th November. It was nice to be thanked for the work I did in Huddersfield, Tyneside and in NW and SW London in presenting arguments to help in stalling and stopping "reconfigurations".
4. Some blame the size and complexity of the NHS. When I point out that Amazon and the big multinationals cope quite nicely they go on to talk about resources.
5. We live in a world of limited resources and people understand we cannot always have what we want. When I point out other countries spend more, that the UK has a comparatively low tax regime and serious books regard spending more on health and social care as not only inevitable, but affordable and desirable; and that actually what we face is nothing more than a choice

not a barrier ; the conversation usually moves on.

6. Some people are rugged individualists with enough money to look after themselves. When I point out to them they are not always the best qualified to decide whether laser surgery or a new joint is necessary for their prostate or knee problem and that doctors with a financial interest are not always as professional as we would like them to be when they have a financial interest they usually admit to hesitation at least.

7. Others bemoan the silos that NHS professionals work in and that they as a patient have become frustrated by the inability of consultants to talk to one another about a problem which probably requires a multi-disciplinary discussion rather than an endless spiral of referrals for ever more diagnostic tests and cross referrals to other disciplines. One at least has taken out the cheap insurance scheme from Benenden which only intervenes if the NHS is not available in a reasonable time for diagnostic tests and treatment. As the waiting lists for diagnostics increases this scheme is likely to become more popular. He was certain it was working for him.

8. These same people also point out the costs to the NHS of endless delays , duplication of tests , endless streams of small interventions by isolated professionals leaving the bigger causal problem undiagnosed and ineffectively treated. When I point out that multi -disciplinary team meetings are very expensive and not necessarily covered in the tariffs for treatment and that both pressure to limit costs and to fulfil the wishes of commissioners of care often leads to sub-optimal care being delivered they understand. When I go on to cite the demise of the Nuffield Speech and Language Unit for children with dyspraxia as an example of a service closed because commissioners found it easier to deny ,delay and dilute care for small children with dyspraxia until it was too late to intervene most effectively, they understand even more.

9. Which brings me on to discussions with my friend closest still to power in the NHS: his call was for morality to be given more importance in the NHS and in public life generally. Without morality at the core of what we do mistakes are inevitable. Being more of a resources man myself I didn't acknowledge the insight strongly enough. It took a visit to Liverpool Local History centre at the splendid new Public Library and a visit to the library of the Athenaeum in Liverpool to strike a chord. It was in looking up information on Thomas Steers, the engineer responsible for building the first docks in Liverpool who went on to be mayor of Liverpool, build houses for the poor, schools, churches, and theatres in Liverpool. He promoted and did work leading to the building of canals and his family extended his work over the next century. What stood out was discovering the words written in his honour at the unveiling of a plaque belatedly commemorating his life in 1931. The plaque was destroyed in the second world war along with most of the church but the words linger in the book[1] as follows:

"Let us remind ourselves that our institutions can be no other than our character makes them: that the foundations of character are moral and that the salvation of morality, and all that is best in the world is to be found in character. It is our British character that has made us as a nation go boldly forward on the road to history. Let us continue in that path without violence, without intemperance, but with an inflexible determination to be just to all. This is power, and

[1] Thomas Steers: The Engineer of Liverpool's First Dock by Henry Peet : Butler and Tanner Ltd , Frome and London 1932

this power alone can carry the world and us from the unrest of the present order of things to the unbroken road of a more equitable, more peaceful and safer future."

If you then contrast these words with the closing remarks by Richard Millet KC at the conclusion of the Grenfell Tower Inquiry hearings, where he said the deaths were avoidable and that there was a "merry-go-round of buck-passing". Every one of the 74 deaths from the fire was avoidable, as there was enough common knowledge to prevent what happened on the night; you understand the significance of morality.

"From all of the evidence that you have heard at phase 2, you are able to distil a single overall conclusion: that there was nothing unknown or not reasonably knowable which caused or contributed to the fire and its consequences.

"On the contrary, each and every one of the risks which eventuated at Grenfell Tower on that night were well known by many and ought to have been known by all who had any part to play. As a result, you will be able to conclude with confidence that each and every one of the deaths that occurred in Grenfell Tower on 14 June 2017 was avoidable."

He said the reasons were many, complex, and in many cases, inextricably interlinked. Some had an immediately causative effect and others less so. He suggested it was open to the inquiry panel to conclude that there was:

- a long run-up of incompetence and poor practices in the construction industry and the fire engineering and architects' profession
- weak and incompetent building control
- cynical and possibly even dishonest practices in the cladding and insulation materials manufacturing sector
- incompetence, weakness, and malpractice by those responsible for testing and certifying those materials
- the failure of central government to act – despite known risks
- failures of competence, training, and oversight within the Tenant Management Organisation, and similar failings of the Tenant Management Organisation by Royal Borough of Kensington and Chelsea
- a failure by the London Fire Brigade to learn the lessons of Lakanal House and other fires, and to train its operational staff to collect, understand, and act on the risks presented by modern construction methods and materials.
- Piecemeal legislation and outdated guidance

Behind all of these distinct factors, he said, there lay complex, opaque, and piecemeal legislation, and an over-reliance by law and policy makers on guidance, some of which, including the statutory guidance, was ambiguous and dangerously out-of-date, and much of which was created by non-governmental bodies and influenced by commercial interests:

"Listening to the last three and a half days of overarching closing statements from a range of core participants, if everything that has been said is correct, then nobody was to blame for the Grenfell Tower fire. Can that really be right? Is the answer that you are to give to the survivors, to the grieving families and to the wider public to be that the Grenfell Tower fire was just a terrible accident, just one of those unfortunate incidents that happen occasionally? Or is it to be that there are so many to blame, that no one individual or organisation shoulders very much blame?"

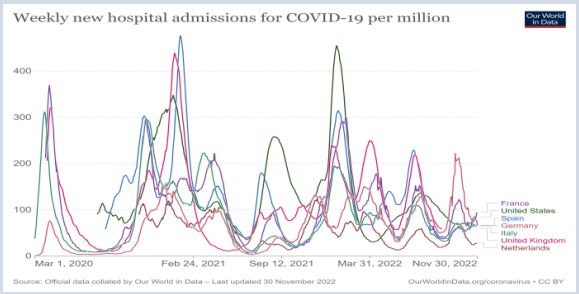
At the start of the inquiry, Mr Millett said that it was likely that at least some of the core participants would indulge in a "merry-go-round of buck-passing". This metaphor may by now have become rather worn, but the "merry-go-round turns still, the notes of its melody clearly audible in the last few days". If you listen closely to the tune, he said, you can begin to hear that many core participants have adopted a particular technique; namely, "the deflection of criticism by reference to causative relevance, and then, in turn, to take a narrow and technical approach to causative relevance in order to escape blame for the fire and the ensuing deaths, but then to blame others without any regard necessarily to causative impact."

See https://www.thefpa.co.uk/news/grenfell-inquiry-closes-with-excoriating-summary

The moral of this story is that if you are really interested in discussing the future of the NHS then listen properly to your friends and be prepared to argue for what is right.

Covid Latest

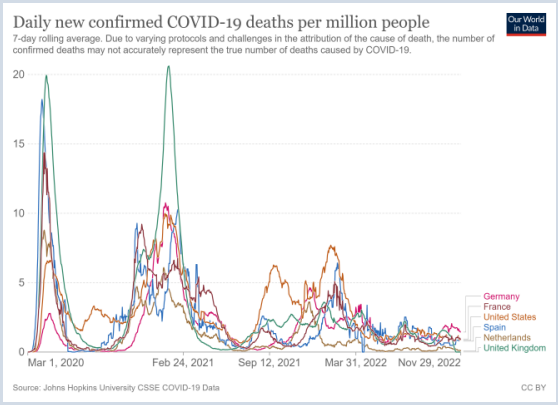
In travelling through France and the UK it is clear that most people are continuing as though Covid was over. The old and vulnerable are less evident; and represent the tiny minority still wearing masks.



But what do the statistics reveal?

This seems to reveal that hospitalisations remain high with another upward surge likely as reports are of new more contagious variants coming through.

Although newspapers seem to be taking a more alarmist line than the WHO:



The i quotes Steve Griffin, of Leeds University,:

"In the absence of testing, improved ventilation or mask wearing in high-risk indoor environments, there really is only one way that viral prevalence is likely to go between now and Christmas, running into January.

"The antibody evasiveness of BQ1.1 could mean yet another damaging wave when the NHS is already at crisis point.

Moreover, evidence suggests that BQ1.1, like BA5, is capable of infecting lower down in the lungs, which may begin to cause problems if immunity continues to wane in many."

Covid Deaths however remain low, at "only" 423 in the last reported weekly figures.

They are not taking any chances in Austria however:

Prof. Christina Pagel 🇺🇦

@chrischirp

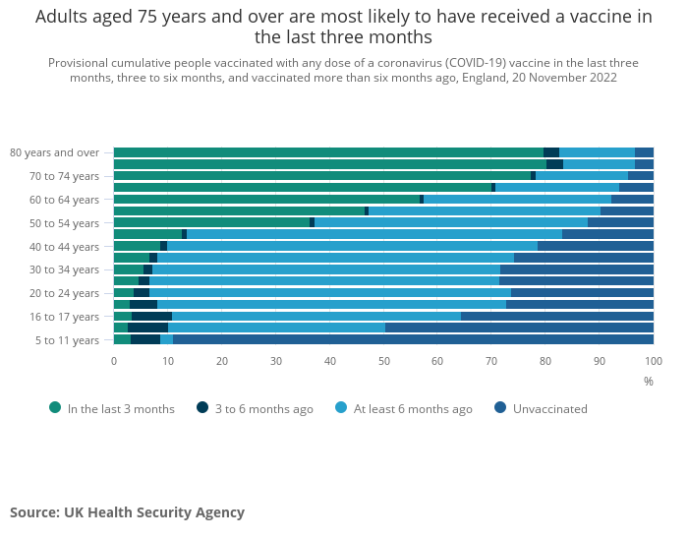
My friend has just returned from Vienna - reports 95% of people on public transport wearing FFP2 masks (no great policing of it).
People are entitled to 5 free PCR tests a month and kids in nursery/school still regularly tested.
He had a great time. We *could* do this.

The latest reports on reinfections shows that these increase as the time since vaccination increases, pointing to the need to keep up the vaccination levels.

> Other reports identify the long term factors associated with vaccine resistance .
> Negative childhood experiences count for a lot.
>
> *"Personality tests at age 18 showed people in the vaccine-resistant group were vulnerable to frequent extreme emotions of fear and anger.*
>
> *They tended to shut down mentally when under stress.*
>
> *They also felt fatalistic about health matters, reporting at age 15 on a scale called "health locus of control" that there is nothing people can do to improve their health. As teens they often misinterpreted situations by unnecessarily jumping to the conclusion they were being threatened.*
>
> *The resistant group also described themselves as non-conformists who valued personal freedom and self-reliance over following social norms. As they grew older, many experienced mental health problems characterised by apathy, faulty decision-making and susceptibility to conspiracy theories."*

My fear is not resistance however but complacency.

The following chart published on 28th November by the UK Health Security Agency doesn't augur well to me, with only the elderly maintaining vaccination levels.



Strikes, Staffing issues and productivity

It is wrong to fall prey to anglo-saxon exceptionalism, either for the better or the worse.

A closer look at events in Europe shows the UK has more in common with Europe than often supposed.

For example labour shortages and the threat of strike action exist across Europe.

In the UK 100,000 Nurses will go on strike in December as a warning shot in the campaign in the UK of nurses looking for a fair pay rise.

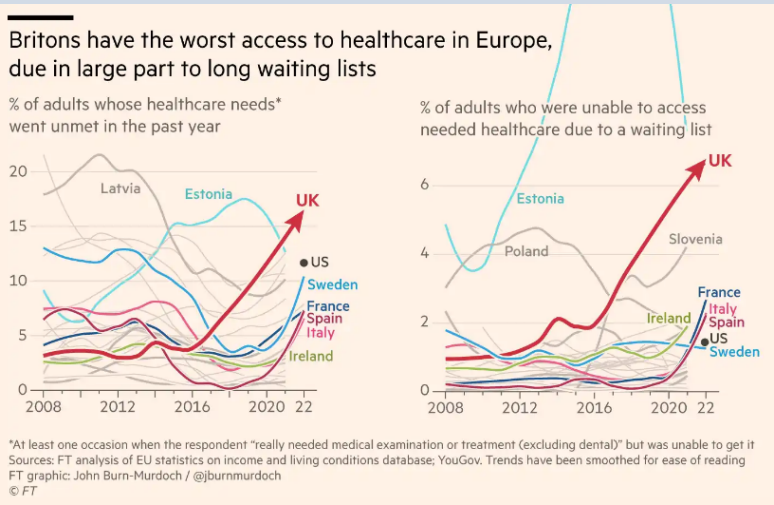
French doctors are to go on strike in December. As well as laboratory scientists, transport workers, airlines, nuclear plant operatives etc. https://www.thelocal.fr/tag/Strikes/

In Germany Nurses are to go on strike as part of a campaign by public sector workers. Already a benchmark of 8.5% has been set by the industrial workers unions.

Le Monde report that Primary Care Doctors are striking in Spain. And in Portugal nurses are on strike.

There are common threads of issues, some of which are aggravated in the UK, but exist to some extent across Europe.

Healthcare staff have emerged from the Covid crisis wounded and exhausted. Some have fallen or have withdrawn leaving a depleted workforce to address backlogs and a continuing heavy workload.



This is having a pronounced impact on access to healthcare in the UK with the FT pointing out that the UK has the worst record amongst 36 European nations.

Worsening healthcare is imposing economic headwinds as more of the workforce are reporting long term sick (1in 6 in the UK).

Research shows that spending on healthcare has benefits for jobs, growth, the economy, future resilience to public health threats as well as to public welfare generally.

Whilst labour shortages are a problem it will take time to train more staff even if numbers in training are increased. This justifies short term measures to boost pay and retention levels in the short term.

For example in France overtime pay has been doubled and retired staff incentivised to return to the workforce.

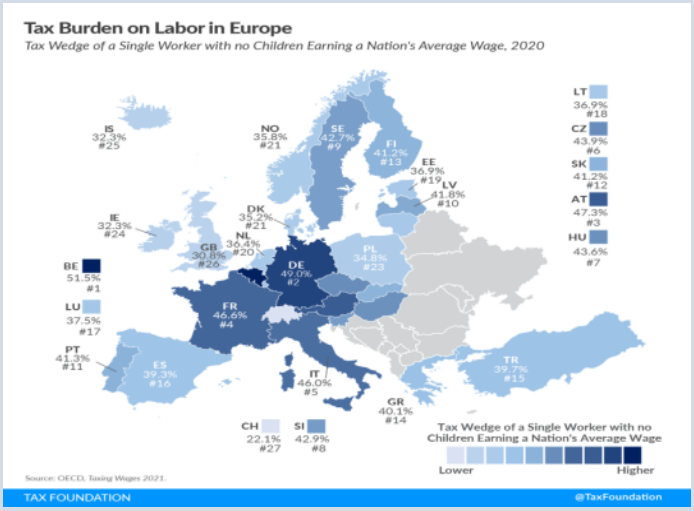
Inflation is a problem across Europe and stands at around 10%.

There is no reason that healthcare workers should be asked to accept a reduction in real pay levels on top of an increased workload.

It is generally accepted that austerity policies , targeting public spending , including healthcare, since the Financial Crash in 2008 has been counterproductive and a failure .

When discussing productivity it is not generally appreciated that the public sector has much higher levels of productivity compared to the US healthcare sector ,

Or, I might add that the best way to improve productivity would be more investment.



That the supposed high UK tax rates is a barrier to raising funds for healthcare is belied by this chart from the tax foundation.

Latest round-up from across Europe

Europe has published its Health programme for 2023. While Europe works together on common health concerns and has allocated a Euros735m budget, the UK can only look on smugly.

After all, the UK spent £75bn on Covid alone in 2021/22 . The UK must be awash with resources to prepare for Future crises, Health promotion and prevention, Cancer care, Health systems and Workforce, Digital and IT issues etc.

What could possibly be gained by acting in co-operation with European partners?

The EU Global Health Strategy was published on 30th November.

For all the fine words I suspect there will be commentators who will see this as an aggressive strategy to support the interests of the EU Pharmaceutical and healthcare industry.

Corporate Europe Observatory highlight how the EU turns a blind eye where necessary when exporters interests exceed health concerns.

The European Observatory for Healthcare Systems has just published its review of the United Kingdom health system. There is a 220 page full review and a shorter summary.

There looks to be much to discover.

The two things that stood out were the revelations that Out of pocket expenses rose to 17% of total spending in 2019, plus the population of the UK rose by 12.2% between 1995 and 2020.

I suspect neither of these things was factored into the plans of the era.

The French Health ministry has published its Annual review and accounts for 2021. I discussed the 2020 version in my April 2022 edition of this newsletter. The contrast with the DHSC version to be published in January 2023 will take some explaining.

Not least why the French limited their extra Covid costs to 17bn Euros whereas according to the figures in the Autumn Statement, in table 2.3 above, the excess Covid costs were £74.6bn.

The Ex-Chancellor of the Exchequer and now Prime Minister might also like to talk about this. He wouldn't be the first Prime Minister called to answer embarrassing questions as Edouard Philippe was called to explain himself.

The UK's own **Covid Inquiry** is only now starting ….

The Kings Fund offer space to Bill Morgan to "explain" the staffing crisis in the NHS in his report NHS staffing shortages: Why do politicians struggle to give the NHS the staff it needs? Bill Morgan November 2022.

There is a problem with this report.

It is supposed to be independent but the process by which it has been produced means it should really be called the excuses that are offered for staffing shortages by the NHS establishment.

It is a politicised product that offers as a solution more overseas recruitment ...and better planning.

Preposterously it claims the Germans regret having too many doctors.

It is shallow, evasive and doomed to be ignored. It rightly fingers the Treasury as one of the guilty parties but somehow everybody else escapes.

David Green of Civitas/IEA wrote about the professional interests at work in the Eighties.

The truth is it suits many people that there are shortages. It maintains pay levels. There is not a word said about this issue in the report from a quick read. It provides a ready excuse for further rationalisation (you cannot get the staff you see), for quality failures and inefficiency.

Neo-liberal dogma, professional interests, and the conservative party all have been hostile to a successful NHS.

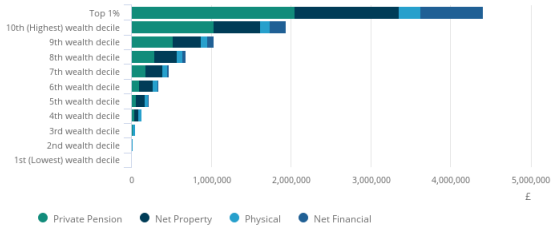
There are many that would wish to "Starve the Beast".

Someone really independent should be given the task to write about the real reasons for staff shortages.

The Nuffield Trust blames Brexit for medical shortages ["Has Brexit affected the UK's medical workforce?"](#).

Figure 3: Physical wealth made up the largest share of wealth for the least wealthy households compared with property for mid-range households and pension for the most wealthy

Wealth components median by household total wealth decile, Great Britain, April 2018 to March 2020



Source: The Office for National Statistics - Wealth and Assets Survey

Conclusion

There is no shortage of things to talk about. But references to the Treasury concerns for fiscal probity and the need for belt tightening were put into perspective by this recent chart from the ONS.

As ever the problem is not so much resources but the distribution of resources…

… and the matching of these with needs for healthcare.

Best wishes, seasonal greetings and if you kiss under the mistletoe, don't kiss your granny afterwards.