



# 2004 Healthy Ageing Conference

**Robert Perkins**  
**Ben Irvine**

A CNE Health Conference  
07 October 2004

## **Healthy Ageing 2004**

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The speakers at this conference included an outstanding array of international health policy experts who publicly shared their cutting edge research on the future of European health care. In addition, CNE put together a range of leading panelists from the worlds of politics, academia and journalism.

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**Robert Perkins** is president of Consensus Research Group (CRG), a New York based consulting and marketing research firm. With offices in New York and Düsseldorf, CRG interviews business professionals, medical professionals and the general public for firms like Purdue Pharma, the United States Chamber of Commerce, Standard & Poor's, Warnaco, Pfizer, Dolce & Gabbana, and 24/7 Real Media.

Prior to joining CRG, Robert worked for some of the most recognized names in American business: Jay Chiat, Barry Diller, Steen Reinemund, Calvin Klein and Hugh Hefner. He also has extensive experience in the business of politics, wherein he pioneered fund raising techniques for Ambassador Howard Baker, Senators Richard Lugar and Lamar Alexander and former Ambassador Bill Brock. From 1987-1989, Mr. Troy served in the Office of Legal Counsel of the U.S. Department of Justice as an attorney-advisor. From 1983-84, he clerked for D.C. Circuit Judge Robert Bork. Mr. Troy has served as a lecturer-in-law at his alma mater, Columbia Law School, where he was Book Review Editor of the Law Review, a Harlan Fiske Stone, and a James Kent Scholar. He graduated from Cornell University's School of Industrial and Labor Relations in 1980.

**Ben Irvine** joined the International Policy Network (IPN) as Director of Health Projects in July 2004. Irvine is responsible for IPN's work on pharmaceutical policy, including intellectual property protection and access to essential medicines. Irvine also manages the recently launched Campaign for Fighting Disease which is coordinated by IPN. Current topics of interest are pharmaceutical patent protection, the treatment of neglected diseases and the imposition of tariffs and VAT on medicines imported by developing countries.

Before joining IPN, Ben Irvine spent four years as Project Manager and latterly Director of the Health Studies Unit at the free market London-based think tank Civitas: The Institute for the Study of Civil Society. While at Civitas, Irvine wrote and edited several books, pamphlets and papers and peer reviewed articles on European health care system policy and reform. He also studied and published on European pharmaceutical pricing and reimbursement mechanisms and parallel trade.

After degrees in Music (University of Glasgow and RSAMD) and a Graduate Diploma in Law (York), he graduated with a Master's Degree (EMPA) in European Law and Comparative Public Policy and Administration from the University of Leuven, in Belgium.

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## **Stephen Pollard**

Ladies and Gentlemen, can I welcome you this morning, my name is Stephen Pollard, I'm a senior fellow at the Centre for the New Europe and director of our health policy unit. I'd like to welcome you to this conference on a subject which really doesn't need any introduction from me, I'm sure everybody who's here by definition is interested in the subject of health care, and anybody who's interested in the subject of health care is of course interested in what patients think about it and the demographic implications, or the implications of changing demography and all the issues that are associated with that.

Just a brief word about the genesis of this conference: A couple of years ago at CNE we were lucky enough to have a look at some research which Pfizer had conducted in to what patients thought of their own health care systems across Western Europe at the time, and we were so interested by this research that we staged a smaller scale event on this, which was really just to introduce that research to a wider audience. Since then the research has widened in scope quite considerably and we thought that it merited a much bigger and more sustained analysis from a conference such as this, so here we are today.

The moderator for today's event Bart Crols. Bart is a long standing friend of CNE; we've welcomed Bart to many of our conferences, but I think this is the first that he has moderated for us so we'll hope it's the first of many. I'm delighted to introduce you to Bart Crols.

## **Bart Crols**

I'm sure Stephen will do fine. I have the pleasure of introducing today's keynote speaker, Bob Perkins. Bob is the president of Consensus Research Group, a New York based consulting and marketing research firm which has done business for such companies as Standard & Poor's, Warnaco, Pfizer, and Dolce & Gabbana, and basically what it does it interviews business professionals, medical professionals and the general public. Before that Bob has in his previous life, he's got sort of a well packed previous life, before that he used to work for some of the most recognised names in American business including Calvin Klein, Hugh Hefner, and before that he was also involved in politics, pioneering fund raising techniques for such noted politicians as Richard Lugar, Senator Richard Lugar, Lamar Alexander – and just a few years ago, when he was a bit younger, he used to be a pilot trainer on the T38, the US air force T38 Talon which is still being used by NASA to train its astronauts, but that was only a few years ago, maybe he can share a bit of that experience later on. Bob I'm very happy to hand the floor to you. Ladies and gentlemen, Bob will speak for about half an hour after which I will open the floor to you, the public, for about fifteen minutes. We have other speakers, as well, and a number of panel discussions, but I'm very eager to immediately open the floor to you after Bob has finished his remarks.

## **Bob Perkins**

Good morning. Thank you for that introduction. I'll tell you a little bit more about myself and the study. The numbers we are going to go through today come from a variety of studies we at Consensus have conducted over the last two years both across Europe – both Western Europe and the new accession countries to the EU as well – as well as some specific research we've done to illustrate specific things, we also did a broad survey of the European voters right after the last elections to the European Parliament. Right before I left New York – and while we're here a small group of us went out to dinner, and because I was taking a flight and I was in a hurry, we went to a Chinese restaurant, and before I ran out to catch a cab I of course had to open my fortune cookie and – lo and behold – my fortune cookie said, “put the

data you have uncovered to beneficial use," so that's my objective in today's meeting to answer your questions and to put my data to beneficial use.

For those of you that think fortune cookies are true, I give you at no charge what so ever my lucky numbers: 10, 16, 24, 24, 27, 30, 32, I was born on the 24th July so at least there's a little bit of a lucky number there for what it's worth. But anyway, we consider that a good omen for today's presentation.

As it was said, there will be some questions. I hope you have lots of questions, there's a ton of interesting data here and I think it's really an interesting background. The next slide talks a little bit about Consensus, I think you've heard enough about that, we work primarily for three areas: financial services companies including AIG, S&P, Marsh & McLennan, and Ernst & Young; the pharmaceutical industry; and, ironically, because of my own background with Calvin Klein, we do a lot of work in the fashion and department store business. Wal-Mart's a client, so we have a very distributed practice in Europe, the United States and in Asia. We cover all three continents and we have offices here in Düsseldorf as well as in Philadelphia, Los Angeles and New York. A little bit about us.

Next, we are going to overview three points here today. First of all we start about this trinity of factors, the first point that my colleague Tully Plessner, the chairman of our firm, mentioned some time ago is that the Europeans are very dissatisfied – and in this speech I'm going to talk about the word *uncertain*, but we'll see that people in Europe do not believe that health care has improved significantly over the last ten years. There's a great sense of frustration about that.

The second point is that there's anxiety about the future. What will the future bring, driven primarily about a new demographic reality, and we've heard a lot about demographic reality: we are in the middle, and we'll talk about this specifically, but we're in the middle of the most significant ageing in the history of the world. Fifty years ago the average age in Europe was thirty, today it's forty, and in fifty years it will be fifty, that is a staggering fact that is going to impact this entire discussion to a great degree. Also, there is a new health care mindset emerging. It's a mindset that's concerned, it's anxious, it's frustrated. It's also saying we're going to have to be more proactive, we're going to have to take care of ourselves and we are going to have to keep ourselves healthier. This leads to, really, a changing status of accountability. Voters in particular are holding governments accountable to a new degree for delivering better health care services. A quick one sentence summary of this might be to say: Voters are discovering that cost containment is really rationing and they don't like it.

So that's really what we are going to spend the next twenty-five minutes talking about, and hopefully most of the morning. Let's start off with just voters' view of the European health care in general. We asked people 25 years of age and older in Europe how satisfied they are, on a scale of zero to ten, with their health care, and the next slide shows that only 35% of those over the age of 25 gave a top three box rating of an 8, 9 or 10, so this is to say that two thirds of Europeans do not feel their health care is excellent or very good. Now, it's slightly higher amongst older people, older people are slightly more happy and if you're a mathematician and you think of the averages, so if the whole group says it's 35 and those over 65 say it's forty four, those under 65 must say it's thirty, and the truth of the matter is that's our first tension. The dissatisfaction with the health care system is growing strongest under the youngest people who themselves are seeing more and more of what governments are

doing and experiencing most first hand the impact of government. We asked voters how much do you think, what's happened to the quality of health care in your country during the past ten years, would you say it's improved, stayed the same or declined. As the next slide shows 55% of the people we queried say it's either unchanged or declined and 45% say it's improved, so we have roughly a third say it's declined, we have roughly if you'll pardon the flexibility of the data here just to keep it simple, a third says it's declined a third says it's stayed the same and a third say it's improved.

Now we all know, as we think about health care in Europe over the last ten years, that any sort of rational read would say health care has increased dramatically over the last ten years, if you look at, if we had a doctor here, if we had a public health economist here, she would probably say, "Well you know the public is completely out of touch, life expectancies have gone up, treatment modalities have improved, the amount of time in a hospital stay has gone down, look at what we've been able to do on a whole range of chronic diseases where we've been able to improve, help the quality of life as people grow older, look at urgent diseases like HIV AIDS, ten years ago it was a death sentence today for many people it's a manageable disease..." Of course health care has improved. And we at Consensus are not making a statement about the reality of health care, all we are saying is that when you go out amongst the public and ask them, they do not share this enthusiasm. So the first reality, from a public policy perspective and from the perspective of elected officials, is voters do not have a sense that you've done a great job over the last ten years.

Now when we ask people what's important to them, we see that health care is very important. Not only do people not give government high marks for the health care they're delivering, and we'll talk about that in a second, they also say health care is very very important. We asked people just after the European elections what national issues are most important to them, and job creation and health care are at the top of the list. So the quality of health care is more important than education, inflation, the cost of living, anti-terrorism, environmental protection, social benefits, crime, law enforcement, narcotics and drug addiction, public housing and immigration issues. So the twin pillars, if you say, of voters' concerns are job creation and the quality of health care.

Now we don't have data over time; we've not been doing these studies for the last twenty-five years, but obviously the importance of health care has been migrating up, driven to a great degree by the ageing we will talk about in few minutes. It's also clearly become an issue where what's available versus what is received is – the gap has changed significantly, but clearly voters find quality of health care very very important.

We went on to say, "Okay, we have this interesting conundrum. Health care's very very important, only a third of you think it's improved over the last ten years. Two thirds, then, who do you blame for the lack of health care improvement?," and the answer in Europe is very very simple: People blame the government. We gave people ten credits and said assign these ten credits to these various groups, who's responsible? And basically five of the ten credits went to government; the other credits were pretty much randomly displayed amongst doctors, hospitals, pharmaceutical companies, pharmacists, other medical professionals and university and medical centres. So people have a very clear mind who's responsible for the lack of improvement in health care: it's government. It's not like many issues where, if you look at education for example, people find that to be a much more complicated topic – it's government, it's teachers, it's students... I mean people are much less able to assign belief,

responsibility in that case. So by way of background, we have an opportunity to say that people blame governments specifically for the failure of improvement.

Now by way of an interesting side bar and a little bit off our storyline, when we did the research around the European Parliament, we asked people, "How effective has the European Parliament been on these various issues?," and we found the same trend – they scored very poorly in, let's say, less *well* in general, and health care was an area, when we said "rank the effectiveness of the European Parliament", Europe, anti-terrorism and environmental protection were 40 and 38, quality of health care was 34, and job creation was 31. These are all middle-of-the-pack ratings we would normally expect to see in the 50s for top three boxes on a situation like this. So we see that this focus exists among the European public on the inability of government to deliver what they perceive to be quality health care.

Now as I said earlier, one of the things driving this is the tremendous impact of an ageing population and the next chart is one of these great slides that you love to show when you're in the research business, because it shows things going right off the charts. As I said earlier, we're in the middle; the average age in 1950 was 29.5 years, to be precise, and in 2000, just a few years ago, was 37.7 and in 2050 it will be 49.5, so we see the dramatic increase in the average age of the population. Just to put this in context, the proportion of voters over the age of 50 will be greater than 50% in most of the developed countries by the year 2050; it's projected that between now and 2050, Spain and Italy will actually lose population, not gain population, which will be the first time that's happened since the great plague, so we have a tremendous demographic change going on.

Now this is driven by a couple of things. First of all primarily by the birth dearth, by a lack of replacement babies being born, and secondly by a dramatic increase in life expectancies as medical care, whether it's as good as people would like or not, it's certainly improved and extended the average quality of life. These demographic realities are having a huge impact on budgets as governments have fewer and fewer workers to support more and more retired people. It's having dramatic impact on the projection of budgets as people who, you've probably all heard the old story in the United States that when social security was passed retirement was set at 65 and the average person died at 64, so social security was a great benefit and expected to last for one year of a person's life. Today, the average life expectancy in the United States is pushing 70, and if you get to 60 it's now about 82, 83 and a half – so social security has been dramatically transformed in terms of its budget implications by changes in the life expectancy, and European governments are seeing that same increase. As Europeans grow older they demand more health care spending.

We asked people, "Should governments increase spending on health care because people are living longer and deserve access to new medicines?" For the elderly, 35% agree strongly, 32% agree somewhat. Two thirds of the population agree that the government should plan to increase spending on health care as they age. Now you might ask the question – one of my favourite answers to questions – if someone says, "Well, Bob what about this or what about that?," and I always like to say "Gee, I don't know, I slept through that class at medical school, I'm not a doctor."

People look at their spouses, they look at their parents, they look at the world around them and they see lots of medical advantages, they see what new medicines mean and the ability of people to live longer, fuller more productive lives and they say we want that for ourselves

and if that costs more, then somebody should figure out how to pay for it, and that's a conflict we're going to talk about in a few minutes at a little more length, but it starts out with a basic understanding on behalf of the voters that they're going to need more and better medical care in the future. In research, there's sort of a buzz phrase called "the collective is corrective" – as you get more and more people, they start to correct mistakes, so if you look at a small sample of people you might have some error, but as the sample sizes get bigger and bigger and bigger the error starts to dampen itself out.

Here we have the collective being corrective in the sense of it's telling governments we expect you to do what you need to do to resolve the budget problems you face to help deliver more spending to improve our health care. They also see investments as new medicines are vital. We asked people, "With longer life expectancy, will increased pharmaceutical industry investments and new medicines to treat the elderly contribute to the quality of their health care?" Over 50% of the people over the age of 55 reacted very favourably to that, and of those 55 and over, almost 85% of the people over 55 agree somewhat favourably or very favourably to that reaction.

People perceive medicines as a very important way to resolve that problem and they think it's very important. They are also very much in favour of investments. A majority of the public think government investments and keeping people well are more important than drug price control. 55% of the people agree with that, a fourth roughly agree very strongly. So we are starting to get a sense of what the European population is thinking as a group, they're saying we are growing old, we are going to need more spending on health care, we are going to need new medicines and we are going to need an increased focus on wellness. Now this is a very demanding population, and governments often push back and by saying, "Well we understand that, but we have limited resources we can't solve all the problems," and we are going to examine this in detail in just a few seconds. We asked voters in general, "So what do you think about governments' arguments that they don't have enough money to fund increased spending on health care?" 46% of the people agree strongly that governments should reduce wasteful spending and eliminate unnecessary programmes so they can pay for important new medicines and treatments. In other words, voters aren't buying the "but gee, there's no money left to do this" argument. Voters are saying, "we think if you manage your budget better, if you reallocate your spending, you can afford proper health care spending without increasing taxes."

This is a challenge to governments. We have a demanding voter population seeing better health care available to them and saying it's your responsibility to deliver to us. 42% agree strongly and 82% agree in total, that the public should have more to say about how government spends on new health care and new medicines that can save lives. Again, this is an area that's very close to voters, voters say, "Gee, this is a very important area; government hasn't done a very good job with it so we should be more concerned by it." So that's sort of one phase, that's sort of the next phase of our analysis.

Now, in trying to gain a sense of how voters feel about this, we thought, "Let's look at a subgroup of people that have a lot of insight into the health care situation." In the United States we have a phrase called "the canary in the coalmine" – coalminers long ago, when they worried about the buildup of gases and bad air in mines, took canaries with them, and they put the canary at the top of the mine and if the canary died they knew they had bad air and they got out very quickly. The canary in the health care system is doctors. They' re really

closest to doctors and we've just finished a survey of doctors across fifteen different European countries. This data shows three trends that indicate the canary in the coalmine is not doing very well: 78% of Europe's doctors agree that bureaucratic interference and regulation have led to decline in the quality of health care delivered to patients. 39% strongly agree.

So while we perceive, as sort of outside the system looking in at all the improvements in health care, we think, "Gee the system's doing a lot better, people are spending more money, doctors are saying that the impact of government and bureaucratic interference is actually having a negative impact on the quality of health care patients receive." So the people providing the health care are not pleased with the status quo. Secondly, 83% agree that doctors could treat their patients more effectively if the public had more information, more health care information about preventive medicine – almost half, 46% agree strongly.

So there's this sense that, both from the patients and from the doctors of patients, that there's going to have to be more. People are going to have to become more involved in their own health care, and this means they are going to need more information to do that. Now, we'll talk about information in a little bit more detail later in my presentation, but this is a profound finding because it indicates a really a shift from the old "doctor knows best, don't ask me any questions, just come in and do what you're told and leave" to a new theory in which doctors expect patients to partner with them and share information, a profound shift in how doctors perceive the doctor-patient relationship.

Finally and most importantly, 91% of European doctors agree that governments must develop alternative sources of funding for health care to meet the future needs of an ageing population. Doctors are saying that the answer to this question is "increase government spending" or "more rational government spending" or "changes in government spending" or "reallocating budgets". I think the issue here is resources are being cost-contained, and as I said earlier, cost-containment is really turning into rationing.

To examine that a little more fully, I'd like to take two seconds and do a case study. We recently did a fair amount of research in Germany about German attitudes towards their health care that illustrates the conundrum that bureaucrats and government leaders feel exactly. First of all, there's a German doctor Schöffski who has done a great report about the diffusion of medicines in Europe. As a starting point, just to pick one subclass of the Schöffski report – and I understand he spoke to this group some time back [*editor's note: see [http://www.cne.org/pub\\_pdf/2003\\_06\\_05\\_Schoeffski.pdf](http://www.cne.org/pub_pdf/2003_06_05_Schoeffski.pdf)*] and if you're not familiar with Schöffski, it's a fabulous piece of research. Schöffski says that 25%, only 24% actually, of Germans that should be treated for cardiovascular disease are. That is, three-fourths aren't treated, and if you sort of try to relate this back to our earlier discussion, assuming Schöffski's right and we have a great deal of faith in his research, no wonder people are dissatisfied, because three-fourths of Germans that should be treated for cardiovascular disease aren't, and they say, "How can this possibly be?" and how it possibly is, is really an access issue built around the level at which, "how bad does your cholesterol have to be before you qualify for a statin?" In the United States, it's about 200. In Germany it's about 240, so it's not the price of the statin, it's the ability to access the statin and it's the ability to receive treatment. And if you say, "Well CVM is just one disease", Schöffski goes through a long list: asthmatics have about the same number of people who are treated. The impact on this is quite staggering, the projected increase in strokes caused by the lack of treatment is in the hundreds of thousands in Schöffski's research.

So, we start off with a situation where Germans are under treated and they perceive this, where as in all of Europe – and when we asked who's to blame for the decline in health care you'll recall that we had five units, or 50%, assigned to government. In a recent survey we did in Germany 72% of the people, 7.2 of the ten units went to government, so there's a much stronger unhappiness in Germany with governments and governments' failure to introduce the appropriate amount of health care. Now the German government, as many of you know, currently is trying to revise its health care system by changing the way that covers formularies and this is a process that's typical around the world. In the United States we recently passed what's called the medicare modernisation act of 2004, and of course because we all love to speak in initials, it's called MMA. The principle thing MMA does is give health care prescription drug coverage to seniors. If you're over 65 years of age, starting in 2006 the federal government will pay for your prescription medicine which is a relatively new phenomenon. One of the arguments is how many medicines, how many disease categories should be covered by this programme and how many medicines should be available for each disease category and if you want to take these sort of extremes of the argument patient advocacy groups are arguing there should be many categories and therefore many drugs covered and I think they number about 180, whereas government bureaucrats who have to pay for this would like to have one category and have one drug called Aspirin – it's cheap and it works for everything. So that's the conundrum, it's an access argument not a price argument.

The Germans are having the same discussion, so we asked German voters: "What do you think about the exclusion of innovative, patented medicines with additional therapeutic value from the health reform changes allowing patients to receive these medicines without additional co-payments?" 85% agreed with that, including 42% who strongly agree, so people are saying, "We want access to the best possible medicine." We then asked people if the ministry of health rejects the exclusion, saying that limiting patient access only to the oldest and least expensive medicines, 87% of the voters feel the decision will have a negative effect on the quality of the health care, including half of the voters who see that as very negative.

So this is the conundrum that European governments are facing: The voters are saying, "We hold you accountable for health care and we do not expect that you manage your health care budget by excluding access to new medicines and to better treatments". This is the challenge facing them, and the German situation is merely an illustration of the larger situation faced by many European governments. Now we asked all Europeans – to shift out of our German example for just a second – "What does it mean to improve health care?" – and I think this is a very interesting question, I'll read the question: "I'd like to read you a few headlines from recent issues of magazines. Would you urge members of the European Parliament to strongly support the position outlining that headline? Give it serious consideration? Question it seriously? Or strongly oppose it?" 53% were "serious consideration" to public access to accurate and up to date health care information; that is the highest ranked one and we'll talk about this in a little bit more detail, but as I said earlier, this represents a significant change in the classic view of the doctor-patient relationship.

The next most popular one was increasing the number of hospital beds in clinics, probably to surrogate to reduce waiting times. The next one, almost as popular, was a healthy ageing programme that focuses on staying well and treating medical problems of the elderly. This is really a bimodal question; staying well is not getting the best possible treatment once you're

sick, staying well in the minds of voters is having access to information to do things to prevent them from getting sick in the future. Once you're sick, then it's to get the best possible care to cure that illness. Now, you might say to yourself, "How could people possibly want more programmes to stay healthy? How could they possibly want more access to information when they have the internet?," and our researchers have found this very interesting, we've been doing one-on-ones with key opinion leaders or government officials or patient advocacy groups, and one of the people will say, "Well, we need more access to information" with a computer on his desk and I'm not sure what your most favourite search engine is, but mine's Google and I want to ask them, "Well, have you typed the health care information into Google?" I mean you get sixteen million hits instantaneously.

And the answer is that people are not saying, "If I become a research scientist myself I can't sleuth out this information." What people are saying is: "I used to get this information from doctors. As doctors have had less and less time to spend with me, as doctors have become more and more distant..." Doctors have become more judged by what I would call tailored economic modes: how many patients do you see an hour, how long does the average patient last, classic industrial measures of success. People feel removed from that source of information and they haven't found an equally viable, equally believable source of information to replace it, and what I'm going to call "popular information" whether that be the internet whether that be magazines whether that be friends and family, haven't yet risen to the level of authority that doctors had, so people are feeling an information vacuum, we've lost doctors and in a very complex, very rapidly changing world, we haven't been able to replace them with another source. They would like doctors to be able to prescribe medicines they feel are appropriate without government restriction based on cost. Patients continue to believe that doctors know what's best and that doctors – as I said earlier, this is not a price issue, this is an access issue. People want to have the best and newest medicines available to them.

And finally, as we saw earlier, there is a real belief that we've got to continue to discover new medicines. People believe there are lots of diseases out there that medical research can cure if we get lucky and people don't know exactly how that works but they do know it's intensely important. We asked people what specific health care proposals that they support – and these findings echo the earlier slide – these are two different studies – we asked, we gave people some specific programmes and asked, "on a scale of, would you urge," again these to get serious consideration better health care information on how to stay well, notice that's not on what you do once you're sick, but how to stay well, how to avoid disease, special incentives to encourage research and development of new medicines. This is an interesting one, because it really has two underlying beliefs to it. One we've talked about, which is the underlying belief that I need new medicines to stay well and as I grow older I'm going to want new medicines. Another one that we haven't talked about is a belief that Europeans have, that their health would be better off if there was greater research and development done on new medicines inside Europe. *Time* magazine, here in Europe, recently ran a cover story called "the brain drain" on the flight of European research and development to other countries. That upsets Europeans, not because it's going to the United States but because they believe as a group that they would receive better health care, they would have more vibrant economies if the research and development for new medicines was done in their country.

Now I was presenting these findings to a large pharmaceutical organisation and the director of medical research interrupted me and said, "But Bob, you know this is wrong, you know

that it doesn't make any difference where a medicine is discovered, they get into some pipelines slower than other countries but that has nothing to do with where the medicine was discovered". And my point was, "I don't know. It could be wrong but that's not what people believe. People believe that research and development, their health care would be better if research and development was done in their own country." They also want to see an increase in the percentage of GDP for health care; this should not be confused with a desire to increase taxes, this is a desire for governments to reallocate their budgets to better spend money for health care. As we said earlier, the first thing they think needs to be done is to get rid of waste and inefficiency, the second thing they think needs to be done is spending on things that are less important be put off, be taken away so there can be more money for important spending.

If you go back to when we asked people what's important, remember that job creation was first, health care was second and there was a long laundry list of things that were important but less important than health care. And voters are telling governments, "It's your job to reallocate your spending to reflect this reality". And the last one, of course, brings that point home; eliminate wasteful spending and fraud in health care. To go back up just a moment here...

The change in the system to allow doctors more time with these patients, we've talked about the lack of health care information, we're going to finish on that because it's such a critical finding. Patients want to have more information in a way that they can understand it and relate to it and believe in it. The easiest way they can see that happening is to have more time with their doctors and the next one's a very interesting one: a healthy ageing alliance of doctors, patient groups and pharma companies. There is a general belief that in many parts of politics, but particularly in health care, given how complex this is, given how difficult this is, given how important this is, we need to drift away from the us-them-you relationship and drift towards a more "we're all in this together, let's figure this out" model.

One of the questions we've been asking Europeans for the last couple of years is, "Who do you think is responsible for the discovery of new medicines?", and the answer is "everybody". They really allocate their credits pretty equally across governments, doctors, medical centres, pharmaceutical companies, although pharmaceutical companies get a slightly higher score. People really see it as a team sport. They see it is important, and as you think about how new medicines are discovered, that's not such an irrational view of the world. Yes they have to be discovered, yes they have to be tested, yes they have to be put in the pipeline, yes doctors have to be told about it. It involves lots of people, so what the European population is saying here is, "Hey, rather than making this government-versus-everybody else, why can't we have a more collaborative effort to try and deliver better health care"?

The last point is, and government's first step should be to eliminate wasteful spending which would let them do the fourth point, which is increase the percentage GDP that goes to health care. So this is the picture of our relatively demanding and ageing voter group who is going to put increasing pressure on government to deliver better and more effective health care in the future.

There is only sort of one non-monetary variable in this equation, and I'd like to conclude with that, and that's information. In a survey of 2003 we asked the European public to agree or disagree with a number of statements. 72% agreed the first step towards increasing the quality

of health care is information, learning more about how to stay healthy and the roles of prescription medicines, doctors, hospitals, scientific and academic institutions in fighting disease and curing illness. There's a strong sense that appropriate sources of information, underline the word appropriate, don't exist yet, and that the public would be better served if it became more involved and more active. This is really a challenge, that all the players in the health care world face: how to provide that information. Because it's not "information, the age of". "Here is a three ring binder with six thousand pages in it, go home and read it and take care of yourself", this is not a "physician, heal thyself" argument. This is, "How do we present and provide information in a way that people can believe it, understand it and act on it in a very crowded and busy world?"

Well that's our brief tour of European attitudes to our health care. As a famous French author once said, "in a revolution as in a novel the most difficult part to invent is the end," and the challenge I'm leaving you with, the challenge our research is leaving governments and other people in the health care industry with, is really quite simple: We have a demanding and ageing population expecting to have better and better health care and not wanting to increase taxes necessarily to pay for that. So how are governments going to respond to these ageing, better-informed voters. That's really the issue we face today. So thank you very much and I look forward to answering some questions.

### **Bart Crols**

Thank you, Bob for a very interesting presentation, and especially for allowing us to share in the wealth of data you've provided. I'm sure if you could just remain there for another fifteen minutes or so I'm sure there is a lot of appetite amongst the public for many questions you might want to put to Mr Perkins, to Bob. Can I just ask you to keep your questions brief and any remarks you may have to keep them brief. If you have a question, please raise your hand and identify yourself. Ok, so at the back.

### **Question 1**

Anders Sandberg from the Eudoxa think tank in Stockholm. That diagram showing the median age might actually be underestimating the effect in 2050 given the current breakthroughs that are occurring in the genomics of ageing, and here is really the problem because they are going to get widely published in a few years, the new understanding of the links between metabolic ageing, and they are, likely – my scientific opinion – to actually make people live much longer but even if it doesn't people are going to believe that it's likely that we're going to live longer. We're right now seeing a confluence of the visions what science can provide for a treatment and that might actually cause an extra strain on the system, since people are not getting the information they need to find out is this something that is happening right now or in the possible future. Have you studied how opinions depend on the knowledge about the research areas?

### **Bob Perkins**

Two things, first of all you are absolutely right the changes in medical science could change those numbers significantly. From a mathematical perspective, the rate of birth is even more important than the rate of death. So we see less change there over time but we have seen changes, for example, in the United States in birth rates so these are just our best guesses. You are absolutely right. We haven't looked at the research in the way you've asked but it's very clear that people do want more information about this, and that information is a very, very important variable. And I think, while we don't have literal research to prove this, our instinct

is that the sense of the world is getting better everywhere else and it's not getting better here in my own world which is what's driving the dissatisfaction with the status quo that we've seen.

## Question 2

[Name unclear] from the Centre for European Policy Studies in Brussels. From the data you have provided, it seems that the government is basically criticised for how the money is spent on the use in the health care system and not for that the government interferes into the health care system. Do you have any data on how high the share of the population is which supports the partial or full privatisation of the health care systems, and secondly you provided the data on the development the median age in the population, however, since we are talking about public policy it seems maybe a little bit more appropriate to study how the age of the median voter increases, I mean that's, respect actually the increase is even more sharply, bearing in mind that the turnout and the elderly is much higher as among the young, and this has of course much more severe implications than for the young.

## Bob Perkins

I'll take your two points backwards if I might. You're right, as I think I mentioned in my remarks, in most of the developed world, over half the voters will be over fifty by 2050 which is a staggering number, and given turnout and registration in places where you have to register such as the United States, that number's accentuated. Clearly one of the reasons the Medicare Modernisation Act of 2004 was passed was a belief that both parties had in the United States that older voters demanded prescription drug coverage. Whether that turned out to be a good calculus or not is not obvious at this stage of the game, but you are absolutely right the average age of a voter is going up even faster.

Going back to your first question, first of all I disagree a little bit with your premise. Voters disagree dramatically with government interference in the doctor-patient relationship to the extent that it impacts the doctors ability to prescribe new medicines or other new treatments...

[break in transcript]

...essential to them. So, they are criticising the way governments spend their money because of the interference they see, and the German effort to limit access to certain medications through the current health care reform is a perfect case of that: Germans don't like that, based on our research, at all. So, what they're saying is. "We don't understand, the health care budget is very big, we don't understand it, you do whatever you have to do but don't restrict the ability of my doctor to prescribe medications he thinks are best for me, don't keep me away from new medicines".

Now, so the subset of your first question as I understood it was, "What about the ability, what are voters attitudes toward other systems?", and I think that a statistic that's not in my deck, but I'll cite from memory, which is always dangerous – we asked people about the ability to introduce co-pays. Now as you know, European systems are not alike, some systems tend to have much more of a two track system like England. In other countries, like Germany, there's a strong sense of solidarity among Europeans, much stronger than we find in the United States for example, but I would say you can break it into thirds. A third of the voters are willing to accept some sort of base system that has a pay incremental out-of-pocket personal co-pay insurance – pick your scheme out, if you like, for acceleration or to avoid waiting lists or what you like. Another third are uncertain and the final third oppose it. But there are two

ways to look at that, you know one way to look at it is you have this great foundation a third of the people are willing to accept some sort of co-pay or something and we ought to, all we have to do is to get that to 51% and we have ourselves an election; another way to look at it is that two thirds aren't and that's a pretty hefty number.

People in their own minds haven't crystallised, and that's why the word I used in my prepared remarks was *uncertain*. People, in their own minds, haven't crystallised exactly what they think ought to be next. What has crystallised is unhappiness with the status quo and a belief that governments are using cost-containment as a form, as a way to promote rationing. That they don't like, that they are very certain about it, and how they react to this is less obvious and I think that's going to be the challenge of – we were talking about this last night, a smaller group of us – that's where people who write and talk about it are going to have an opportunity to inform public opinion and sort of mould it and shape it a little. The public's not sure what to do about this, they know what they want, they know they're not getting it but don't have a clear, obvious next step.

### **Question 3**

My name is Simon. It was very interesting for me to know how, in Germany, the voters think about health care problems and I understand now very well that the fierce battle between the different parties in Germany and even in the factions of the parliament, and you say the patients are very much interested in health care issues. I don't understand why the media don't send more emissions concerning health care problems because, in Germany, on television there's very little information about health care, and I think it's maybe also the case in other states in Europe.

### **Bob Perkins**

Well I think one of the reasons the Centre for the New Europe was so interested in having some of this data made public was to promote comments and discussion, and hopefully media coverage, of some of these issues. I think that, as I said in my remarks, we're really at a transition stage. This is, in many parts of the world, but it's clearly the case in Europe, where thinking that health care is essentially “doctors tell patients what to do and patients do it and that's that”, to a much more robust, complicated system where patients are much more informed, much more active in their treatment and it's a much more *public* policy debate, and to some degree I would argue that patients are actually ahead of other institutions like government and the media in sensing the need for this and not having it responded to.

And that's really one of our findings, that there are people that think, “Well, this is too complicated”. Voters know it's a problem, they're very interested in the solution and they're looking for different people, not only doctors but government doctors, medical researches, pharmaceutical industry, universities and medical centres that come together and try to help resolve what they see is a looming crisis.

### **Question 4**

You mentioned about spending on pharmaceutical products and pharmaceutical development, there is a sector, which is medical technology, the medical device arena. Have you discovered any special aspects for the medical technology as compared to the pharmaceutical developments in respect of your survey?

### **Bob Perkins**

It's an excellent question, basically no, there's a limit to how – one of the great words of research is granularity. I don't know if you know that word but it's "how small can you get your focus, how granular can you get it". Clearly new medicines and improvements in medical technology are in the same general ballpark, they're involved in technological advances that make people's lives better. My guess is that people feel very strongly that has to continue.

What people believe very strongly in a slightly broader sense is that innovation is very important. People do not look at health care and say, "Boy we've done a lot of great work we've discovered everything we need to know and now we can just sit back and do good medicine". People look at health care and say, "There's a lot left to learn and it's very important that that accumulation of knowledge continues, particularly because" – and they personalise it – "because I'm getting older and I want better health care as I get older". So I think this covers new medicines, I think this covers new treatment modalities, I think this covers new technology which is probably not seen as much but is equally important. If you just think about pacemakers and what's going on – you know in the United States this has become a big issue because our vice president has an installed pacemaker so it's a matter of some discussion, but I think your question's an excellent one.

#### **Question 5 (Bart Crols)**

Bob, since your findings, or your group's findings, have an immediate bearing on governments' ability to act, operate in politics in the economy in health care, I'm sure these findings – as politicians, by definition, need to be re-elected – have they been in touch with your group? I'm sure they want to know what public opinion feels about these issues, have they been in touch with you about, you know, sharing some of the data on this study?

#### **Bob Perkins**

Because this data's been commissioned by and large by a range of private companies, we haven't. We've done some statements like this, but we haven't had any specific briefings of governments, we've done a lot of research among governments and I think the government is in general, to make a broad statement, sort of taking the "if we just close our eyes and count to ten, maybe this problem will go away". One official we interviewed in the ministry of health in a country that shall remain nameless said, "You know Bob, death is a positive budget outcome", to go back to what an earlier questioner asked, but no we haven't made a great deal of presentations to governments.

#### **Question 6**

I have a question concerning the control of the quality in health care. We spoke about different topics, and I've heard in one of your last slides points concerning prevention, research and developments, [unclear], information, fraud. etc and that the feeling of people in terms of quality of the health care are focused on these points, but if you go in the North of Europe or in the South, the feeling of quality in health care seems different. Did you take that in consideration when you were creating your question and asking the panel of voters?

#### **Bob Perkins**

How do you think quality is defined in Northern Germany?

#### **Question 6 (continued)**

It's not concerning only Germany for example, we have different systems as you say, we are in a very transitory period and there is a common position that people are unsatisfied with the quality of their health care system. But because our systems are different we may have the feeling that our system is not good in terms of quality, which is in another sense than another country, and if we ask the same question to a lot of different countries we are maybe in the position to have different interpretations of what is said in a country or what is said in another country. I take as an example that in the UK there was, and is, still a big problem concerning hip replacement and the patients are looking to have surgery in other countries. We had during the summer in France for example a big strike because of the surgeons, so a patient can say, "Yes I consider that waiting list in the hospitals or in my public system is not quality in my system and the access to the health care network is one of the major important points for me". If you take the Italian example, Italians they do consider that they have very good doctors but they don't trust the system. So all these points are cultural points, so my question is, did you take in consideration in the questions you had and in the analysis of the answers that from one country to another country or one region to another region you should, I would say, moderate a little bit the way the answer was given.

### **Bob Perkins**

Well I'm going to agree and disagree, because it seems like I've got to be at least right on one of those two approaches. First of all, we are more struck by the similarities than we are the differences. We're more struck that while, and we certainly looked at this data on a country by country basis, while, and the three examples you gave are excellent examples, while those are all true, they all lead to the same conclusion which is: our health care is declining.

And what we've been struck by is, while every country has its own laundry list of specific reasons, the most common trend among all the European countries is the belief that the quality of health care is declining. So while the reasons are different on a country by country region you could not say, you can't look at the data, particularly the data we've discussed today and say this is a specific policy prescription for what to do in Italy and clearly, if we look at the Italian data, you'd see that the specific policy prescriptions would be different than the UK data – which is your point, that's what I agree with completely, but what strikes us is that there's a common belief in all European countries the quality of health here is not going up, governments not doing as much as they should, new medicines and new treatments are being denied and that has to change as we grow older. So the, a common slide that we use is: actually similarities are greater than differences, and I think that's exactly true in your case. But you're absolutely right: the specific reasons, the underlying reasons tend to have very local or general deals which is one reason why we talked about Germany as a specific case because that's very specific to Germany. We had broken this data down country by country, other people have asked us if we have broken it down by sort of Northern Europe versus Southern Europe or old EU countries versus new EU countries, do we say that, is that alright to say, the "old" EU countries and the "new" EU countries and that analysis is really more complicated than we have time to discuss today, but I think your point is an excellent one.

### **Bart Crols**

Ok Bob, thank you very much for taking your time to answer some of the questions from the public. I will now throw open the debate to our distinguished panel. We have a sort of thirty minute panel discussion, but something I have to say from the outset, I've gone through the CV's from the different speakers and panel members and all be they have a strong interest in health care they all come from varied backgrounds, there's one who has a, of course I've

already mentioned Bob comes from, there's a US Air force history, there's another who has a degree in music another one has written a cookbook for CEO's and a political thriller mind you, and of course Stephen Pollard has advised both Labour and Tory administrations so that's. Let me just, we've got thirty minutes on this panel, if you would all agree you would each have about five minutes and then we have another fifteen minutes sort of time to react to each others remarks and discussion and comments.

I would start with you Alberto. Alberto Mingardi is an Italian journalist, he is the policy director of the free market think tank Bruno Leoni Institute and he's published numerous columns in the Italian press, but also the English Language press including the *Wall Street Journal*, *Economic Affairs* and has edited and published a few books. So Alberto, you come from a country with a very high debt rate, I'm sure Italian government would have something to say about today's findings given the fact they are cash strapped, so what's your view on this.

### **Alberto Mingardi**

Well, of course, my views are typically very far and very distant from those of the Italian government, so I can not speak on their behalf, and I will avoid actually summarising their view on the subject because basically you enter into spending containment which is a big issue over there now. I would like to make just some comments on what Bob summarised as the findings of his research made by Consensus which is very interesting indeed, especially for people in countries like Italy, where of course we are in a very peculiar situation because well you know, all Europe is ageing – but by 2050 so to speak, just 23% of British people would be over 65, 34% of Italian would be over 65, so as Bob indicated, I mean as far as Italy and Spain are concerned I mean the demographic transition is going to be particularly interesting to watch, and particularly to a certain extent dramatic because I mean there's going to be a great change in habits of people and also great change on these traditional levels, I mean all of us know that basically the current model cannot work with this demography and when I say so of course I'm talking about health care which is an important part of the problem, but the most significant part of the problem is basically the pension system, I mean the pay as you go system as we know it cannot survive these demographical trends, I mean we can just postpone the problem, but nothing is to change unless we undertake a serious pension reform.

I would like just to focus very briefly on a couple of defining of these, of this search. First of all I would like to say that I'm actually not surprised by the fact that most of Europe blames government for health care not improving enough, I'm not surprised for a very simple reason because health care is so strongly associated with government all over Europe that if you don't blame government, who is to be blamed? So I mean actually the Spanish [unclear] between health and government is what we are here at CNE to disentangle. For example, so they blame government because government is by far the most important actor in the field. But at the same time, you know, we have some proposals that I'm not very sure about, I mean for example, healthy ageing problems that focus on staying well and treating the medical problems of the elderly, I mean 50% of the people agree on that as a positive proposal of what to do to improve health care, and of course information is very important. You know patients are experiencing lack of information every day when they get into hospital, I mean that's a common experience with people in public hospitals, at least in my country, but I suppose all over Europe. Still at the same time we should be very careful about information on health problems not becoming just lifestyle which is what is happening in a significant portion of

western European countries, I mean having just government promoting this or that particular lifestyle at the expense of unhealthy habits most of the time actually bring us the reason, you know budget reason, I mean we need you not to do this and that because if you do this and that then you become a burden for the welfare state, so I think, I mean it's very important especially to diversify information at the present stage, I mean it's particularly important from the medical class point of view to assure better information to people in hospital. The most dreadful thing you can experience is that when you enter hospital you get a diagnosis and then people are not coming to you, I mean soon enough to you and your family to give you the impression that you are being treated as a human being, and of course this is, from a human point of view a very terrible situation we should some how try to fix, but I think it's very important not to reduce government involvement in information to, you know, seconding lifestyles, I mean we should diversify information. It's not that we should simply tell people something about red meat or smoking, this this and that. It's very significant, for example, that Italy does no longer have a ministry of health care, we have a minister for health, so lifestyles, I mean, as our minister believes are really a primary part of his job.

The second thing I want to comment upon is that when you go into the support for specific health care proposals you have 49% responding positively to special incentives to encourage foreign R&D of new medicines. Of course part of it is related with brain drain, which is something I completely agree that is having a great emotional impact of people, I mean people want Europe to be first so to speak, at least they want their country to rise back to a positive status on the international arena. That's a bit of nationalism over here, but also it's a matter of pride, and that's understandable, but at the same time I would like just to underline one single thing:

I mean more than special incentives, that is a new thing to get into the business, we basically need the state to stop entering into a whole bunch of interventionist measures that are making research more and more difficult in our country. For example, as far as Italy's concerned I think KPMG it's quite a respectable firm, KPMG just made a study – for full disclosure, it's a study financed by an Italian pharmaceutical company – which is about the tax burden of pharmaceutical companies in Italy and how these tax burdens, between regular taxes and special taxes and taxation on research and development activities that unfortunately we have, is coming to a 64.89% in 2004 and is going to be, if the budget laws goes as it is right now, to 75.49% in to next year. So I think, for example, if this is just a number and it's just about taxation, but if we got into this particular sector the first thing we have to do is have government stop hindering research and development. In doing so, government is really pushing people to relocate their own businesses and especially their R & D departments to other countries, so before an incentive before doing something is a stop doing something which is bad, the priority we have to follow and take on.

The last comment I want to make is on a healthy ageing alliance of doctor-patient groups and pharma companies which is supported by 43%. Now, of course it is a very nice formula, I can easily understand why people like that, because it gives a flavour of common good and alliance for working better, "all together" and all of this, but the point is that is very unlikely to happen as we know why, I mean you've got different constituencies over here that have very different priorities. So, for example, when you have a budget situation like ours, I mean more expenses for pharmaceuticals means clearly less expenses for hospitals, and you can imagine how doctors may be happy for this. So it's a very nice formula, but in order to make that happen, again we should think about changing the structure of incentives in the long run

and making research possible by reducing the number of disincentives for research in other countries. Thank you.

### **Bart Crols**

Thank you Alberto. Stephen I turn to you. Stephen is currently the senior fellow at the Centre for the New Europe, but he has an extensive background in policy making, he was the research director at the Fabian Society, which is the Labour Party's think tank and also the head of research at the Social Market Foundation. He has advised, as I already said, both the Conservative and Labour parties and he recently conducted a seminar at 10 Downing Street, the PM's residence, on public service reforms. He has published, while he has a track record of numerous columns in such papers as *The Times*, the *Sunday Telegraph*, the *Wall Street Journal* and he is also finishing a biography of the British Home Secretary David Blunkett. So Stephen, I turn to you.

### **Stephen Pollard**

Thank you very much Bart. Well there's so much material in that, there are so many different areas one could cover, I mean, Alberto sort of talking about research and so on and the implications there and there's the whole issue of DTC advertising... Indeed in some ways I think that one could say that these sorts of issues extend way beyond health and cover the whole nature of representative democracy and what we expect from politicians and government, as I say, way, way beyond health care. But I'd like really just to focus, throw out some sort of random thoughts and focus on one aspect of it which is the funding area, which I think in some ways is the most, well, in most ways, really, is the most important.

Now what I took from the beginning of Bob's presentation, where he quite rightly concentrated on the demographics and how these sort of impact on all these issues, it strikes me that from a public policy perspective there is a sort of inevitable, inexorable logic about all these, you know, as we have an increasingly ageing population then by definition that means that just – even if that were the only factor – we have a tax base which is shrinking, given, or at least the ability of governments to taken tax is shrinking anyway with increasing globalisation of the economy, but this, looking specifically at the ageing population aspect, which means therefore that health budgets are inevitably under ever growing constraint.

At the very time when health care spending, when the population wants health care spending to rise, the question is: where is the money coming from? And how, as Bob's research said, should the money best be spent? And yet at the same time it's not as if, this would be a sort of horrific, horrendous dilemma where we're becoming poorer as a result of this, we're not, we're becoming ever richer, and it's one of the most recognised facts of economic life, that as populations get richer they choose freely to spend ever increasing amounts of their wealth on health care. That is a decision that individuals take as all the economic history shows. So it's not as if, as I say, we're in some kind of terrible bind where we're getting poorer and yet we need to spend more money, people do want to spend money on health care, so the question is how is it best done, and it seems to me that the inexorable logic of this is to move away from the tax-based or insurance-based funding mechanisms that we have at the moment and finding ways of allowing people to effectively save for their own health care to have individualised health care systems.

Now there are, of course, a myriad of different ways of doing that, but some variation on the theme of sort of individual health care packages, seems to me the only real and sustainable

answer, now that might include pension provision as well, it might include all sorts of different things, and just to throw in a brief plug, we're publishing in about three weeks time a book which I think is the, I've been at CNE since 2001, I think it's by far the most important thing we've ever published, by Wilfred Prewo, who is one of our associates, one of our board members, a German economist, which is called *From Welfare State to Social State* and the book details in specifics, I mean policy wonks are apt to talk in vague general terms about how we should move from A to B but to ignore the more difficult questions which politicians and administrators have to face in doing that. Well the book, which I say will be out, I think, the 29th October, details in absolute specific terms how we should move from this kind of system that we have at the moment to, as I say, this more individualised system with people increasingly taking greater care of their own health care destinies.

Now I'm British and I'm loathed in a European context to talk about Britain because I think too many Brits just are very insular and narrow minded about what goes on in Britain, but I do think that the debate in Britain in recent years over the NHS is instructive, not just in a British context because I think it brings home how the populations across Europe really are increasingly concerned and increasingly interested in what is going on, I mean for instance in a British context, Bart referred to my background in Labour policy making. Well, I was making the case about ten years ago and was, at one point, literally spat on for doing this within the Labour party, the NHS, the sort of monopoly state-funded, state-provided health care system was not just financially bankrupt but intellectually bankrupt too. And at the time, as I say, ten years or so ago, to make that case was regarded as so far beyond the pale that you were just a lunatic. Well, the terms of that debate have changed; Anthony might well want to speak himself, I mean he in a former life when he was working on the *Observer*, he can tell you his own story, but he I think had exactly the same reaction as I did, where as now you can argue this case, you can say that the system is not sustainable as it is at the moment and people disagree with you, they say you're wrong but that's a wholly different debate because you then are arguing on how do you do it and is it right or wrong rather than what you're saying being beyond the pale. The current British government's answer is really in many ways just to put its head in the sand and argue that what needs to be done is simply to spend as much money as is physically possible on the NHS, modernise it a bit, bring in elements of competition and then sort of pray that that will achieve the right results, and the way that this has been sold is to argue that it's not simply tax but that it is pretty similar in some ways to a European insurance model.

The word in 2002, when Gordon Brown, the Labour chancellor, announced massive spending increases in the NHS- such that from 1997 to now, spending on the NHS has increased by 40% in real terms, which you know is almost an unprecedented increase, and it was done by raising money not through the general taxation system but through one aspect of it that we have in Britain, National Insurance, which is a sort of notional idea of insurance but it is in effect simply one part of the pool. But the government increasingly stresses this idea of insurance, insurance, insurance. Well as a political trick this has something to commend itself because the idea is that your money is not just being put into the sort of "black hole" of health care spending but that you have, notionally anyway, some kind of control or say over it, but my view is that this will backfire in that if the government's view that simply spending money and making the NHS more competitive is the right response, well, people like me will shut up because the system will work and we can all go home, but I don't think that that is going to happen and so what that will mean is that people already have been accustomed through constant repetition from the government to this idea that it is their health care service

and they are legitimately able to expect certain provision of services in return for that and they're not getting them and yet they're spending increasing amounts of money through the tax/national insurance system and I think that's the "tipping point" to use the sort of phrase that is sometimes used, I think that is the tipping point when the whole argument as to how we structure our system really opens up.

Just one final "throw-away" remark, a gentlemen asked in questions about the media and surely you know, given the research that we've heard, that the public is really interested and Bob said, you know, that the public is genuinely interested in these ideas, you know why doesn't the media cover them more, well you know I think I would like to – just having a background in the media, just to make one sort of salutary remark over that – I used to work for a tabloid newspaper in Britain called the *Express*, and I was hired to write specifically about public policy issues, the idea being that ordinary people were not just interested in stories about celebrities and about, you know, vicars doing nasty things with children and things, but what they really wanted to know about was their pensions and their children's schooling and their health care provision, and you get a wonderful warm glow of satisfaction that you are explaining these issues to people who haven't had them explained to them in the past and you feel very good about yourself, until you look at the research findings that newspapers do about why people buy newspapers and what they actually want and the single most depressing statistic, I think this is true for almost every newspaper, but when you ask people what they really want from their newspapers and what they want from the media by quite a high margin the page that most people turn to first was the TV listings and after that they turn for the sports news and then buried deep deep deep down are issues as it were. So yes, there may be a thirst for knowledge about these things but sometimes what people say they want and what they really want and we see that with tax, with a question about "would you be willing to pay more tax?" which is so often used in election campaigns and people say yes, but actually when it comes to, if services will increase, when it comes to hard cash, no, they don't really want to spend more tax, they want everything and they want it now and they want it free and I think we can sometimes have this warm glow that people do want genuine information. Actually I'm not sure that's always true, anyway. Thank you.

### **Bart Crols**

With that note I turn to you, Anthony. You're a journalist, so now you know. You've been the *Times* of London's EU correspondent based in Brussels for the past year or so, you're at the heart of EU policy making, European Parliament sessions in Brussels, the EU policy making European Commission is based in Brussels, you used to be the health editor at the *Observer*, you've written extensively and spoken extensively about health care reform in the UK. What's your take on today's topic and the results you've seen?

### **Anthony Browne**

A couple of points I'd like to make. One is just about the actual size of the problem that governments and societies in Europe face, and one is about the implications which are largely touching what Stephen was talking about. Bob Perkins did an excellent summary of the demographic problems facing Europe and the health care impact, but I think actually to some extent he might have understated it slightly in the sense that, as one of the questioners pointed out, that actually just from an electoral government point of view there are going to be more older voters and it's older voters that turn out a lot more at polling booths and there have been reports in the UK that soon more than half of voters in Britain will be pensioners because young people just don't vote. And those people that are voting are the ones that

really really care about health care, I mean again he did a summary of actually the importance that voters give to health care, he had it number two on the list, but if you actually look at the voters that go to the polling booths, it's almost certainly number one because twenty year olds don't care about health care because they think they are immortal and they won't need health care for forty years, which is never for them. But for pensioners, they really really care about it, and I know when I was health editor at the *Observer* newspaper I spoke an awful lot to patients an awful lot of time, and people are absolutely passionate about it because if you are sixty years old and you've got a heart problem that the waiting list, the government policy on heart bypasses is a life and death issue for you and it's the only thing that you'll end up voting about and really really care about and that's more and more for an awful lot of people. It's not just a shallow level of concern about health care, it's an absolute life and death issue for an increasingly large part of the electorate and it's just not going to go away, and those that do vote, vote about it. That's the whole demographics, that is just going to get a lot bigger.

There is also the economic side that as Stephen mentioned, health care is a superior good as economists call it – that is, the richer society gets, we've done things like food and shelter, we've all got that so we spend more on other things like health care and education, but also a lot of pensioners are actually quite rich, I mean there's a lot of concern about the inadequate pension systems and that is a very serious issue, but actually a lot of pensioners do have an awful lot of money and if you're 65 years old and you've got quite a lot of money in the bank and you've got a house that's worth quite a lot, do you save it all up for your children's inheritance or do you actually get that medicine or get that operation that you want. And in Britain, and this goes on to the second point about implications, in Britain, I'm sure it's maybe similar elsewhere in Europe, but a lot of pensioners are actually just going out and paying for their own health care, and there's a huge increase in private operations, they're just doing it their own way, some of them are actually going overseas, you actually get quite a lot of stories of pensioners who go to India for example for hip replacements, one person mentioned earlier the problem of hip replacements in Britain, but these are actually people who, who actually contact directly hospitals in India, it's cheaper to get the flights out there, get the operations and they're paying for themselves.

So there's huge public concern about it and there's actually more and more people are actually willing to spend more money on it. And this comes onto the second point, Bob raised the problem as it were but didn't give a solution when asked to give a solution, but what is going to happen from this, and this is what Stephen talked about, and here it's going to be very different in different European countries because we've all got different models of health care and most European countries have got some form of social insurance and to some extent they're more flexible than the NHS system that we have in Britain, which is a total taxpayer monopoly, or a total government monopoly. Also, in terms of European context, it's all down to health policies, it's down to national governments, and there's actually very little that the European Commission does or the European Parliament does on actual health policy, I mean they can raise issues about awareness and information and they certainly do some work on that and sort of healthy living programmes and so on, but in terms of actually how you pay for hospitals and doctors and how you raise money for it, it's really all down to national governments and it's something that they themselves must face.

I must admit I do side with Stephen in the – I didn't before but I do now – in how this response is going to be, how we're actually going to get, everybody wants more money for health care but how do you pay for it?

What he was referring to earlier, when I started being health editor at the *Observer* newspaper, which was a left-of-centre Sunday newspaper, I was quite a big believer in the NHS, and it was only on reporting on the problems of a state monopoly, state funded monopoly state, that I really started losing my faith in it and got more and more convinced in the need for a far more flexible approach both in the providers of health care having more sort of private providers or health care, but also in just encouraging people to spend more out of their pockets on health care and also just looking at alternative streams of health care such as some sort of social insurance and it's – like Stephen, I was a bit of a [unclear] at the time when I started writing about this – but it's gratifying now that in Britain, we now have the sort of debate that all across the government, not just in the government, but all parties are saying this is the way to go forward, and if you think the implications of this from a European perspective that Britain has had the most monopolistic health care system of any western European country and it's totally losing faith in it – and across a political spectrum, it's not just the Conservatives it's Labour, as well. So if you want to look at the past you can, sort of health care provisions, you can look at the sort of system that Britain had, but if you want to learn any lessons from this, then we're going in the same sort of direction of more individual health care, there are groups of doctors that are formed to actually campaign for more individualised health care called doctors, one group called doctors for reform, but that's definitely the direction we are going to go in.

### **Bart Crols**

Thank you for those remarks. I would like to break off the debate for about fifteen minutes and offer you some coffee. When we come back at quarter to twelve we will hear from the other side, the supply side, a Swedish member of European Parliament Christopher Fjellner.

### COFFEE BREAK

### **Bart Crols**

We'll resume the conference. It's my pleasure to present to you one of the youngest members of European Parliament and rumour also has it he's one of sort of up-and-coming hot shots of Europe. He was elected in June, he's 27 years old, Christopher Fjellner a member of the Swedish conservative party and also the president of the Swedish young conservatives, he sits on the very influential budgetary control committee and also the international trade committee, so I present to you Christopher Fjellner. After which you will have the opportunity to ask any questions. So, after sort of hearing all everything from the demand side, what the public wants, I give you the supply side and what they aim to do about it.

### **Christopher Fjellner**

Thank you very much. My name is, as you heard, Christopher Fjellner and as you also heard I'm the president of the Swedish young conservatives. It's very interesting to be here in Brussels as a newly elected member of the European Parliament, and I'm very grateful to have been invited here to speak on this very interesting and important topic, it's on the top of mind of many politicians and as I understood that you were speaking of earlier, I could unfortunately not attend the beginning of this conference, I had a little fight with our party leader and that took more or less the whole morning but I heard that it's on top of mind also of many in the general public. To start with I would like to excuse myself for two things, the first is that my English might at some times be a little bit lacking of the right terminology, I've been raised in Sweden, a fairly globalised country, I didn't have the best education in English but I had the TV series Beverly Hills 90210, unfortunately they didn't introduce that many

terms concerning health care and growth. And secondly I might have a couple of conclusions according to my experience as the president of the Swedish young conservatives and my perspective might be at some point, may be a little bit too Swedish, but please correct me if you have a different view of something.

Today I would like to address two things that I think is very important, first of all I think it's very important that politicians change their perspective on health care and start looking upon health care as a possibility instead of a trouble, instead of always looking upon health care as a cost – see the potential of the growth, economic growth and the potential for the economy within health care. Secondly I would like to make an argument for the fact that politicians throughout Europe, but not only throughout Europe around the world have to make health care a part of globalisation. Still in Europe today it's a very regional market, and I think it's very important to see to that it's a globalised market. I think these two issues is very connected to each other and if we shall succeed in making health care something to boost economic growth it's important to have a functioning global market and to make people realise that it could be an engine for growth, I think we need that market. So they are interdependent.

First of all, the first thing that was striking to me when I was invited here, when I was starting to think about this subject was two different industries in Sweden that have been developing quite a kind of similar, “at the same time in the same way” – but they've met a very different reaction. One is symbolised by this, my Swedish mobile phone, my new toy, my favourite toy. It's an Ericsson, it's a great mobile phone and I would say it's quite fantastic, the development of these small things, because nowadays they are small. Ten years almost nobody could afford or have them, I remember my first cell phone it was a big brick and I could hardly use it at all, but nowadays it's making life easier for almost everybody, and, I can tell you, I'm over-consuming this. If that were something I could be accused of, I would be guilty as charged. And the cost for me of this is astronomical and I would say that, if you look upon percentage of GDP, I haven't studied the figures but I wouldn't be surprised if the cost compared to GDP is increasing enormously during the last ten years for telecom industry. But in Sweden this is one of the main growing industries, a driving force behind economic growth in Sweden.

The other industry that has been developing, very similar and parallel, could be symbolised by Prozac or some cardiac medicine of some sort. Luckily I don't carry that with me because I've not yet needed that, but staying in Brussels and the European Parliament I'll probably need both Prozac and some heart medicine quite soon. But still, since the beginning of the 90s, the pharmaceutical industry has been developing enormously in Sweden just the same way the cellular phones have been developing, and the driving force behind it have been new innovations and new products. You can see that the number of prescriptions in Sweden during the 90s increased over 50%, and these prescriptions have also, of course, led to a lot of better lives for many people. But that is something that people don't talk that much about. In Sweden the big debate is about the cost and I heard that the three main groups of growing medicines in Sweden were Prozac like anti-depressive medicine, anti-cholesterol medicine and heart condition medicines, and those three together have saved more lives than people that are dying in traffic in Sweden, so it's obviously something that has improved things tremendously, including the improvement of the everyday lives of people. But today still you can see the difference in the reaction towards cellular phones on one hand and the change in medicine on the other hand.

Politicians mainly, and also others, want different measures taken to stop the growing cost – because of course, as within cellular phones we have a growing cost for this. At the same time as the prescriptions increased with 50%, the part of GDP that the households and the public sectors spent upon medicine increased with almost 100%, but on the other hand when you look upon the economic growth and what the industry in itself does for Sweden we can see that it has become one of the main industries of Sweden. From 1990 the industry was exporting, around 1990, the industry was exporting around seven billion Swedish Krona, but the year 2000 that figure had risen up towards thirty four billion Swedish Krona. So the pharmaceutical business is in Sweden a big success, just as big as the telecom industry, but the strange thing is that it is acknowledged as a success when it's produced and innovated – but not when it is consumed. That's the big difference, when it actually does the good things it's supposed to do people focus upon the cost. If we go back to the mobile phone, I don't think anybody would say that we have a big problem, we have a new Eriksson out on the market people will want to use it and the cost will increase dramatically but strangely that's the main political perspective at least in Sweden when it comes to new drugs.

One thing, and this is an example taken from drugs, but I'm sure that the example could be transferred to many other parts of health care as well. I think one of the main reasons for this is of course how the financing is organised, that it's supposedly someone else paying for it. Many people look upon productivity within the health care sector as – even though it's growing enormously, people think that the only way to have more health care out of the system is to have more doctors, more nurses – they don't look at all the fantastic technological advances. And even though the technological advances have been great – and the reason for that is probably due to the fact that the pharmaceutical companies and the health care industry is investing an enormous amount of their money into increasing the productivity. The pharmaceutical industry is investing, I think, 13% of its income from sales into research, and the medical technology industry is having – the figure in that case they're investing 7% of their incomes from sales into development. This is far more than the airplane industry, electronics industry, or chemical industry, so the productivity that you can expect from that is probably much higher. And I think the best way to see that the health care system is looked upon as a real potential area for growth, one of the most important things, is to give it a growth perspective, is to see to that we tear down the borders surrounding the health care systems as such, so that those health care providers that actually use these technological advances, who see to it that the productivity is giving lower costs and better allocation of resources also has the benefit of it, and I would say that we should start within the European Union.

Within the European Union the health care sector should be looked upon as a commodity among others, but it isn't. We are supposed to be able to find medical service everywhere, anywhere within the European Union. Tell that to the thousands of people that are still in different queues in Sweden or other countries, waiting for health care that they already paid for through their taxes. If we should see too that the health care systems would be transparent and that it would be possible for patients to move across the borders, then those countries who can't supply and deliver the best health care, that have all these service problems, they would be net importers, they would suffer from that of course, but those who have the possibility and have the best service can become exporters and in those countries, when you see that directly, then you can see that it could become an export industry, something driving growth. As all competition and trade, it leads to better allocation of resources, but unfortunately this is not the perspective that I met within the European

Parliament. The best thing that I can think of right now is probably the service directive that is one thing that should see to it that you will be able to get good health care anywhere within the European Union. Unfortunately many people now want to take out the health care sector from that specific directive. That would be very bad for many reasons, but I think it would also be bad due to the fact that it would take away the potential of different countries to use their medical system as an engine for growth. I wouldn't be satisfied though if we could make one market, one export and import situation within the European Union because I think it's just as important to actually globalise and see to that we get a global market for health care.

If there's one single thing that in Europe specifically points to the importance of this, and it's the demographic situation. We know for a fact that we will need to have doctors and nurses coming from other countries, and also probably people from Europe going to other countries, I read about this Swedish company that's starting a health care centre in Thailand where people could go, but that is still something odd and will become so if we don't succeed to make a global market for health care. The most important thing in this field is probably to have success in the general agreement on trades and services, but unfortunately the European Union before the first negotiation round already took out health care and said that this will not be within that. I would say that's a big mistake and Europe will suffer from it.

I actually had an opportunity to ask the new commissioner on international trade, the trade commissioner Mr Mandelson about this, due to the fact that this is one of the most important areas where we can have economic growth in Europe and to actually achieve a new GATT treaty should be one of his main priorities, and especially within the health care industry and education industry, those industries that really need the kind of pressure, competition, deregulation that a big agreement on international trade could be a driving force behind. So I asked him what he would do to this, the fact that health care was dropped from the GATT negotiations. Unfortunately, his response was, he started with "honourable member of this house, I would not like to start off on the wrong foot with you" and after that, it was probably some kind of insult, as much an insult as you can have in that situation but, but unfortunately his answer was no we will not, Europe will not have a global market for this. And I think that is sad, both because we are missing the opportunity to have an important engine for growth and also due to the fact that we will really need that global market when the demographic hits us. And it will hit us hard.

I should try to round up here. There is actually one organisation that has stolen the line that I would like to conclude with, or actually that I hope would be the line that leads this, the development of health care in Europe in the future. That is the French organisation Doctors Without Borders. My French is awfully bad so I shouldn't go there, anyhow, that movement is a movement that was founded in France and that tries to take doctors and medical services out to the former poor, often now growing countries, the developing countries. Doctors Without Borders is something I think is enormously important to have within Europe, around Europe, but we should also have "doctors without borders" the other way around so to say, in ten, twenty years we will need doctors from India who can come here from China and treat us when we grow old. So I think I will conclude there. Thank you very much for listening.

### **Bart Crols**

Thank you very much Christopher. Just stay up there for a couple of minutes because I'm about to open a Q and A session, anyway, don't worry about your French, I know Strasbourg has a lot of excellent restaurants in which you can practice your French.

### **Christopher Fjellner**

I know two sentences, one you can guess, the one that everyone knows, the sentence I usually refer to it, but I haven't had any use for either of those two sentences since I arrived in Brussels, not yet.

### **Bart Crols**

So again we have a couple of minutes for Q and A session, so please keep your questions, first identify yourselves and keep your questions or comments brief. I see Tim has a...

### **Question: Tim Evans**

I think your speech was very interesting because you are part of the new class in the parliament and you're part of a group of people, not just from Sweden but from a number of other countries who, I think, are from a younger generation – and we saw earlier in the research that Bob presented how young people are carrying with them less deference to politicians, let's put it that way. Less of the traditional view that government will do all this for us and much more of the view that health care increasingly has to be commoditised in some way; that people are carrying more of the psychology of consumerism.

CNE is not just in the business of doing events and publications and getting media coverage and all the other things we do, we are also very interested, as you know, in interfacing with the commission and with the parliament, so my question to you is tactically, what scope do you think there is for building alliances of likeminded, liberal, consumer oriented MEP's in the parliament across the political tribe and across the nationalities for really taking a lot of the research we heard earlier today about demographics and expectations and about building a coalition in the parliament that can be more honest with voters and what they can expect in the future. Are we getting a critical mass in the parliament, particularly among younger people who would support this?

### **Christopher Fjellner**

I wish I had a very simple and clear answer to that but I spend much of my days trying to locate those people within the parliament that actually might cheer some of my views. In the first month I was just trying to find my way in the Parliament; now I'm trying to find people, also not just different rooms. And I must say that I've realised one thing that is not as much as I might of thought before I came here: the question of age. For example, I've been walking around with one of my favourite books, it's called *In Defence of Global Capitalism* by a friend of mine called Johan Norberg, and I've been sitting with that in meetings and trying to see who reacts around me and how do they react, and just the other day I had the, one of the vice chairmen in the commission for international trade, luckily the former famous hockey player who is the general manager, I think, of the Slovak hockey team at the moment, but I would say that I've been surprised that this is not an age issue mainly but an issue of how important do you think ideology is and how much do you want to be provocative, because actually to say, after I asked Mandelson if he would like to put in health again in the GATT negotiations, a lot of my colleagues were actually like, "um, strange guy" and I think, I hope there's critical

mass, I can't tell you now but I will definitely do all I can to help to find that critical mass and get it working together and hopefully I'll have the possibility to come back here in a year or so and say that now we've reached critical mass, now let's start to make some real changes.

### **Bart Crols**

Thank you, any more questions, I see another question at the back.

### **Question**

Thank you. This might tie in actually to the previous question. Benjamin Tetlock, an American psychologist, has been studying what he calls "taboo trade offs", and that is a trade off between a (sacred) value and a secular value like for example between human life and money, and usually people react extremely badly to that kind of trade off and they are feeling dirty even making this kind of trade off and essentially what you have been discussing here is a taboo trade off here in Europe because health is a sacred value to us, while on the other hand economics – or even democracy – it's a much more secular value so the problem might be that as long as in the Parliament health is treated as sacred, it's not allowed to be traded and that is really going to impair their ability to solve these problems. So maybe the key question is how do we spread these ideas, make people realise that health might be extremely important, and extremely good, it might be one of the highest values we have, but it shouldn't be too sacred to be doing something useful with it.

### **Christopher Fjellner**

And I think we have lots to learn from the left, the political left so to say, they're very good to you know, merge these different values and present them more appealingly to people, and when it comes to, in Sweden at least, when you talk about health everybody feels, "Okay, the government had to take care of everything because we wouldn't like anybody to be without health," but then I normally just translate that into food, another very, probably even more important business, shall the government take care of everything within food business, shall the government provide the way, or can we, as we've done into food see to that we only help those who can't handle themselves in that sense. So maybe there are parallels that you can use to break through, but I think you are very right when it comes to these examples such as money compared to life.

### **Bart Crols**

There's room for one final question from the public, anyone?

### **Question**

Only one remark to your speech, you said that there's a chance for the European economy also in medical issues to take part in a better growth of the economy. I've been once in Singapore, and in Singapore they are expecting many people from neighbouring countries to come to Singapore for treatment but I never saw anything else in Europe, so I agree with you.

### **Christopher Fjellner**

I would say that, sorry for going back to Sweden again, but back in Sweden you have regional borders; you can't go from the region of Stockholm to have medical care in my region, the region of Uppsala. This makes great problems for patients. You can have queues in one part of Sweden and have enormous access in other parts of Sweden, and it's like we still have some kind of small Berlin walls throughout Europe, but just for patients. You're not as a

patient able to, even though it's cheaper than ever to fly around Europe, it's not as simple to do that when you try to get the most basic thing, medical care.

### **Bart Crols**

Yeah, I just see one final question there in the right, there.

### **Question**

Referring back to what you said during your speech on the services directive I just thought, also tying in with what the previous person just asked, I recall that in the run up to the EP elections that in Sweden, actually, the services directive was quite an issue and, if I recall the discussion correctly, that most people saw it as undermining the Swedish health care system and that was potentially threatening. I was wondering whether you could probably reveal your knowledge of the Swedish position on that proposal and how you would probably participate in discussions on that.

### **Christopher Fjellner**

You're very well informed when it comes to Swedish politics because you're correct, it was a big debate and many people were actually saying that this, before the election, they were saying that this is a threat to the Swedish model of this welfare state, but that was before the election. As many questions normally come after the election, the government doesn't think it's such a big problem, but it was a good way of scaring people to go and vote for the welfare state parties, so to speak, and then you can guess for yourself what party that is. But there was another, not just the Swedish model. Another fundamental thing was debated, connecting to the service directive, and that is that Swedes – probably not only Swedes but many people particularly in Sweden – maybe have a problem with people moving to Sweden for different reasons, working in Sweden, living in Sweden.

I remember before we were joining the European Union, a friend of mine was sitting in a some kind of call centre answering strange questions that might occur, come up, and then there was this radio show that phoned in and said, "Okay, I've heard that it was a prank call that they aired on the radio show and said that if we join the European Union then we'll have forty thousand German gay men moving to Sweden" and she was like that can't be correct, so there won't be any German gay men coming to Sweden, and she said, actually I can't promise you that because there might be one there might be one hundred thousand German gay men, one hundred thousand, I shall tell my friend that, and the exact same thing happened again, and you know the debate upon special succession, accession rules, you know what I mean, and then the debate was ok, if we don't have any special rules here we'll have not forty thousand gay people, but then it was forty thousand lazy Poles who will come to Sweden and live off our welfare system. No lazy Poles arrived, and during the service directive the debate about that, we had the same debate over again but now it was forty thousand willing to work Estonians coming there stealing our jobs, so I think it was both people coming taking our jobs and the threat to the welfare state that made the service directive very controversial in Sweden. Anyway, thank you very much for letting me come here and speak to you, I hope to be seeing more of all of you in the future, here or in other places around Brussels. Thank you very much.

### **Bart Crols**

Thank you very much Christopher. Our next speaker is Ben Irvine who joined the International Policy Network, IPN, as its director of health projects as recently as July of this

year. He's been responsible for IPN's work on pharmaceutical policy, intellectual property rights and access to essential medicines, also a topic of today. Before that he was for four years at the free market London based think tank Civitas and he's written extensively about European health care policy and policy reform. He's published on pharmaceutical pricing and also parallel trade. I'm especially pleased to note that he has a degree from my old, own university in Belgium, Leuven, he holds a masters degree in European law and comparative public policy administration. Ben Irvine.

### **Ben Irvine**

Thank you Bart. It's a great honour and pleasure to be with you all here today. When I was originally invited to speak, it was on the back of a question some six months ago from Tim, down at the front here, he asked: "Is there any cause for optimism among free market oriented people and libertarians in health care in Europe?" I answered with a firm "yes and no."

Over the next twenty minutes or so, I'm going to give an impression of where our health care systems are coming from. I kind of get the feeling we should have done this at the beginning of the day, but hey, then flirt with the basics of health care markets very briefly, suggest where I and others in this room might like to get to and cover what's actually been happening and what might be on the cards for the next few years. So, bit of fact, bit of opinion and I look forward to hearing your contradictions later on.

So, some background elements, starting in Germany, as I think most of us probably know, the period from 1880 to 1950 saw the introduction of the guarantee of health care as a majority of citizens in all European states saw a parallel involvement of the state in health care, at that time the universalisation of access to public health really took place between 1940 and 1980. The British: we think of the NHS there, health, education, welfare came to dominate public spending, then through the 70s and 80s and 90s health care became a major political priority across Europe, all European countries having public systems, greater demand from patients, that made sort of steep rises in health care expenditure, governments started to look at ways of controlling costs, containing that expenditure. So from the late 70s onwards we see a sort of universal epidemic of sustained and pretty extensive system reform.

Now what about aims? Well that's quite simple: they're pretty much the same in every country, there's no country that can claim, every OECD country that is, no country can claim to be really better than any others. There are six: adequacy and equity in access to care (not financing, note), income protection, macro-economic efficiency, micro-economic efficiency, freedom of choice for consumers, and appropriate autonomy for providers. Now the reform drivers, many of these were being touched on today already, expenditure obviously a major one owing to increased coverage, demography, ageing populations – today's subject, we have become more demanding, that's also been highlighted by the first speaker today – advances of medical technology, been touched on from the floor, medical inflation, costs rising more than general inflation and also rapidly increasing pharmaceutical costs, that's a little bit of a red herring that last one because they also have the knock-on effect of cutting back on other costs, and of course they would come down as well, improving quality of life.

Now ideology: The best example of that perhaps is a wholesale change, post communism, of the recently acceded states away from the centrally planned health economy. Outcomes, well, again little bit of a red herring, health care is not the most important factor when you're

looking at health of a population, but you can usefully look at conditions amenable to medical intervention and draw some conclusions about the performance of a system. Voter satisfaction certainly touched on a few times already, patient satisfaction, there are some good studies that show that there's a great deal of variety around Europe on these matters and that satisfaction is changing significantly across the continent.

Finally, the old EU. Treaties, legislation, jurisprudence as well, we're seeing pretty major involvement, we know about the European health card, we have cross border care, I might take issue with our previous speaker, I think there is a significant amount of that happening already: new proposals for the working time directive, the EU trials database, Stockholm a couple of weeks back saw the opening of the European centre for disease control, we just had the informal health council and that, apart from anything else, is identifying common threats across the continent: ageing, AIDS, SARS and so on. Could we move on.

Now before going into some reforms we'll sort of picture what it is that we are reforming. Any health care system is concerned with the relationships between three actors: the citizens or *patients*, the third party *payer* – these are the people that collect payments and perhaps pool them and then distribute them, and of course the *providers* of primary care, secondary care and so on. All reforms impact on the relationships between those so that leaves us with the insurer market the provider market and the health care procurement market the last one. Now before going into some detail let's look at the next slide and some sort of essentials about markets: I believe they're a good thing in health care, they can lead to performance improvement, spur efficiency and innovation – but regardless of that there's still a significant portion of the population who are still extraordinarily hostile to the involvement in markets. They base their arguments around a paper published in the sixties by Kenneth Arrow, *Market Failure in Health*, which does discuss moral hazards and skimming and so forth but also says that government and charitable intervention in the case of market failure can correct.

So, what are the key elements? Well we can debate these perhaps, but a price mechanism choice, information is essential and effective competition was relying on lack of barriers to entrance and those who want to leave the market, some sense of stability as well, predictability, now specifically in health care we need money to follow patients clearly and more than adequate comparable easily accessible information regarding quality cost and so on of health care. So, considering those, is there an idea type that recognises those floors that people love to seize upon but also recognises the positive impact of markets in health care. We're going to move on quickly, well here's a clue, I don't know if you can actually see the detail of that [referring to slide] but across the top we have increasing respect for the role of an individual in a health care system and across the bottom going in the opposite direction increasing role for the state. Way at the other end we have the UK and towards my side here we have Switzerland, now to the, from your perspective, right I think, yes, of Switzerland, Stephen's idea that he mentioned earlier on, real individual control about how your health care is funded would come in there.

So I think I've answered my question already about what my favourite health care system, where I'd like to go, but bearing in mind Stephen's idea, next slide please, Switzerland, I'll leave you to read the details, but I'll just skim through some. The primary role of the Swiss government is to create the legal and regulatory framework to ensure that access to a high standard of care is guaranteed to all and ensure supply of essential public health care services, a competitive environment results from that lot there, you see patients treated as valued

customers, innovation being encouraged. Those individuals, and I know this from my research for a few years in the Swiss health care system, are price conscious, it doesn't mean they always act on information but nevertheless they could were they minded to do so. Social solidarity is also insured, bearing in mind there is OECD aims, quality of care is high and the system is responsive in terms of treating need, so, can we move on to the next one?

The insurance market in Europe in health care, well there's a variety of arrangements to be touched on, I'm afraid of the sort of slightly American perspective which lumps Europe together as one, I don't want to misrepresent the views, but there is significant variety, tax, social insurance, mixture of the two, parallel systems going on Germany was mentioned earlier on a parallel private and social insurance going on. Is there insurer choice? Well there is in some countries, not in others, all of these systems have standards sort of pro-equity features, obligation to contract, risk adjustment mechanisms and so on. In terms of trends, well I think there's been a pretty clear in terms of insurance and I'm talking about tax and social insurance here, there's been public/private integration, there's been a move really to integrate systems in some countries but also to embrace them in others, there has been a shift in some countries from tax to social insurance but also vice versa in others. There 's a significant push from governments and also social insurers to manage insured behaviour using sort of other funding mechanisms, co-payments, deductibles, at the same time, I heard this one from Simon Stevens, Tony Blair's former health care adviser, there's been a significant push to manage down consumer expectations as well, which perhaps goes alongside benefits regulation, clinical guidelines and so on, which we've seen in many countries, not just in the UK. Now in France, skimming through to examples, over thirty years this is my public/private integration rationale, since the introduction of universal health care, which includes a free access for the least well off to mutual insurance to cover co-payments, you can really say that the private insurance sector in France has been legitimised and normalised as part of the wider health care system. Other reforms that are going on in France are many fold at the moment: significant financial incentives to sort of encourage patients ("responsibilisation"), now the Netherlands is perhaps even more exciting, honestly.

Choice was introduced in the 1990's in the Netherlands, choice of insurer that is, for those that are covered by the social insurance part. But the major reforms that have been discussed for decades, the Decker and Simmons plans that many of you may have heard about, in a slightly amended form are going to go ahead, it seems that the sort of public/private split is going to be removed largely. Everyone from 2006, if it happens – which in the Netherlands you know, who knows? – will have private, for-profit competitive insurance with insurers competing on price not package, not risk, there will be open enrolment of standard package set by the government. Yes, there will be options, as in Switzerland, to go for a higher deductible which will give you a lower premium. There may also be a no-claims bonus system also featured in Switzerland. So that's a pretty big and exciting reform from someone in Britain who looks for major change, in Germany there's something similar going on, not quite as radical but potential....

[break in transcript]

[On Germany] ...sort of ideas crop up in discussions that I've been watching for the last three years, choice of social insurance was introduced in the nineties for most. 2004 reforms have been mainly aimed at sort of curbing expenditure and cutting premiums, they've been rising rapidly and there's been a distinct need to do that and they've been met with some success,

but "citizens' insurance" is the phrase that's on peoples mind who are watching German health care reform. Now there's CDU and CSU, who are still bickering about this significantly, as was alluded to earlier on, but it is likely to be introduced sometime after the 2006 federal election. What does it mean, well there's still a discussion about the source of funds that will be used but essentially it's bringing more people from the private element of German health care into the statutory health care system. Also, insurance reform in Germany: I think just literally a couple of weeks back happened there's a new dental prosthesis insurance system, social insurance introduced, and of course five years ago or so social insurance was introduced for long term care. I think that's the only country in Europe that does that. Other countries, well maybe I should skip those and go on to the EU new member states, there's been radical shift from as I said the old system to, in the case of Hungary, discussed competitive social insurance but didn't actually do it. The Czech Republic and Slovakia have introduced competitive social insurance, the rest have introduced non-competitive social insurance. So those are important and very ideological major shifts.

Moving on to the provider market: Choice, choice, choice everywhere. There was none in many countries, it was limited in others, it's extensive in many. France for example, the other major issue here was gate keeping, are we moving towards gate keeping in countries or away from gate keeping. Some countries have seen new forms of ownership; management of hospital emerging and the public/private balance has been changing as well. Now in France gate keeping has been incentivised with pretty much no success, but there are current reforms that, ongoing, introduce a real financial incentive for patients to choose to go to a GP before they go to a specialist provider, so that might have some effect.

In Germany, again gate keeping, part of the 2004 reforms. A co-payment was introduced ten Euros per quarter, that is now being waved by some sickness funds if you agree to use a sort of gate keeping system, so again that's an important cost containment reform ultimately. In the UK, perhaps much more exciting – Stephen's not so excited, but I think the sort of radical increase in choice in the UK, and this comes from all political parties no matter which one wins next year – alongside significant amounts of comparable information we're told, there is a website where you can compare waiting lists and success rates and so on, the NHS information authority it's called, so you know there is a real change going on there, and we have foundation trusts which are watered down, yes, but they are a major change nonetheless. We have co-operative providers for out of hours care, we have the private sector being brought in also from Europe from Canada from the States to provide buckets of hip replacements as were alluded to earlier on.

Now, Spain also provided structures, Switzerland the first example of HMO's in Europe, that's worth noting. In the EU new member states more choice, more completion, but I haven't got anything else to say about them I'm afraid.

Now moving on to the procurement insurance market rather, the UK in 1991 following the lead of America and subsequently other tax funded countries – Spain, Sweden – have introduced various internal market type reforms, separating purchasers and providers in social insurance countries, we're also beginning to see the introduction or at least the discussion of selective contracting between third party payers and providers. Payment of positions in hospitals has changed a lot over the last 15-20 years in terms of first doctor contact with your GP, you can either base payment on capitalisation, essentially, or fee for service, and there's been a major shift towards capitalisation. Germany's done this, Sweden in

'85 apparently, some countries use a combination of the two as I've mentioned France has already introduced a sort of capitalisation payment for its gate keeping doctor which hasn't had much success.

Hospital payment has also changed significantly. There's been a shift away from the open ended retrospective funding of activities to reimbursement based on actual activity. Shock. Horror. Those are very much basing their reforms, they used to spent something like 70% of health budget on hospital care as opposed to primary care. Hospital care in the EU is about 50% on average of expenditure, so there's been a shift away from that.

I'm quite interested in the outsourcing of health care. In the UK the NHS modernisation plan envisaged the outsourcing to commercial firms. Simon Stevens, I mentioned a second ago, has been at the centre of the introduction of such schemes and his new employer United Health, a big US firm, is likely to be managing significant NHS budgets soon, in fact there's a pilot going on right now. Also as a means to cut waiting lists, the department of health contracted with for-profit, independent sector treatment centres; some of them are from Europe, others are from all over the place as I mentioned, but also our private hospital chains have sort of come on board and in a sense been normalised as part of the health care economy for NHS patients, so they' re providing hundreds of thousands of elective operations now.

Now approach to care, this hasn't actually been mentioned yet today which surprised me somewhat, there will be a significant push for the integration of primary, secondary and intermediate care, the Kaiser model, disease management and so on are going to be major elements for all governments across Europe as I see it.

Now can we move on and just summarise the sort of major themes. I won't go through all the detail here. Cost containment measures can be divided into three types: budget shifting, budget setting and direct and indirect controls over supply and demand. We can discuss those in questions if need be. Management, quality and competition again, the subject of this talk really, there's been a significant increase in managerial functions of both payers and providers, we've seen quality norms and standards being made much more explicit across the continent, and competition, a subject of great debate has become an essential part of many health care systems.

Centralisation is another subject which we've seen across the continent, far from being a retreat which is what many of us may have hoped, the state has made significant advances in recent years in all European countries, although reforms that we've alluded to may be implemented at a local level, they're predicated on this centralisation of regulatory authority, but at the same time we've also of course seen decentralisation of funding, of management planning operating responsibility, re-centralisation of other functions, (regionalisation), hospital planning springs to mind. For example especially tertiary care. And then we've seen "cross national decentralisation", forgive that phrase I made it up, by which I'm thinking of the role of the European Union, other member states, my previous speaker alluding to a genuine market in European health care.

Can we move quickly onwards? This [referring to slide], I've pinched this from another think tank and adapted it slightly; this is my impression of what direction we've been going in. The other think tank was Reform Britain, who are aligned with doctors for reform, which was mentioned by Anthony Brown earlier on actually. I see the NHS as moving distinctly in that

direction, other countries where, I think, around about where the NHS is now and are also still moving further down there, as are the new member states of the European Union. Some ineffective political structures at the moment have a lack of funds but that's the clear direction of travel as I see it, so can we move on again?

Has there been a health system convergence? Well yes. Given the common impetus of aims and reform drivers including public health focus, Alain Enthoven's managed competition, patient choice agenda, which you see all over the place and the Kaiser integrated care factor, yes we're going in the same direction, there has been convergence. There are others, however, in Britain, Scotland and Wales deliberately going in the opposite direction to Tony Blair et al, but are there differences between the sort of tax and social insurance countries, well, yeah, in broad terms tax finance countries are seeking to improve micro-efficiency of their health system by increasing elements of management and competition. Meanwhile the social insurance countries like France and Germany have sort to increase macro-economic control over costs by more assertive central regulation, while also enhancing the element of selectivity, that's competition, in contracts between purchasers and providers.

Now what future for markets? Well I should have said to watch actually, the Netherlands. Clearly, it's a real test case as I see it: Will costs skyrocket as many argue they have in Switzerland for example and in the States of course? If not, who else will follow them? But also the UK, that's another one to watch. Will, following the next election, or the one after that, will there be, is there a possibility for reform of funding mechanisms? Provider side is kind of sorted in the UK, I think it's going in the right direction. The rest, well, looking also at the competitive pro-market new member states, just one statistic I read on the way over on the Eurostar: In Poland 64%, of people support market orientated reform of their health care system, that's a figure worth watching.

Now, in terms of sectors, other sectors to watch in certain countries, health care professionals we've touched on already. There might be a market in health care professions on a European basis or even a global basis, though there are moral questions which we need to ask. Elective surgery: I think there's a potential for market involvement there, also in terms of managing long term conditions, we already see pharmaceutical companies in the UK involved in pilots in managing long term conditions and then of course there's the diagnostic technology stuff, there are people sending x-rays to be assessed and from London to India at the moment, I think there's much more scope for that sort of thing.

Finally, will there be a European health system? Horror of all horrors, to many in this room. Well, I think to pick up on something Johan Hjertqvist wrote recently – you're looking shocked – he argued that the union of twenty-five countries and four hundred and fifty million people is in the early phase of integrating into a joint health services market by its rulings in the European court, step by step transferring powers from governments to consumers, or to itself rather. Johan is right I think. Take the Dutch example; there are questions over article fifty-four of the non-life insurance directive. So we mustn't run away with ourselves here, it's true, health reform policy is no longer purely a sovereign matter but we're definitely going in the right direction. Thank you.

### **Bart Crols**

Thanks Ben for this birds-eye view of a topic that could easily fill a two-day conference, unfortunately we've only got time for maybe two questions. In the meantime could I ask

Jorgo or Johan to join me in front for the upcoming panel discussion? So again any questions you may have please raise your hand and identify yourself.

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## Q&A

### Question

Do you expect that the open method of co-ordination within the EU may contribute to a better system of health care?

### Ben Irvine

Well now I'm going to reveal myself as having been out of the nitty gritty of European policy for too long, can you very briefly fill me in on details of the open method of co-ordination then I'll be happy to respond to that.

### Question, continued

The open method of co-ordination means that the EU intends to have reports from several countries and they, the commission, will put some benchmarks and, getting the reports of the different countries, they decide if one country is below the average or is better than the average, it means it might be some pressure from the European commission to reform the health care systems.

### Ben Irvine

In terms of performance, waiting lists, expenditure, so on, well I suppose the short answer is yes, but it might well put pressure on governments to amend their health care systems. Another question is do you want the European commission to have that role, I see a legitimate role for the European Commission. I believe recently there's been a proposal that it should actively enable the travel of patients from one country to another where excess supply exists; I think that's a quite legitimate role but if you're actually saying the European Commission should have a role deciding about exactly how a health system in a sovereign state should run then, no, I'm more concerned about that.

### Bart Crols

Okay, thank you very much and we will move on with the panel discussion, which will also conclude this morning's meeting. I would like to start with our newcomer just joined us here, Jorgo Chatzimarkakis, he is a German liberal member of the German delegation, he is also a member of the group in parliament, the European Liberals, he sits on the Imac, the influential Imac committee the economic and multi fares committee and also on the trade and industry committees. I should mention he is also a former vice president of CNE in Brussels. My first question to you, given the situation in Germany, the current difficulties with the, well facing the socialist green government in reforming labour markets in trying to tackle the social welfare states as such, where do you see, going back to the previous topic, where do you see markets kicking in in health care reform in Germany?

### Jorgo Chatzimarkakis MEP

First of all thank you very much for the invitation, it's good to come back to CNE to get some influences, some true liberal or libertarian influences, because people in parliament try to make you more and more socialist than you were before. You must know that the European

Parliament, although it's divided into different groups, and although different parties of course run for elections within the parliament, party distinctions don't play such a big role as in national parliaments maybe, because the system of the parliament is a different one, so it's good to be here, good to get the virus of the free market and bring it back to parliament.

The situation in Germany is quite interesting because in Germany it's not only that the red-green coalition has problems with health care and health care reform, but actually it's especially the conservative party, which declines in the opinion polls because of that reason, because the conservative party consisting of two parties: the Christian Social Union of Bavaria, which has a slightly more socialist approach than the CDU, the Christian Democrat Union. They argue very much and they have big, big problems at the moment which could one day, in some weeks, become a severe power problem for the leader of the CDU and that of course could hinder, well to get across with the red-green coalition which we have now because if the Christian democrats lose then it will be very difficult to change government. So what we see at the moment, especially in this topic, is that it's the red-green coalition that wins. Why? Because they bring into the discussion much more honesty. It's especially the chancellor who, despite all the demonstrations in his country, is in favour of slight reforms but at least some reforms, which are supported at least by my party. Although his party lost 20, 25, 50% in every regional election for two years now, he said take it or leave it, my political destiny is bound to that reform and I will fulfill this reform. And I must tell you one thing, people, ordinary people like me like this attitude and a very recent poll shows that whereas having been down behind his opponent half a year ago or some three months ago, he now is again on top. If asked, "Whom do you want to be governed by?" in polls, he's back on top. Why? Because people after all these years and after the economical wonder, miracle we had in the 50's and 60's in Germany where everybody thought, "Well, it's heaven, we have achieved after this big defeat in the second world war, we have achieved something".

This very socialist mentality grew in Germany and I must say we were ruling, we were the ruling party so I don't want to blame all the others. I have to blame also my party, the so called liberal free democratic party in Germany because we ruled for thirty years in that special time where people thought, well everything, risk has to be ruled out, everything has to be paid by the society, the social democratisation of the society, we call it, and we always said whether they are red or whether they are black they are social democrats, or some of you would say socialists. And so it came that for many years, although we knew that the pension system – which is closely linked to the health care system in Germany – would have severe problems some day, and it's especially my generation, I'm born 1966, especially my generation will have to pay for this, so it came out of my generation which now becomes more and more in power in parliaments in governments and so on. That said, ten years ago Mr Bloom, who is maybe the most famous minister for labour and the social welfare system in Germany, why don't you say the truth but we were not strong enough, we were quite weak ten years ago and when he lost his elections in 1998 it became more and more clear that the pension system in Germany, after having heard for ten years "it's secure, nothing will happen" is not secure, will collapse. And we face those problems we will have in the future, my generation will have in the future right now trying to bring through this reform. So people want honesty and they, well, some of them are so annoyed by parties and by politicians that they don't go to elections so we have a high, very high rate of abstention, the turn out is very low. This explains why in some German regions, especially the right extremes, but also the former communist have high amounts of votes because people want honesty and I think now is the time, talking about the ageing society, not to fight this

development. It's there, how do you want to cope with the development which is a big development in Germany which also has historic roots. For women in Germany – I'm married, I have a Greek name but I have a German mother and a German wife and so I know at least something about the mentality. The mentality is, and I'm living in the border region to France and to Luxembourg in Germany, and there the mentality is totally different, the mentality is once you've had children you stay at home. If you go to work you are so called [German word] which is not to translate because it doesn't exist in any other language this word, you're a bad mother, a raven mother so you cannot translate. I can explain to you where it comes from, it comes from the Third Reich because in this time women were expelled out of jobs out of business in Germany, especially in Germany while in other countries Czech Republic, Poland, women continued to work especially France. In France if you have a baby and you are mother and you don't go to work people ask what's wrong, why aren't you going to work, in Germany it's the opposite, if you go to work, my wife is working and everybody in Germany says "How could you do that?", so it's a mentality question, why in Germany we have a lack of young people, a lack of births, a lack of fertility you can name it and we cannot cope with this problem, it's very difficult to change mentality because more and more young ladies are studying.

So you know about this. Now what should be the consequence – and now I speak to you as a German politician but especially as a European politician. We can deplore the situation, yes we can deplore it, we can say it's a pity, the Chinese will overrun some day, but this is not what we should do, we should concentrate. And I must admit that I will organise a conference not for my constituency but for part of Europe which I feel responsible for, it's Crete, the island of Crete, because my father comes from there, and they, for the first time, this part of the island has not a European Parliamentarian so I decided to represent them. I will organise a conference there because they face similar problems, problems of this kind but also problems of tourism such that tourists don't come. I would propose the following: when we have an ageing society we should concentrate on what we can do best in the situation and people are very interested, very keen on wellness, therapies, things like that and I think we as Europeans and I have just come from the committee of industry where I'm also a member, we try to boost our industry, we try to do whatever we can for competitiveness, the Lisbon strategy... But there are no smart ideas up to now, and I would say that if we continue like that, having no smart ideas but just saying some catch words, one day we will be a big region for tourists from China, in twenty years time, who will say, "Look this is the continent where all the nice things we have now in China come from". It's like you would go to the Parthenon in Athens and those developments, some of you laugh but it's quite a serious question, because industry more and more leaves Europe.

So, why shouldn't we concentrate to certain extent we will have a tourist agreement with China somewhere in the next years, and it's very important, why shouldn't we concentrate on this issue to a certain extent, not regulating the market but at least creating a framework that helps this market to evolve. Concentrate on the market of health care of wellness of therapy. At least in the Crete example it would fit very, very well. That's one side of the question, but the other side is, we should take or make the best out of the situation that we have less people here, less people means maybe less productivity but it means you can better concentrate on those you have. The classes will be, the school classes will be smaller so you can concentrate much better on the best raw material we have. It's science, it's research, it's knowledge, and we should change our attitude to a certain extent, stop to deplore the situation and try to do the best out of it and maybe one day... And I'm sure if we create the right framework for it we

will be ahead of the other regions of the world, and this is what concerns me most at the moment, the question that we will lose our competitive position worldwide.

### **Bart Crols**

Thank you Jorgo. I just have one just brief question before I hand over to your colleagues on the panel. Your remarks about Chancellor Schroeder, about him sort of having the will to push through reforms that are necessary I sort of, I sense that you would be, as a party, willing perhaps to replace the greens in the current government and back up Schroeder in the current reforms, especially given your views about the Christian Democrats.

### **Jorgo Chatzimarkakis**

Very interesting question. But I don't think that this would work, I mean theoretically of course it would work but practically, politically no. It won't work: the greens are rising, nobody exactly knows why they are rising in Germany, they play on one hand the reform card, on the other hand they don't so maybe that's the explanation of their rise. No we wouldn't join Chancellor Schroeder, what we would do is we would support him in single topics, we strongly would support him where his own party does not support him. The greens also support reforms at the moment, they wouldn't say that they are free market oriented but they are much more in favour of free market than the social democrats are.

### **Bart Crols**

Thank you. Ivan Csaba, you are the economic adviser to the Hungarian alliance of free democrats, you're also a former professor of political science at the central European university in Budapest and the chief economic consultant of a company health management unit, but you are also a member, you're a citizen of a new EU country. We've had a German angle, so what's your view on it, as fresh as it is, only dating back to May.

### **Ivan Csaba**

I'm not sure that I'm going to represent the Hungarian angle in this, in fact I would like to speak as a health economist and I would like to start with the observation which was also underlined by Robert Perkins' presentation. A recent OECD publication has uncovered that around 50% of the population in the OECD member states would urge a sort of health care reform, but the puzzle is that we can reach the same conclusion in the case of a more market oriented health system. You find the same dissatisfaction and the urge of a reform and a relatively status quo health system such as for instance the NHS, and this is a matter of life, a matter of fact that in health care we cannot, well I don't know personally a perfect health system, it is a system of imperfections and it seems to be the case that in a system of unavoidable imperfections. This is a strange thing that on the one hand we see a sort of convergence but in many cases we see attempts to learn partly from the mistakes of other countries and from a closer look find a mixture of puzzling instruments and one of them is the attempt to introduce the market type elements into the health system. And on the other hand you see quite widespread disagreement amongst politicians, experts and the public about the desirable direction ahead. There this disagreement lies.

An economist from Princeton University once made a distinction between vertical and horizontal economics and he made the point that the vertical economics that is the health economics system would be inclined to advocate free market ideas, yet a horizontal economist may actually step back from his original views but in the same vein as someone could be a vertical supporter of the British NHS and of horizontal detractor of the NHS. We heard from

Ben that his favourite health system is the Swiss one, or on the other day I met a respected Swiss health economist and he made a speech that personally cannot advocate the Swiss health system because he does not understand it and actually I reached the same conclusion, not because of the presentation because to start with it is not clear to me that health insurance is compulsory or not in Switzerland.

If we look at the sources of disagreement, an important distinction should be made and this is the distinction between objectives and means. It seems there is this economic controversy about market failures even the means can be subjected to a considerable debate but I would like to point to the fact that it has not necessarily been the case that there is a consensus as far as our health system is concerned or it is not necessarily the case that the same weight given to different components that Ben was listing represents a bunch of objectives so that some of them could be regarded as quite like macro-economic efficiency or micro-economic efficiency. But going to the heart of the matter I would like to list three components that could be regarded as important or potential objectives of a health system, yes there is an obvious disagreement from the point of view of different social values, there is an individualist objective that we can identify. This regards a health care service and, in this case, the public policy objective to have a health system which functions as a well operating service as any other sectors in the service industry. Satisfying individual preferences.

The second objective is a departure from this individualist perspective and it is existing in the European tradition. This could be labeled as a population based approach saying that the objective – or it is an important aspect of a public service as health care that it should contribute to the greatest benefit of the population in terms of health so it should improve the population's health and it can lead us then to a sort of quasi-utilitarian calculus. At the end it is important to mention the third policy objective which is related to social justice in one way or another, that is: health care could be regarded as, from one perspective, as treating the inequalities created by the capitalist system – or, from another perspective, a health system could serve the objective of addressing arbitrary differences between people that could be for public policy concern for instance genetic differences, class differences and so on, so the important point that I wanted to make, because it is impossible to have a debate about those objectives, some of them are originating from belief strongly held values but it is important to recognise that very often we do not simply discuss and debate about the best instruments, the best techniques to organise the health system, but we debate about the legitimacy about those, amongst others about those three potentially important objectives of the health system.

The final point that I wanted to make is about markets, since the title of the presentation was "what role for markets" and, as a economist, I would like to make this important point that my research and studies about health care and health care markets lead me to the conclusion – and actually the similar sort of conclusion could be reached if someone moved to industrial economics – that markets can be organised in many different ways. We speak about markets in a very general way, partly relying on a textbook version of price regulating markets, but from a closer look markets could be quite different and it is the case with health care, you can set different rules of the game, you can organise competitive markets quite differently. For instance, you can make a distinction and it leads us back to Ben's presentation between a sort of free-for-all passive third party payment type competition that the American health care market uses to be before the revolution, or the so called revolution started, and you can have a sort of pay driven competition as well where organised institutions, insurers, go beyond their

passive role and actively regulate the market, there is a market but it is not necessarily price based, including bargaining, long term relations, exclusive contracting, and so forth.

Those two types of market can lead to excellent different efficiency results, and it seems to be the case that the second version, the pay driven type of competition, can provide superior public policy results as well, but a number of questions remain with regard to this type of competitive arrangement, including the fallbacks of competition between some sort of third party payers – and here we face the problem of cream skimming, cherry picking to minimise the socially wasteful activity, we also may face might embarrassing and actually interesting issues if we consider for instance the potential competition amongst health packages or for some sort of third party payers since we immediately leave the problem of incomplete contracts and interesting exciting public policy issues with regulating and some sort of health packages or intervening as we see in the case of the American congress for instance, which imposes newer regulations on the industry, yet the incomplete contract is there and the question is then who should decide those health packages that are such sort of collective payers that are the public who are collective decision making mechanism, or whether the individual who may not foresee in advance the sort of new innovations can come into the market and therefore may not have a perfect contract to protect his own interest. Thank you very much.

### **Bart Crols**

Thank you Ivan. Turning to Johan, Johan Hjertqvist you're the director of the Timbro health policy unit of the Swedish free market think tank Timbro. What does Scandinavia have to offer, I'd like to pick your brains on this issue, what's your view on this issue in terms of the role of markets, the possible role of markets to play in this issue?

### **Johan Hjertqvist**

Thank you. You might say that Scandinavia up until now, or a couple of years ago you could find a rather distinct Scandinavian or “Northern Europe” model for health care based on public funding: Of course tax funding a strong political influence, rather limited consumer influence, regional systems for especially provision of health care but also partly for the funding. Since a couple of years you can now witness Denmark and Norway staying to the publicly funded model. Sweden tried or, as we now would say, as we have a decentralised rationed system in Sweden where elected regional parliaments are responsible for delivering, also you might say indirectly funding the health care. Also in Sweden you try, in parts of the countries, especially in Stockholm region which I've been covering, writing some about also being engaged in the practical reform policy, tried to sub-divide internal markets you might say, and now Sweden is country for setback, policy setback when it comes to health care reform, while at the same time Norway and Denmark move more into different reform approaches. You have a stronger consumer influence there, you have understood that you must use different kind of economic incentives to make especially primary care efficient and so on.

Still you can sense the early Stockholm region reform from more than ten years ago. In the Swedish system the national government tries to rub out many of those changes, I'm afraid. Right now there will be we wait for a government proposal to the parliament to really ban, even criminalise for-profit private health care delivered in a hospital form so the successful turn from Swedish-based or Swedish-origin health care company to run a private hospitals in Sweden will probably be impossible to continue in that context. This is of course a sad story

in the sense that what we need not only in Sweden but with the population that has a highest average level of age around Europe not only Sweden but all around Europe is to shift the...

[break in transcript]

...present, or the traditionally European mentality meaning that what can the government do to improve my health care into a quite different one, that is, "What action can I take myself to improve my health status in co-operation with family and friends and close networks?" And so on. That kind of mentality shift would be necessary again not only in Sweden or Scandinavia but around Europe as we, in all welfare states or welfare societies try to, within the publicly funded, and here I would include also the public or semi-public insurance systems, we try to squeeze in more and more of consumer patient choice, more and more of options so to say when it comes to treatment, medical treatments and medications and of course everybody understands with the most dramatic speed we heard of today and you can read about everyday, the speed of scientific and medical development in health care, of course it's quite easy to understand that in a limited time there will be a clash between the demand, the consumer driven demand and what the systems, the publicly funded systems can deliver, so of course we're quickly moving into a situation in Europe I would say where you can't fund the system the traditional way even if you raise the taxes – which is still an option, I would say fading, but still an option in Sweden, people still believe that if you raise the taxes that this money will be directed into improving health care.

So you must change the attitude completely, and Ben Irvine quoted me from one of my blogs I think CNN would cite we're moving into more and more integration in Europe because to me it's quite evident that the European Union as such, you might like it you might hate the idea of it, you'll have to take some action, it's quite a usual step of logics in politics: When you sit on a ticking bomb or a big problem you try to make somebody else solve the problem and I wouldn't be surprised if more and more European governments ask for some kind of European solutions, European level action here. According to my imagination, the European Union as such will have to take on many of those problems, and of course, to just conclude then, it's extremely important that you take the right action, this will not happen immediately of course but in a number of years, and that a number of pillars that must be the foundation for that kind of wide spread and long range reform I would say, first understanding that people are not, or at least very seldom the problem, but the system. The problem is not that Europe is ageing I would say, but rather what attitude do we have to supporting older people, staying in the labour market, assisting people with different kinds of health needs etc. Or do you welcome entrepreneurs in health care or do you try to ban them, do we accept individual choice and responsibility, do we understand and accept that when you increase the choice the rights of the consumer do you try to balance that development by also increasing the individual responsibility, balancing those influences.

Especially important, and I agree with those who say that funding reform here's essential, do we accept that kind of a need when you're balancing point also in the funding? You can talk about medical savings accounts or whatever you want to call them but that kind of approach is balancing the demand and output. And finally the consumer information, I'm right now transforming the Timbro health activities into a new kind of what-do-you-call "do tank" rather than think tank, trying to stress that we not only deliver, I hope, good ideas but also move a step further, that is delivering empowerment tools for consumers, you can really take on making informed choices comparing by the kind of consumer index we're building in

Sweden already, you can find it on a website in Sweden. But also on the European Union level comparing to, in what way are health consumers treated by the different national systems by building the kind of knowledge you will be able to empower the consumer to build the pressure from below, I would say, which is quite necessary to – moving to a subject of this panel, more of market solutions, to me it's necessary in a European environment, European social model that we're talking about now how to reform, to not only introduce a market right on that would be extremely controversial as we all understand, but also build some kind of environment or infrastructure for European consumers to accept that kind of solution acting, knowing that they can rely upon different kind of information to make informed choices, I think that will be important, necessary to open for more market solutions in the health care.

**Bart Crols**

Thank you Johan. That concludes this morning's conference. I would like to thank all the participants in the debate, especially our keynote speaker for their contributions to the debate that seems to be picking up speed.

– end –

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