Alternative European Healthcare Perspectives June 26
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It becomes ever more difficult to sum up the past month in a few words. Wes Streeting has gone, but we have another young, gay, PPE Oxford educated, London based, Secretary of State for Health, James Murray, whose only link to healthcare is that he suffered Myasthenia_gravis which required successful treatment at one of London's specialist hospitals at Queen Square. He is MP for Ealing North. This should be good news for Ealing hospital A&E department, which had been earmarked for closure in the notorious NW London 'Shaping a Healthier Future' and for specialist services.

But, he seems never to have done a proper job in his life and as a councillor specialised in Housing, with some success. Any man entering the Treasury at a young and pliable age however (he has been shadow Treasury Secretary and then Treasury Secretary since 2020) has probably been indoctrinated into believing the route to success is financial discipline and austerity. We will find out soon enough whether he is a breath of fresh air or more of the same. I am not optimistic and as always, we judge by action not CVs.

The local election results had told us mostly what we already knew: that the British government has run out of rope in its quest to reach a New Labour nirvana where the demands of the British people for improved public services and living standards are reconciled with the needs of world capitalism for lightly taxed, loosely regulated, speculation and exploitation. That dream has died on the political tomb of Peter Mandelson, New Labour's totemic figure. That Hartlepool Council, his old constituency, voted in a clean sweep of Reform councillors says it all.

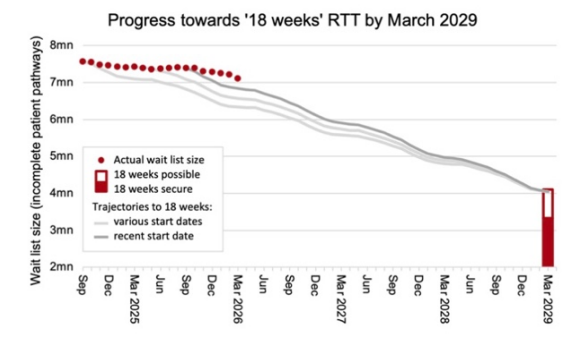
Keir Starmer presented on 11May his latest reset that he hopes can string out his administration and his own time in power a bit longer. No one believes it will work.

Worse, the country is divided amongst the options that exist. No one is presenting a compelling vision for the future that would unite and attract the support of the majority. Even Reform, now the largest party in the most recent elections, only secured about 27% of the vote. Non-voters were the largest category.

Where the country craves leadership, instead we have disunity and the crumbling of the United Kingdom itself.

In healthcare, while the Prime Minister wants to move closer to Europe, he doesn't mean towards European style standards of healthcare capacity and performance.

Wes Streeting had taken his eye off the ball actively preparing his leadership bid. It is hilarious that he claimed the small improvement in NHS waiting times as qualification for high office.



Source HSJ

His claim in his resignation letter that he was meeting his targets on waiting times is undermined by its reliance on late removals from the list, and a last-minute push to clear waiting lists by the year end. It is progress but a poor return for almost two years of leadership and four and a half years with the health portfolio (he was shadow health spokesman for Labour prior to the last general election).

The drama of the moment meanwhile has moved to the by-election in Makerfield which could see the return of the King of the North, Andy Burnham, to Parliament, which would put him in position to join the other candidates to replace Keir Starmer as Leader.

The thing is, Andy Burnham is a known quantity, known especially as a not very effective Secretary of State for Health in 2009/10 (during the dying days of Gordon Brown's government) and who was previously rejected as Leader in preference to Jeremy Corbyn and Ed Miliband.

The by-election result is not a foregone conclusion with Reform strong in the area. Burnham is already revealing his true colours by seeking to reassure the markets and by asserting he will maintain fiscal rules.

It won't work and Richard Murphy explains why. Murphy is also not very complimentary on Burnham's record. He also explodes the myth of subservience to the bond markets.

Meanwhile there is a pause for everyone to gather breath. The Straits of Hormuz are still blocked. Israel continues to bomb Gaza and Southern Lebanon. And the price of oil is over $100 per barrel, up from $60 prior to Trump's bombing campaign. Summer in Ukraine will encourage more killing despite efforts to rekindle peace talks. Britain openly engaged in a proxy war with Russia.

Given this bleak picture therefore my intention in the newsletter is to develop previous discussions: on whether it is possible to reconcile the strengths of European Social Insurance funding models with the strengths of superior tax-funded healthcare systems in Europe in order to improve the NHS. I will note the potential for a political campaign that could bring this about.

In addition, I will look at developments in the rest of Europe. Following a change of leadership in Hungary there has been change at the top in Bulgaria, a member of the EU. Macron may be seeing out his days in France; but that is not stopping him putting his men in prominent offices of influence in Europe. His chief of staff is being nominated for the head of the European Central bank.

I also draw attention to two books: John Kampfner's *Braver New World- the countries Daring to do Things Others Won't* and Daisy Fancourt's *Art Cure-The Science of How the Arts Transform Our Health*. There is hope after all.

As usual I round off with a miscellany of issues that have taken my eye or in the case of my colonoscopy my renewed attention.

Improving the NHS Funding model.

Last month I reviewed an IPPR report "Bismarck vs Beveridge revisited". It looked at the differences between social Insurance based funding systems in Europe and tax-based funding systems. It came down in

favour of the tax-based system despite the superior performance of social insurance-based systems.

While this judgement may be correct I have investigated the more interesting questions of what it is about such systems that generates differences in performance, what can be learnt from superior tax-based systems and how changes might be co-ordinated with political, legal, organisational, and managerial changes to enable NHS performance in the UK to be improved.

I used an AI SillyBilly to tease out the issues and arguments surrounding both systems and come up with ideas for how the NHS might adopt the positive features in both systems to a greater extent than currently. I asked the following questions of this AI tool:

- What are the advantages of European Social insurance funded healthcare systems?
- What are the advantages of Scandinavian tax-based healthcare systems?
- Can you devise a populist political strategy for changing the NHS in the UK to take advantage of the advantages of Scandinavian-type improvements but also some of the advantages of social insurance-based systems?
- What legal, structural and managerial reforms would you include to reinforce this strategy?
- Would you reinforce and make applicable EU laws on the role of statutory negligence to apply to politicians and civil servants failing to respond to unmet need?
- How would social care fit within this framework?

There ensued a lengthy discussion between me and the machine, which I have linked here.

The tool got down to the heart of the matter and came up with a plausible political strategy for improving the NHS way beyond the rather timid suggestions from the IPPR in *Bismarck vs Beverage revisited* for increased capital spending.

Admittedly I gave it some hints in the way I framed questions but my suggestion for James Murray is that he uses this and seeks further clarification.

I look forward to seeing what he comes back with, but the main thing I took is that progress in the UK will be linked to popular political initiatives and innovative changes of direction, not merely more of the same.

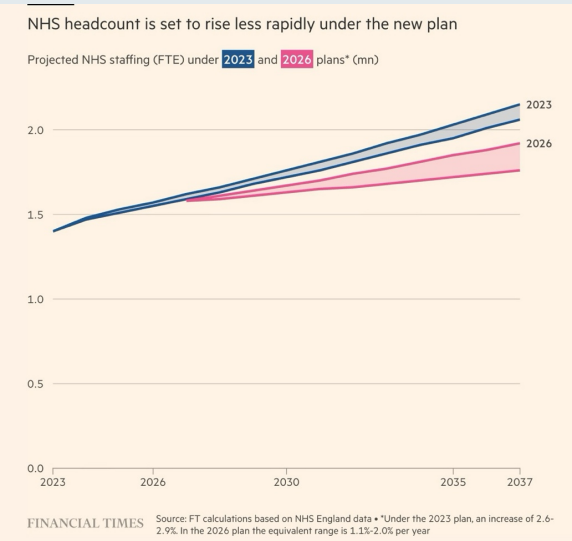
This blog from the Nuffield suggests the same, albeit more tentatively. There are dangers in the use of AI as these responses to Richard Dawkins in the Telegraph and to the increasing use of AI in medicine in the BMJ make clear.

But, the test is in whether it can deliver. I'll let you the reader be the judge of that.

As an as aside I note in the FT of 19 May that the government has discovered AI and it will be used to fill the gap in its workforce strategy.

The BMA are not pleased. My theory is that staffing savings are the necessary price used to pay for the enormous costs of AI the government is undoubtedly being asked to pay for its use.

This is not going to end well and will likely be the first big test for Master Murray.



Developments across Europe

Hungary: The End of the Orbán Era

Following a historic, landslide victory by Péter Magyar's Tisza Party, Viktor Orbán's 16-year rule came to an end. Taking office as Prime Minister, Magyar has immediately shifted Hungary back toward a pro-EU, democratic stance.

- **EU and Ukraine Relations:** In a major victory for European unity, Hungary is no longer blocking EU foreign policy or financial aid to Ukraine. The new government promptly resolved regional deadlocks, allowing a €90bn EU loan for Ukraine to pass.
- **Healthcare Overhaul:** The Tisza Party has launched a comprehensive healthcare restructuring to fix Hungary's historically underfunded system. Key promises include re-establishing an independent health ministry, slashing value-added tax (VAT) on prescription medicine, and raising healthcare spending to 7% of GDP to lift national life expectancy

Bulgaria: Radev's Absolute Majority

Breaking a multi-year cycle of unstable coalition collapses, Bulgaria's election resulted in an unprecedented absolute majority for the newly formed Progressive Bulgaria party led by Rumen Radev. Radev stepped down as president to assume the role of Prime Minister.

- **EU Friction Risks:** Unlike Hungary's pro-EU pivot, Radev is a pro-Russian Eurosceptic. European leaders express concern that Bulgaria may become a new "Trojan horse" within the EU, potentially creating friction over future joint ammunition procurement and Eurozone integration.
- **State-Driven Healthcare:** Backed by his massive parliamentary majority, Radev is advancing a "patriotic centralist" platform. This involves heavy state intervention in healthcare to solve chronic underfunding, raise low medical salaries, and reduce the massive 35% out-of-pocket medical costs currently paid by Bulgarian citizens.

France

In order to bolster his legacy Emmanuel Macron is looking to replace the Head of the Bank of France with his own Chief of Staff, Emmanual Moulin.

He is being accused of 'Institutional lock-in'. Opposition parties are furious, accusing Macron of aggressively placing ultra-loyalists into top independent jobs (such as the Constitutional Court and national audit watchdog) to insulate the state's structures ahead of the 2027 presidential election,

which the far-right National Rally is currently projected to win.

Opposing lawmakers need a three-fifths combined majority to successfully veto and reject Moulin's nomination. If blocked, it would deal an embarrassing 'lame-duck' blow to Macron's administration; if approved, Moulin will take his seat on the ECB Governing Council in June. He would be well-placed to influence the replacement for the current head of the ECB, Christine Lagarde, herself rumoured as a potential French Presidential candidate.

Spain

A nationwide healthcare strike week is actively underway across Spain, beginning May 18, and scheduled to run through Friday, May 22, 2026. Organised by the Spanish Confederation of Medical Unions (CESM) and various regional groups, this is the fourth phase of a recurring monthly industrial action that began in February. Over 176,000 doctors and healthcare professionals **are** participating, pushing back against the Ministry of Health's controversial *Estatuto Marco* (Framework Statute).

The latest updates regarding the strikes highlight several critical developments:

- **Madrid Enters fourth Week of Indefinite Regional Escalation**

In the Community of Madrid, doctors represented by the majority union **Amyts** have entered their fourth week of an indefinite strike. Striking workers are holding daily protests in front of major medical hubs, including:

- **Hospital Clínico San Carlos**
- **Hospital de Móstoles**
- **Hospital de La Princesa**
- The **Ministry of Health** headquarters financial evaluations estimate that the Madrid regional healthcare disruptions have already accumulated costs exceeding **€12.8 million.**
- **Severe Operational Disruption Across Hospitals** The ongoing industrial action is severely impacting public healthcare logistics across Spain:

Mass Cancellations: Thousands of elective surgeries, specialist consultations, and routine appointments are being postponed daily.

A&E Backlogs: In regions like the Balearic Islands, regional Health Minister Manuela García publicly criticized the strike's impact, noting a sharp rise in patients awaiting beds in the Accident & Emergency (A&E) department at Son Espases University Hospital in Mallorca.

Next Scheduled Phase: If a negotiation breakthrough is not achieved this week, the next national rolling strike week is already locked in for **15–19 June 2026**.

- **Patient Legal Protections and Emergency Status**

Spanish law mandates that regional health services enforce minimum essential coverage during public sector walkouts. This is but a local manifestation of a general European healthcare staffing crisis as highlighted by the European Healthcare Observatory and the WHO.

You can see why Wes Streeting wanted no part of it. There are some battles you cannot win.
It's easier to plot to be the next Prime Minister.

Book Reviews

My first book choice leads on naturally from our regular examination of European health systems. It is John Kampfners *Brave new World-The countries Daring to Do Things others Won't.*

I don't know how he has done it, but he has persuaded his publishers to pay him to travel the world and draw lessons from those places that have appeared to do better at functions we struggle with in the UK.

It's a heterodox collection of essays looking at:

- Care of the Elderly in Japan centring on the workings of the Long-term Care Insurance system introduced in 2000.
- Promoting Multiculturism in Canada: and where it went wrong, after the government doubled immigration quotas, without providing housing or healthcare to match.
- Social Housing in Vienna where 60% of residents live in subsidised public housing.
- Education in Finland where teachers are taught to help young people to learn how to think rather than hand down absorption of narrow silos of information. Result: A Finnish high school graduate has pretty much the same skills as an English university graduate.
- The Taiwanese Healthcare system: which had un-apologetically adopted a cherry-picking policy towards other countries healthcare systems when it established its healthcare insurance system 30 years ago. They have no GP's as we know it . Patients have free access to any doctor at any time. There are no gatekeepers, with decisions the responsibility of individuals. Doctors are paid for consulting with patients. The more they see the more they get paid. The money follows the patient, and the patient goes out of their way to travel to the best specialist centres. This together with a slick IT infrastructure ensures a cheap and efficient healthcare system.
- Costa Rican environmental restoration. It's record shows that necessity is the model of invention. As one of the countries most vulnerable to climate change it has done the most to restore its environment and the mangroves. The Uk by contrast its using its newfound post Brexit freedoms to avoid EU Environmental controls to speed environmental destruction.
- Morocco shows how a country can respond quickly to external energy shocks to benefit from shifting to green energy sources. The tale of the plan to supply the UK with solar energy is telling of the consequences of blowing up the Nord Stream 2 pipeline preventing Russia from supplying Germany with cheap gas.
- India tells the story of how new technology can transform the lives of millions of poor people through secure communications and payments systems.

- Estonia shows how a state can transform itself by switching to digital forms of administration.
- Romania, via the region of Timisoara, has developed new forms of politics that delivers better outcomes for citizens. It required courage.

The final essay is a telling lesson for the UK. The old ways are long gone, and solutions require planning for the long term, being candid with citizens.

Let's hope the Prime Minister, whoever it will be, can read the book, and act on it.

My second book is Daisy Fancourt *Art Cure -the Science of How the Arts Transform our Health.* Being of the glass half empty school of thought myself, it is good to be reminded that the Arts helps us live longer, can unlock health and happiness and can even save lives.

In Art Cure, Fancourt (she is Professor of Psychobiology and Epidemiology at University College London) reveals the life-changing power of the arts: songs support the architectural development of children's brains. Creative hobbies help our brains to stay resilient against dementia. Visual art and music act just like drugs to reduce depression, stress and pain. Dance builds neural pathways for people with brain injuries. Going to live music events, museums, exhibitions and the theatre decrease our risk of future loneliness and frailty. Her book not only argues the case but provides backing with reference to hundreds of studies contained in over 70 pages of notes.

The more you think about it the more it should inform commissioning decisions on support for babies and infants with developmental issues, including dyspraxia, speech and language issues, but also for mental illness, ageing symptoms, mobility issues etc. etc.

In my experience the urgent drives out the best and I can but endorse her final words:

> *Maybe, through campaigning, fundraising, educating and lobbying, you and those around you can help schools, workplaces, hospitals and nursing homes embed the arts in their daily activities so the arts become more accessible, more available -there at those moments of stress, loneliness, pain or illness when we most need them. Maybe, from the ground up, we as a collective can help our societies embrace the arts, culture and creativity and realise the remarkable impact they have. For sickness. For Health. For all.*

UK government funding for the arts lags significantly behind most of Europe. While the UK spends approximately 0.46% of its GDP on culture, the European average sits at 0.76%. European countries treat arts as a fundamental public good, whereas the UK relies increasingly on private and lottery funding.

Between 2010 and 2022, per-person cultural spending by the UK government dropped by 13%. Local authority arts budgets saw severe cuts. Countries such as Germany, France, and Belgium significantly increased their culture budgets—by 33%, 27%, and 40% respectively—during the same period the UK was making cuts. The UK needs a reset alright.

Stimulated by reading the book I went to see *Holding the Line* at a community theatre in Newcastle. It was a play about the NHS 111 service and was terrific on many levels. If it comes near you book early. You won't regret it and you may live longer.

Round up from across Europe and elsewhere.

The role of private equity in social care

The FT points out in its 6 May edition that spending in the UK on specialist providers has increased at 20% more than inflation between 2022/23 and 2024/25 to £3.7bn in 2024/25. More than half have private equity owners.

Witherslack, which operates 39 special needs schools and 38 care homes for children, recorded the highest annual ebitda margins of 26 per cent while profits grew by nearly 30% in the year to March 2025 to £44mn. Witherslack is majority owned by Mubadala Capital, an arm of Abu Dhabi's SWF (Sovereign Wealth Fund).

Other providers, including Polaris, which is owned by Capvest Equity Partners, and Keys Group, which is owned by G Square Capital, have also reported rapidly rising profits and ebitda margins of 15-20 per cent.

(Note: **EBITDA** stands for **Earnings Before Interest, Taxes, Depreciation, and Amortization**. It is a popular financial metric used to evaluate a company's overall core operational profitability and financial health by stripping away the costs of financing, accounting rules, and tax environments)

Samantha Jones, permanent secretary at the Department of Health and Social Care, had been a chair and director of Keys Group and an operating partner at G Square Capital before taking up her role as department head last year."

In case you were wondering whether this was a UK thing I would recommend reading *Private equity investment in long-term care in Europe: trends, impact and policy options* from the European Health Observatory.

Private equity (PE) plays a major role in the European social care sector by using external capital to acquire, consolidate, and commercialise care homes, clinics, and domiciliary services. By buying fragmented providers and merging them into large corporate chains, PE firms aim to streamline operations and generate high returns for their investors—often through leveraged debt and real estate sales—before selling the business within three to five years.

Critics point to:

- Quality of Care: Critics and healthcare researchers argue that PE's short-term focus on profit extraction can lead to cost-cutting, particularly in staffing levels, which has been associated with diminished quality of care and worse outcomes for residents.
- Working Conditions**:** Care workers in PE-backed facilities often face low pay, poor working conditions, and high turnover rates as operators look to reduce payroll expenses to maximize profit margins.
- Financial Vulnerability**:** The heavy debt loads PE firms place on care companies to finance acquisitions can make these businesses vulnerable to economic downturns, potentially risking service continuity.

This is the price of government passivity in the face of rising demand and shortages of capital.

It seems that the notoriously fragmented UK healthcare IT is also in the firing line, with French suppliers competing for the contracts.

Palliative Care - The BMJ reports:

The UK ranked top in world comparisons of the quality of death and dying in 2010, 2015, and 2021. However, a 2025 report suggests that around 30% of people who died in the UK in 2023 had unmet palliative care need. It estimates this figure will rise by 23% by 2050 if nothing changes. Inequalities persist, especially for older people, those experiencing social deprivation, people from ethnic minorities, and those with illnesses other than cancer. While needs based referral to specialist palliative care services are most effective at three to six months before death, patients globally consistently access palliative care services too late, with a median of 18.9 days before death, often because of poor recognition of needs or availability of services.

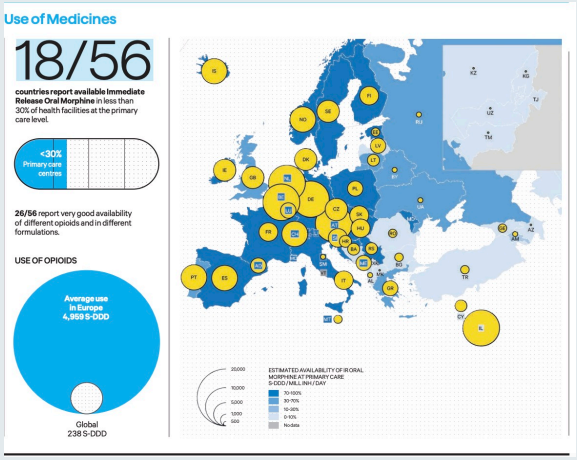
Specialist palliative care reduces hospital bed days, deaths in hospital, and healthcare costs, but it cannot work in isolation. The number of general practitioners per head of population is falling, district nursing numbers are in sharp decline, and adult social care is struggling to cope with rising demand. Less than 20% of the £22bn of UK public expenditure for people in the last year of life was spent in community care, with increasing reliance on unpaid carers. Collectively, these issues present a major challenge.

The Health and Care Act 2022 specified that integrated care boards in England have a legal responsibility to commission health services that meet their population needs. The National Institute for Health and Care Research invested £3m into a policy research unit for palliative and end of life care to drive service improvements. In 2025, the Commission on Palliative and End of Life Care made 10 recommendations, including mandating and funding 24/7 specialist palliative care that is coordinated with general care and improving community services. While specific to England, these recommendations are relevant across the devolved nations. The challenge lies in implementation, and the leadership and resources to make it work sustainably.

Coverage is patchy across Europe. You might like to see the Atlas of European Palliative Care.

Key Findings
Education Gaps: Only 15 countries have integrated palliative care into all medical school curricula.
Access to Medicines: While 83% of Western European countries provide broad access to oral morphine, only 30% of countries in Central and Eastern Europe do the same.
Legal Recognition: Only 9 countries have enacted laws specific to palliative care. Austria recently recognised it as a legal right and committed to public funding.
Paediatric Services: 41 countries now offer some form of palliative care for children, an increase from 38 in 2019.
Service Availability: The number of specialised palliative care services has grown by 10% since 2019, yet major regional disparities remain.

Be careful where you are planning to die:



European Co-operation

The BMJ makes a call for both Europe and the UK to step up to fill the breach in managing global health as a result of the withdrawal from the WHO of the US.

At a time when the threats to global health are increasing in scale and intensity, investment in global health is diminishing. Fernández and Dijkstra's analysis in The BMJ exposes a central paradox in contemporary global health governance that holds lessons for others: the European Union aspires to lead on pandemic preparedness and health security yet has struggled to translate its considerable financial, regulatory, and political capacity into credible leadership. In the current context of a fractured geopolitical landscape and needed leadership, this assessment should be read not simply as an institutional critique, but as a warning issued at a moment of profound global vulnerability.

The EU's difficulties coincide with the US's withdrawal from the World Health Organization (WHO) and reduced engagement in other multilateral health initiatives, as well as with only partially absorbed lessons from covid19. Persistent weaknesses in preparedness for the next disease pandemic, inequities in access to countermeasures, and a continuing erosion of trust between countries remain evident. These challenges are unfolding within a deteriorating global order, shaped by the Trump administration's unpredictability and disregard for international law, which has accelerated fragmentation of the postwar multilateral system and intensified geopolitical rivalry.

In this context, health is increasingly subordinated to security, industrial, and foreign policy priorities rather than treated as a domain requiring collective global action. Pandemic preparedness is framed as national resilience or technological advantage, not a shared global good. Leadership vacuums in global health governance therefore matter: they deepen inequities, weaken early warning and response systems, and increase insecurity for all. This shift towards securitisation of health reflects Europe's own political constraints: internal divisions, heightened sensitivity to industrial competitiveness, and a desire to preserve internal cohesion have fostered an inward-looking approach to global health engagement, particularly in negotiations that require redistribution of power, resources, or trust.

The World Health Assembly (WHA) in May 2026, therefore, arrives at an unusually consequential moment. Decisions taken in Geneva this year will shape surveillance systems, access to countermeasures, and the capacity of future emergency responses on which clinicians depend. Core annexes of the pandemic agreement—a rare international health treaty, negotiated since the end of covid-19—remained unresolved in the run up to the WHA; trust between countries in the global north and global

south is fragile; and WHO continues to face sustained political pressure and tightening financial constraints. Although attention may focus on a single treaty, the implications are far wider. This WHA will test whether multilateral health governance can still function amid geopolitical rivalry, fiscal retrenchment, and declining solidarity.

It seems that the neoliberal agenda of destroying social institutions is gathering pace. It will be worth paying attention to the World health assembly. I'll return to this next month.

European Health Observatory – More on Paying for health -this is hot off the press.

It's a very useful summary of the issues involved in financing healthcare. It is recommended as additional bedtime reading for James Murray. It provides these lessons:

> *What are the lessons? The full volume presents health financing experience and case studies from diverse countries across income levels and regions to understand the options for addressing challenges across the three main functions of health financing (Box 0.1.1). Looking ahead, challenges in revenue raising involve selecting appropriate funding sources that generate adequate and stable resources, as well as ensuring equity in financing, particularly for lower-income groups who should pay only as much as they can afford. Pooling challenges encompass the inclusion of diverse population groups in risk pools with uniform financial contributions and health benefits, implementing necessary financial transfers between pools, and defining realistic benefit packages that adapt to emerging medical innovations. Purchasing health care necessitates payment mechanisms that are aligned with purchaser objectives, incentivizing high-quality care and promoting continuity of care in cases involving multiple providers. The COVID-19 pandemic underscored the imperative of global cooperation in financing public goods such as pandemic preparedness. There is no "best" way to finance a health system; each health system has its own needs, constraints, preferences and contexts that will influence what the optimal revenue raising, pooling and purchasing strategies are. However, health financing systems that successfully push towards UHC (Universal Health Coverage) typically share some common traits of good governance such as clear priorities, robust financial regulations, effective monitoring mechanisms, transparent decision-making processes that involve and engage stakeholders and a commitment to equity and fairness in resource distribution and procurement. These features https://www.gov.uk/government/publications/health-bill-icbs-as-strategic-commissioners-fact-sheet/health-bill-icbs-as-strategic-commissioners-fact-sheet can prove crucial in developing strategies to address the challenges listed above and move towards the ultimate goal of ensuring that people have access to high-quality, affordable, accessible, efficient and equitable health services that they need.*

Box 0.1.1 Key challenges for the future in financing health systems for UHC

Revenue raising

- Securing reliable revenue sources of adequate size to fund the desired health system, especially as populations age and informal work sectors grow in many places.
- Reducing user fees and OOP payments, especially for lower-income groups and those in poorer health, by increasing the reliance on public sources of funding.
- Assuring that revenues are raised equitably, with the largest financial burden borne by those who can most afford it rather than those who need the most health care.

It may not have all the answers but does suggest there are more alternatives than normally discussed in the UK.

Latest on Healthcare Commissioning / Planning in the UK and Europe

The UK government have produced a policy paper on the ICB's role in Commissioning. I groaned when I read it. It seems to be localising the task to the lowest level of neighbourhood. This repeats the problem of fragmentation in the UK system.
I checked how they do planning in France and Germany. In France healthcare planning is the responsibility of 18 Agences Régionales de Sante and in Germany the 16 individual federal states.

It begs the question of whether planning is different to commissioning?

- The answer is yes and no.
- **Planning:** This is the *thinking and strategy* phase. It involves assessing the health needs of a local population, studying data, and determining what services, capacity, and workforce are required to meet those needs.
- **Commissioning:** This is the *entire, end-to-end process* of managing healthcare for a population. It encompasses the plan, but goes much further to include buying the services, securing contracts, monitoring performance, and evaluating health outcomes.

Finally, my polyps were non-cancerous, but I haven't had a good reason for why the threshold for the bowel cancer screening test in the UK is so much higher than in the rest of Europe (s*ee my discussion last month*), or why the UK **does lag behind** much of Western and Northern Europe in terms of long-term survival. Patients diagnosed with bowel cancer in the UK are more likely to be diagnosed at a late, advanced stage, leading to five-year survival rates that remain below the European average. Tip: *At the slightest unusual sign ask for a symptomatic test where the threshold is much lower than the standard screening test.*

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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
May	Negotiation: Decision making criteria, Medical Workforce, European strategic realignment. Insurance vs Tax Funding: the evidence. Cancer prevention, Sleep Dementia.
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.

Database of Alternative European Healthcare Perspective 2021-2024