Alternative European Healthcare Perspectives September 2025

Roger Steer

This month I'm going to recap on Covid, give perspective on the latest trends in the world economy and implications for healthcare, and tackle the issues presented to the public as crucial for our healthcare; doctors pay, reconfiguring health services, access to new drugs, productivity. I also have a dig at Nick Clegg. As usual, there is a roundup of other issues to take my eye across Europe and elsewhere of relevance to the NHS.

It's five years since Covid first took off. Remember how Donald Trump, US president at the time, refused to believe it was a threat.

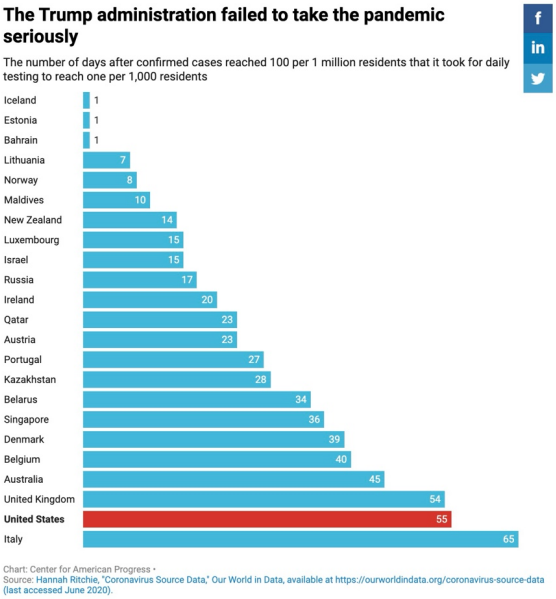
He bombastically, declared it would be beaten by Easter. This link may jog memories.

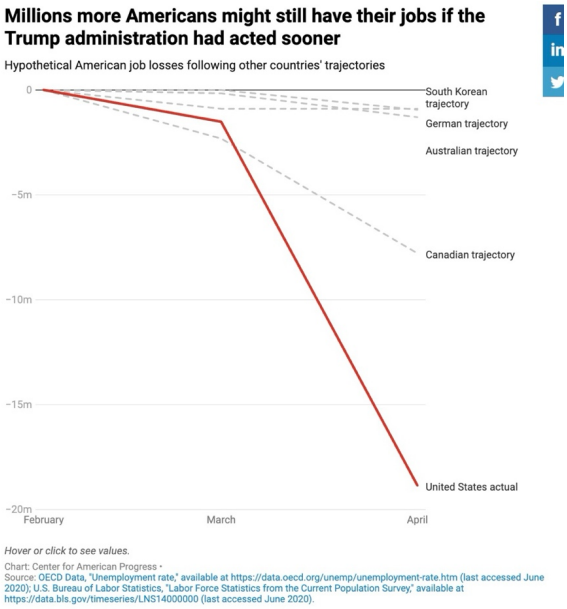
Trump had cut back on Public Health provision and withdrawn funds from the WHO.

As a result, there was a lack of preparedness and responsiveness to adequately deal with the crisis, made worse by Presidential denial, inaction and perverse behaviour.

There was a failure to prevent layoffs of state and local government employees. Covid was used as an excuse to scale back the state and shed public employees. There was also a failure to support small businesses, with 24% going out of business.

As a result, the US was slow to deal with the Covid crisis and failed to keep people in work: as the two charts illustrate.





Trump was promptly voted out of office along with his UK emulator Boris Johnson, but he came back from the electoral grave.

Trump was being incompetent then and seemingly he has learnt nothing in the intervening years. He is going ahead in withdrawing US funds from the WHO.

His secretary of state, Robert Kennedy Jr, has sacked the entire Vaccination Advisory Committee, fuelling anti vaccine attitudes, all while the US (and the UK) is dealing with new measles outbreaks.

Plans for Medicaid funding cuts put at risk already inadequate protections for the tens of millions of people in the US with little or no medical insurance (see the discussion in August's newsletter).

In the meantime, Covid has not gone away as this recap from the Guardian demonstrates:

- Infection rates are rising;
- New variants are constantly evolving, some with resistance to acquired immunity;
- It's not like the common cold and is more like a fast evolving and contagious flu, with similar death rates;
- Vaccines give protection but they need regular updating. Free vaccinations have been withdrawn and limited to the elderly (75+) and the immunosuppressed; and,
- Young Children will have no immunity as they will not have been vaccinated.

The experts fear that growing vaccine hesitancy, which is described as 'one of the most pressing concerns' in public health, could have an impact on whether these children receive a jab or people turn up for their boosters.

Another consideration, when it comes to building immunity, is the growing body of research suggesting that for several months after a Covid infection, people become more vulnerable to other infections and there can be lingering effects on the heart, cardiovascular system and the brain.

In the background the UK Covid Inquiry rumbles on.

The latest document published by the Government is the National Resilience Plan. I searched for mentions of the NHS. There are two mentions: the first is the recruitment of 500,000 volunteers, and the second the training of 4,000 recruits to a national academy. I cannot wait to see the delivery plan and revised workforce plan for the NHS 10-year plan.

The world economy and the EU

The UK 's latest growth figure for 2025 Q2 announced on 14 August was 0.4%. Although again, Sacha on YouTube (a commentator talking authoritatively on government statistics) points to the assumptions underpinning this performance. As in the previous quarter a big boost to growth was achieved by adjustments made in the last month of the quarter.

Admittedly growth was better than in the EU (0.1%). But growth is faltering all over the world: if you believe the figures that is. Trump dismissed the head of Labour Statistics because he didn't like the numbers. In the UK the Head of the Office for National Statistics and the Chair of the UK Statistics Authority resigned recently.

This followed controversy over 'adjustments' made to official statistics. Apparently, there have been 79 instances of indicators having to be withdrawn as unreliable, according to John Burn-Murdoch of the FT and he summed up the situation in the UK as,

> *Producing high-quality statistics to help us answer the defining questions of the day is not about proving one side right or wrong. It's about providing the evidence base that is essential for informed policymaking and an educated electorate, in whichever direction that evidence points. In an age of eroding trust and media fragmentation, the ability to cut through the noise with empirical evidence is critical. Navigating these dark and stormy seas, Britain is increasingly rudderless and the statistical lights continue to flicker out one by one.*

The only thing providing a small stimulus to figures has been forward purchasing of goods to avoid Trump's tariffs. This however is a short-lived phenomenon and the inevitable negative effect on the world economy can only be a matter of time.

Anyone with a grasp of economic history knows what happens in a trade war when nations engage in tariff hikes to defend their industries. It's bad for everyone. Not that I am a liberal purist on these matters. The IMF and the Bretton Woods agreement always had adjustment mechanisms to help countries recover and in need of time to adjust to trade imbalances.

Hence Trump used a declaration of a national emergency to justify imposing tariffs on the world, not only to balance trade with the world, but also to raise funds to pay for tax cuts. In other words, a tax on trade is being used to solve imbalances in US trade and address the US fiscal deficit. The matter is before the US constitutional courts.

Optimists point to the superior US economic performance in recent years. What they forget is that it is based on increases in US debt, which now stands at 122.5% of GDP. The current account deficit is about $2TRN and acts to sustain economic growth. See the linked video from Jeffrey Sachs where he discusses this, saying '*This isn't a Presidency , it's a one man circus'*. Trade has been the engine of worldwide economic growth over the last 40 years, but Trump is planning to put this engine into reverse.

The weird thing is that the newspapers are full of other things: wars in the Middle East and Ukraine; war mongering in other parts of the world (Taiwan) and illegal migration.

Not that there aren't links between all these issues for which again see Jeffrey Sachs.

In Sach's view, the overriding issue is the global threat of nuclear war or nuclear accidents prompted by the proxy war in Ukraine between the US and Russia. He sees this as a symptom of the western mindset of seeking dominance in the world despite the rise of China and the fact that the US has only 4% of the world population.

This manifests in the lingering methods of erstwhile British imperialism: dealing with national resistance by seeking regime change.

Between 1945 and 1989 seventy countries had undergone regime change: there have been many more since. The rule is 'if you are not with us, you are an enemy'. As

Sachs sees it the Ukraine war was provoked by NATO expansion, a US-led coup in Ukraine in 2014, and a refusal to listen to Russian concerns. This has roots going back to the first Crimean war, British involvement in the Middle East and the formation of Israel. Its future is in a looming conflict with China, much more powerful than Russia.

It doesn't have to be this way as advances in technology, and the peaceful rise of China exemplifies.

But, while the quest for world dominance continues conflict is inevitable. And once total victory is the goal, Israel shows what it leads to: never-ending war.

The EU position is clearly not part of this Anglo-Saxon mindset but it seems to have been bullied into financing the war in Ukraine; with €50 billion transferred from the EU social Fund.The UK contribution of £21.8bn is on top of this.

So, if ever you wondered where the black hole in UK government finances has come from and why there is no money to fund essential heath and social care this is a leading explanation. It also goes a long way to explain why millions of people may be fleeing the Middle East, East Africa and Ukraine to avoid the permanent wars imposed on them. That and the lack of funds to fight climate change.

Brexit

Another recent milestone (millstone) has been the ninth anniversary of the Brexit decision; pushing the UK away from (what was) social democratic Europe into the arms of the neo-liberal USA. The verdict of history has not been kind to the Conservative party. In the words of Nick Cohen,

> *For Brexit was the Tory Iraq. A momentous national decision sold on a false prospectus. So brazen were Boris Johnson, Michael Gove and Dominic Cummings that they owned the furious lies by campaigning on a self-confessed lie that Brexit would save the NHS £350m a week.*
>
> *They then promised that the fishing industry would prosper. It's collapsed. They promised that farmers would flourish. They have been hammered. They promised that there was no need to believe Tony Blair, John Major and all the others who warned that Brexit would cause endless trouble in Ireland. Brexit duly went on to partition the UK and put an economic border in the Irish Sea. They promised that the UK would strike new trade deals with the US, China and India to compensate for the loss of the EU single market. No deals materialised.*
>
> *And to cap it all, instead of the promised prosperity, Brexit did indeed wipe 5 per cent off UK growth, just as Campbell said.*

In fact, the US trade deal is that the UK pays tariffs of 10% and 25% on steel. The Indian trade deal impact assessment shows a positive impact of 0.13% on UK GDP in the long run. Trade links to China, are similarly modest in impact.

The issue is however so toxic and polarised that the population may vote for Reform at the next election just to test the proposition that Brexit was indeed a disaster and no matter which set of leaders try to make it work, there is no getting away

from the reality: cutting ourselves off from free trade with the EU was a national disaster. It also has had a destabilising effect on the EU, which is struggling to sustain cohesive policies. Be careful of what you wish for is my advice to die-hard Brexiteers.

Doctors Pay

In the UK one of the more controversial events has been the junior doctors' strike in their latest campaign for full pay restoration to 2010 levels. The Government's position is that there is no money. This position is undermined by every previous pay negotiation where money had been found, if necessary, by going to the Treasury. For now, the prospect of a prolonged face-off looks likely with both sides aiming to get the public on their side.

The Nuffield Trust has attempted to bring some light to the issue in their 2025 update of the *Exploring the earnings of NHS doctors in England*. Perhaps they hope to persuade us that doctors have nothing to complain about by offering the figures in these two charts.

Overview of recent doctor pay settlements, basic salary and average total NHS earnings

23/07/2025

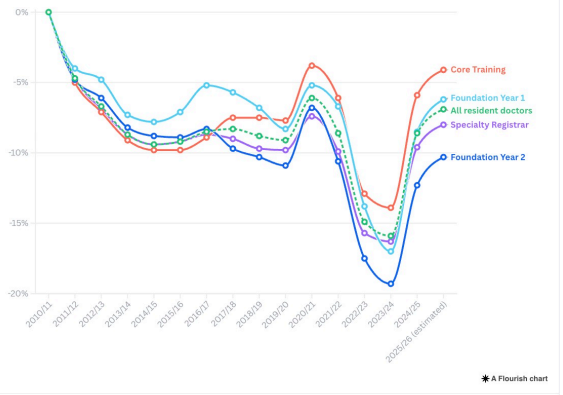
	Number employed in NHS, headcount	Recent pay deals			2024/25 earnings	2025/26 earnings	
	March 2025	2023/24	2024/25	2025/26	Reported average total NHS earnings*	Basic salary	Estimated average total NHS earnings*
Resident doctors							
Foundation year 1	8,296	14.30%	6.0% plus £1,000	4.0% plus £750	£43,400	£38,831	£45,900
Foundation year 2	7,413	13.70%			£51,600	£44,439	£54,400
Core training	24,921	12.5% - 14.6%			£67,400	£52,656 - £65,048	£70,800
Specialty registrar	47,022	12.2% - 14.6%			£76,700	£52,656 - £73,992	£80,500
Consultants, GPs and other doctors							
Specialty, Associate Specialists and Staff Grade (SAS) doctors	14,195	7.8% - 14.3%	6.0%	4.0%	£102,500	£49,502 - £111,441	£106,500
Consultant	63,996	6.0% - 19.6%	6.0%	4.0%	£155,400	£109,725 - £145,478	£161,600
Salaried GP	18,866	6.0%	6.0%	4.0%	£108,300 (alternative method £92,400) in 2022/23	£76,038 - £114,743	£127,300
GP partner	18,309	2.10% assuming uplift within practice funding	2.0%	2.80%	£163,500 (£168,000) in 2022/23	n/a	£175,000

Note: See methodology appendix for details. *Estimates for total earnings are for full-time staff – calculated as the sum of basic pay per full-time equivalent and non-basic pay per head – and will include earnings for additional hours outside of their contract. The table does not include some locally employed doctors which are categorised separately to the staff groups shown.

Source: Nuffield Trust analysis of NHS Digital data.

Figure 1: Real-terms changes to pay for resident doctors since 2010/11

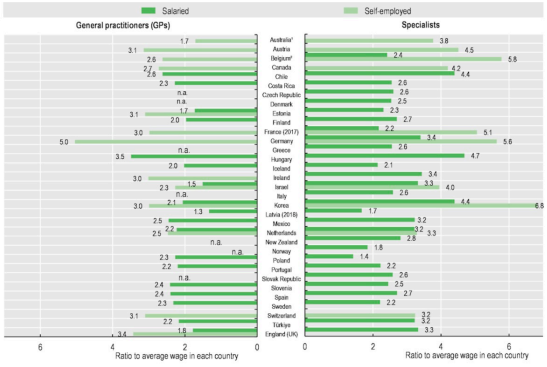
23/07/2025



Source: Nuffield Trust analysis of NHS England's **NHS staff earnings estimates**, ONS's **inflation and price indices** and OBR's **inflation forecasts**. See methodology appendix for more details.

Unfortunately, these figures do not include earnings as a locum, from agencies, as this is regarded as private income, nor any earnings from private practice. So, it gives an unrealistic view. A better comparison is the (latest) OECD comparison of doctor's earnings which gives a more rounded view of pay comparisons.

Figure 8.11. Remuneration of doctors, ratio to average wage, 2021 (or nearest year)



1. Includes physicians in training (resulting in an underestimation). 2. Includes practice expenses (resulting in an overestimation).

Source: OECD Health Statistics 2023 and OECD Employment Database 2023.

The acid test though for junior doctors contemplating where best to ply their trade, is how salaries compare to US levels. For those of a nervous disposition they should look away now. The average rate for a physician is £$378,000. For heart

surgeons over $1m. Anaesthetists over $500,000. Emergency doctors $342,000.

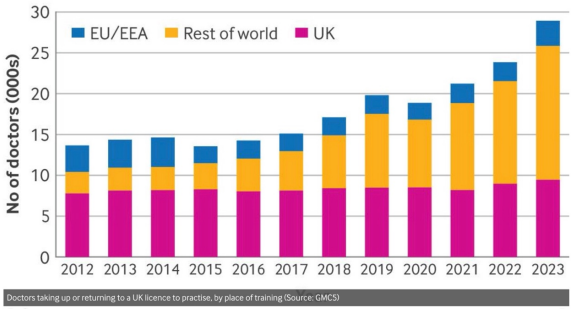
And, for those contemplating Australian rates, they look comparable to the UK, after taking account of the exchange rate of 2 Australian dollars to the pound. But its sunnier.

In the end there is no point in looking to the US where inequality is the main factor driving pay and where the average pay of the top 1% was $430,000 last year.

My advice to Streeting is to concentrate on obtaining better data on the total earnings of doctors and better comparisons with European countries that we traditionally have compared the UK with.

And, to improve working conditions, job security, accommodation and food.

Plus, do something about the reliance on overseas doctors.



Of the 28,956 doctors newly taking up or returning to a General Medical Council licence in 2023, more than two thirds had trained outside the UK, of whom 3,158 (11% of the total) had trained in the European Union and 16,471 (57%) outside it.

The Kings Fund discusses the past impact of strikes and the underlying issues.

It looks at the impact on staff, on NHS finances, on patient care and on public perceptions.

It concludes that it's possible to over-rationalise and in the end, disputes are governed by passions. A lot is at stake for the government if strikes persist.

Reconfiguring health services

This topic has been reinstated for discussion by the Nuffield Trust who published in August a blog entitled *Moving care out of Hospital -can England can learn from other countries?*

Good question.

Unfortunately, the title should have been what England can learn from Denmark and Ireland. Only two countries have been looked at whereas there is a wide spread of systems and different approaches across Europe.

Nonetheless it seems the Nuffield Trust has spent over a year looking at the progress in both Denmark and Ireland in implementing plans to move care out of hospitals and improve out-of-hospital care and will be publishing a full report in due course.

What they present in their blog are their main findings and implications for the NHS's own 10-year plan.

- First, neither Denmark nor Ireland made this shift by reducing existing spend on hospitals. Instead, they are boosting community resources in parallel – helping to avoid difficult trade-offs.
- Second, it's not just about the money. Shifting care means moving staff too
- Finally, these countries have been much clearer on the 'how' of change

Their conclusion is,

> *The Danish and Irish strategies have come alongside stronger financial incentives to shift system behaviour, clear and transparent delivery*

plans, and dedicated funding – all areas where the plan for England currently looks weak in comparison.

Personally, I am a little tired of drawing lessons from Denmark, which is far better funded (they spend about €1000 more per person than the UK) and where there is a local income tax of 22-25% to reinforce local services.

Even Ireland is better funded than the NHS.

What this reinforces to me is that a UK reconfiguration strategy driven by the financial imperative to cut acute services and where there is: a lack of planning of how it can be achieved; where there are fewer incentives than in other countries; where there are staff shortages that are not going to get fixed in the near future; and a lack of capital availability is looking like another top-down failed initiative.

I would encourage the Nuffield Trust to look at other countries, including France and Germany where local engagement of all local partners and access to substantial capital has been secured.

In my community in France the issue is the future of the local community hospital in Challans.

Challans has 22,000 residents and a small community hospital. Options for its future include refurbishment and modernisation for €65m or a new hospital for €234m.

If it were the UK, it would have been closed long ago. But France has a way of dealing with central authorities imposing strictures from above. It all goes back to the French Revolution. When the new government came to lay the law down locally, their man was run through with a pike. See the Vendee Wars and the first massacre at Machecoul, just down the road.

Reconfiguring local services can seem straightforward from afar but still waters run deep.

If I were advising the UK Government I would not be basing my financial strategy on shifting care out of hospitals. Instead, I would be financing local expansion of services and the workforce. Only when this has happened and social care improved can the future of acute services be safely assessed.

In France all health workers are regarded as civil servants and have job security and substantial rights. This makes it expensive to contemplate reconfiguring services. A lesson the UK government is finding out now as the bill for ICB restructuring is estimated at £1bn.

ICBs are now idly twiddling their thumbs waiting until the Treasury approves the spending before proceeding. It's difficult to believe no one anticipated this.

Access to new drugs

According to the Daily Telegraph the UK is being strong-armed into paying more for drugs from the US. Last month I linked this article from the Lancet which presents long term evidence that the costs of new drugs are higher than the benefits. Who will tell the President?

The UK's expenditure on new innovative medicines currently stands at just 0.28% of GDP, around a third of America's proportionate spending of 0.78% of its GDP. Even in Europe, the UK lags other countries, with Germany spending 0.4% of its GDP and Italy spending 0.5%. This lower spending is partly due to the UK's higher proportion of spending on generic medicines and a voluntary scheme that

caps NHS spending on branded medicines, requiring industry rebates.

There is an official lobbying process where the DHSC operates the Voluntary Scheme to control drug costs but this seems to have been Trumped by the latest trade discussions where the

Productivity

Sally Gainsbury of the Nuffield Trust in a recent article in the BMJ, *Improving productivity in the NHS*, points out a similar set of issues as we see with new drugs.

Encouraging more technological innovation and more priority to consumer pressures for more and better services will have a negative effect on NHS services as priority will be given to less serious concerns and more treatments of dubious benefit.

Gainsbury points out:

> *"Between 2015 and 2020, 84% of new drugs recommended by NICE were less cost effective than existing NHS services."*
>
> *"Greater use of technology from the digital wellness industry is likely to lead to an increase rather than a decrease in demand for NHS services because patients may seek further investigation or treatment after taking commercial tests, or using wearable devices."*
>
> *"In many cases this will include people who will receive little or no benefit, other than reassurance for worries they previously would not have had. Screening programmes also increase this demand and may result in over-treatment or invasive investigations in people who will never go on to experience symptoms or disease, as well as misplaced reassurance to those with false negative results."*

Although the latest official measures estimate that by 2022-23, the NHS was producing 5.4% less care for every £1 spent on it than in 2019-20, the answer is not to do more willy nilly but to maintain an evidenced based approach based on investment in proven priorities.

As I have said before, the best way of improving productivity is to catch up on the waiting list as soon as possible. Increasing production is the best way to increase productivity.

Politicians

Nick Clegg opines in his autobiography/ account of his time working for Meta on the difference between politicians and the tech bros running Silicon Valley.

> *Politics, at its heart, is a competition between stories about how things should be...You win elections if more people sympathise with your telling of events and your vision of the future than with those of your opponents. But Silicon Valley is full of people who see the world a different way: engineers. Theirs is a world of facts and process. The engineer's mindset is to identify a problem and fix it, then move onto the next problem.*

My take on this is that the NHS is run too much by politicians keen to tell plausible but false stories for electoral purposes and not enough by people interested in facts and process.

Roundup from around Europe

NotebookLM – It's quite a task to attempt to survey European healthcare and I'm ever looking for shortcuts.

Fortunately, as a life member of the Royal Society of Medicine I have access to more journals, e-resources etc than I can ever ask for, plus I have a subscription to Deepdyve another huge searchable repository of articles and journals.

But, this month, thanks to John Naughton the Science and Technology correspondent of the Observer, I have found NotebookLM, a Google product, enabling the saving of large volumes of data and documents which can be searched and analysed for you.

So far, I have scratched the surface of the usefulness of the tool but after downloading all my previous newsletters it has greatly eased the process of retrieving what I may have said previously on a particular topic.

It's free for now and I highly recommend it. I'm sure there are already some enterprising finance directors who have already started using it to produce their monthly reports.

The **European Health Observatory** is another essential repository of useful information. It produces pdfs of all the health systems in Europe and from around the world. These can be merged into one PDF and then saved into NotebookLM to be used in summaries and be subject to interrogation.

It will be an acid test of how useful NotebookLM is.

Here are my first results from asking NotebookLM what the likely results of European healthcare plans are. It states,

> *European health systems are actively pursuing various reforms and strategic plans to address current economic and political challenges, including the long-term repercussions of the COVID-19 pandemic, demographic shifts, and evolving financial landscapes. While there's public support for increased spending, even if it means higher taxation, the actual levels of funding remain a political choice. The likely results of these healthcare plans involve a mix of successes in modernisation and efficiency, alongside persistent challenges, particularly concerning equitable access and workforce issues.*

So far, so obvious.

It concludes,

> *European healthcare plans are largely geared towards modernising infrastructure, strengthening primary and community care, digitalising services, and addressing workforce shortages, often supported by significant investments from national and EU recovery funds. While these efforts are expected to improve efficiency, access, and resilience, their success will hinge on overcoming persistent challenges such as political instability, economic pressures, workforce retention, and the complexities of fragmented governance structures.*

The summary is only as good as the information being fed in and I can detect gaps and biases and the need to check sources. For example, it reflects the

backward-looking nature of the Observatory rather than the prospective and up to date plans. But it's not bad. I can see it being useful.

For now, the Observatory reports [the German Parliament has appointed a commission to investigate the Germany's Covid Response]. It gives them something to do I suppose. Or a new stick to beat the last government.

UK vs EU waiting lists

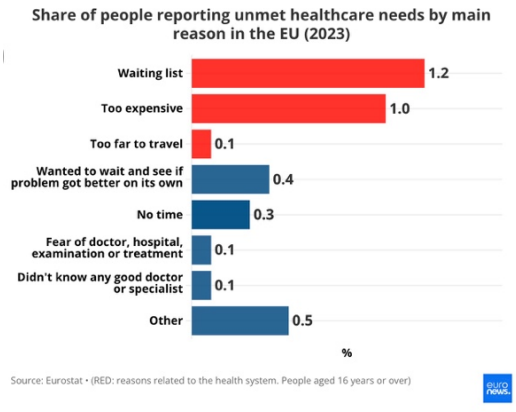
[The latest news] on UK Waiting Lists is neither unexpected nor surprising. The HSJ has reported Mark Cubbon, Director of Elective Services, as saying waiting list targets will not be met.

In fact, the waiting list has gone up slightly this month and stands at 7.37m, far above pre-Covid levels.

While the [Nuffield Trust] and [HSJ journalists] beat about the bush it's the HSJ comments sections that get down to the issue,

> *Credit to Mark for saying the quiet part out loud - we're not on track. That honesty is refreshing, but the real story is why, and here the blame sits squarely with this government, aided by NHSE and DHSC, for getting it spectacularly wrong.*
>
> *Chronic underfunding, short-term pots instead of sustained investment, and perverse incentives like capping recovery funding have actively throttled capacity.*
>
> *Ring-fenced elective hubs exist largely on paper, regularly raided to prop up emergency pressures. Workforce planning has been reactive at best, ignoring the reality that without the people, extra theatre sessions are just PowerPoint targets. Staff are already knackered, burned out by years of firefighting, constant reorganisation, and political promises that evaporate on contact with reality. And now, rewarding only the best performers creates zero incentive for those in the trenches making hard-won progress under the toughest conditions, the very trusts that need support the most. The incentives reward list validation and cosmetic improvements over real throughput, because that's what ministers want in a press release. NHSE and DHSC have been complicit in this game, trading long-term resilience for short-term headlines. Until ambition, funding, and policy are aligned, and stop undermining each other, these targets will remain political theatre, not operational reality.*

I've reported in the past that other European countries do not have such issues, so much so that there is little or no reporting on the matter. What there is are reports on the levels of unmet needs. Last month I gave this chart showing levels of unmet need across Europe from waiting lists and other factors.



The UK figure would be about 10 if I divide the number of people on waiting lists by the population.

There is no comparison to the EU figures.

Why?

The UK has a culture of meeting arbitrary financial targets in healthcare using rationing and waiting lists rather than increasing capacity and improving productivity. And of accepting failure to meet patients needs. You can see why the population are revolting.

See the Nuffield Dashboard for the best quick view of how things are going. The answer is not far enough, fast enough.

AI – there have been several useful posts on websites highlighting the opportunities and risks of AI in medicine. This one from a doctor is well rounded and advises a flexible, cautious response.

But the big question remains as to whether the trillions spent on AI will generate returns to justify the hype.

> *The US has a record high stock market, unlimited spending on AI capacity by the tech giants, along with sharply increased borrowing to pay for it; but no sign yet of any significant revenues or profits from AI – and alongside that: a slowing rest of the economy, a widening trade deficit in goods and increasing unemployment and prices. All this as we go into the second half of 2025.*

Ref : Michael Roberts "Tariffs and the UK economy " August 2025.

The latest version of Chat GPT-5 came out in August to mixed responses. And the markets crashed on August 20. The cause, this report: "the State of AI in Business" published by MIT.

The first line of the executive summary gives the game away,

Despite $30–40 billion in enterprise investment into GenAI, this report uncovers a surprising result in that 95% of organisations are getting zero return.

Stocks in US AI technology companies fell in value at the close of trading on 20th August, with the NASDAQ Composite index down 1.4%. Among those losing value were Palantir, down 9.4% and Arm Holdings down 5%. According to the Financial Times [paywall], Tuesday saw the biggest one-day fall in the market since the beginning of August.

AI News linked here, gives more discussion around the report. But it appears to be bad news for those inflating the AI hype.

I hope the DHSC read this before signing the contract.

Nursing pay levels – lest people think I am paying too much attention to doctors pay these charts should get our leaders thinking.

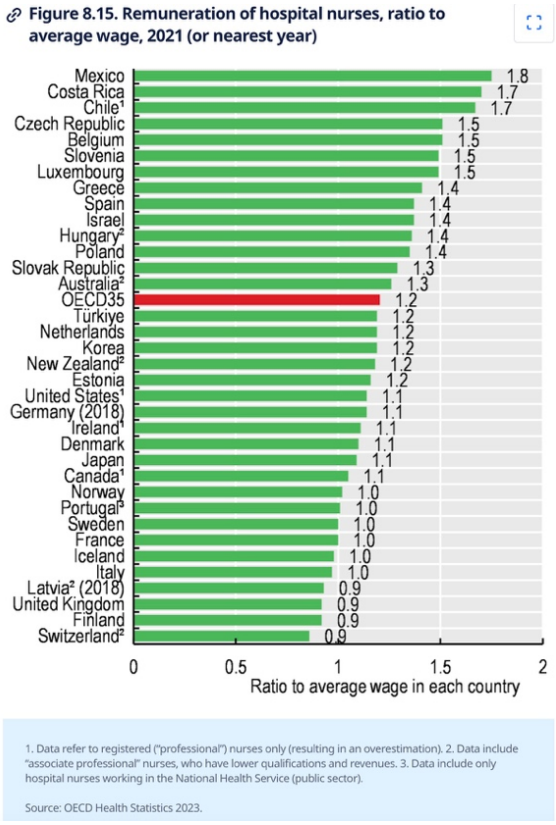
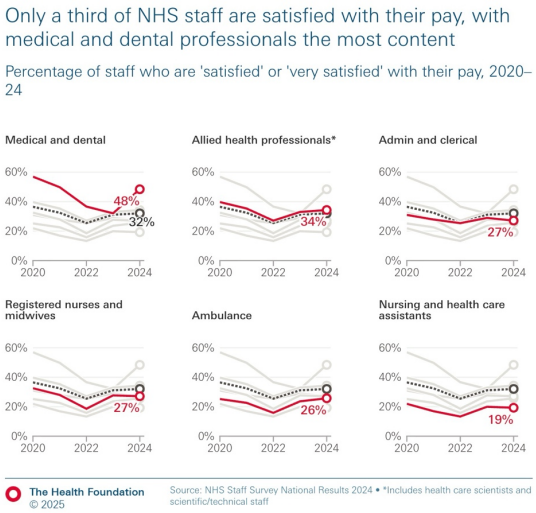


Fig 2
Nurses and midwives joining UK professional register, by place of training (Source: NMC[6])

Not only are nurses poorly paid but the UK has become dangerously reliant on nurses from overseas.

Leaders who cannot take action today do not need to preoccupy themselves with being leaders tomorrow



The French pathology industry – the FT has reported on big changes to the French Pathology industry.

Unfortunately, the article is paywalled, but the meat of the matter is that France has been paying too much for pathology services.

It didn't matter so much when local technicians ran the show, but Private Equity has been buying up the industry and making a killing.

> *France's heavily indebted laboratory groups are poised for a wave of restructurings, after a government-led audit of the sector recommended measures including profit caps to slash outsized margins.*
>
> *The recommendations published last month by the government body in charge of auditing France's health sector said that "measures must be taken to bring the cost of biology back to a fair price", including "the introduction of profitability-based regulation".*
>
> *France's medical laboratory sector includes some heavily indebted companies that have been acquired through leveraged buyouts in recent years, as private equity firms target an industry that generates margins that are much higher than the rest of France's broader medical sector. Reducing those margins would probably result in the "restructuring of large groups"…*
>
> *… the report said.*

This may be bad news for Synlab, mentioned in the article, who supply four pathology networks in the UK (including St Thomas' and Guys/Kings College).

Synlab was launched on the Frankfurt stock exchange in 2021 at a share price of €18, they are now trading at €12.80.

The UK in the meantime is still struggling to get to first base if this submission from the Royal Society of Pathology to the 10-year plan is anything to go by.

Funny they didn't mention the Pathology modernisation plan.

Given the rebirth of strategic commissioning driven by ICBs, pathology is still ripe for a bit of restructuring in the UK.

But, as all the spare change is to be devoted to funding war in the Ukraine, to help Trump balance his books, it may be another 10 years before pathology modernisation is contemplated.

I fear my newsletter next month is not going to be any more cheerful!

27/08/2025

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2025	Key Issues
January	United healthcare, Trump's new Team, "free to Obey", Losing faith with Deliverism, Major Trends in 2024
February	Trumps early steps, State of Play in Europe, Preventing Chris Ham, Bidenomics Failures, AI and the NHS, and Waiting lists in Europe.
March	Trump latest on healthcare; Mario Draghi and improving Europe. On the UK as per "Get In", Field Marshall Alan Brooke and Sam Freedman. DHSC accounts 2023/24, German healthcare reforms and more on UK death rates and prevention policies.
April	Wilful Blindness; Ignorance and Bliss. Abolition of NHS England. Benefits cuts in UK vs Benefits for the disabled in Europe. Covid. On why the NHS has Queues.
May	Trump sours the world; The Unaccountability Machine; Public attitudes to Health in UK and EU; the Care Dividend. Cataracts.
June	Inactivity levels; Population planning; Waiting lists; The Unaccountability Machine and crack-up capitalism; Homelessness, Social Care Review; Assisted Dying, Rachel Reeves and German Plans
July	Trump floods the Zone, UK economy, lessons on Planning and for Wes Streeting, Long term care and Primary Care. Gatekeeping.
August	Trump impact on Healthcare, EU budget, NHS 10-year Plan, Neo-natal care. Rachel Reeves, Unmet needs in Europe and New Drugs benefits.

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