Alternative European Healthcare Perspective January 2026

Roger Steer

You cannot say you were not warned.

My January 2025 and February 2025 newsletters gave ample coverage of the warning signs and first steps of Donald Trump.

A man that overtly copies fascistic methods is …becoming more fascist. His Immigration and Customs Enforcement (ICE) gangs are rounding up and deporting hundreds of thousands of people (3.5m are in a backlog in the immigration courts) for not having the proper documents. Anyone resisting risks their lives.

Following the publication of the new US Security Strategy the Venezuelan President has been seized and is being used as leverage to enable the US to run the country, primarily so the US can gain access to the Venezuelan oil reserves.

Iran is being threatened with further attacks if it fails to comply with US wishes.

All countries trading with Iran face 25% tariffs.

Greenland, a member of Nato, is being threatened with annexation with additional tariffs applying to all countries who oppose this, including the UK – Trump is chickening out on this for now but the threats remain.

The US has withdrawn from 66 international organisations (and the World Health Organization) on the grounds that their aims are not in US interests. Most are fighting climate change. How quickly do they forget that only one year ago Los Angeles was burning. US Health insurance premiums have rocketed from January 2026 as Obamacare subsidies are withdrawn.

International Law is being left in tatters, seemingly the only constraint on Donald Trump being his own sense of morality. So far, few people are standing up to be counted. One is Mark Carney in his remarkable speech at Davos. Another is Jeffrey Sachs.

In Europe there is an inevitable reaction to these events. See European Ccommission on trends for 2026. ‘Strategic Autonomy’ is the term being used for diversifying trade and building self-sufficiency in defence and competitiveness.

In the UK the mood is turning sour for the government and for the Prime Minister in particular. Darts crowds at Alexandra Palace have taken to singing “Keir Starmer is a wanker”.

He is not helped by Wes Streeting’s continuing failure to improve much in the NHS for patients and voters. It is no comfort that Streeting is seen by some as a Prime Minister in waiting.

All of which gives me ample scope for filling this newsletter. After discussing these broad themes, I give my usual round-up of other events and documents that have caught my eye across Europe and elsewhere of relevance to readers.

US healthcare

Donald Trump has published his Great Healthcare Plan. Some excerpts are given below.

> *The Great Healthcare Plan is currently a highlevel White House framework that would require new Congressional legislation, so its provisions (sending subsidies directly to people, expanded HSAs, "mostfavourednation" drug pricing, extra transparency rules) have not yet replaced the WISeR model or the 2026 ACA/Medicaid changes outlined below in this summary of recent developments in American healthcare.*
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> *US healthcare is entering 2026 with tighter federal spending, looming coverage losses in Medicaid and the ACA (affordable Care Act) marketplaces, and the first wave of Medicare drug price negotiations, alongside ongoing legal and political fights over access and data use. Policy direction is broadly toward cost containment and subsidy rollbacks rather than coverage expansion.*
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> *Federal coverage and ACA changes*
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> • *A large "subsidy cliff" hit on 31 December 2025 as enhanced Affordable Care Act premium tax credits expired, raising marketplace premiums for millions and risking coverage losses unless Congress acts.*
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> • *Incentive payments for states to newly expand Medicaid under the American Rescue Plan have also ended, reducing federal support for expansion and putting pressure on nonexpansion and lateexpansion states.*
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> *Medicaid and Medicare in 2026*
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> • *Recent legislation and administrative actions are reducing the federal Medicaid match rate for expansion populations and tightening eligibility, with estimates that up to 10 million lowincome people could eventually lose Medicaid coverage and about 1.3 million more could be uninsured by 2026.*
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> • *For Medicare, 2026 brings higher Part A and B premiums and deductibles, worrying fixedincome retirees, while new payment and priorauthorization pilots such as the WISeR (wasteful and Inappropriate service reduction) model are being launched in selected states.*
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> *Medicare drug price negotiation*
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> • *The Inflation Reduction Act's first set of negotiated prices for 10 highspend Medicare drugs takes effect in 2026, with projected annual savings of about 1.5 billion dollars in outofpocket costs for beneficiaries and 6 billion dollars for Medicare.*
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> • *The program will add more drugs in later years, but a 2025 budget bill narrowed which products can be negotiated, which is expected to raise Medicare spending by at least 5 billion dollars relative to the original design.*
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> *New 2026 marketplace and immigration rules*
>
> • *From January 2026, the cap on how much ACA enrolees may have to repay in excess premium tax*

credits at tax filing is removed, increasing financial risk for people with volatile incomes.

- *Lawfully present noncitizens with incomes below the poverty line who are barred from Medicaid because of immigration status will no longer qualify for ACA premium tax credits, creating a new coverage gap for this group.*

Other current policy and legal developments

- *A federal judge recently ordered the administration to restore nearly 12 million dollars in funding to paediatric programs, including rural health and earlyidentification initiatives, pending ongoing litigation.*

- *States continue to drive major access debates, including renewed abortion litigation, statelevel challenges to federal health data sharing in the context of immigration enforcement, and a broader partisan fight over whether to revive stalled federal health legislation.*

NB references are Linked here.

Politico.com remains a very good source on what is happening in the US. I was particularly struck by news that American healthcare spending increased by 7.2% last year. But, then I realised that the report covered the last year under President Biden. Given the collapse in US government statistics we may never know what happened in 2025.

Another article that caught my eye was this one describing how billions are to be spent on US healthcare in rural locations. Plainly the Trump government regards the health budget as a means to reward its supporters in rural areas.

European healthcare

Recent European healthcare developments most relevant to UK readers centre on digital health and data, medicines and regulation, workforce and mobility, and renewed UKEU cooperation on health protection and research. These changes matter even postBrexit because they shape supply chains, labour markets and regulatory benchmarks that the UK is already aligning with de facto in several areas.

Digital health and data

- The EU has agreed a European Health Data Space regulation requiring all electronic health record systems in member states to be interoperable at EU level and to support citizens' crossborder access to their own data. Member states must create digital health authorities to implement the new rules, which will also enable controlled secondary use of anonymised data for research and policy.

- The UK is pursuing parallel goals through domestic initiatives such as the Data (Use and Access) Bill and the Federated Data Platform, aiming to drive interoperability via updated technical standards and improve data sharing across NHS providers. This creates strong incentives for UK suppliers and systems to track and mirror emerging EU interoperability norms.

Medicines, devices and regulation

- The EU is overhauling its pharmaceutical legislation with objectives including improving access to affordable medicines, reinforcing supply chains, promoting innovation and integrating environmental and antimicrobial resistance considerations. The reforms will simplify procedures for promising medicines, promote electronic product information and increase transparency around public funding and comparative clinical data.
- In parallel, the UK's MHRA continues to position itself as a fast and flexible regulator, for example through approvals of adapted COVID19 vaccines and a steady flow of new medicines, while also needing to manage divergence from evolving EMA frameworks that still govern most of Europe's medicines market. For UK policymakers and industry, the emerging EU framework will remain a key reference point for alignment or managed divergence in areas such as incentives for innovation, supplyshortage management and environmental standards.

Workforce and mobility

- A joint OECD–European Commission assessment in Health at a Glance: Europe 2024 highlights longstanding health workforce shortages across Europe, intensified by the pandemic, and sets out strategies to attract, train and retain staff, including reforms to working conditions and skill mix. Ageing populations and rising multimorbidity are projected to increase demand for health and longterm care workers, putting further pressure on countries that already rely heavily on international recruitment.
- The UK continues to depend substantially on EUtrained health and social care professionals, with UK regulators such as the General Medical Council and nursing and midwifery bodies maintaining recognition of many EU qualifications so that tens of thousands of EUqualified staff can keep practising in the NHS and social care. European workforce shortages and evolving EU policies on training, retention and mobility therefore have direct implications for UK staffing strategies and ethical recruitment debates.

UK–EU cooperation and health security

- A recent report from the NHS Confederation and the Independent Commission on UKEU Relations argues for a standalone UKEU Health Protection Agreement, separate from the Trade and Cooperation Agreement, focused on areas such as pandemic preparedness, vaccine cooperation, critical medicines shortages, and alignment on international standards for medicines and devices. The report notes that existing pragmatic arrangements, including the UK's association to the EU Critical Medicines Alliance and continued professional recognition measures, have already mitigated some potential negative impacts of EU exit on health systems.

- With the Trade and Cooperation Agreement scheduled for review in 2026, the authors see a political window for deepening collaboration on surveillance, joint procurement and research on topics like antimicrobial resistance and health security, framing this as a matter of geographical pragmatism rather than broader singlemarket or freemovement questions. For UK readers, this points to health as one of the more promising domains for constructive UK–EU reengagement in the near term.

System performance and strategic pressures

- Health at a Glance: Europe 2024 emphasises that European health systems are still managing the legacy of COVID19, including treatment backlogs, unmet care needs and renewed attention to resilience. It also underlines the fiscal pressures created by population ageing and rising expectations, underscoring the need for productivity gains, prevention and healthier longevity to moderate demand.
- These themes closely mirror debates in the UK about elective recovery, productivity, prevention and sustainable funding, suggesting that UK policymakers can draw on a growing European evidence base on workforce reform, digital health, longterm care and healthy ageing as they plan the next phase of NHS and social care reforms.

NB References can be found here linking to this text.

My interpretation is that while efforts are being made to mitigate Brexit the damage will compound over the years rather than reduce.

The price for an end to trade barriers is 'Dynamic alignment'" meaning acceptance of EU standards and supervision by the European Court of Justice. Which makes most people wonder, what was the point of Brexit?

The answer to that question may be in a more contentious and multi-polar world moving closer to Europe may be no bad thing. Most people refuse to admit to making mistakes, however.

UK healthcare

As of January 2026, Wes Streeting is the Secretary of State for Health and Social Care, but he is increasingly the subject of intense speculation regarding his ambitions to succeed Keir Starmer as Prime Minister.

While Streeting officially denies "plotting" a leadership challenge, several recent developments highlight the tension between his current role and his perceived political manoeuvring:

- Public Challenges to Government Performance: In a keynote speech on January 13, 2026, Streeting criticised the "excuses culture" in government and urged Labour to "get it right first time" to avoid further policy U-turns. These remarks have been widely interpreted by political analysts as a "shot across the bows" of the Prime Minister.

• Leadership Manoeuvring: Recent reports suggest Streeting has told colleagues he is not "plotting" but rather "planning" for the future of the Labour Party. Some supporters have reportedly urged him to make a leadership move before the local elections in May 2026.

• Criticism of Performance as Health Secretary: Detractors and former advisers have accused Streeting of being more focused on his public image than the "detail of his brief". There are claims that he has "subcontracted" significant portions of his role to advisors like Alan Milburn to focus on his own political standing.

• NHS Performance: Despite these distractions, Streeting's department reported in January 2026 that the NHS delivered 100,000 more appointments per week than under the previous government. However, the Institute for Government has labelled his reform approach "chaotic and incoherent," warning that waiting list targets remain unlikely to be met.

• Vulnerability in Ilford North: Critics point out that while he is a frontrunner for national leadership, Streeting holds one of the narrowest majorities in Parliament (just 528 votes), making his political future precarious.

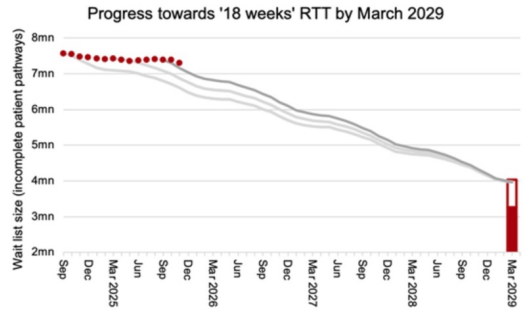
Streeting has previously admitted to having prime ministerial ambitions, stating in 2023 that he would "die happy" if he had the chance to lead the Labour Party.

His keynote speech to the Institute of Government referenced and linked earlier reveals to most that Streeting is confusing his own rhetoric for reality. His speech includes the following:

> *Over the past 18 months the NHS has improved in ways that haven't happened for over a decade.*
>
> *That is the result of the combination of investment and a modernisation agenda that is transforming the way the NHS runs. My approach to modernisation of public services is based on five principles:*
>
> - *Power to the people*
> - *Freedom to the frontline, with accountability*
> - *Shifting from crisis response to prevention*
> - *Productivity and potential unleashed through technology*
> - *Spending taxpayers' money with care"*
>
> When called to identify improvements his rallying cry was:
>
> *"For the first time in 15 years, waiting lists are falling. Ambulances are arriving faster and A&E waits are shorter. Patient satisfaction with GPs has gone from 60% to 75%. Fewer staff are leaving than at any point in the*

past decade, outside of the pandemic. The progress we are making in the NHS shows that things can get better."

The reality is that waiting times are only marginally better and what has been achieved (not much) was done while by ignoring efficiency and financial targets.

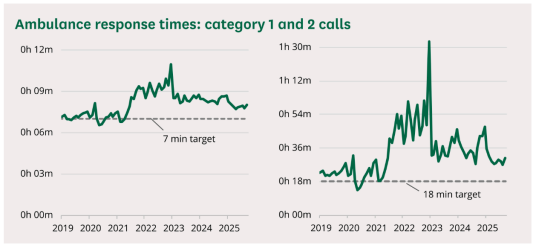


Source: HSJ latest figures

[He is belatedly discovering he cannot have his cake and eat it.] If every Trust reacts like [Morecambe] to hitting targets expect the waiting lists to shoot up. In my day all elective surgery was cancelled in the last three months of the year if savings had to be made. On the other hand if every Trust acts like [South Tees] expect the NHS budget to overspend.

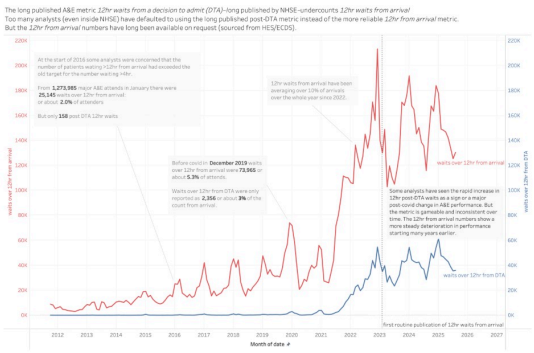
Ambulance response times are still too late for many people and still outside the target.

And, [according to Stepen Black A&E waits are not only very high but are underestimated]. Published figures (the blue line in the following chart) do not count the waits since admission to A&E (the red line) but waits for beds for admission to hospital. Reporting the latter seriously understates the problem.



Ambulance response times have risen, with the average response to a Category 2 call (for e.g. suspected heart attacks and strokes) at over 1 hour 30 minutes in December 2022 compared with a target of 18 minutes. Performance has subsequently improved but remains outside the target.

Source: NHS England, Ambulance Quality Indicators



This extract from a Guardian article of 5th January 2026 gives the game away on delays in receiving timely stroke care:

> *Given that stroke affects around 100,000 people a year in the UK, this translates into many thousands of patients annually whose outcomes could have been materially better with timely access to adequately staffed stroke teams.*

Nayak pointed to the annual reports produced by the Sentinel Stroke national audit programme team based at King's College London, which assess the NHS's performance in England, Wales and Northern Ireland against official guidelines for stroke care.

The most recent report found that it took four hours and 11 minutes to get someone who had had a stroke to hospital in

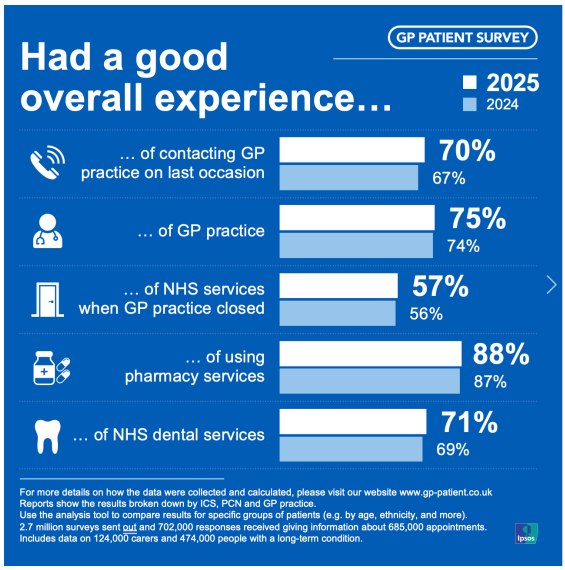
2024-25, longer than in 2023-24 and more than 90 minutes longer than a decade ago.

This is the problem with managing by anecdote. There may have been a momentary improvement in ambulance statistics but it's the working of the system as a whole that matters. And as a whole Streeting is not listening to those closest to the problem

And if he won't listen to the Stroke Physicians he won't like listening to the A&E surgeons or the Royal College of Nurses.

Promising to end corridor care by 2029 is neither good enough nor likely to save the Labour Government from more bad headlines. But even I have to admit the headline: '*NHS corridor care is 'torture' leading to patient deaths and staff nightmares*' will take some beating."

But Streeting is also not above misrepresenting statistics. Patient satisfaction with GPs went up from 74% to 75%. Not from 60% as he claimed.



Things can get better alright, but it will not be enough to fulfil Labour promises or satisfy future voters.

As for 'Power to the People'. Wes Streeting was probably not born then but for those of a certain age it evokes the slogan of Citizen Smith, leader of the Tooting Popular front. A story of a would-be idealistic leader worn down by reality. His script writer is having a little joke.

And 'Freedom to the Frontline' must be another embarrassing joke reminiscent of the "Arbeit Macht Frei" slogan over the entrance to Auschwitz.

I recommend he reads 'Freedom to Obey' by Johann Chapoutot, subtitled How the Nazis invented Modern Management, before going down that route. It looks like targets and terror from where I look, rather than local autonomy to do what's best.

'Shifting from crisis to prevention' implies that prevention is an adequate strategy to prevent crisis. Unfortunately, it is not. There is a pervasive crisis that needs to be addressed by more immediate measures than theoretical prevention, when all of the indicators show rising demand and inadequate capacity.

It's yet another example of Wilful Blindness.

As for productivity and potential being unleashed by technology, this naively assumes that this can be funded, will reduce demand and be cheaper than currently. All the international statistics show that the UK under-provides, already spends far more on prevention than other countries and delays new treatments because they are too expensive. No evidence is produced or plan for the transformative power of technology.

The NHS app was launched in 2018 and is making life better for some, but the NHS has not been transformed.

The evidence for AI remains equally elusive. American healthcare which presumably relies on better technology is

more expensive than UK healthcare and results in over-consumption of healthcare, with worse results.

Finally, the advocation to spend taxpayers' money with care invokes the household budget trope started by Margaret Thatcher.

Streeting needs to read a bit more of Richard Murphy and of Modern Monetary Theory. There are no limits to State spending if you have a sovereign currency. The only restraint is the wisdom to spend money wisely. There is no reason why the UK state could not finance the spending on more investment and improved capacity of the NHS (*After all it was done to rescue the banks in 2008 and for Covid in 2020*).

Other countries are already spending and investing more in their health and social care systems. The true obstacle is that the state taking more responsibility for healthcare delivery in the UK would cut the demand for private healthcare. Shortages, rationing and the back door are the features of the UK system and Streeting is not going to change that.

I suspect Streeting will try to become Prime Minister before his shortcomings for the NHS become apparent.

If you don't believe me, you might believe the Times, which reveals that Streeting seeking to overthrow the Prime Minister is not a figment of the imagination. Although there is an alternative explanation which sees Streeting being promoted as Peter Mandelson's revenge for Starmer sacking him.

Either way, God help us.

Round-up across Europe and elsewhere

On how the UK could stop the enshittification of IT – This remarkable article by Cory Doctorow ,(see the bottom of his wiki entry for his theory of the enshittification of IT), details that the UK is currently able to break away from the self-imposed in-juncture not to reverse engineer the products of the US IT industry (article 6 of the European Software directive 2001).

Not only would doing so free the UK from the tithes paid to the companies but help to improve these products for UK consumers.

Judging by the Prime Minister's response to the imposition of an extra 10%/25% tariff for the temerity of opposing the annexation of Greenland, this is unlikely but shows that options do exist from freeing ourselves of the UK's vassal state status and the over-reliance on poor quality US IT products.

More signs of disarray in the UK

As if things were not bad enough in the NHS the publication of two further documents in the last few days have underlined issues.

The first is the NAO publication providing an update on the New Hospitals Building programme and the second , the Impact statement of the NHS 10 year plan.

On the first the headlines are of 50% cost increases and delays of up to twenty years. But the kicker is not spelt out except as footnotes to charts: that approval to individual projects is subject to approval of revised business cases. None of the projects in waves one to three had yet achieved this up to the Outline Business Case (OBC) stage.

Given that costs have spiralled, and savings anticipated gobbled up in the meantime within cost improvement programmes, it beggars' belief that new hospitals will be affordable or deliverable. Although for hospitals falling down the 'do

minimum' is not an option, for most of the others the ' minimum option' is almost certainly the only viable option.

Expect further delays as the news is broken to doctors promised a shiny new, but unaffordable, hospital.

The other thing that struck me is that 357 public sector staff are employed on this programme and there is a 39% vacancy rate. This is not a problem as the posts will be filled by the commercial project teams queuing up for this work. But, it does mean that there will be no incentive to control costs and there will be no opportunity for local staff with local knowledge to contribute.

It also says that all senior staff associated with the project have resigned. I hope there is a record of their exit interviews.

The second; the impact assessment of the NHS 10-year plan, impacts on the first in that new hospitals risk being built too small if the heroic assumptions about the success of demand mitigation strategies are overwhelmed by the rise in population, increased morbidity and failures to reform social care (an issue ignored in both documents).

Roy Lilley provides a good review of the document in his 20 January edition of NHSManagers.net but what strikes me is the unquantifiable uncertainty that pervades the document.

There is no firm evidence for any of the claims within the plan. Increasing and improving more local health services may uncover more demand not reduce demand for hospital care, no assumptions are made about social care and the impact on beds, there is no evidence that spending more money on prevention actually counteracts the impact of increasing inequality, poor housing and the UK diet, based on industrialised food and excessive consumption of sugar, fat and salt and lack of nutrients.

Similarly spending more money on technology may identify more interventions not less and keep people with multi morbidities alive longer. Neither would justify cutting capacity, which is the financial assumption underpinning these plans.

It confirms rather what we all knew. That bold ambition is no substitute for a plan, wishful thinking is not a wise course of action in planning bed and staff numbers, and that it will not be too much longer before a new set of politicians and planners have another go.

As if the previous discussion was not bad enough there are reports the Treasury is implementing a new, stricter approach to NHS funding, with specific reviews designed to inform the 2027 Spending Review by targeting 'wasteful' spending and shifting care out of hospitals.

Key details regarding the planning for 2027 and the surrounding period include:

- ***Review of 'Wasteful' Spending:*** *The Chief Secretary to the Treasury is leading reviews into public service funding, including the health system, to identify and cut "wasteful duplication" and improve value for money.*

- ***Shift in Care Model:*** *The Treasury is pushing for a shift of care from hospitals back into community, primary care, and mental health services.*

- ***Efficiency Targets:*** *The NHS is expected to deliver 5% efficiency savings over the Spending Review period (covering 2026/27 to 2028/29) and is tasked with 2% annual productivity growth.*

- ***2027 Spending Review Focus:*** *The findings from these reviews will directly inform the 2027 Spending Review, which will determine the next multi-year funding settlement.*

- ***Administrative Cost Cuts:*** *The government has confirmed that UK government departments, which includes the Department of Health and Social Care, will face at least 11% real-terms reductions in administration budgets by 2028-29.*

- ***Capital Funding Pressure:*** *While some funding is ring-fenced for technology, capital allocations for 2026/27 to 2029/30 are planned on a broadly flat real basis, with warnings that overspends in 2026/27 will be deducted from 2027/28 capital allocations.*

While there are strong demands for efficiency and 'left-shift' funding (hospital to community), the overall Department of Health and Social Care budget is still projected to see average annual real-terms growth of 2.8% over the 2025 Spending Review period (2026/27–2028/29) – after 5% efficiencies are assumed.

Implicit in this is that the Treasury are not convinced that NHS spending cannot be cut further and that improvements in community, primary and mental health cannot be funded from cuts to acute care, administration and capital funding.

The evidence is that community care and primary care are supplementary to acute care, not a substitute and that the key problem at the moment is lack of capacity and resources to deliver sufficient healthcare. But you can take the Treasury to the evidence, but you cannot make them change their mind.

This is not a hopeful sign for the future.

Contrast with France – my local hospital in France by contrast is progressing well. It took 10 years to plan and is the largest hospital building project in Europe. But, it seems to have been built as planned in four years

> *Construction of the new Nantes University Hospital (Nouvel Hôpital de Nantes) on the Île de Nantes is a major project in France, with significant progress made on the site as of late 2025. It is scheduled to be completed and operational in* ***2027.***

The project, which replaces the existing Hôtel Dieu and Nord-Laënnec sites, aims to be a hub for research, education, and patient care.

This video gives a review of the scope and planning of the project. It received €400m from the European Investment Bank.

Eat your heart out Brexiteers.

Politico Europe is a good source of European healthcare stories. One that took my eye was, 'The EU's magical, mystery trade weapon — and other options to nail Trump'.

This lists the tactics available to the EU for handling Trump.

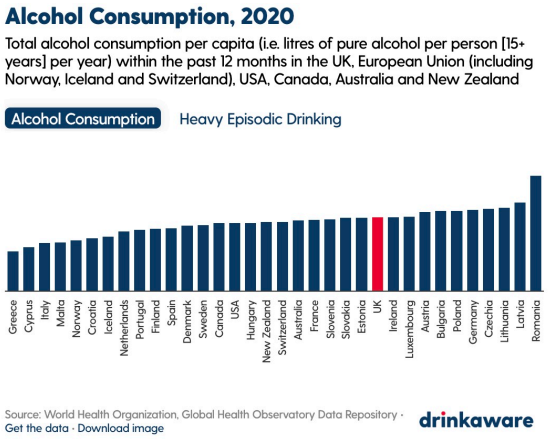
1. Unfreezing €93bn of tariffs due to be applicable from 7 February.
2. Invoking the Anti-Coercion Instrument. This all-purpose tool is meant to deter other countries from using trade tactics to extort concessions in other areas. It was designed for the Chinese but is applicable as an instrument that could be used against the USA. With it, Brussels can impose or increase customs duties, restrict exports or imports through quotas or licenses, and impose restrictions on trade in services. It also can curb access to public procurement, foreign direct investment, intellectual property rights and access to the bloc's financial markets.
3. Playing the China card. That is, following the example of Mark Carney in Canada of pivoting trade and diplomacy toward China.
4. Dumping US assets. The EU holds over €8trn of US securities. Even dumping a small proportion onto markets could cause a collapse in prices or deflate the dollar.
5. Play for time. Under the recent EU/US trade agreement the USA was due to benefit from reduced tariffs. Delay in ratification would delay the benefit for the USA.
6. Prepare for a Trade War. Despite the chance that the US Supreme Court may declare Trump's tariffs illegal the EU heads of State are preparing for the consequences of a Trade War.

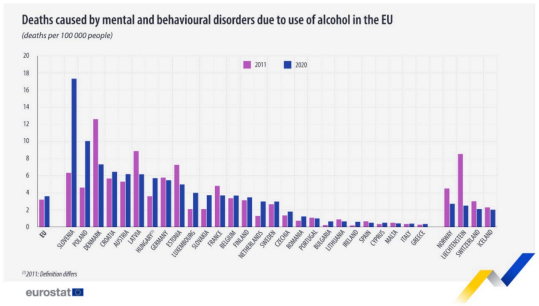
Another article to catch my eye was 'Alcohol too cheap in Europe as health impact mounts, WHO warns'. The message is that EU alcohol prices are too low,

Excise tax on beer in 2024, compared with 2022, measured in their percentage of the price of the most-sold brand.

UK excise duties on beer are about 22%.

For many it may be another good argument for harmonising with Europe. Higher taxes do not seem to be putting people off:





Source dataset: hlth_cd_asdr2

The UK figure for alcohol deaths in 2023 was 15.9 per 100,000 so was one of the highest in Europe. Probably induced by depression at the price of alcohol in the UK compared to Europe.

The final Article from Politico is on the effects of stopping use of weight reduction drugs, 'Weight rebound after obesity drugs shows need for long-term treatment, researchers say'.

The article claims research shows that use of modern drugs to control drugs is ineffective if use of drugs stops, rendering the costs of treatment as uneconomic. A blow for NOVO Nordisk shareholders and those looking for a quick fix to weight problems.

The European Health Observatory had published last year, **"**Primary prevention in hospitals in 20 high-income countries in Europe – A case of not "Making Every Contact Count"? in their Health policy review.

It shows the Europeans in a poor light compared to the UK in promoting prevention within hospitals. Whether it makes any difference is not assessed. But it is probably a good thing to do anyway.

Another article in the Policy review to take my eye was 'Private equity expansion and impacts in united states healthcare'. It details how private equity firms have sought profitable opportunities within the US healthcare market in recent years. Their success in this has not had any health gains however, resulting in calls for restrictions, and is raising alarms in Europe that such trends in the European Health market should be monitored and assessed.

More on Peter Thiel and AI

Controversy about Peter Thiel, Palantir and the claims for AI in the NHS continue. Campaigners see the embedding of Palantir's products within the NHS as not in the long-term interest of the NHS. See https://www.youtube.com/live/chhMKUGCb1k

Criticisms centre on the militaristic and security uses of its technology, its use of marketing hype on AI to conceal the difficulties of having a fragmented, commercialised and uncontrolled data structure in the NHS, and its foot in the door tactics involving free offers to wedge itself into the NHS, from which it may be impossible to remove them.

Just as the arguments around digital ID are not always rational it may be that the obstacles to use of Palantir are already too great.

But as another example of AI hype, I attach another example from Radio 4.

https://www.youtube.com/watch?v=c3IDecbBDdk

In this case it is said that AI can be used by companies such as Basecamp Research to cure all known diseases by understanding all known organisms not previously known to science. It all sounds plausible until you do the arithmetic involved in cataloguing billions of organisms, analysing billions of strands of DNA,etc.

A good contract if you can attract the finance....

I'm reading 'The Singularity is Near' by Ray Kurzweil, first published in 2005, about humans transcending Biology. It defines the Singularity as a future period during which the pace of technological change will be so rapid, its impact so deep, that human life will be irreversibly transformed. It is based on the law of accelerating returns or the inherent acceleration of the rate of evolution, with technological evolution as a continuation of biological evolution.

He obviously has not read the "Impact of AI on healthcare" by the European Commission.

It concludes:

> *There are a number of challenges that need to be overcome to allow for the effective and efficient deployment of AI across healthcare systems. Technological and data challenges such as data fragmentation remain a persistent issue, with healthcare systems struggling to standardise formats and ensure interoperability across platforms. This lack of uniformity limits the ability of AI tools to be seamlessly integrated into clinical workflows to process and analyse data effectively, diminishing their overall utility. Additionally, many healthcare systems rely on outdated IT infrastructure, which is insufficient to support modern AI applications, creating an additional barrier to adoption.*
>
> *The lack of standardised local performance testing protocols to address variations in performance across health care systems, show the added value of deploying AI systems in clinical practice, as well as the lack of post-deployment monitoring mechanisms to assess the long-term performance of AI tools and how end-users interact with them is another barrier to adoption as it often results in a lack of trust and confidence amongst HCPs. This is further compounded by the lack of transparency and explainability of AI solutions, often referred to as the "black box" phenomenon.*
>
> *The regulatory environment governing AI in healthcare, while robust, presents complexities that may contribute to hesitancy in AI deployment. The interplay of multiple regulations also raises challenges to deployers to navigate. Concerns surrounding data privacy, security, and liability further complicate the terrain. Organisational and financial challenges also hinder the deployment of AI solutions. The absence of clear financing mechanisms and reimbursement frameworks for AI-based systems*

makes it difficult for healthcare providers to justify investments in these technologies. Inadequate end-user engagement during the development of AI solutions can lead to tools that misalign with the practical needs of healthcare professionals or patients. Additionally, a lack of standardised models for assessing the local added value of AI tools limits deployers' ability to evaluate solutions in terms of hospital level performance and potential benefits.

Obstacles on assessing the local-added value is often compounded by unclear of strategic direction and clear AI deployment roadmap in some healthcare systems, which undermines efforts to integrate AI effectively.

Social and cultural factors also play an important role in delaying AI adoption. The level of trust among HCPs and patients regarding the reliability and ethical implications of AI is a key factor, which is often exacerbated by concerns surrounding job-security and overreliance on technology, as well as its impact on the doctor-patient relationship. One of the drivers of the lack of trust and concerns shared by HCPs and patients is digital health literacy and technological competence to understand how AI tools operate, their potential and limitations, and their use as supportive tools in the provision of care.

Personally, as a reader of the Eagle comic in my formative years, technological evolution has not yet caught up with images of limitless energy and progress postulated in the early sixties. The 40-year timetable for the harnessing of nuclear fusion is still forty years away 55 years later.

Science has not yet caught up with photosynthesis. Searching and finding sources in books has improved immeasurably but the wisdom in books has not necessarily been erased by time or technology.

But I will reserve my judgement until I have finished Kurzweil's book.

I suspect that as with these newsletters there will always be more to say.

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2026	Key Issues
January	Summary of 2025 newsletters, Reith Lectures, Thiel, Tipping points and the future according to McKinsey's. Productivity.
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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