An Alternative European Perspective

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The subtext of this monthly review of European healthcare issues is to identify whether Europe can offer lessons to the UK on health and social care issues or indeed how Europe can learn its own lessons and put flesh on the bones of its previous promises of a Social Europe.

In January I identified an important report from the The European Health Observatory which published the results of a review of the Dutch healthcare market reforms of the last fifteen years but actually looks back over a longer period as market reforms were debated and considered for twenty years before that. It thus speaks to recent planned changes before the UK Parliament, currently finishing their course through the House of Lords.

It also speaks to reports that the Secretary of State is planning to present his own proposals for 'reform'. There is plenty to mull over here. I also give a further progress report on Covid issues and a quick summary of relevant literature published in the last month.

More or less market reforms?

The market reform in Dutch health care: Results, lessons and prospects by Patrick Jeurissen and Hans Maarse is well written and as a bonus gives a bracing review of the context of market reform in healthcare. Thus,

> *we can broadly categorise health systems in two families: Bismarck's social insurance and Beveridge's tax-funded health systems. The idea that the private sector could have a major role in health care seemed highly questionable after the seminal analysis of Kenneth Arrow (1963) on information asymmetries and opportunistic rent-seeking strategies in health care. His analysis did not end discussions of alternatives, however, most notably in countries with a substantial private sector such as the United States of America. In the mid-1970s Alain Enthoven brought a proposal to the table that sought to create universal access and competition in the US private health care system. Called regulated or managed competition, at the time it was the most sophisticated proposal thus far for a "market" approach to health policy (Starr, 1982)[1].*

On the basis that the Netherlands system now seems to be performing well it poses the following question,

> *The Netherlands seems to be the country that has gone farthest in implementing Enthoven's model and his ideas on managed competition. The Netherlands' system is respected among policy-makers. Routinely, it scores very well in the annual*

[1] Enthoven A (1988). Theory and practice of managed competition in health care finance. Amsterdam/ New York: North Holland.
Starr P (1982). The social transformation of American medicine. New York: Basic Books.

surveys of the US Commonwealth Fund think tank. It was very favourably reviewed by Emanuel (2020)[2] in his recent scholarly search to find the best health care systems. The Dutch performance on universal access is much better than that of the United States, and it easily equals those of the better performing tax-funded European systems. In comparison to most other Organisation for Economic Co-operation and Development (OECD) countries, the growth of health care expenditures has slowed substantially in the last decade. And competition is more intense than in the high-priced Swiss health care system.

Have the Dutch indeed found the Holy Grail of health systems governance? Or are there caveats or paradoxes to consider?

The study attempts to answer this question and follows the progress of Dutch Health reforms since 2006,

The main policy goals (in policy documents often referred to as public values) of this "market reform" were to achieve a health care system offering high-quality care to patients that would be accessible to every person (universal access), based upon solidarity and affordability (financial sustainability). Another goal of the reform was to enhance freedom of choice. The primary function of the state was to regulate health care and preserve the public values in health care.

In fact the debate never stopped with *"voices calling for a reversal of the market reform and a reassertion of the role of the state in health care".* The terms of that debate were described thus,

The choice for market reform can be interpreted as a reaction to a period of ever-extending state intervention in health care. Growing concerns about escalating health care expenditures, particularly after the oil crises in the 1970s, had resulted in an avalanche of regulatory and budgetary instruments, including hospital planning, expenditure caps, price controls, user charges and various other policy instruments. After years of mostly disappointing experience with these instruments, the idea emerged that an alternative strategy was needed to make the direction of health care more effective and to establish a proper balance between equity and efficiency. Health care had to be transformed from a supply driven system into a demand-led system, in which the state concentrated on the introduction of an effective regulatory system and an effective supervisory system.

This concept of an alternative model for the organisation of health care fits well with the ideas of the so-called New Public Management (Clarke & Newman,1997[3]; Pollitt, 1993[4]), which had gained much

[2] Emanuel E (2020). Which country has the world's best health care? New York: PublicAffairs.

[3] Clarke J, Newman J (1997). The managerial state. London: SAGE.

[4] Pollitt C (1993). Managerialism and the public services: cuts or cultural change in the 1990s? Oxford: Blackwell Business.

popularity in the Netherlands. The advocates of this new wave in public policy-making postulated that the state had to transform itself from a "bureaucratic state[5]" into a "managerial state", in which it would carry system responsibility and delegate a great deal of its steering to regulatory agencies at arm's length. Competition in health insurance and health care provision was depicted as a more effective instrument for achieving the state's policy goals in health care than detailed bureaucratic intervention.

Competition was certainly not presented as a goal in itself, but rather as an alternative institutional vehicle for achieving the state's policy goals.

In choosing a health care system based on regulated competition, the Netherlands changed its system in a more fundamental way than other western European countries. Belgium, Germany and Switzerland, each in their own way, restructured their health care systems by moving away from detailed hierarchical control towards systems with more freedom of choice and room for entrepreneurial behaviour for insurers and providers. This restructuring was done with the intention of improving performance in terms of quality of care, accessibility and financial sustainability (Thomson et al., 2013[6]; van de Ven et al., 2013[7]).

So there is no hiding place. But have market reforms delivered?

Summarising the review:

1. Money is wasted on marketing. The total costs of marketing and commissioning are identified as 0.6% of total costs; albeit marketing itself was only E2.18 per enrollee in 2018.
2. The system is cumbersome with winners and losers and an on-going debate on the operations of the tax allowance system to cross-subsidise the cost of care.
3. The market has resulted in many mergers and the concentration of market power in insurance companies and the centralisation and closure of clinical facilities. Regulators have been seen to be weak.
4. There have been complaints of 'overreached competition' with unnecessary and costly requirements for procurement procedures resisted by municipalities.
5. The market in social care has resulted in a race to the bottom with prices reducing, forcing large scale bankruptcies and losses of jobs. It has also proved to be

[5] For a twist on this categorisation I recommend the book discussed here, https://www.theguardian.com/books/2015/may/06/the-utopia-of-rules-on-technology-stupidity-and-the-secret-joys-of-bureaucracy-david-graeber-review

[6] Thomson S, Busse R, Crivelli L, van de Ven W, van de Voorde C (2013). Statutory health insurance competition in Europe: a four-country comparison. Health Policy, 109(3):209–225.

[7] van de Ven W, Beck K, Buchner F, Schokkaert E, Schut F, Shmueli A, Wasem J (2013). Preconditions for efficiency and affordability in competitive healthcare markets: are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy, 109(3):226–245.

administratively costly and prone to inconsistency across different municipalities.

6. Despite accusations that competition would affect quality no evidence was found for this.
7. The existence of user charges (or mandatory deductible in the local jargon) at 6% has been proven to have had a deterrent effect and thus to penalise those that need services most. The rates have not increased for several years and many campaign for their abolition.
8. There are accusations of high administrative costs and hassle in the way the systems work. General practitioners urge a shift from the contract model in health care to the professional model based on trust. A rough estimate of administrative costs of hospitals in the Netherlands is that they accounted for 18–20% of total hospital costs over the period 2005-2017. There are also accusations that administrative costs for GPs are very high, as the chart below from the Commonwealth Fund illustrates.

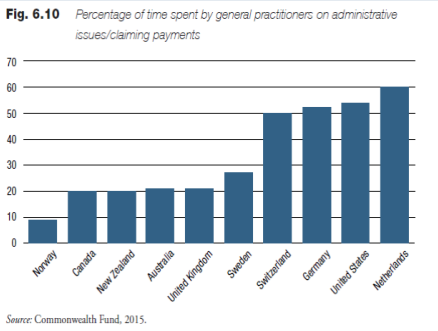

Fig. 6.10 *Percentage of time spent by general practitioners on administrative issues/claiming payments*

Source: Commonwealth Fund, 2015.

9. It is claimed excessive administrative costs are linked to the requirement to comply with increased quality standards; although there is no evidence of increased quality of care, merely of compliance with increased standards.
10. Insurers have a split role to save money and increase quality. Many are non-profit organisations but it is still felt by many their role should be a state function. Doubts have been expressed on their ability to influence providers and their ability to do anything more than squeeze contracts.
11. The medical profession continues to contest the contract model. But it has attracted the riposte, *"In every system you need a police officer who looks at what it costs and what it yields and in our system health insurers play this role"* (Schippers, 2017b[8]). That the medical profession does not appreciate this crucial role is no surprise, as it is claimed, "*It has always constituted a guild system accustomed to running its own affairs and averse to interference from the outside".*
12. Covid has exposed the excessively decentralised structure and lack of centralised direction. According to the Netherlands Prime Minister, the crisis had made manifest the need for more central coordination and state direction in health care. "With eight thousand 'know-all' general practitioners, a hundred hospitals, eight academic centres and 70 public health agencies, we have a world-famous health care sector. Yet we must draw lessons from what has happened". The Minister of Health was clearer, depicting the crisis as a big plea for less competition and more central coordination. In other words, a decentralised structure does not work in times of pandemic. (see p150 for quotes).

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13. The market reforms have been blamed for lack of capacity and closures, and the lack of intensive care and treatment capacity; all due to market pressures. The authors argue that these events would never have happened in a state-led health care system. They obviously haven't noticed what has happened in the UK with its lack of bed and staff resources.

The review's conclusions are couched in diplomatic terms but the final words best sum up the authors' views,

> *The experience with health care reform in the Netherlands is a good illustration of health care reform as a process of ups and downs. The rhetoric of reform has in some respects been remote from the hard realities of daily practice. High expectations and frustrations have gone hand in hand. Regulatory adjustments are certainly needed to correct for failures. Competition is not a one-size-fits-all model for health care. There is an argument for reinforcing the role of the state in some respects. However, a new large-scale reform directed at restoring the role of the state in health care runs the risk of public failures and, consequently, new frustrations. What is most needed is a strong focus on substantive issues to achieve value-driven health care instead of a renewed focus on institutional reform.*
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> *The main lesson from the COVID-19 pandemic is that competition works only under normal public health conditions. It fails to work in the context of a worldwide and persistent pandemic. Given its strong emphasis on efficiency, competition fails to build up a reserve capacity that can be quickly mobilised. Building up such a capacity is a public problem that must be addressed by the state.*

Which brings us nicely to Sajid Javid, the UK Secretary of State for Health and Social Care, sponsor of legislation currently before Parliament to reform the English system – The Health and Social Care Bill. This reverses many of the market reform/ managed competition ideas incorporated in the current law.

So much so that Lord Lansley, a previous not disinterested Health Secretary, has spoken against the bill along the following lines,

1. *This Bill enshrines in law an approach that is markedly different from that which has characterised virtually all health legislation in England since the 1980s. That earlier legislation progressively built an NHS based on key principles: autonomous NHS providers held to account by commissioners, who would pay them for the services they actually delivered; patients' rights to choose a provider; money following the patient; clinical leadership; and, since 2013, an NHS that is operationally independent of politicians but with a series of checks and balances, including a mandated focus on improving clinical outcomes.*
2. *This Bill turns back the clock. Providers' freedoms are to be limited; the purchaser/provider split is blurred; the NHS is being centralised; payment systems are being delinked from activity; and political direction is being reimposed.*
3. *The Bill in fact goes beyond the NHS's own long-term plan. The powers of direction and intervention put in the Bill by the former Secretary of State in Clauses 39 (General power to direct NHS England) and 40 (Reconfiguration of*

services: intervention powers) are not welcome—including to the National Health Service—are a potential political own goal and should be taken out.

4. *Although I see the presentational appeal of repealing Section 75 of the 2012 Act, relating to procurement, virtually the same provisions are contained in Clause 70 of this Bill—highlighting the folly of trying to fix problems in secondary legislation through primary legislation. The slogan is "Collaboration not competition" —ironically, precisely the words that JP Morgan and Rockefeller used when creating vast monopolies.*
5. *This Bill takes complexity to a whole new level. We have ICS boards and ICS partnership boards—the latter sitting on top of health and well-being boards. Each ICS is large, so the workaround is to have places within them which map to local authority boundaries. That is just on the commissioner side. On the provider side, we have new provider collaboratives which, in fairness, is where the power in the NHS will lie. The Bill makes no provision for them in terms of transparency, openness or accountability.*
6. *Integration of NHS and social care demands joint planning, so why are the integrated care partnerships and health and well-being boards not made to be the same organisation?*
7. *Hospital foundation trusts should lose their independence.*
8. *Finally, if someone has limited assets and must meet heavy care costs, they may end up losing virtually all of their lifetime assets before the cap is applied, but the well-off person would lose only a fraction of their assets.*

Obviously Lansley is unhappy at the legislation Javid is supposedly championing, and Javid had reportedly wished for a pause - but Javid is now reported to be planning to present plans for a further reorganisation.

This drew a response from Richard Murray, head of the King's Fund, who said,

"The Health and Care Bill proposes to reduce the freedoms of foundation trusts on spending, expects all NHS trusts to collaborate more closely and gives ministers new powers over local services. Any further changes must be consistent with these proposals or risk looking incoherent."

In my view the UK is looking increasingly incoherent, to put it politely. If the state does not know what it is doing, then the case for market reform grows; which may be the secret agenda. But *"capacity is a public problem that must be addressed by the state".* The market is never going to be the answer to everything as the neo-liberals seem to think. The sooner the Prime Minister, the Health Secretary and the government wake up to this the better. They could start by looking at the Dutch experience laid out so well in the report discussed above.

The latest news on Covid

Last month I called out as *bullshit* the failure of the UK government to strengthen public health controls as the omicron variant swept all before it. They now plan to call Covid over and take away all restrictions after 27 January. What can they be thinking?

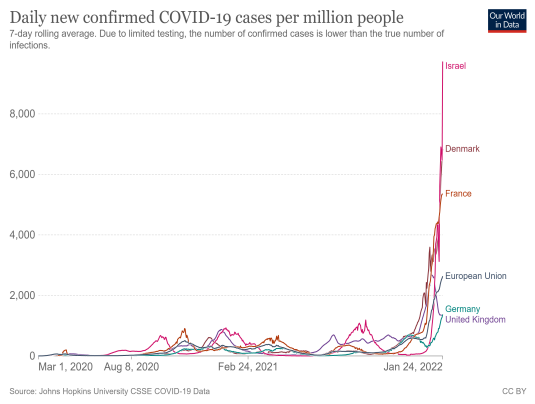
The advice from the WHO meanwhile is that it ***may*** be possible to call off the emergency phase in 2022. Hans Kluge, WHO Regional Director for Europe, issued this statement on 24 January,

> *This pandemic, like all other pandemics before it, will end, but it is far too early to relax. With the millions of infections occurring in the world in recent and coming weeks, coupled with waning immunity and winter seasonality, it is almost a given that*

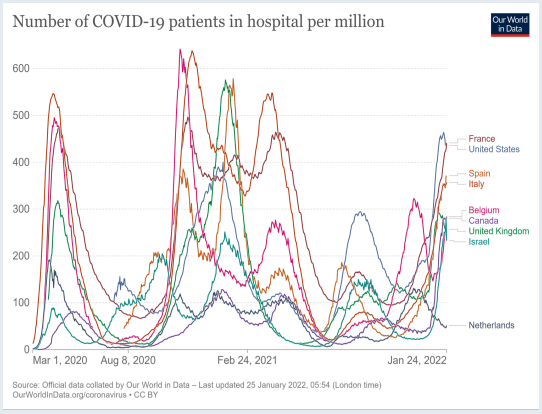
new COVID-19 variants will emerge and return. But with strong surveillance and monitoring of new variants, high vaccination uptake and third doses, ventilation, affordable equitable access to antivirals, targeted testing, and shielding high-risk groups with high-quality masks and physical distancing if and when a new variant appears, I believe that a new wave could no longer require the return to pandemic-era, population-wide lockdowns or similar measures.

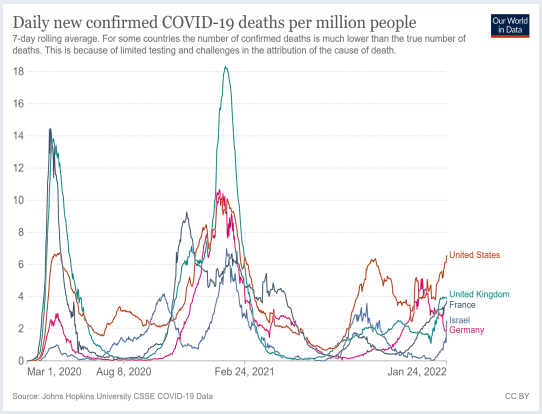
But already there are reports of a new possibly more contagious variant.

Let's look at the latest figures.



I have chosen the countries in the chart to show that even countries that have invested most in vaccines (Israel) are still open to rapid rates of infection. A rise seemingly exacerbated in Denmark and France by the new omicron variant BA.2. 'So what' seems to be the reaction of many in the UK. But let's look at hospitalisations and deaths.





To me these charts are not reassuring. Although the UK has avoided a repeat of the disastrous experience of a year ago, death rates around the world appear to be climbing to levels approaching those of the peaks of a year ago and the curves haven't flattened, apart from in the UK. It hardly justifies opening the champagne, or for having a party.

Summary of information across Europe

The European Centre for Disease Control somehow has failed to spot the new variant in its survey of variants of concern. Which is a concern. On investigation however the BA 2 variant is the B.1.1.529 variant currently on the variants of concern list, which had apparently changed its name to avoid confusion. Which is confusing. Either way it's spreading, fast.

Euronews reports that the Netherlands, never knowingly late to a party, are

announcing the reopening of bars and restaurants, in the future, even as reports continue of record infection rates. The same report quotes Chancellor Olaf Scholz of Germany as saying, "*It is time to stay the course*" as he confirmed the access restrictions that have been in place for months are to remain in place in the workplaces, on buses, trains, restaurants, and shops.

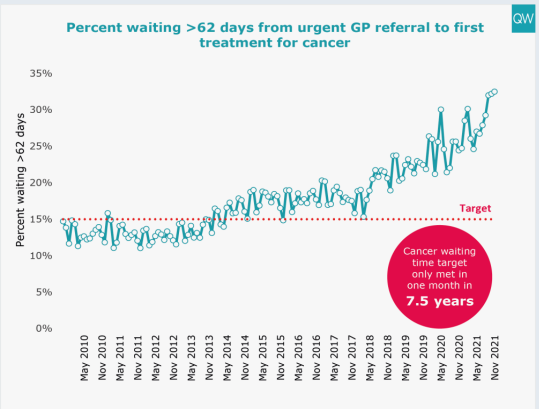
This may explain why Germany has suffered less than the UK during the Covid pandemic (although Dr Rodney Jones says it's because they count only confirmed Covid deaths).

Liberation reports that, bizarrely, the French government is announcing future lifting of restrictions even as the country suffers a massive wave of infections with 10% of the population being infected in January alone. You just know that every effort will be made to preserve the half term skiing holiday tradition in an election year.

As reported above, **WHO Europe** had given the message "it is far too early to relax" on 24 January and simultaneously provided a list of key Covid statistics across Europe reminding us all of the European context within which we need to place ourselves (even for those that would rather not admit it). For the health community the figure of 13% of health workers not immunised and the 10-20% Long Covid rate may be the most significant.

The European Health Observatory lists not only an extensive range of reports from all countries across Europe but further in in-depth reports on a clutch of countries, Malta, Slovakia, France, Denmark and Austria. It is disappointing that the UK has excluded itself from appearing in a desperate attempt to distance itself from geography, despite Norway and Iceland, appearing alongside the EU 27 countries. The UK government is not keen on accountability and scrutiny however. I note that it is likely to be next month before the DHSC Annual Report and Accounts for 2020/21 appear.

The Nuffield Trust published a very useful performance summary for the NHS for the period November/December 2021 but disappointedly fails to provide a UK context or European context. It continues the NHS tradition of comparing performance with the past, not with what others have achieved. As it stands it is a litany of disaster with the UK media, inexplicably, seeming to take little interest it seems from my perch in France. In particular I couldn't help pick out the problems in cancer care of delays with waits more than doubling since 2018.



CHPI has unsportingly linked a focus on cancer care with the commercial interests of NHS consultants. It seems there are winners and losers. CHPI identified 481 medical consultants with equity stakes in 34 different joint ventures with private hospital companies. 73% of these medical consultants were employed directly by the NHS. Over the six-year period covering 2015 to 2020 these 34 joint ventures generated £1.24bn in revenue and recorded an operating profit of £258m.

Medical consultants with a stake in these joint ventures received an estimated £31.3m because of their equity stakes. Their average

stake was 1.65%, generating an average of £11,600 each per year.

I find these revelations underwhelming. That consultants hold equity stakes of 1.65% in joint ventures is not proof of venality but naivety. It's a bit like the criticism of corruption of our politicians. The surprise is not that it happens but how cheap they are. In Europe that is; in the US the going rate is $750,000 if the case of Krysten Senema is anything to go by. Funny this gets little mention in the mainstream media.

Talking of corruption, the Byline Times is good on this theme. And for a European dimension I recommend Corporate Europe which has warned of how Macron seeks to promote French corporate interests during his EU presidency. Plus ca change as they say over here.

Politico Europe reminds us all that new European-wide travel rules will come in on 1 February. In other words the vaccine pass, designed to limit the lives of those that choose not to vaccinate themselves.

It seems the UK has joined this European Club. As the saying goes, 'Needs must when the devil drives'.

Which brings us to the fate of Boris Johnson and implicitly Brexit and much else. I fear you might have to wait for my next episode.
