

# Alternative European Healthcare Perspective August 2024

[Roger Steer](#)

It's August already, and there is plenty to think while lying on the lilo. Elections have come and gone. It's too early to draw many conclusions on what to expect in the UK and Europe and for now the appearance is of 'business as usual'. This month I try to update readers on the key messages that are emerging.

## The heavy cloud of political uncertainty

As noted last month, now there is at least some certainty in the general direction of healthcare policies in the UK and the EU.

A five-year expectation of continuity of political management has been secured following election results and the reappointment of Ursula von der Leyen as President of the European Commission.

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*Events in the US however mean that there is a cloud hanging over that future.*

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The bright spot for the future election there is that Kamala Harris has explicit healthcare policies that mark her out as a potential winner.

The following analysis is based on the Becker Report, a healthcare industry newsletter from the USA.

Reproductive health rights are likely to be a cornerstone of Kamala Harris' campaign. Surveys suggest she would have a polling advantage when it comes to women's health and abortion. [63% of adults said abortion should be legal in all or most cases](#). [A Gallup poll in May](#) found

32% of voters said they would only vote for a candidate who shares their views on the topic, and nearly twice as many voters support abortion, as do not.

She has advocated for investments to address the nation's maternal health crisis and reduce health inequities, and in 2022, produced [the administration's Blueprint for Addressing the Maternal Health Crisis](#).

While serving as California's attorney general from 2011 to 2017, Harris strongly opposed healthcare consolidation and prosecuted numerous industry players for alleged fraud or antitrust violations. As a presidential candidate in 2019, Harris [proposed](#) her own 'Medicare for All' plan.

In April 2024 she revealed [two rules](#) that set minimum staffing requirements for long-term care facilities and at-home services, and require facilities to have a registered nurse on site 24/7.

She has advocated for student loan debt forgiveness during her time as California attorney general and as vice president, [particularly](#) for those working in public service sectors such as education, law enforcement and healthcare.

Taken as a whole, her election platform is appealing to women; offering Medicare for all, and writing off student debt would

be very popular. [Trump's record on healthcare](#) by contrast was nothing to write home about. He reduced coverage and increased costs.

However, polling organisation have got it very wrong in recent elections. The Labour Party were predicted to get 40% of the vote and got 34%; and the French polls wrongly predicted the winner there. So, all to play for.

### Time to reflect on Covid

The UK independent Inquiry came out with its [first report](#) on planning and preparedness for a pandemic. It doesn't pull any punches.

### These are just extracts from the summary:

*In 2019, it was widely believed, in the UK and abroad, that the UK was not only properly prepared but was one of the best-prepared countries in the world to respond to a pandemic. This Report concludes that, in reality, the UK was ill prepared for dealing with a catastrophic emergency, let alone the coronavirus (Covid-19) pandemic that actually struck.*

*In 2020, the UK lacked resilience. Going into the pandemic, there had been a slowdown in health improvement, and health inequalities had widened. High pre-existing levels of heart disease, diabetes, respiratory illness and obesity, and general levels of ill-health and health inequalities, meant that the UK was more vulnerable. Public services, particularly health and social care, were running close to, if not beyond, capacity in normal times.*

*..., in the area of preparedness and resilience, money spent on systems for*

*our protection is vital and will be vastly outweighed by the cost of not doing so.*

*Had the UK been better prepared for and more resilient to the pandemic, some of that financial and human cost may have been avoided. ....*

*Preparedness for and resilience to a whole-system civil emergency must be treated in much the same way as we treat a threat from a hostile state.*

*The Inquiry found that the system of building preparedness for the pandemic suffered from several significant flaws:*

- *The UK prepared for the wrong pandemic. ... preparedness was inadequate for a global pandemic of the kind that struck.*
- *The institutions and structures responsible for emergency planning were labyrinthine in their complexity.*
- *There were fatal strategic flaws underpinning the assessment of the risks faced by the UK, how those risks and their consequences could be managed and prevented from worsening, and how they could be responded to.*
- *The UK government's sole pandemic strategy, from 2011, was outdated and lacked adaptability. It was virtually abandoned on its first encounter with the pandemic. It focused on only one type of pandemic, failed adequately to consider prevention or proportionality of response, and paid insufficient attention to the economic and social consequences of pandemic response.*

- *Emergency planning generally failed to account sufficiently for the pre-existing health and societal inequalities and deprivation in society ...as well as a failure to engage appropriately with those who know their communities best, such as local authorities, the voluntary sector and community groups.*
- *There was a failure to learn sufficiently from past civil emergency exercises and outbreaks of disease.*
- *There was a damaging absence of focus on the measures, interventions and infrastructure required in the event of a pandemic – in particular, a system that could be scaled up to test, trace and isolate in the event of a pandemic.*
- *In the years leading up to the pandemic, there was a lack of adequate leadership, coordination and oversight...*
- *The provision of advice itself could be improved. Advisers and advisory groups did not have sufficient freedom and autonomy to express dissenting views and suffered from a lack of significant external oversight and challenge. The advice was often undermined by ‘groupthink’.*
- *The Inquiry has no hesitation in concluding that the processes, planning and policy of the civil contingency structures within the UK government and devolved administrations and civil services failed their citizens.*

It is clear why Rishi Sunak wanted to hold a general election before this report came out.

The [recommendations](#) in the report will not be easy to fulfil without major change, not least in creating more resilience in a system expecting to make efficiency savings/cuts of 5-10% in the course of the next financial year (a figure set to increase if the [recommendations](#) of public sector pay boards are agreed).

[There are eight more reports](#) to come before it will be possible for a full picture to emerge. It would be nice to think that the NHS and Department of Health and Social Care were anticipating these reports, taking lessons to heart and taking purposive action. Instead, all the media attention seems to be on the so-called productivity problem in the NHS.

It wasn't all plain sailing on planning and preparedness in Europe as this report from [Euro found](#). Amongst the key findings were:

1. *Although the number of practising doctors and nurses grew steadily in the EU between 2008 and 2019, medical staff shortages persisted. The gap between countries widened partly due to the migration of healthcare professionals, and countries with existing labour shortages in healthcare saw their situation deteriorate further, hindering their ability to catch up with the rest of the EU.*
2. *The COVID-19 pandemic affected countries differently, leading to huge disparities in the number of infections and deaths. The mitigation strategies adopted by Member States varied in intensity*

*and time frame, highlighting the importance of a coordinated EU exit strategy to achieve faster progress in controlling a pandemic.*

3. *The COVID-19 pandemic has exposed structural inequalities in healthcare capacity across Member States. To ensure no-one is left behind in the aftermath of the crisis, translating the healthcare principles of the European Pillar of Social Rights into a reality by increasing healthcare capacity and coverage will be critical.*
4. *The COVID-19 pandemic underlined how the EU lacked the tools to manage a severe health crisis. Greater coordination and reporting in the area of health as part of a European Health Union would reinforce the crisis preparedness of the EU. The conference on the Future of Europe is an important opportunity for citizens to have their say on Europe's health priorities for the future.*

This echoed findings from the [Nuffield Trust](#) in 2022 looking at the international recovery from Covid.

### **NHS Productivity**

It all kicked off recently in the media following Paul Corrigan's appointment as an adviser to Wes Streeting (along with Alan Milburn and Ara Darzi). Corrigan has previously [blogged on the issue of NHS productivity](#), and in the Times recently has claimed that more NHS cash is not feasible. The claim is that NHS productivity fell recently, although if you read the small print it was in 2022/23 that

we have accurate figures); the argument is that the NHS shouldn't get any more money until it puts its house in order.

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*Corrigan has also suggested GPs should be paid for the number of patients they keep out of hospital.*

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As always, the facts and the nuances are more subtle than the headlines. For a fair reaction to the issues, I commend Andy Cowper in his excellent Newsletter. Among other things, he points out,

*"The Times was quoting this because of Corrigan's points about the fiscal begging bowl: in particular, his claptrap line that "one way to change the impression that we're always asking for more money is to stop asking for more money". Tellingly, the piece did not quote his immediately subsequent remark that "it isn't quite that simple".*

*Discussing "a lot of evidence" of falling productivity in the NHS, Corrigan added, "when people say, 'we've had a 20 per cent increase in doctors and nurses, and we need more money', I just think it's not feasible ... In five years' time, will there need to be more money? Probably almost certainly yes. But hopefully by that time, there might be some more money to use."*

On hope, as I commented in my [November 2021 newsletter](#), 'overreliance

*on hope is not a sound basis for healthcare planning’.*

For those of you with the stomach for getting to the heart of the issues, I direct you to further reading.

<https://www.england.nhs.uk/long-read/nhs-productivity/>

<https://www.instituteforgovernment.org.uk/sites/default/files/2023-10/performance-tracker-2023.pdf>

<https://www.instituteforgovernment.org.uk/publication/fixing-public-services-labour-government/nhs>

<https://ifs.org.uk/articles/there-really-nhs-productivity-crisis>

<https://www.york.ac.uk/media/che/CHE196.pdf>

<https://www.nuffieldtrust.org.uk/news-item/productivity-in-the-nhs-what-s-getting-in-the-way>

Just as I finished writing this piece, the NAO dispelled the myth (almost) and claim in their [latest report](#) that the dip in productivity during Covid has been recovered (see pps 39-41).

What more can I add?

Well, my first point is that there is no mention anywhere that I can see of any international or European perspective on productivity.

Curiously, the [Nuffield Trust](#) which now has an international section, doesn't mention comparisons of productivity either in this section or in their productivity section.

Does that matter? My argument is that it does. It matters if other countries have different rates of productivity, have suffered a dip in productivity and a lag in

recovering from Covid. It matters if some countries recovered more quickly and others more slowly. There might be some lessons to be learnt.

This [linked article](#) attempts this across the EU. Unfortunately, it excludes the UK, but it shows productivity is highest in Sweden, Finland and in other richer countries whilst lagging in the Eastern European countries, where performance (comparatively) has worsened. If it is true that UK performance has lagged similarly then it may be that the things that the UK has in common with Eastern European countries (lack of investment, slow uptake of technology and innovations, loss of trained staff overseas) may be factors. If any of my readers can locate comparative information compiled on a similar basis it might add to the discussion.

But my second point, and in my view the main issue, is that we need to look at comparisons of production not productivity. You can be as technically efficient as you like but if the healthcare is insufficient to meet needs, is delivered ineffectively or inequitably then it is scant consolation. A rusty gun can still kill and my colleagues at Kings College Hospital would often refer to ‘third world medicine’ to describe the NHS in the 1980s. The trick is to be effective in the circumstances.

So, if we look at [OECD Hospital Discharge Statistics](#), we see that the UK is shown as being at the low end of the distribution of total discharges (see fig 5.19) despite average low lengths of stay (see fig 5.20) – this being a recognised indicator of efficiency. The explanation is the [very low number of beds](#). To ram it home, Germany treats almost twice as many patients, and France 50% more than in

the UK. Therefore, it is likely there is suppressed demand in the UK and that the recent rises in length of stay, caused by problems with social care (and morbidity associated with an ageing population) is likely to be a major cause of inefficiency, overheating in hospitals, waiting lists, excess attendances at A&E, blockages, inefficiencies and worsening recruitment and retention of key staff.

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*The mystery is not the fall in productivity but that the show remains on the road at all.*

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This is the main story and is contained in the statement from Wes Streeting that the '[NHS is broken](#)'. Despite the controversy over the statement nobody disputes the facts demonstrating this.

Again, you don't get this in coverage of healthcare issues in Europe. Whatever problems exist in other countries they are of a different order in the UK.

**My advice to the new Health Secretary: taking a European perspective on actions to 'save the NHS'**

In following healthcare debates in Europe and having gone to the trouble of examining differences and similarities, comparisons of performance, organisation, outputs and government actions and levels of responsibility delegated to individuals, local government, the private sector and insurance companies it seems there is ample scope for the UK government to shift the debate on the NHS onto more

positive territory rather than to persist with the impasse as exists at present. I recommend the following steps.

**First, to better account for the activities of the NHS and for the health of the nation.**

It is anomalous that cutting back expenditure and reducing the health of the nation is thought to improve GDP and be positive for the nation. Similarly, attention is always directed at spending as though this was the most significant aspect of management; rather than management of the balance sheet, both of the nation as a whole and of the NHS.

The nation's balance sheet has large swathes of underemployed capital. More attention should be paid to deploying this capital in order to increase investment in public infrastructure, training, and research and development.

This should be properly recognised as capital investment and not counted as revenue spending.

Historically government accounting has been in cash terms and there should be a transition to full separation of capital and revenue accounting. Improvements to health and the resilience and capacity of health services should be accounted positively and acknowledged as an asset on the nation's balance sheet and not regarded as a cost.

The net effect of this could be to shift significant sums from the income and expenditure account to the balance sheet; and to better reflect the positive effect of improvements to health services within government accounts. This would in turn lead to a different attitude: away

from a negative attitude to spending on health and create more financial latitude. For a fuller discussion of this, see the recently published book [Public Net Worth by Ian Ball](#) et al. They estimate “Through better asset and liability management, government revenues can be increased significantly – by several per cent of GDP per annum”.

**Second, to re-categorise volume-related healthcare services expenditure as AME (annually managed expenditure) rather than DHSC, government cash-limited departmental expenditure.**

This is the way benefits are managed, on the basis that such expenditure is driven by the numbers of people claiming their rights to benefits, rather than being rationed according to an arbitrary cash limit, as is the case now with healthcare budgets. This is also the way that healthcare is administered within social insurance-based healthcare funding schemes in Europe.

It largely explains why funding is more flexible, sufficient to meet needs and incentivises providers. None of which applies in the NHS.

Just as it is possible to manage this expenditure in other countries using such methods it would be possible in the UK. The benefit of leaving the funding to Treasury rather than an insurance fund approach is that the Treasury has the full range of funding techniques rather than a government department whose powers are strictly limited.

Also, as the Treasury would in future be tasked with management it would overcome the distrust the Treasury has in DHSC management which has resulted in

over-control of departmental expenditure.

**Third, to automatically finance any capital expenditure that can demonstrate positive returns over, say, thirty years.**

At present the appraisal methods and capital funding regimes are insufficient, short-termist, and fail to provide for the renewal and maintenance of public sector assets. It has been readily identified by the ONS and NAO that capital investment is the main driver of productivity growth, and the lack of investment is the main reason why productivity in the NHS has reduced from rates higher than the rest of the economy to lower levels recently.

Such projects could be the responsibility of a National Infrastructure Bank to administer and finance rather than the DHSC. The funding for this needs to be adequate: the £7bn recently announced is scratching the surface.

The focus should be on reviewing the performance of the investment activity rather than controlling inputs. Thus, the management of the investment process can be improved rather than it being regarded as sunk cost and any poor performance lost in the accounting process. Rarely if ever is there any accounting for poor investment decisions.

The excessive zeal to control capital spending examined in the [Health Foundation's recent study](#) shows starkly how much the NHS is undercapitalised compared to European averages.

*“Over the past decade, the UK had a lower level of capital investment in health care compared with the EU14 countries for which data are*

*available. Between 2010 and 2019, average health capital investment in the UK was £5.8bn a year. If the UK had matched other EU14 countries' average investment in health capital (as a share of GDP), the UK would have invested £33bn more between 2010 and 2019 (around 55% higher than actual investment during that period)"*

The alternative approach to funding public investment, used to finance Network Rail, of pretending that an arm's length agency was a private sector organisation, but with its debts underwritten by the state was counterproductive in that it neither escaped classification as public debt nor resulted in increased value for money. Similarly, PFI has been revealed to have been far more costly than publicly procured investment.

**Fourth, allied with the above the Green Book (the Treasury guidance on Investment appraisal in the public sector and in healthcare) should be revised.**

The requirements to subject future benefits to high discount factors while short-term costs are exaggerated should be removed. Health and social care needs are increasing over time and there is a case for a methodology that is biased towards longer-term investments rather than penalising them.

The requirement for a proper comparison of funding costs from the private and public sector should be underlined and all cases where the Public Sector Comparator is superior should be funded by the state. The revised methodology would not preclude private financing, but the game should not be fixed in its favour.

Controversial decisions should be properly debated with opposition voices being funded as in the French system. See my [November 2023](#) newsletter.

**Fifth, to resolve the Social Care Funding problem by instituting a compulsory social care insurance scheme.**

Currently this is managed by dumping costs onto the individual, hospitals and prisons. But other European countries manage this successfully through an insurance scheme. Contributions need only be small and could be built up over the years with a strong case being made for establishing the fund from a once off levy on the wealthy, via inheritance tax or otherwise, or by the sale of investment bonds to the public. There is no shortage of available capital for such purposes. See this blog by [Richard Murphy](#).

**Sixth, to commit to reduce shortages of clinical staff by increasing significantly the numbers of trainees and funded posts.**

There has always been a reluctance to do this out of the misplaced concern about the ability of the NHS to offer jobs to all qualified staff. This was a counterproductive worry as it ensured continuing shortages, pressure on the price of labour upward, fuelling expensive agency and temporary staff costs, and added insecurity and job anxiety for trainees. This anxiety should be resolved by guaranteeing jobs to all successful trainees. This would result in less of a brain drain and attract more applicants.

Any short-term costs would be matched and exceeded by long-term savings. My coverage of the French experience of [Numerus clausus](#) –the control of numbers

in the French system –shows this. It was discussed in my August 2022 newsletter and demonstrates the folly of allowing professional interests to dictate training numbers.

As I write news is coming through of a 20% pay award to junior doctors. That will help in the short term, but the long-term solution is to increase the supply thereby undercutting the bargaining power of doctors.

**Seventh, shift the emphasis from contracting out of services to the contracting in of expertise, if required.**

Expertise, whether that is in the form of management services, or in technology, should be used for short-term, output-based contracts not for long-term transfers of ownership and control of services, premises and patents. All the evidence is that contracting out has resulted in the erosion of public service capacity and an increase in long-term costs. See the work of [Mazzucato](#).

A truth and reconciliation commission should establish this as fact once and for all, as this is still disputed by enthusiasts for contracting out. Not that in certain circumstances it should be ruled out but that it should not be the presumed best option.

**Eighth, there should be acceptance that there are better ways of working, using modern technology and techniques, for which expertise from the private sector should be utilised.**

The NHS has always embraced serial reorganisations, restructurings and technological change over the years. It is a myth that it has been internal restraints holding back the NHS; mostly it has been

external restraints established by finance, employment law and legislation delegating authority to a local level providing a local veto on change advocated by others who know less about the local circumstances than those at the sharp end. Turkeys do not vote for Christmas.

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*In the short term, as an act of good faith, the Secretary of State should provide a moratorium on significant change in acute clinical services to overcome the fear that clinical staff and local communities have over reckless change, so-called ‘transforming services’.*

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Such a moratorium should not hold back changes to social care, primary care, End of Life care, clinical support services and non-clinical support services.

Only when the dust has settled on changes in these arrangements will we know what changes in clinical services in the acute sector will be required. And only when the chicken and egg race is avoided, of only being able to fund expansion of the necessary change in the non-acute sector, after cuts in acute care. Expanding non-acute care is complementary to changes in the acute sector not a substitute. There is too much change driven by arbitrary financial pressures rather than good evidence and sound planning.

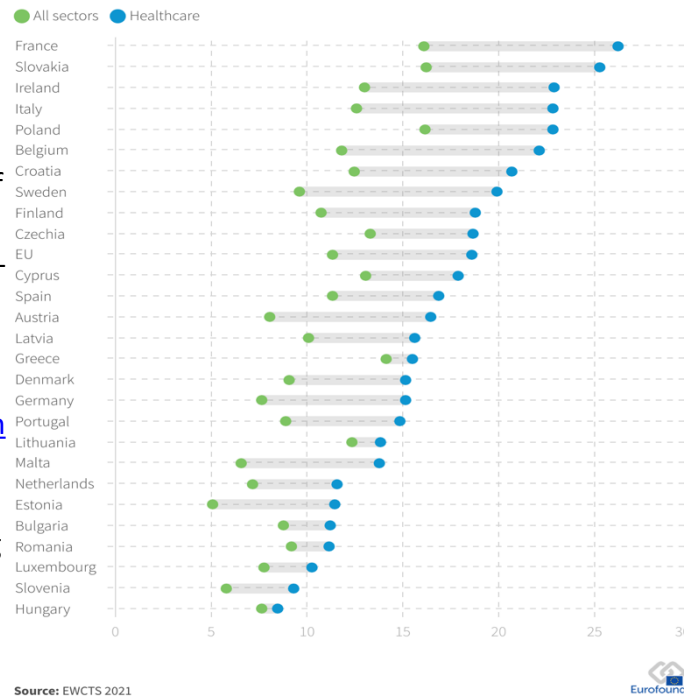
Staff should not be living in fear for their jobs by embracing change, and time should be taken to evolve plans,

demonstrate evidence and re-establish a proper working environment before changes are made to local acute services. Staff should be guaranteed their posts and livelihoods for any change down the track.

[working in Europe 2023, published 2 May 2024](#)

Don't you just long for the UK to be included?

At a time of staff shortages and capacity constraints, steps should be taken to lessen anxiety, improve working conditions and prevent wastage of trained staff overseas or to non-clinical employment. See this 2011 report from [The European Foundation](#) for the Improvement of Living and Working Conditions, covering labour relations in European healthcare.



It looks like healthcare workers don't have it easy, compared to other workers,

anywhere in Europe; and the work to harmonise across Europe has some way to go.

[Euronews](#) has a very useful Health tab linking to several interesting stories. The most recent is on [cybersecurity across Europe](#).

Its isn't just the UK that has cybersecurity issues. Perhaps there might there be avenues of co-operation and co-ordination to prevent such attacks?

### Latest round-up from across Europe

As usual the [European Healthcare Observatory](#) go to the beach at this time of year. The last news reported was on [26 June](#). A lot has changed since then.

There is a treasure trove of information on the [Eurofound](#) website however.

This chart updated in July 2024 gives food for thought. It shows the share of extremely and highly strained jobs in the healthcare sector, compared with all sectors, EU Member States, 2021 (%). It's taken from the publication: [Living and](#)

*"During and following the COVID-19 pandemic there was an increase in cyberattacks on healthcare providers, as demonstrated by the European Union Agency for Cybersecurity's (ENISA) first analysis of the cyber threat landscape for the health sector published last year. The analysis showed that between January 2021 and March 2023, the EU health sector witnessed*

*frequent cyberattacks, with 53% affecting healthcare providers and 42% hospitals. The cybersecurity agency warned in its report that these attacks are likely to continue, and flagged risks posed by vulnerabilities in healthcare systems and medical devices.”*

On [Deepdyve](#) I came across this article from the European Geriatric Society .It contrasts the relatively healthy state of geriatric medicine in Europe compared to the US, and cites US research showing that a third of US posts had been lost over twenty years and only 43% of trainee posts were filled. The [British Geriatric Society](#) reports that the UK is certainly not in as good a state as the European position. Numbers are insufficient. The key messages from a recent survey are,

*“ For the first time since 2016, geriatric medicine is the biggest medical specialty.*

- There are 2,328 consultant geriatricians in the UK. For every 697 individuals aged 85 and over in the UK, there is one consultant geriatrician. This does not meet the UK-wide target of one consultant geriatrician per every 500 people aged 85 and over that the BGS recommends. At least 1,786 additional geriatricians are needed by 2030 to make up for this shortfall. If including intended retirement plans, this number increases to 2,566.*
- There is an uneven distribution of geriatricians across the country, with urban areas, particularly*

*London, typically being better served. This is despite non-metropolitan areas being more likely to have ageing populations.*

- A higher proportion of consultant geriatricians care for patients on virtual wards compared to other specialties.*
- Most consultant geriatricians do not feel in control of their workload.*
- Most consultant geriatricians reported a substantial level of rota gaps and vacancies in their department, and this appears to be a bigger problem than other specialties. The majority of geriatricians felt this impacted patient care.*
- Leadership roles significantly contribute to job satisfaction, but this is often not recognised in appraisals.*
- Just under half (44%) of consultant geriatricians will reach their intended retirement age in the next ten years, equating to 1,025 consultants who will need to be replaced.”*

[Another article from Deepdyve](#) cites the experience of the 2.2m Eastern European migrants in the UK. They under-utilise healthcare services in the UK; they go to their home country to access needed healthcare. I would guess not many people know that. Is it a good thing? Is it a vote of confidence in the NHS? Which brings us back to the NHS:

In the last few days the [NAO have published a review of the Financial Management and Sustainability of the NHS](#). This has stimulated the Kings Fund to make [a statement](#),

*'This report comprehensively shows the desperate state of NHS finances that the new government has inherited. It should act as a warning to politicians of the tough decisions yet to come.*

*Deep financial deficits have now spread widely across the NHS and are having a substantial impact on patients. Some NHS trusts have been forced to reduce staffing or delay transformation plans that could give patients faster access and higher quality care when they need it.*

*For too long, financial planning in the NHS has been plagued by a lack of candour and transparency. Many*

*local NHS organisations feel pressure to submit financial savings plans based on hope rather than reality.*

*In his new role, the Secretary of State for Health and Social Care has talked about the need for honesty. The government can now decide if it wants NHS organisations to keep submitting overly optimistic financial plans, or the financial plans NHS leaders really believe they can achieve.'*

The Kings Fund should reflect on the role it has played in allowing this situation. It cannot say [it didn't know any of this](#). It shouldn't be difficult to tell the truth about the [shortfalls in healthcare](#). And it shouldn't be difficult to be leaders rather than followers behind politicians who know far less than they do. Too often NHS leaders and healthcare think tanks have been complicit in creating the NHS we see today.

[Link to Database of previous newsletters 2021-2024](#)