

Alternative European Healthcare Perspective

October 2024

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It's official: the UK is the sick man of Europe. It has been obvious to me and readers of this newsletter in comparing UK and EU health performance statistics; but now the IPPR Commission on Health and Prosperity has confirmed it in [Our Greatest Asset The Final Report published on 17 September](#), where it states,

We lag our peers on health outcomes, the number of people with a long-term condition is rising, and people are spending longer in poor health. And, health is worsening throughout the life course – bringing real challenges for children, adolescents, working-age adults, and those who have retired.

This report follows hard on the heels of the [Darzi Independent Review of the NHS](#) initiated by the new Labour government.

Meanwhile, the EU has appointed its top team to the Commission. [These are the commissioner-designates chosen by the President](#). More on the chosen [here](#). The list however is subject to ratification by the European Parliament following interviews.

And, there are some [people in the firing line](#). We'll see what happens in the increasingly fractious Parliament: the process must be completed by the 1 December.

The script has been laid out in the Draghi report on [Strengthening European competitiveness](#). Draghi was the past European Central Bank President. The report's reception hasn't been wholeheartedly favourable. It has been accused of not listening to the broader concerns relating to eastern Europe, the environment and to social issues. I'll be discussing the main themes from these reports below as well as reporting on other significant reports to have taken my eye over the past month.

The state of play for UK healthcare

The honeymoon period of the new government has been short-lived; encapsulated in the

recent headline of the New Statesman: *What's the Story? - Labour are in power But we still don't know how they want to use it*. The New Statesman has a three page spread covering an interview with the Health Secretary Wes Streeting (mainly devoted to a fetching photograph); it shed no further light, concluding with a statement of good intentions – but little else,

Now we are going to do something that, frankly, lots of people in our country still don't believe is possible, which is to take Britain from the depths of the crises left by the Conservatives to building a better future.

This week saw a speech from the Chancellor, [Rachel Reeves, at the Labour Party Conference](#); again no further elucidation: we will have to wait for the Budget and for [the new NHS ten-year plan](#). But we do have the IPPR report and the Darzi report to mull over.

The IPPR report

The IPPR report not only describes the poor state of UK public health but suggests the possibility of doing something about it. It notes that other countries have done better. The UK has delivered relatively disappointing gains in healthy life expectancy since the beginning of the 21st century. By contrast, Japan

transitioned from least to most healthy country in the G7 in the second half of the 20th century – and has a healthy life expectancy at birth around four years higher than the UK. South Korea, Ireland and Singapore have all improved healthy life expectancy substantially in the last few years (World Health Organisation 2020).

It further notes the UK’s high levels of health inequality. There is currently a 15-year gap in healthy life expectancy at birth between Wokingham and Blackpool (ONS 2024b). Major improvements in Britain’s overall health could be achieved simply by securing the kind of health outcomes everywhere in Britain shown to be possible in the healthiest parts of the UK.

Finally, it notes that much of the UK’s disease burden is preventable, treatable or otherwise manageable. The evidence suggests that 40% of cancers, 80% of cardiovascular deaths and 40% of cases of dementia could be prevented through action on known and identifiable risk factors. Many mental health problems can also be prevented, and conditions like Type II Diabetes, chronic kidney disease and alcohol use disorder can be entirely prevented (IHME 2024).

The report makes the following policy prescriptions.

FIGURE 5.1: POLICY SUMMARY

Work	Work that creates health	<i>A healthy work employer standard, with adoption supported by a Wellbeing Premium cut to business taxes</i>
	Support back into appropriate work when we fall sick	<i>Bespoke skills in supporting disabled people and people with long-term conditions in job centres, focussing on appropriate work not just any work, and supported by a new NHS 'back to work' national programme</i>
Markets	Protection from products that make us sick	<i>New levies and regulations on health harming products</i>
	Genuinely healthy, affordable and enticing choices of food and leisure	<i>A National Health Investment Bank to reinvest proceeds from health levies into health vital industries</i>
Families	World leading support for families at the start of life	<i>Restart Sure Start by restoring funding and infrastructure to 2010 levels</i>
	Financial security for families and enough good food to eat	<i>Free school meals for primary school children and an end to the two-child limit</i>
Places	Access to core community spaces, like libraries and swimming pools	<i>New investment and powers to restore (or protect) the community assets key to healthy lives</i>
	A real say in how places with poor health and low opportunity transform for the better	<i>A new local power to designate 'HAPI' Neighbourhoods – modelled on Clean Air Zones – with national investment and new powers</i>
Services	Access to a local, neighbourhood health centre	<i>Build a Neighbourhood Health Centre in every part of the country – a one-stop shop for diagnostics, primary care, mental health and public health</i>
	Access to a brilliant health service when we do need it	<i>Modernising reforms of the health service, to make sure we continue to have access to appropriate care at times of acute need in the years and decades to come</i>

This is all good stuff but unlikely to deliver much short-term relief. Just as with Sure Start

the first time around, there was little impact after ten years and a new government would just as likely cancel it again on the basis that early year child rearing is a parental responsibility.

Neither are GPs universally in favour of neighbourhood GP centres if it works against their interests, nor are the pressures likely to drop off soon to ensure the NHS can deliver a so-called 'brilliant health service'.

The report remarkably fails to say anything about the gaps in performance that ensure the NHS cannot deliver a brilliant service now or the obstacles towards achieving this.

The Darzi report

[Lord Darzi](#) is an [honourable man](#). In that he has achieved many honours. He consulted widely upon with the great and good of the healthcare industry. His report reflects the consensus view that if the NHS is not, as in Streeting’s pejorative terms, broken, it is in Darzi’s words, in serious trouble.

He had only to look out of the window to see the waiting lists, declining public health, chaos in A&E, lack of access to GPs, the decline in community services and mental health services, the crumbling infrastructure and the poverty of the IT and medical equipment support to our clinicians.

He highlights shortfalls in cancer services and cardiovascular services and quality standards generally, but fails to provide a comprehensive review of services, even in the appendices, not because there isn’t the evidence but presumably it might lead people to the wrong conclusions.

Thus, although he starts by saying that performance shortfalls are driven by the austerity policies of governments since 2010 his analysis lurches into a litany of excuses: spending on the wrong things, not enough capital, patients not shouting loud enough, staff disengaged (not powerless), management all

over the place, re-employed into monitoring and regulating rather than doing. Then despite saying he was not asked to provide solutions he gives away in paragraph 28 what will be in the new NHS 10-year plan:

- *“Re-engage staff and re-empower patients. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.*
- *Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population ages. Financial flows must lock-in this change irreversibly or it will not happen.*
- *Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.*
- *Drive productivity in hospitals. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and re-engaging and empowering staff.*
- *Tilt towards technology. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform*

care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation’s prosperity. With the NHS budget at £165 billion this year, the health service’s productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.*
- *Reform to make the structure deliver. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.”*

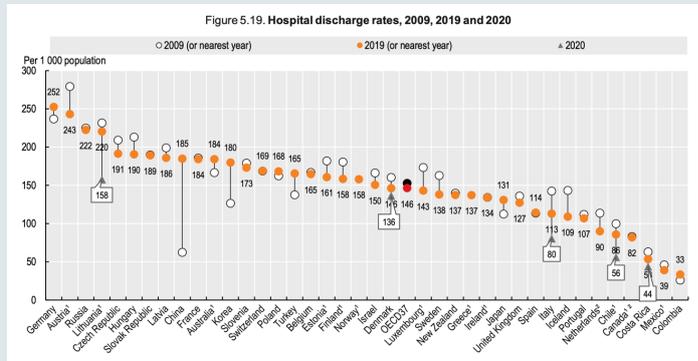
We will have to wait a bit longer to fill in the gaps but Darzi seems to be fuelled in making these suggestions by the same old policies pursued over the last forty years.

The belief that community services are a substitute for acute care, that there are no healthcare consequences of defunding elderly care, that it's OK to run the NHS at 95% occupancy levels, that more can be wrung out of primary care despite numbers and capacity not keeping up with population growth and the increased morbidity in the elderly population; and above all that the NHS has a productivity problem rather than a production problem.

Nowhere in his analysis does he mention conflicts of interest and the problems of a two-tier service.

Nowhere does he highlight the stark contrast with other European countries in terms of

quantity of healthcare and treatment (and diagnostic capacity) provided (I highlighted this in last month's newsletter) but is encapsulated in the diagram below:



Nowhere does he acknowledge that it has been the policy of successive governments to ensure that there are shortages of NHS capacity which in turn ensures the NHS cannot meet the demands made of it.

The priority is always to meet financial targets rather than healthcare needs and the medical profession is only too happy to supply extra services otherwise, at a price.

The NHS has always rationed its services, and the rationing is now ever more overt. NHS resources have always been poorly distributed and outcomes unequal; but it's not getting any better, despite fifty years of supposed resource re-allocation. If this is truly where the next 10-year plan is leading, then awkward questions will have to be asked about what the plans are to ensure that enough healthcare will be delivered.

Already the assumption that beds can continue to be cut has been shown to be ludicrous: the evidence suggests increasing need for end-of-life care, increasing demand from the increasingly elderly population and of course the paucity of community and social care.

And, squeezing more care out of poorly trained junior staff is not going to make the service more efficient or improve quality.

Patients are not interested in productivity; they want the right quantity of healthcare delivered when they need it. Are we just haggling about the price? Or the way in which demand is artificially sustained to support the private healthcare market?

Meanwhile in Europe

The story across Europe is who will be finally chosen for Ursula Von der Leyen's team of commissioners at the Commission for the next five years.

If you are wondering why it is so important you need to know they have [two trillion euros to distribute in European funds](#). Although the designated nominees are now in place, questions are being asked about some of them (*see earlier linked article*) and we will not know the final line up until 1 December.

What we do know is that UK influence in Europe is now much reduced and all the dire

predictions to the [economy post Brexit](#) have come true, [despite the full trade barriers not yet being fully in place](#). [Starmer is still talking about whether to agree to exchanges of students between Europe and the UK](#).

But not very seriously.

Figure VI.3: International comparison of health system capacity going into the Covid-19 pandemic

	Practising physicians per 1,000, 2019	Practising nurses per 1,000, 2019	Hospital beds per 1,000, 2019	Occupancy rate of curative (acute) care beds, 2019	Total health spending: US dollars per capita, 2019	Average length of stay in hospital, 2019	Capital expenditure on health as share of GDP, average over 2015-19
UK	3.0	8.2	2.5	89.1	4,268.7	6.7	0.4
Australia	3.8	12.2			5,545.9	5.3	0.8
Austria	5.3	10.4	7.2	73.0	5,263.0	8.3	0.9
Belgium	3.5	11.6	5.6	72.5	5,049.6	6.0	1.0
Canada	2.7	10.7	2.5	91.6	3,116.0	7.6	0.9
Denmark	4.3	10.1	2.6		6,099.0		0.5
Finland	3.6	13.5	3.4		4,460.0	7.7	0.7
France	3.2	8.8	5.8	75.9	4,504.5	8.8	0.6
Germany	4.4	11.8	7.9	78.9	5,487.0	8.8	1.1
Ireland	3.3	13.4	2.9	89.9	5,452.7	5.9	0.4
Israel	3.3	5.1	3.0	91.6	3,354.0	6.7	0.6
Italy	4.1	6.2	3.2	78.1	2,911.0	8.0	0.4
Netherlands	3.6	10.8	3.0	63.7	5,341.0	4.4	0.9
Portugal	5.3	7.0	3.5	82.0	2,222.0	8.0	0.7
Spain	4.4	5.9	3.0	75.9	2,716.8	8.1	0.6
Sweden	4.3	10.9	2.1		5,633.0	5.6	0.6

The latest news however is that relations between France and Germany, the axis of the EU, have taken a turn for the

worse following the [French Commissioner's abrupt resignation](#).

The fuller story is in the New Statesman from Wolfgang Munchau – *'Ursula von der Leyen has damaged the relationship between France and Germany'* 20-26th September.

It's a spat about disagreements on regulatory policies which Munchau predicts Germany will use to undo the deadline on banning the sale of diesel and petrol cars, and the large fines that will be levied from 2025 for failing to meet emission targets.

He puts it in the wider context identified by Draghi of European competitiveness. Munchau concludes,

Breton (the French Commissioner concerned) and Von der Leyen's battle was ultimately between two losers – one of them has gone, while the other will limp on for another five years without a strategy. There are no winners.

Mario (Whatever it takes) Draghi published his Improving European competitiveness report in September. It makes for incisive and depressing reading. For those who want to compare with the [Johnson Government's Industrial Strategy](#), the UK version is not in the same league for insight

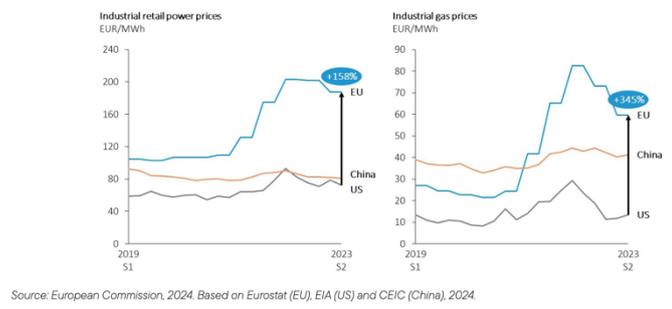
but at least it is more hopeful. Or deluded.

Draghi gets quickly to the big issue: energy prices.

Following the loss of cheap Russian gas, the EU (and the UK) is now industrially uncompetitive. It's less of an issue for the [UK as its industrial](#)

[sector](#) is much smaller (9.4%) but for countries like Germany (20.4%) it's a really big issue. You can see Germany wants the conflict with

FIGURE 1
Gas and retail price gap for industry



Ukraine to go away. And why nuclear power is being developed once more.

But the Draghi report is not just about energy prices.

There are chapters on:

Rare minerals - the Chinese have control.

Broadband technology - the EU companies are too fragmented.

Computing and AI - the battle is lost to the US and China.

Microprocessors - the EU only has a small and diminishing niche.

Energy-intensive Industries - metals, chemicals, paper, where the EU competitiveness is eroding because of high energy prices.

Clean technologies - China dominates manufacturing.

Automotive Industries - EU has lost market share.

Defence - strong in parts but spending low.

Space - growing but poorly funded.

Pharma - strong, growing but now falling behind in new products.

Transport - set to grow with the completion of European high speed train networks.

FIGURE 8
Development of global carbon prices
ETS historical price developments, USD per tonne

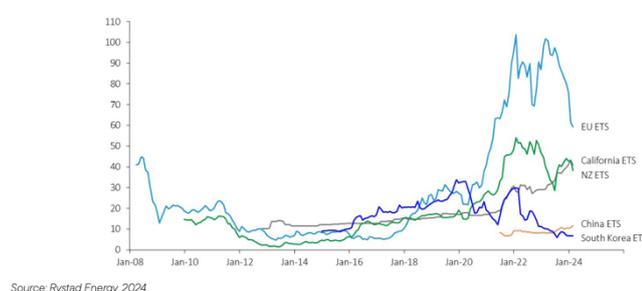


FIGURE 2
The shift in vehicle production

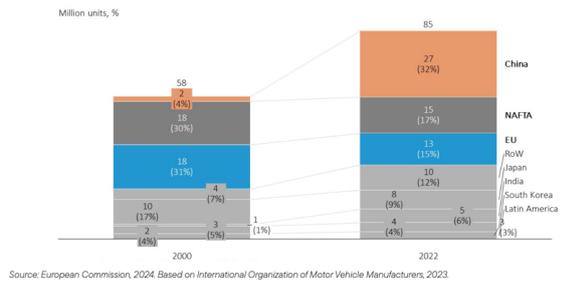


FIGURE 1
EU trade in medicinal and pharmaceutical products

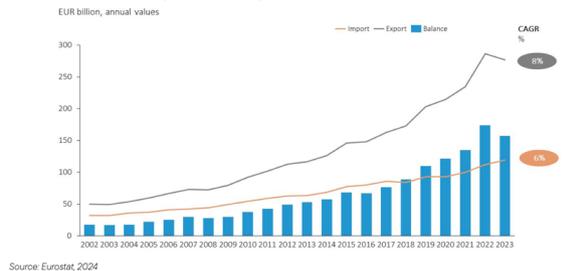


FIGURE 4
EU-level corridors covered by TEN-T by 2050



But it's not all doom and gloom. It's going to be much easier for rich US and Chinese tourists to do their European shopping tours.

The report concludes by calling for more innovation, skills development, investment, competition and governance. It calls for the EU to do fewer things better, including the development of a more centralised financial market. Watch out London.

Round up of other European Healthcare matters

The **European Healthcare Observatory** is back from its summer holidays and there is a [Special Edition of EuroHealth](#) published on 17 September. The introduction to the journal concludes,

The past few years have taught us that access to high-quality healthcare for all requires continuous, strong international cooperation. Pandemics, the climate crisis, and other large-scale threats to our health systems know no borders and require global solutions and solidarity. By working together, we can overcome many of the challenges facing our health systems, ensuring better health for all and stronger societies.

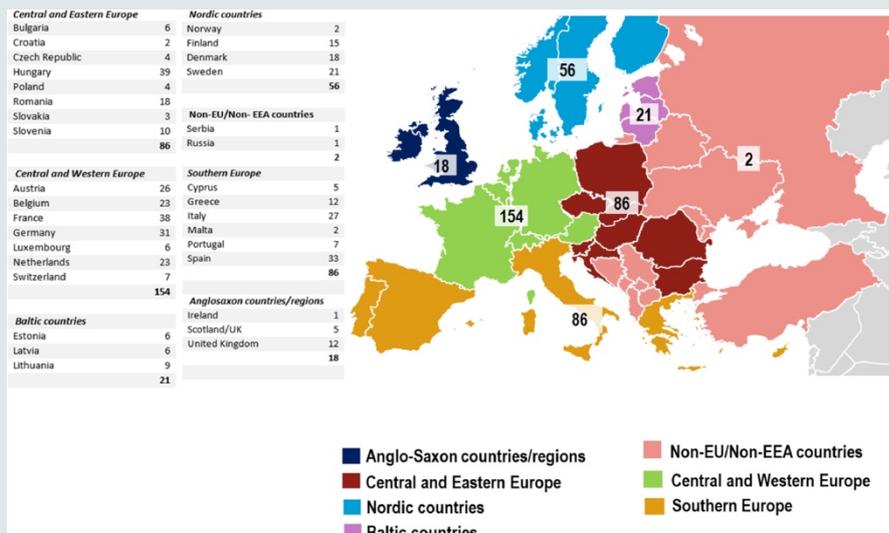
Some countries are better at this than others as the article available from the Health Policy Tab under publications shows.

The article itself from Dec 2022 [Cross-border healthcare collaborations in Europe \(2007–2017\): Moving towards a European Health Union?](#)

Concludes,

Our findings show that Central and Western European countries continue to be frontrunners with respect to leadership of cross-border healthcare collaboration initiatives, paralleling findings from the HealthACCESS study, which was carried out in the period before 2007.

Yet, taking the population size in the countries analysed into consideration, Baltic countries (34.35 projects per 10 mill inhabitants) and Nordic countries (21.13 projects per 10 mill inhabitants) dominate in CBHC collaborations.



•Despite the current challenging economic climate, nearly half of the public (48%) support the government increasing taxes to spend more on the NHS.

Euronews has reported on the rise of [social media influencers on healthcare](#). They have their work cut out. Here in Sheffield, fresher's week is accompanied by

The UK was never very good at collaboration. Meanwhile, the pursuit of a European Healthcare Union is still on the cards. This popped up on the Observatory website yesterday [‘Everything-you-always-wanted-to-know-about-european-union-health-policies-but-were-afraid-to-ask’](#). It is 300 pages long and will tell you more than you want to know about European healthcare policies.

For those interested in Spain [A review of the Spanish Healthcare System](#) also came out in September.

The Kings Fund delivered some relevant new studies. [People power: lessons from the health care response to the Grenfell Tower fire](#) makes for a salutary read. Giving people what they want has never been more complicated it seems.

If you need reminding of what people want then juxtaposed is the latest edition of the [Public Attitudes survey from 2023](#). In the words of the Kings Fund,

- *Despite the challenges the NHS is currently facing, the public are not looking for changes to the principles of the NHS. They do not want a different model – they want the one they have got to work. They are clear they want to see improvements in waiting times for services, funding and the number of NHS staff.*

heavy promotions for junk food and cut-price alcohol deals. And it seems to be working if the numbers of students in my local is any gauge.

Euronews also reports that [Novo Nordisk is making a killing](#) from sales of its fat loss products in the US (\$866 per month). Buy shares now; once insurance companies start to cover the costs the price will go through the roof.

The Nuffield Trust and Health Foundation published their [NHS performance tracker](#). This is an easy to grasp selection of indicators the government use to summarise performance, compared to itself.

Even though there is a Nuffield Trust international section we still do not have good comprehensive and comparative data on how waiting lists, A&E performance, ambulance waits, pay comparisons, quality indicators and much else compares with other European countries. I do my best but you would think that the leading healthcare think-tanks would be more curious to know why, for example, ambulance handover delays do not seem to be a problem in Europe, while it appears [unfathomably complex in the UK](#).

Youtube is proving to be a good source for interesting discussions. See the German media view of the UK healthcare system: <https://www.youtube.com/watch?v=JXi3rUaXylw>

And this discussion of medical inflation from the European observatory - <https://www.youtube.com/watch?v=vwGNRcEiiC0>

Bloomberg discuss the decline of European healthcare systems: <https://www.youtube.com/watch?v=5cG6ltpwLv4>

Comparing healthcare systems from a US viewpoint: <https://www.youtube.com/watch?v=wfsJXo1h1G0>

World Sexual Health Day on 4 September was accompanied by a [report highlighting the issue in Europe](#). It appears the [rate of reported cases is rising](#) in Europe; by alarming proportions. This makes it seem curious that funding in Sheffield has been reduced by 30% (according to a recent discussion I held with a consultant). [They are not alone.](#)

The Commonwealth Fund latest survey shows the UK system in a mixed light: good in some things but poor in outcomes. The Health Foundation discusses the survey [here](#), concluding,

This survey reveals the extent of pressures on the NHS. On many indicators, the UK ranks among the lower performers, especially in relation to waiting times for hospital services and some aspects of primary care.

While no health system consistently outperformed others in this survey, many of the countries where people reported shorter waiting times and easier access to services have higher levels of spending, though higher spending does not deliver better performance in all cases.

The Office for Health Economics has reported on [worldwide drugs shortages](#). I cannot help but be suspicious that this is a marketing strategy on behalf of sponsors.

The best way to sustain prices is to reduce supply. The BMA know this, the pharmaceutical companies know this, but it is always looked on as a cock-up rather than a conspiracy. Or are people being just polite while working to fix things in the background.

It would be nice to think so.

Next month we should know whether the UK government budget and the new Healthcare Plan will indeed fix things in the UK healthcare system.

And, for those with a broader perspective, to wait a little longer to know whether Donald Trump will be re-elected or not.

[Either way keep going and keep vigilant.](#)

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