Globalisation
How will it affect the NHS?

Key points
- Knowledge and experience of other healthcare systems may raise expectations in the UK.
- The expectations of increasingly diverse populations in the UK may make it harder to achieve high levels of satisfaction with the NHS.
- The likely growth of international patients – both inward and outward – poses many challenges to the NHS.
- The NHS needs to think about, and plan for, the health needs of new immigrants.
- EU moves could make it easier for UK patients to seek healthcare elsewhere in Europe, funded by the NHS. While some will benefit from these opportunities, there is a risk that this will result in increased health inequalities in the UK.

Globalisation is seen as a major driver of change in the wider economy, but has received less attention in health services. The NHS does not compete internationally and, like other health systems, has been able to treat globalisation as if it is of marginal significance. This position is not sustainable, and what the NHS provides and what patients and the public expect will be increasingly shaped by forces from outside the UK.

The public is increasingly aware of the quality and availability of care in other countries. Will this raise expectations around quality, access and the speed with which new treatments are available more quickly than we can keep up with?

The NHS may face unexpected demands from future immigration, whether caused by economic choice or war and persecution. Can the NHS meet the needs of an increasingly diverse population?

This paper looks at what the NHS needs to do to be better prepared for some of the challenges – and opportunities – globalisation will bring.

Patient expectations
The NHS founding principle of needs-based care, largely free at the point of use, still commands widespread support, but British people are now much more aware that the quality and availability of care varies between and within countries.

When the NHS was ‘born’ in 1948, the public was largely unaware of how health systems were organised in other countries. People were more likely to make comparisons with the previous fragmented UK system. The situation is very different today. The media provides news of medical advances around the world.

The Futures Debate series is designed to stimulate new thinking on future challenges to the health and social care system, and you can be part of the debate. Have your say now in our forum at www.debatelapers.org.uk. The debates will feed into the NHS Confederation’s annual conference and exhibition, Delivering the future today, in Manchester from 18 to 20 June.
International organisations such as the World Health Organisation, the Organisation for Economic Co-operation and Development, and the European Commission publish country rankings on key healthcare indicators. Internet searches yield information about new treatments, and foreign travel and migration help spread ideas about alternative approaches to healthcare delivery and entitlements.

Furthermore, devolution of responsibility for NHS policy to the four UK nations is leading to divergences in health policy which could have a profound effect on national consciousness.

**Undermining public confidence in the system**

**Slow response to public concern**

In the 1980s, public pride in the NHS began to give way to a growing sense that health systems in other western countries were providing faster access and better-quality care, albeit at higher cost. It also became apparent that UK patients were being denied new technologies which were available elsewhere.

The Conservatives introduced market-based reforms and emphasised responsiveness to patients, but the clamour for increased spending grew louder.

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**Migrants and expectations**

In the future, Britain may face greater levels of migration, and increasing ethnic and cultural diversity which may reach parts of the country that have not experienced it before.

The evidence from patient surveys is that areas which are more diverse have lower levels of satisfaction with NHS services. This may be because they have to accommodate diverse expectations, not all of which resonate with traditional NHS values.

Serving a more diverse country will increase pressure to offer more personalised care, but that very diversity may make it harder to do so.

It is possible that immigration and emigration will drive debates around whether eligibility to access NHS treatment should be strengthened and whether there should be ‘earned’ access to treatment.

Ben Page, Ipsos MORI
The Labour Government was slow to read the public mood until Tony Blair’s pledge in January 2000 to bring NHS spending levels up to the European average.

Expenditure and the pace of reform quickened, but this was not matched by the UK’s place in the league tables. In 2006, the UK made it into the top ten European countries for male cancer mortality rates, but remained near the bottom for female cancer mortality.

Comparisons fuelled public concern
An analysis of mortality in 19 industrialised countries found improvements across the board between 1997 and 2003, but the UK ranked 16th with only Ireland, Portugal and the US having worse mortality rates.

This type of comparison served to fuel concern about the quality of NHS care. Right-wing pressure groups argued that the time had come to replace the tax-funded NHS with an insurance-based system like those in Switzerland, France, Germany and the Netherlands.

However, the Commonwealth Fund, a private foundation which campaigns to promote a high-performance health system, found that dissatisfaction with the system was significantly higher in Australia, Germany and the US than in the UK. While there seems to be no clear correlation between spending rates and levels of satisfaction, some countries have been more successful at instilling public confidence in their health systems. For example, people in the Netherlands are more confident of getting high-quality, safe care than those in the UK, and French and Danish people consistently report much higher levels of satisfaction with healthcare in their countries.

“Maintaining confidence in the system is essential for its sustainability, so any health department that ignores its performance in international rankings does so at its peril.”

Always important to the public
Of course, satisfaction ratings are an imperfect measure of system performance and are particularly prone to the influence of prior expectations and reporting biases. Ratings may be influenced by the popularity of the government at the time of the survey, or by public confidence in economic prospects, and they are highly susceptible to media influences.

But what is always important to the public is the security of knowing that high-quality services will be available when they need them. People also want to be sure that healthcare resources are equitably distributed and used efficiently. Maintaining confidence in the system is essential for its sustainability, so any health department that ignores its performance in international rankings does so at its peril.

Pressure to change access arrangements
GPs as gatekeepers
Patients in some European countries and in the US can access specialist care directly without needing a referral from a family doctor. Historically, British patients have accepted the GP gate-keeping system, but this could change if concern about waiting times persists.

For example, recent reports that delays in referral and diagnosis contribute to worse cancer treatment outcomes in the UK than those in many other developed countries could fuel a demand to bypass GPs and go directly to specialists. Health systems that rely on GPs to manage demand tend to provide better value for money, so a breakdown in the referral system could have consequences for the costs of care.

Waiting times
British patients are much less likely to face financial barriers to accessing healthcare than those in many other developed countries. However, the UK does not fare so well when it comes to other barriers to access. Waiting times for elective admissions are still longer in the UK than elsewhere. The Commonwealth Fund ranked the UK fourth after Germany, New Zealand and Australia in its league table of access indicators, a better result than for Canada and the US.

Since 2002, waiting times in primary and secondary care in England have steadily fallen, but Scotland, Wales and Northern Ireland have lagged behind. If this divergence continues, it could lead to an increase in cross-border flows in search of the shortest waits.

The impact of legal rulings
Alongside issues such as cost and convenience of accessing care, waiting times are one of the drivers behind patient mobility within Europe, with some patients seeking...
care in another country to avoid long waits at home. Yvonne Watts, who went to France for a hip replacement to avoid a long wait in England, asked her local primary care trust (PCT) to reimburse her costs. When her request was refused, she took her case to the courts, ultimately reaching the European Court of Justice. The judgement upheld patients’ rights to receive medical treatment anywhere in the European Union (EU) and confirmed that, subject to certain conditions, the costs, or a proportion of them, must be reimbursed by patients’ home country.

International patients

Citizens of one country seeking healthcare abroad have, to date, been largely limited in the UK to self-payers such as those seeking cosmetic surgery, dental work or treatments unavailable at home. However, in other developed countries there has been interest in a wider range of healthcare, including major surgery. This comes not just from individuals paying for their own care, but also from US insurance companies wanting to reduce costs. Some countries see increasing the number of international patients as a priority for their economies. Improving standards in some hospitals in developing countries, including international accreditation and links with educational facilities in the UK and US, together with low costs, have helped this process.

Increased demand for new treatments

Commercial pressures and increased information

Commercial pressures from multinational companies can influence attitudes to, and demand for, healthcare. Direct-to-consumer advertising of prescription medicines is allowed in the US and New Zealand, but not in the EU.

Nevertheless, drug companies have shown themselves to be adept at getting publicity for their products by encouraging press coverage. A 1990 article about Prozac in US magazine Newsweek resulted in widespread publicity in many European news media and a dramatic increase in sales of the drug. Similarly, anti-impotence drug Viagra became a news sensation throughout the world and sales soared.

The explosion of health information on the internet exacerbates this trend and is much harder to regulate than print media. Many health websites are sponsored by commercial companies whose main interest is to market their products and many drugs can now be bought online without a prescription.

Patients’ requests for medicines are a powerful driver of prescribing decisions. Many pharmaceutical companies have teamed up with patient groups to raise awareness of conditions that they claim are under-diagnosed and under-treated. These so-called disease awareness programmes – dubbed ‘disease mongering’ by their critics – are legal in the UK as long as they do not mention specific products.
Commercial promotion of diseases or treatments can encourage healthy people to think they need medical attention. This increases the likelihood that demand will be distorted and resources will be diverted away from those who really need them. It also undermines the efforts of the National Institute for Health and Clinical Excellence (NICE) and others to promote rational, evidence-based prescribing. This is why direct to consumer advertising is banned in Europe.

**Prescription only medicines**

Striking the right balance between maximising patients’ access to health information, including prescription only medicines, and regulatory safeguards to ensure that information does not stray into advertising, has been the subject of long-running discussions in the EU. This recently prompted the European Commission to undertake a public consultation on ideas for reviewing the rules governing the information that pharmaceutical companies can provide to patients and the public. Among the ideas considered was the possibility of pharmaceutical companies communicating information about their products directly to consumers via television and radio.

If adopted, this proposal could create the pressure for increased prescribing of possibly inappropriate treatments, with negative consequences both for the patients concerned and in terms of NHS resources. An appropriate regulatory framework for overseeing information to patients will therefore be essential to prevent such distorting effects.

Persistent pressure from industry lobbyists has recently prompted the European Commission to issue a draft proposal which would allow pharmaceutical companies to communicate information about their products directly to consumers, including via television and radio.

This could add to the pressure for increased prescribing of possibly inappropriate treatments. Rigorous regulation of industry’s promotional efforts will be essential to counter these distorting effects and to ensure equitable distribution of the public resources spent on healthcare.

**Conclusion**

No healthcare system can operate as an island, assuming public ignorance of what happens elsewhere. British patients’ expectations, though still relatively modest, are rising in response to increased awareness of what is, or should be, possible – fast access to effective treatments provided by well-trained, responsive professionals.

The travelling public knows that facilities may be better and waiting times shorter in neighbouring countries like France, Germany, the Netherlands and the Scandinavian

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**Travel, immigration and disease**

Greater movement of people around the globe may lead to the spread of some diseases into areas where they have never existed or are thought to have been eradicated. Although this is easy to overemphasise, it could lead to extra demands on the NHS – as with drug-resistant TB.

Economic migrants may come from relatively well-off sections of their own communities and may be less likely to suffer from some diseases than those forced to move – asylum seekers and refugees.

However, they may have lifestyle factors which can affect their risk of developing diseases. For example, many Eastern European countries have higher rates of smoking than the UK. If migrants continue to smoke in these numbers, there will be ramifications for the UK health system in the longer term. In the shorter term, there is also the need for culturally-sensitive health promotion.

Globalisation has also contributed to the speed with which diseases can travel around the world, and therefore also the time available to prepare for them. Air travel, in particular, may lead to the rapid spread of diseases such as pandemic flu.

But very often there is simply a mismatch between expectations based on one country’s health system and what is encountered elsewhere. For example, many eastern Europeans are used to a system in which family doctors have a different status and role: if adequate information is not made available in the UK, they may not be able to make best use of the services that are available.
countries. Comparable or better health outcomes are often achieved in these countries.

In the healthcare context, patient and public expectations are often seen as problematic. For example, patients are sometimes accused of having unrealistic expectations of services or treatment efficacy. Policymakers’ difficulties in reconciling demand with resource availability are frequently attributed to rising expectations, with the implication that these are in some way unreasonable.

But it should not be viewed as unreasonable to expect high standards of care. Higher public expectations could be just the driver that is needed to stimulate improvements.

The NHS can provide high standards of care, but it is struggling to catch up with countries that have experienced longer periods of relatively high investment in their health systems. Knowing that other European countries manage to achieve better health outcomes provides the NHS with an opportunity to learn from others and should act as a spur to do better.

Greater public awareness should help to strengthen political resolve to redistribute resources to ensure that good health and social care is available to all who need it. We have much to learn from our European neighbours. Surely it is time to end the obsession with the US and turn our attention to seeking good-practice examples in countries that achieve better results.

Developments in Europe increasingly impact on, and influence, the NHS. In particular, forthcoming proposals on cross-border healthcare will have far-reaching implications. Patients will also be able to access much more health-related information in the future – both on options for obtaining treatment abroad and on available treatments, including pharmaceuticals. It is important to ensure that such developments do not widen health inequalities.

Finally, we should attempt to learn from the experiment taking place in our own backyard. Studies comparing patients’ experience in the four UK nations are remarkably scarce and statistics are rarely published in a comparable form, yet these studies are an unprecedented opportunity to learn what happens when policy approaches diverge – an opportunity not to be missed.

Join the debate

- Is the effect of the globalisation of healthcare overstated?
- Are there opportunities for the NHS to benefit from this?
- What do we need to do in the face of rising patient expectations?
- Could globalisation undermine the consensus underpinning the NHS?
- In an increasingly diverse society, how can we ensure care is provided in a way in which everyone’s satisfaction is maximised?
- Are European rules allowing patients to be treated abroad a threat to the NHS?
- Are there other effects which we have not covered?

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