Alternative European Healthcare Perspectives May 2026

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It's been quite a month for negotiations. Trump has backed off an apocalypse in the Middle East, while Israel is ploughing on with a 'might is right' doctrine. In the UK Wes Streeting has pulled in the Prime Minister to help in his difficulties in negotiating a new deal with the doctors. Meanwhile in Europe countries are getting on with constructing stronger alliances as part of a strategic realignment policy, which Starmer may or may not join. The devil will be in the detail.

The EUobserver points out that vulnerability to oil price volatility can be reduced by investing in alternative energy.

The UK's very own Climate Change Committee estimates that every pound of investment can yield £4 of returns. It seems that the EU's financial models don't disaggregate the benefits of investments made by public authorities, creating an institutional barrier to such investment. In the UK the Treasury has the matter under review as this AI search reveals:

"Following a 2025 review, HM Treasury is commissioning a new, independent expert review of the Green Book discount rate, expected to report in 2026. This review focuses on whether the current Social Time Preference Rate (STPR) unfairly undervalues long-term transformational projects and environmental impacts, potentially leading to lower rates for long-term investments. [1, 2, 3]

Key Aspects of the Review and Current System

- **Purpose of Review:** To address concerns that the standard discount rate discourages long-term investment in areas like climate change and infrastructure.
- **Current Rate:** The standard STPR is currently 3.5% for the first 30 years, reducing for longer-term projects (3% for years 31-75, 2.5% for 75+).
- **Review Focus (2026):** Academics Prof Mark Freeman and Prof Ben Groom will examine if the current STPR system remains appropriate or if a Social Opportunity Cost (SOC) approach is better.
- **Specific Impacts:** A lower rate of 1.5% is often used for health and life impacts, and the review will consider how this applies to environmental, long-term, and intergenerational effects.
- **Timeline:** The 2025 Green Book Review, published in June 2025, highlighted the need for this review. [1, 2, 3, 4, 5, 6, 7]

Contextual Findings

- **Transformational Change:** The Treasury will improve guidance to ensure the appraisal of transformational projects better accounts for their long-term value, as highlighted in the 2025 Green Book Review.

- **Alternative Approaches:** Independent analysis in response to the review suggests maintaining the STPR method but potentially lowering it for long-term projects to better reflect environmental and social costs, notes the cetex.org response.
- **BCR Thresholds:** The Treasury has clarified that a Benefit-Cost Ratio (BCR) under 1.0 does not automatically disqualify projects, easing reliance on rigid, short-term valuation. [1, 2, 3, 4]"

It shouldn't be revolutionary to examine the real returns on investments rather than make general assumptions on the benefits of public spending. For example, it is well known that "*Health is an investment, not a cost*" and that returns on strategic health investments can be very high. If you don't believe me, at least the World Economic Forum agrees.

UK negotiation with medical workforce

My host Roy Lilley has discussed the options for reducing the dependency of the state on medical professionals. I'm afraid that the tactics suggested (substitution, standardisation, consultant-isation and digitisation) risk aggravating the position.

Why would trainee doctors co-operate in their own demise? It risks transferring one dependence onto other dependencies i.e. specialists or third-party suppliers.

The idea of cutting back training posts is a classic example of the government shooting itself in the foot. What conceivable benefit can it achieve to increase shortages in the future and force graduates to look for opportunities overseas?

Wes Streeting looks increasingly desperate to get out of the impasse of his own making. It will take more than fancy footwork and irrational threats. He needs to read up on negotiation theory. A common error is bias in negotiations and to achieve sustainable deals, negotiators must anticipate and integrate everyone who would have to bear any negative consequences of a deal, including co-workers, children, and communities. Streeting on the contrary is looking to impose a solution and for a long time refused to talk. The latest wheeze is to prevent doctors from striking.

My thinking on this matter is informed by David Green's 1986 book *Challenge to the NHS*. subtitled, *A study of competition in American health care and the lessons for Britain*. It explains the reasons for the exorbitant earnings and professional power of the American medical profession as rooted in the shortages of doctors in the booming America of the late 19th century and 20th centuries. Doctors could make or break a growing town in the wild west. This gave them great negotiating power that they have not relinquished to this day. In retrospect the measures advocated in the book to follow US initiatives in health maintenance organisations and accountable care organisations, designed to increase competition and reduce the negotiating power of the medical profession, have instead consolidated the power of the medical profession.

My view is also influenced by the French system of control of the numbers of doctors being trained in France – the Numerus Clausus. This was discussed in my August 2022 edition of this newsletter (alongside the resignation of Boris Johnson). Essentially the rise and fall of the French Health service can be plotted against

measures to increase and reduce the numbers of doctors. The more the supply increases the lower the wages and the more healthcare gets delivered, and vice versa.

There is no future in planning for shortages of doctors. This is handing monopoly power to the medical profession. Thatcher built up coal stocks before taking on the miners.

Doctors have a high proportion of privately educated entrants to the profession who have been doing much better in the jobs market than other people. It may be that a high proportion of entitled entrants to the profession, with unrealistic expectations of what average salaries are, is the root of the problem. I would recruit a lot more highly educated ordinary public sector trained students, from ordinary families, to train as doctors.

Streeting seems locked into an adversarial relationship with doctors, where he is unwilling to use market forces to undermine the bargaining position of doctors, nor seems able to come to a mutually beneficial negotiated outcome. Instead, he is using the threat of the damage of strikes as a negotiating tactic against the doctors. Private Eye calls this "*Desperate Business*".

European unity

After the French local election results which surprised many by electing left-wing alliances in its major cities, Hungary's Victor Orban, a thorn in the side of the EU, has been replaced by a pro-EU centrist. This will strengthen the EU's hand and make it easier to push through European initiatives. The major one is of strategic realignment away from reliance on the US, towards self-reliance.

Unfortunately, it looks like Europe is being drawn in to becoming a military force, as the US withdraws direct funding from NATO. The first task should be to make peace with Russia rather than engage in another arms race. But Europe has its own military-industrial complex that prefers to see an expansion of its interests.

"The European military-industrial complex is undergoing a rapid, state-led transformation to reduce dependence on non-EU suppliers—specifically the U.S., which accounts for ~63% of procurement. Key initiatives like the European Defence Industrial Strategy (EDIS) and the €1.5 billion European Defence Industry Programme (EDIP) aim to increase intra-EU procurement to 50% by 2030. This shift emphasizes joint production, civilian-military integration, and support for over 2,500 SMEs. [1, 2, 3, 4, 5, 6, 7]

Core Strategic Shift

- **From Dependence to Autonomy:** Currently, 78% of defence spending goes to non-EU suppliers. The goal is to move from emergency response to long-term "defence readiness".
- **Key Targets by 2030:**
  - **50%** of defence procurement should come from the European Defence Technological and Industrial Base (EDTIB).
  - **40%** of defence equipment should be procured through collaborative member state efforts.
  - **35%** of defence trade should occur within the EU. [1, 2, 3, 4]

Primary Financial & Legal Mechanisms

- **EDIP (European Defence Industry Programme):** Provides €1.2 billion in grants to the industry and €300 million for integrating Ukraine's defense industry. It includes tax exemptions and easier procurement rules.
- **European Defence Fund (EDF):** Finances collaborative research and development.
- **ASAP (Act in Support of Ammunition Production):** Designed to ramp up ammunition manufacturing rapidly. [1, 2, 3, 4]

Industry Dynamics

- **Civilian-Military Blurring:** The sector increasingly incorporates dual-use technologies and civilian corporate components, driven by over 230 new defence-tech startups founded since 2022.
- **Workforce:** The sector employs hundreds of thousands, with ~240,000 in aeronautics and ~393,000 in land and naval sectors.
- **Innovation:** There is a heavy focus on AI-enabled drones, space systems, and cyber capabilities, often coordinated with NATO initiatives. [1, 2, 3, 4, 5, 6]

Challenges and Criticisms

- **Funding Adequacy:** Critics and experts question if the proposed €1.5 billion EDIP budget is sufficient to meet the ambitious 2030 targets.
- **Member State Buy-in:** Defense remains a national responsibility; therefore, the success of these EU-level strategies depends on voluntary cooperation and resisting fragmentation.
- **Economic Impact:** Some argue that intense rearmament may drive deindustrialization or divert funds from other social sectors. [1, 2, 3, 4, 5]"

The amount Europe intends to spend look modest and inadequate, insufficient to replace the US in Europe or to satisfy the needs of its own industrial base. And the ambition to reallocate €800bn quoted earlier has an ominous feel, if it means reallocation from health and social care.

The UK is betting on the Global fighter project developing between Italy, Japan, Canada and the UK . Rolls Royce is developing Mach 7 engines. France has its own ideas, however, based on boosting its own initiatives. And Germany is giving priority to its own solutions, including the reintroduction of conscription. It after all has its own problems, as it continues to de-industrialise.

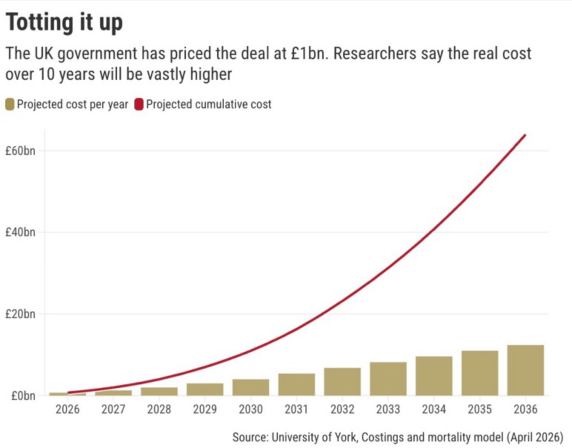
The answer to Germany's problems is suggested as "*Weltinnenpolitik*, or world domestic policy, which internalises the need to address global problems with the coordination typically associated with domestic politics, rather than through traditional foreign policy or interstate

diplomacy. “This is the sufficient condition for avoiding a disorderly de-industrialisation and long-term transformation of Germany into a service society characterised by the extreme inequalities and social deprivation associated with the Anglo-American model” reads like wishful thinking.

It looks less like European unity and more a struggle to dominate international markets in advanced military products. All this presuming that the US will be happy to lose its 63% European market share.

But it’s not just in military products, there is a realignment in pharmaceutical products at stake. Both the UK and the EU have prospered in this growing strategic growth area and Donald Trump has been negotiating for a realignment. Various announcements have been made about the implications of the manoeuvres and negotiations concerning the deal done in December.

This has been investigated by the Bureau of Investigative Journalism: in their recent report “Inside the £64bn deal...”. I recall reporting on this at the time the deal was made and puzzled at the low cost quoted by our government of £1bn over three years. It turns out this was nonsense. This graphic tells the story:



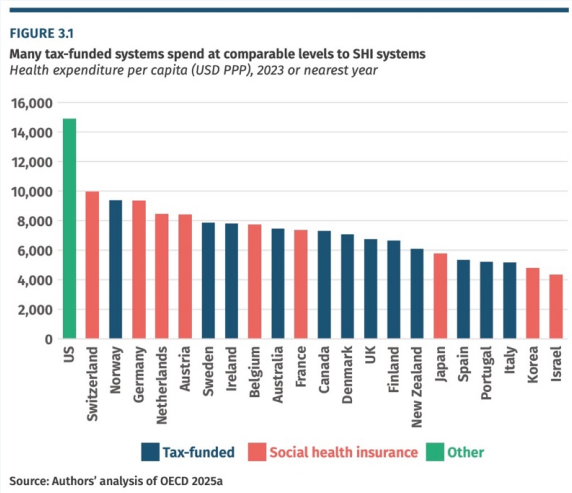
The full report is worth reading and might explain why Peter Mandelson was so keen to be appointed as the UK Ambassador to the US. His consultancy advised both sides in the negotiation.

Insurance vs Taxation Funding of Healthcare

Talking of realignment, an IPPR report published recently “Bismarck vs Beveridge revisited” re-examines the case for a change in the NHS funding model. The confidently expressed answer is that there is no case.

Unfortunately, the evidence is ambiguous. On several important criteria social insurance-based funding models appear superior and within the tax-based funding model group heavy lifting is done by Norway and the other Scandinavian countries to make it appear that the UK should not look to change its funding model.

Spending is generally higher within insurance-based systems.

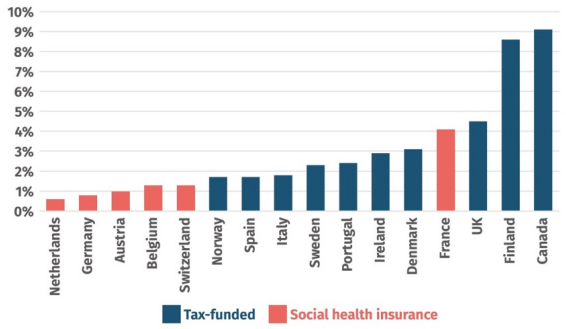


Insurance based systems are better at meeting needs

FIGURE 3.2

The number of people saying their medical care needs aren't met is generally higher in tax-funded systems

Population reporting unmet needs for medical care (%), 2023 or nearest year



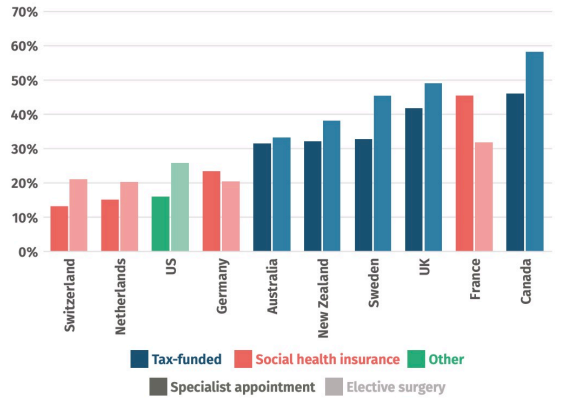
Source: Authors' analysis of OECD 2025a

Patients wait less for treatment within insurance-based systems.

FIGURE 3.4

Waits for specialist care are generally lower in SHI systems than tax-funded systems

People waiting two months or more for elective surgery or specialist appointments (% of survey respondents), 2023 or nearest year



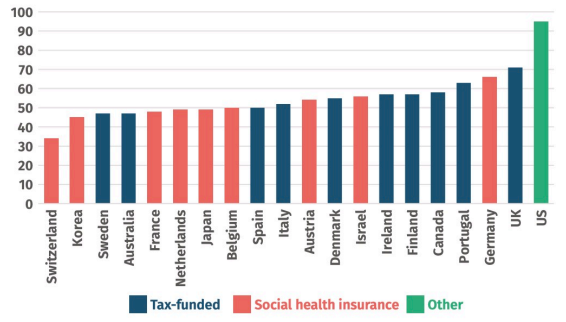
Source: Authors' analysis of CIHI 2024

Social insurance-based systems are generally better at keeping people alive

FIGURE 3.6

Only the US performs worse than the UK on treatable mortality

Treatable mortality per 100,000 people (age-sex standardised), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

All of which makes a strong case in most people's eyes for examining in more detail what it is about these systems that improves performance compared to tax funded systems. Unfortunately, the authors seem to have a limited budget and are content to draw a table at this level of analysis which gives the balance of opinion towards retaining the status quo, albeit with recommendations for increased capital spending and more for primary and community care, social care and public health.

TABLE 2.3

Advantages and disadvantages of models

System	Potential advantages	Potential disadvantages
Social health insurance	**Funding stability:** insurer independence buffers health budgets from short-term political pressures; earmarked contributions may build support for higher spending. **Longer-term investment:** political insulation supports investment in infrastructure, technology and prevention. **Insurer competition:** choice between funds may drive performance improvements.	**Administrative complexity:** multiple insurers and contractual arrangements generate higher overheads. **Labour market dependence:** heavy reliance on payroll contributions increases labour costs and makes revenues vulnerable to unemployment and demographic change. **Fragmentation:** multiple insurers and provider competition creates barriers to care integration for patients with complex conditions.
Tax-funded	**Progressivity and equity:** revenue is raised in proportion to ability to pay. **Administrative simplicity:** fewer payers and contracting arrangements reduce overheads. **Demographic resilience:** lower reliance on payroll contributions makes funding more sustainable as populations age.	**Short-termism:** as the payer is a democratic political entity, funding decisions skew towards short-term pressures over long-term investment. **Funding competition:** healthcare must compete with other public services for general tax revenues, risking chronic underfunding. **Weaker innovation incentives:** lack of competition between insurers/providers, reduces incentives to improve performance.

Source: Authors' analysis of Thorlby and Buzelli 2024

TABLE 3.3

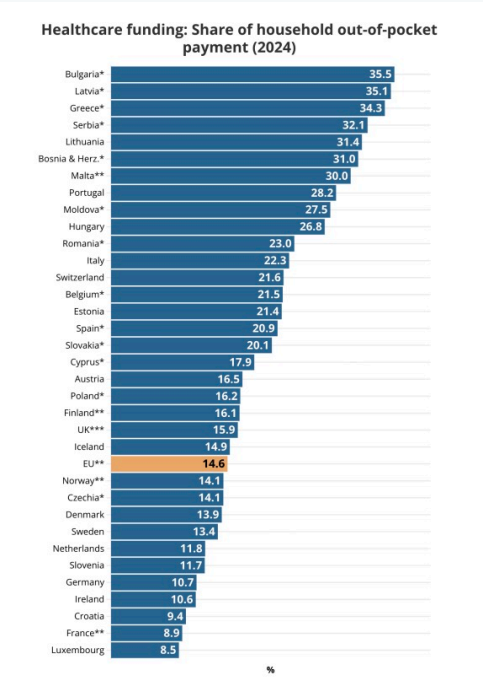
Summary of performance

Domain	Tax-funded systems	SHI systems	NHS position
Capacity	Slightly lower spend and fewer physical assets	Higher spend, more beds and equipment	Below average on most metrics
Access	Less satisfaction with waits, higher reported unmet need.	Lower unmet need, higher satisfaction with access	Poor comparative performance on waiting times
Equity	Lower OOP spend, less reliance on VHI	Higher OOP spend; higher VHI uptake	Low OOP spend; low VHI uptake
Quality	Fewer avoidable admissions, similar level of treatable mortality and AMI outcomes	More avoidable admissions, similar level of treatable mortality and AMI outcomes	Worse on treatable mortality; Worse than average on AMI outcomes. Strong performance on avoidable admissions.
Efficiency	Lower admin costs, shorter hospital stays	Higher admin spend, longer hospital stays	Higher than average hospital stays; low admin spend
Key	Performs well	Average performance	Performs poorly

Source: Authors' analysis

I don't think the above justifies the claim, "*there is no evidence that SHI systems outperform tax-funded systems, or vice versa. Performance varies more within funding model types than between them*." Nor does the claim for out-of-pocket payments being less in the UK hold up. I

discussed this in my March edition and presented this table:



Source: Eurostat • *2023, ** 2022, ***2019
In checking this the ONS gives lower figures for 2023 of 13.8% but I still don't think it should be used to tip the balance of the argument.

There is some evidence that SHI systems outperform tax funded systems, and that other tax funded countries outperform the NHS.

What is needed is a further study on why some tax-funded countries perform better than the UK and what is it about Insurance-funded systems that explains their superior performance, particularly regarding quality of care.

In addition, it would be worthwhile for researchers to address the particular issues identified by Civitas and others of the reasons insurance-funded systems can perform better:

- **"Overpoliticisation**: Because the NHS is a "Department of State," every operational decision (from ward closures to pay deals) becomes a political crisis. Civitas argues this leads to **short-termism**, where politicians "raid" long-term capital budgets (equipment/tech) to fix short-term headlines (waiting lists), a cycle less common in independent French or German hospitals.
- **Managing Professional Interests**: In a monopoly, the relationship between the employer (the state) and the employees (doctors/unions) is binary and adversarial. Civitas argues that the NHS is "undermanaged" because it lacks the **plurality of employers** found in France or Germany. In those systems, competition for staff and diverse hospital ownership prevent any single group from "holding the system to ransom," while also allowing for more flexible, locally negotiated pay.
- **The Reluctance to Increase "Consumption"**: This is the "underconsumptionist" point. In market-based systems, more demand usually leads to **increased supply** (more clinics open to capture insurance revenue). In the NHS, more demand is often viewed as a **financial threat** to the fixed Treasury budget. This leads to what you called a "reluctance to increase spending"—the system is designed to *contain* costs rather than *expand* activity.

In short, Civitas views the NHS not just as a "poorly funded" system, but as a **"frozen" system** that lacks the incentives to grow, manage its staff professionally, or innovate without a direct order from a Minister."

There must be reasons for the disparities in performance:

Comparison of Healthcare Activity and Resources

Indicator	United Kingdom	France	Germany
Doctor Consultations (per person/year)	~2.8–3.2	5.4–5.5	9.6–9.7
Hospital Beds (per 1,000 people)	2.5	5.4	7.7
MRI Units (per million people)	8.6–19	17	35.2
CT Scanners (per million people)	10	19.5	36.5
Physicians (per 1,000 people)	3.2	3.4	4.5+

Round up of other European Healthcare issues

Cancer Prevention

Last month I drew attention to the special edition of EuroHealth devoted to Cancer Care and the UK's own recently announced Cancer Plan. I noted that the UK was adjusting the sensitivity of the bowel screening test as part of the drive to decrease the mortality of the disease.

I have to declare an interest as I have recently undergone two colonoscopies. I am lucky in that I am being treated at A World Centre of Excellence". I had an opportunity to raise the question of the sensitivity of testing with Mr Alex Ball the clinical lead.

The issue is that the sensitivity of the standard screening test, which had not detected my polyps, is higher than for symptomatic testing, which had detected my polyps. He said that the screening sensitivity was being lowered but that there was a risk of very high numbers of cases being identified before the capacity to deal with them was in place.

As always, I looked up the international evidence. The first finding is that bowel cancer is more treatable than others, if caught at an early stage. But 44,000 people have bowel cancer detected each year and around 17,700 die. Bowel Cancer is the second biggest killer of all cancers, more than liver, kidney, prostate (12,000), and Breast Cancer (11,200) and amongst non-smokers it is the leading cause.

Annual UK Cancer Deaths (Estimated)

Cancer Type	Approx. Annual Deaths (UK)	10-Year Trend in Mortality
Bowel (Colorectal)	17,700	Decreased by 6%
Oesophagus	7,800	Decreased by 12%
Liver	6,500	Increased by 14%
Kidney	4,800	Increased by 5%
Stomach	4,300	Decreased by 34%

The second finding was that the UK, while not the worst, is not the best when it comes to preventing deaths from bowel cancer. Which makes it surprising therefore that other countries have a much lower threshold (measured by particles of blood in a sample) for identifying cancers in their general screening programmes.

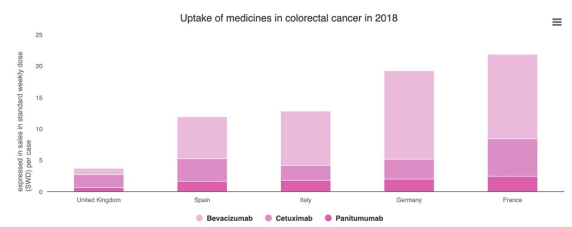
FIT Screening Thresholds Across Europe

Country / Region	Threshold (µg Hb/g)	Sensitivity Profile
Belgium (Flanders)	8.5	Highest sensitivity; detects nearly all cancers but requires many colonoscopies.
Austria (Burgenland)	10	Very high sensitivity; used in regional high-performing programmes.
Slovenia, Italy, Spain	20	Common European standard; balances high detection with hospital capacity.
Finland	25	High sensitivity; part of a long-standing, high-participation programme.
France	30	Standard national threshold; recently transitioned from older test types.
Ireland	45	Moderate sensitivity; explicitly chosen to manage colonoscopy demand.
Netherlands	47	Adjusted from 17 µg to 47 µg to prevent overloading diagnostic services.
UK (Scotland)	80	UK's most sensitive national threshold; soon to be matched by England.
UK (England)	120	Lowest sensitivity; currently being lowered to 80 µg in a phased rollout.

I feel lucky in that my polyps were caught at an early enough stage, before they became cancerous (probably), but I have known people caught by the existing screening programme that were discovered too late. I sense a national scandal.

As in so many things it looks like the delivery of appropriate care is determined by capacity that is deliberately kept in shortage. And according to the ABPI (Association of the British Pharmaceutical

Industry) the rationing of drugs more freely available in other countries to treat disease.

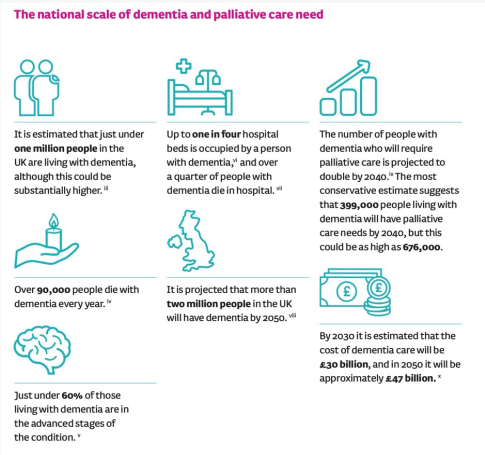


Funnily enough none of this gets mentioned by the Department of Health in another of its good news bulletins.

Europe is not sleeping enough. As Margaret Heffernan has pointed out being sleep deprived is more dangerous than drunk driving. Sleep disorders affect up to 30% of Europeans, causing an annual economic burden of nearly €423 billion. Only 22% of Europeans report regular, uninterrupted sleep, with rates of sleep struggles rising to 35% in recent years. Major issues include obstructive sleep apnoea (18% prevalence) and insomnia (10% prevalence). The UK, France, and Spain report the poorest sleep quality, driven by stress, employment insecurity, and digital device use.

Dementia

Dementia UK have published their roadmap and recommendations for improving dementia care in the UK. It's a big problem in the UK and Europe.



An AI search provides the following summary:

"Dementia care in Europe is adapting to an aging population by developing dementia-friendly communities and innovative models, though significant inequalities exist between nations. Key trends include specialized dementia villages (e.g., De Hogeweyk in the Netherlands) and a shift toward early detection, with high-quality care often found in Nordic countries. [1, 2, 3, 4, 5]

Key Aspects of Dementia Care in Europe:

- **Innovative Care Models:** The "dementia village" model, originating in the Netherlands, provides a safe, normalised, and community-like environment, improving the quality of life for people with moderate to severe dementia. Similar initiatives exist in France, such as the Landais Alzheimer Village.
- **Regional Disparities:** There are major differences in care availability and quality. Countries like the UK (Scotland/England), Netherlands, and Sweden often rank high in dementia-friendly initiatives and policy. Conversely, countries like Bulgaria, North Macedonia, and Serbia face significant gaps in care, with lower availability of specialized services.
- **Care Access & Affordability:** Norway is recognised for high accessibility and affordability of care, while Sweden often leads in providing extensive, publicly funded services.
- **Innovation & Diagnosis:** Sweden is pioneering digital tools, such as the Mindmore

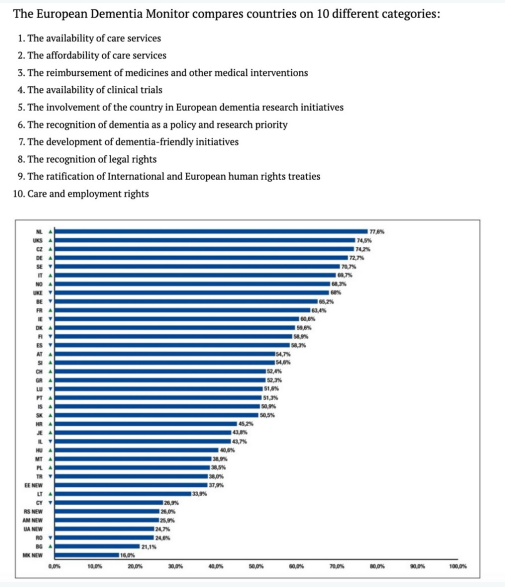
cognitive assessment platform, to enhance early diagnosis.

- **Future Challenges:** As the population ages, the number of people with dementia in Europe is expected to double by 2030, putting immense pressure on healthcare systems, which are currently facing huge economic burdens (exceeding €300 billion annually). [1, 2, 3, 4, 5, 6, 7, 8, 9, 10]

Dementia Care Rankings & Leaders (2023–2025):

- **Overall Care Leaders:** Netherlands, Sweden, Norway, and the UK.
- **Best for Access/Availability:** Luxembourg.
- **Best for Care Affordability:** Norway.
- **Best for Legal Rights/Care:** Czech Republic, Netherlands, UK (Scotland). [1, 2, 3, 4]"

The good news is that Dementia care in the Uk compares relatively well with other European nations, although lagging the best. UKS in the following table is UK Scotland and UKE is UK England.



The bad news is that this overall analysis of European Dementia Care doesn't really communicate the differences in care on the ground as this comparison of capacity to deliver care in France and the UK provided by AI reveals:

"As of recent reports, England (UK) has approximately **340,000 potentially available care home beds** that offer services to older people with dementia. In contrast, France maintains a robust system of "medicalized" nursing homes known as **EHPADs**, which housed roughly **610,000 residents** as of the most recent comprehensive surveys. [1, 2, 3, 4, 5]

Comparison Overview

Directly comparing "designated" dementia beds is difficult because definitions of specialized dementia units vary between the two countries. However, the scale of care provision is as follows:

- **United Kingdom:** While there are roughly 414,000 to 462,000 total care home beds (including residential and nursing) across the UK, it is estimated that **70% of residents** have dementia or severe memory problems. In England specifically, about 340,000 beds are in homes registered to provide services to people with dementia.
- **France:** The French system centres on EHPADs (*Établissements d'hébergement pour personnes âgées dépendantes*). In 2019, there were approximately **611,673 beds** available in these facilities. These homes are highly medicalized, and many are specifically equipped to handle high levels of dependency,

including Alzheimer's disease. [1, 2, 3, 4, 5, 6, 7, 8, 9]

Key Differences in Care Models

- **Medicalization:** French EHPADs are generally more "medicalised" than some UK residential homes, offering higher staffing ratios (e.g., 64 staff per 100 beds in nursing homes compared to lower ratios in senior housing).
- **Accessibility:** France generally has a higher proportion of elderly people living in long-term care facilities (approx. 21% of those over 85) compared to the UK (approx. 16%).
- **System Capacity:** While the UK faces a "postcode lottery" for specialist beds, France has historically invested in national Alzheimer's plans to expand specialized capacity in their nursing homes. [1, 2, 3, 4, 5]

Please note that these figures are based on the most recent available data (2022–2025) and are subject to change as demand for dementia care continues to rise across Europe. [1, 2, 3, 4]

But the UK is also not listening either, as this testimony from a dementia sufferer claims.

Developing alternatives to US Big Tech as part of the realignment away from the US Europe is developing an alternative to Microsoft Office and to Whatsapp. This comes amid reports of Microsoft price increases.

Meanwhile this NHS director is advising that it is already too late (almost) to replace Palantir as the supplier of the NHS data platform.

The BBC is having to cut staff by 20% because more people are not paying the licence fee and instead relying on social media, where they are bombarded with mind-bending advertisements and 'influencers'.

It may be time for the NHS and the UK government to join the EU in developing alternatives to outdated and inappropriate US products. If Iran and China can do it, it surely is possible in the EU. (See this on AI). But, as with tobacco, if the young are already addicted the resistance will be fierce.

France is leading the world

it's good to see that President Macron is being useful in promoting this initiative at a World Health Summit. It was World Health Day - I hadn't noticed. It looks like the UK media are following Trump in denying a role for multinational organisations and joint initiatives.

The rumours are however that the Prime Minister is (was) angling for a Swiss-style deal with the EU to help dig the UK out of its Brexit-shaped hole. This is the sub-text for the controversy over the Mandelson appointment. There are a lot of people who would like to put a stop to such initiatives.

Database of editions of Alternative European Healthcare Perspectives 2025/6

2026	Key Issues
January	Summary of 2025 newsletters, Reith Lectures, Thiel, Tipping points and the future according to McKinsey's. Productivity.
February	The rise of fascism, American, European and UK health developments. Wes Streeting and more on AI.
March	Shameless. Trump, Mandelson, NHS. Normalisation of Deviance, Institutional corruption. Netherlands, Germany, Norway, Belgium Portugal and Spain. Out of pockets payments.
April	Trump wars spells gloom for healthcare. Social trends. Deliverism fails. Alternatives. Is Streeting fixing the NHS? Moral Distress. Cancer
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.
September	Recap on Covid, the World Economy and EU, Brexit, Doctors Pay, Reconfiguring Health Services, Access to New Drugs, Productivity, Politicians, Notebook LM, EU Waiting Lists, Nurses Pay, the French Pathology Industry.

October	Ursula von der Leyen. Spinoza, Stupidity, plans that don't work. Rachel Reeves Dilemma. Immigration. AI bubble. Assisted Dying.
November	The November Budget, East Germany, France. OHE Annual Lecture, The Good, the Bad and the ugly. Waiting lists. Workfare across Europe. The EU campaign for deregulation. Actuaries plan for Social Care.
December	Scanning US and EU healthcare developments, comparing tax rates, problems of international comparisons, verdicts on UK Budget, comparing welfare benefits. Planetary Health.

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