Alternative European Healthcare Perspectives July 2026

Roger Steer

It's another of those months when lots of things are going on. It's not every month that the UK Prime Minister is forced to resign.

On the international front the big news at the end of May was the conclusion of the World Health Assembly (and the continued failure to resolve war in the Ukraine and in the Middle East -although a peace deal was struck on 17 June).

More prosaically here in the UK we saw at the end of May and early June a flurry of reports, books and essays, all trying to promote something.

In the political sphere we have had essays from the Tony Blair Institute, Andy Burnham and the Prime Minister himself; all wittily described as drone warfare by Ed Davey.

The content stakes out known positions: In the case of Blair that he is in the pocket of Big Data desperate for juicy government contracts to help pay for their mindless speculation on AI; for

Andy Burnham that he can be a more human face for Labour; and, for Starmer that everything is fine and dandy and going according to plan. Even Dominic Cummings has arrived late to the party, suggesting that Britain can learn from other countries!

There are the usual round of book promotions: Jeremy Hunt on *Can We Be Rich Again? The Surprising Potential of Britain's Economy*; Marriana Mazzucato *The Common Good Economy: A New Compass*.

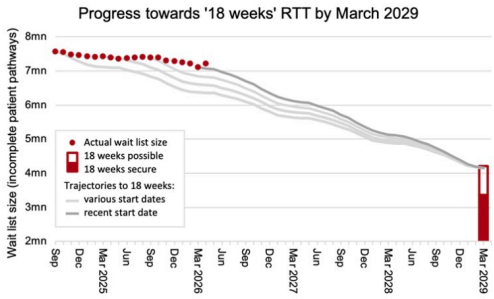
Meanwhile a significant (it has more than 200 pages) report has come from the Government on young people and work. It highlights the increase in the number of young people neither in education, employment or training (NEETs). It resurrects the old question of why things are so much better in the Netherlands.

More significantly (perhaps) the Government unveiled its version of the new Green Book, a new Magenta Book, and have trailed a review of the Social Time

Preference Rate (STPR) — the Green Book discount rate — to ensure it is not undervaluing the long-term benefits of proposals compared to short-term effects. The latter has not been published yet but is expected at the end of June.

Most of these publications ignore health and social care. With the honourable exception of Mazzucato, health and social care are viewed as welfare to be paid for by business and minimised as a cost to business, the sector that holds the fate of the nation in its lap.

All this was overshadowed by more government ministerial resignations and the results of the by-election in Makerfield. Since then, the Labour Party have clutched at the straw represented by Andy Burnham as its last hope of clinging onto power at the next general election. It is now likely there will be a coronation for Burnham with Wes Streeting's meagre chances of replacing the Prime Minister not helped by the predictable bounce back in the size of waiting lists.



The March year-end sprint benefited from a surge in unreported removals, as trusts checked their waiting lists and removed patients who were recorded there in error. This surge was also largely reversed in April, which could indicate that trusts were running out of errors to find.

I finish with a roundup of other issues gleaned from around Europe and the World pertaining to health and social care, albeit obliquely.

World Health Assembly

The WHO is a big deal. Despite Trump withdrawing funding from the organisation, 194 countries participate. It has a funding shortfall.

> *The world spends US$ 9 trillion a year on health. A fully financed WHO over 4 years requires a 1000th of that amount. In return for that investment, the world gains authoritative, evidence-based norms and standards on every facet of health, a framework for access to quality-assured health products, early warning of outbreaks, support to national health systems in every country, and health workers and supplies on the ground when crises hit. To deliver the results*

promised by WHO for 2025–2028 requires its budget of US$ 11.1 billion to be fully and flexibly funded. Member States have responded to the call to action to establish a stronger WHO by agreeing to increase their annual assessed contributions. Now, we call on Member States and partners to fill the US$ 7.1 billion gap needed to achieve the GPW14 goals. Ref WHO

In order to attract funding, the WHO has laid out its investment case. Apparently for every $ spent $37 is delivered as benefits.

The Assembly met in Geneva in late May. For those interested I refer you to the website. Each day's proceedings links to a host of linked documentation. The most significant was this. It refers to the Strategy for the Economics of Health for all. (Mariana Mazzucato (see later) seems to have had a large hand in devising the approach.)

And these weighty remarks by the Director General at the end of proceedings,

We haven't solved every problem this week. That's not the point. But on each one, we have taken a step forward.

You have adopted resolutions and decisions on key health issues: diagnostic imaging; emergency, critical and operative care; haemophilia and other bleeding disorders; NTDs; pharmacovigilance; precision medicine; radiation; steatotic liver disease; stroke; transplantation; tuberculosis – and more.

You also agreed to reform the global health architecture through a Member State-led, WHO-hosted joint process.

You have met this week against a backdrop of outbreaks, conflict, division, uncertainty and constrained resources. That is exactly the point of multilateralism: not to pretend the difficulties of our world are not there, but to address them together; not to erase divisions, but to transcend them; not to supersede national sovereignty, but to reinforce it. Because every nation is healthier and safer when all nations are healthier and safer.

Many of you represent countries under immense pressure. And yet, throughout this week, you have found ways to work through differences, and to reach common decisions. That is not automatic. It is a choice: a choice to prioritise health; a choice to recognise that no country can address today's health challenges alone; a choice to work through WHO, not only as an institution, but as a shared platform for shared action.

As if to emphasise the point an Ebola outbreak occurred in the Congo at about the same time as the WHA. As leading spokespersons have pointed out funding cuts have weakened responses. For more commentary read here.

Solutionism

As noted above **Tony Blair** has been playing with fire in promoting

AI as his latest solution to the problems of the nation. It's nothing new as both he and Wes Streeting have been promoting the same solution for some time. The problems with their approach, Solutionism, are discussed in an essay of my own here.

The concept of solutionism, as Evgeny Morozov developed it in *To Save Everything, Click Here* (2013), is worth stating precisely before applying it. Morozov defines solutionism as, '*recasting all complex social situations either as neatly defined problems with definite, computable solutions or as transparent and self-evident processes that can be easily optimized — if only the right algorithms are in place*.'

The key word is recasting. Solutionism is not merely an enthusiasm for technology; it is a prior act of intellectual sleight of hand in which the problem is redefined so that a technological solution becomes not just plausible but inevitable. The political work is done before the app is even designed.

The fact is the NHS has a capacity problem and tinkering with the back office isn't going to cure that problem. It's a deliberate distraction and prevents other more immediate action from being taken. The last thing the NHS needs is more marketing material from technology companies who in living memory supported the abortive NPfIT programme and who desperately need big contracts to fund their speculation in AI.

Neither Blair nor Streeting refuse funding from such organisations and despite there being some benefits from adopting new technology the jury is still out on whether the changes implied will be either economic, effective or desirable. Meanwhile back in the US, who we might think would be early adopters, they are recording large increases in staffing recruited in health and social care.

Andy Burnham by comparison has been giving out signals, as per his essay to the Times linked earlier, identifying neoliberalism as the problem, failures of regulation and the need for a stronger state to address market failures. As a result, he has come in for a lot of criticism and he has rowed back.

But the cat is out of the bag. I was at the Gary Stevenson presentation of his Channel 4 documentary (to be broadcast in mid-July) at the Sheffield Documentary Film Festival at the weekend. It was a damning expose of the increasing

wealth inequality in the UK and the need for an annual wealth tax. The most significant revelation came in the Q&A however in that he thinks Burnham and a rejuvenated Labour is the answer to stopping Reform. He has 3.2m followers on social media combined. This could be influential.

The Prime Minister (Keir Starmer still) on the other hand was assuring everyone that his plan is working, a view repeated in his resignation statement. But he is let down by claiming as evidence that waiting lists are coming down. He obviously had not been warned they are going back up again. Even his loyal Defence Minister, John Healey, had given up on him. Everyone else had been twiddling their thumbs until the by-election result comes through. A new Prime Minister will be my fifth since I started this newsletter and the seventh in ten years.

The Times they are a Changin

4. Jeremy Hunt is equally convinced that the UK is on the right track. In his new book he gives answers to how Britain can be rich again. Unfortunately, he serves the same dish that he has been serving for a long time, and which consigned the Conservative Party to electoral oblivion.

I have tried to read the book but it's such a mishmash of dubious comparisons (he charts the growth of Louisiana against the UK attributing the success of Louisiana to a low tax regime and the failure of the UK to a failure to reduce taxes) and twisted logic (he cherry picks the superior performance in other countries without getting to the reasons why) that I suggest you look at the 20 things he proposes with a sceptic's eye.

Overall, it's a melange of measures unlikely to have much effect while austerity thinking rules the Treasury, and which advocates spending a fortune on AI as a substitute for improving government services.

Mazzucato in her 2026 book The Common Good Economy: A New Compass by comparison extends the thinking from her previous books looking to restore an effective state rather than Starving the Beast. She argues that conventional economics only fixes problems like climate change or poverty after markets fail, rather than treating them as shared goals from the outset. She contends interconnected crises haven't been treated as collective goals by design, not coincidence.

Her solution is a 'common good

compass' built on five elements: purpose and directionality, co-creation and participation, collective learning, access for all and reward sharing, and transparency and accountability. The first element calls for steering growth toward chosen societal goals by aligning tax incentives, procurement, and funding accordingly.

This builds on her earlier 'mission economy' thinking, which directly inspired Starmer's five government missions. Mazzucato is widely credited as the economist behind Starmer's missions framework. But critics argue Labour hasn't really delivered on the model: some say the government is 'mission-washing' — using the language of missions without adopting the cross-cutting ways of working they require, with mission boards quickly snapping back into ordinary departmental silos.

Reception of the new book is similarly split. Piketty calls it vital; Ghosh praises its roadmap 'from passivity to action'. Critics counter it glosses over market-driven poverty reduction and amounts to performative governance — slogans and checklists rather than real structural change, citing Camden's mission-led governance as an underwhelming test case – see Tilak Doshi's here Substack.

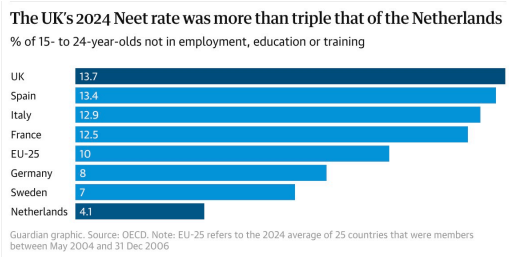
Her approach has seemingly been adopted by the WHO as noted above. Let's hope it works but so far it has helped Camden Council get re-elected even if Starmer's five missions were seemingly being thwarted by Rachel Reeves's parsimony.

Interim government Report Young People and Work.

Everyone knows that young people are feeling hard done by as opportunities dry up at the same time as the interest on their debts increases.

They are being milked for rents, debts and by exploitative employers alike. The lucky ones are marooned at home in a Peter Pan existence where they are never allowed to grow up. To make matters worse their mental illnesses are regarded as symbols of a snowflake generation, trained to be ill-equipped for a tougher world. See also this from the Mental Health Foundation.

What was significant to me was the publicity given to the fact that while other European countries suffer from the same phenomenon the rates vary with the Netherlands being the standout country, not for how it deals with the problem, but for it not being a problem in the first place.



Thus, *According to official UK statistics, roughly 13.5% of young people are not in work or college. Among 18- to 24-year-olds the share rises to 15.8% – nearly one in six.*
In the Netherlands, the equivalent figure has been below 5% for well over a decade. According to Eurostat, whose wider 15-29 age bracket produces a higher figure, the Dutch Neet rate was 5.3% last year.

Although Alan Milburn doesn't think we can copy the Dutch approach I see no reason why the UK couldn't follow in this path.

The Dutch approach revolves around three pillars: vocational education, a welfare safety net prioritising engagement and rehabilitation, and financial incentives that make it worthwhile for businesses to hire young workers.

Educational retention is critical, researchers say. In the UK in 2024, 43% of 18- to 24-year-olds were in education, compared with 67% in the Netherlands. Among 18-year-olds, the figures are 66% and 80%. By age 24, twice as many young people are in education in the Netherlands (43%) as in the UK (21%).

The type of education possibly matters more. Technical education is highly valued in the Netherlands: vocational secondary education (MBO) is the main supplier to the Dutch labour market and often called "the foundation of the economy".

Nearly 70% of Dutch 16- to 19-year-olds in upper secondary education attend an MBO school, with 35% of under-25s studying at technical or professional universities later. In the UK, only 22% of 18- to 21-year-olds were on vocational courses in 2024. (guardian)

See also: https://www.bbc.co.uk/news/articles/cnvpn253re4o for more on the Netherlands.

As with Health and Social Care doing the obvious always seems to be too difficult in the UK. We seem to prefer to stigmatise, deny help and support, and to expect someone else to deal with the problem: whether that be by blaming the individual, their family, or expecting employers to bridge the gap.

Now thanks to Brexit young people are even denied the opportunity to study and work abroad. The country and its young people are reaping the harvest sown over many years.

Updates to the Green Book, Magenta Book, Teal Book etc.

I once supplemented my income by offering to review business cases for local authorities who have a statutory duty to review the plans of the health service. This meant that it was important to be up to date with how such business cases were supposed to be done,

in accordance with the Green Book and any other departmental guidance.

What was usually the case was the guidance had not been followed. This was not because of any evil intent (although vested interests and bias in the identification and elimination of options was common) but because those tasked with writing business cases were always behind the curve, and if it were done properly the plan would be unaffordable; but rather than tell stakeholders themselves they would rather the Treasury did so.

So, with clearer and fuller guidance their task has now been made even harder. There is a promise that the test discount rate may be changed later this month which could have a profound implication but for now I will direct my attention to the colour books:

Here is the full family, as it stands following the 2026 Green Book update. (as per HM Treasury)

The Colour Book Family

Green Book — Appraisal**.** Appraisal involves estimating the social value of different options and selecting the option that represents best value for money, based on the principles of welfare economics. Social value includes economic prosperity, justice, security, the climate, the environment, people's health and wellbeing, as well as distributional effects, relating to the whole population served by the UK government. Covers the upfront economic case before a decision is taken — this is where the Five Case Model and the social time discount rate sit.

Magenta Book — Evaluation**.** Provides guidance on evaluation in government: its scoping, design, conduct, use and dissemination, as well as the capabilities required of government evaluators. It explains how to incorporate evaluation through the design, implementation, delivery and review stages of policy making, and how results can be interpreted and presented. Evaluation should be built into an intervention's design and delivery from the earliest stages. Covers assessing what happened after implementation — this is where the new Test and Learn annex sits.

Teal Book — Project delivery**.** The definitive reference on project delivery, providing guidance to enable practitioners and teams to direct and manage portfolios, programmes and projects. The preferred option identified through appraisal is taken forward to delivery in line with the principles of the Teal Book. This is the newest addition to the family and now explicitly cross-referenced from the Green Book's management case. HotPMOUK Parliament

Orange Book — Risk management**.** Outlines the principles for good risk management across government departments and their arm's length bodies. It aligns with AXELOS's Management of Risk (MoR) framework and promotes both top-down and bottom-up risk engagement. HotPMOMajorprojects

Aqua Book — Analytical quality assurance**.** Provides guidance on producing quality analysis for

government. Covers the modelling, data, and analytical assurance underpinning business cases — relevant whenever a trust's economic case relies on demand modelling or financial projections. HotPMO

Rose Book — Knowledge asset management. Provides guidance on how to manage knowledge assets in government organisations. Less commonly invoked in NHS business cases, but relevant to IP, data, and research assets generated by health programmes. HotPMO

Commercial Playbooks. Produced by the Cabinet Office to improve decision-making and ensure the assessment, procurement and management of public services delivers better outcomes and value for money for the public. Relevant to the commercial case in NHS business cases, particularly for PPPs and complex procurements like the NHP's Hospital 2.0 contracts. HotPMO

Two further books exist but sit outside the project/appraisal family, more concerned with fiscal reporting than decision-making: the Red Book and Blue Book, and the Pink Book, which records statistics on the UK's balance of international trade. The Red Book accompanies the Budget; the Blue Book covers national accounts statistics. Publishing Service

How They Fit Together for NHS Business Cases

The logic chain, as now made explicit in the 2026 Green Book, runs: the Green Book sharpens the case for change and the preferred option; the Teal Book carries that forward through governance, planning, controls, benefits realisation and reporting; the Orange Book strengthens the risk discipline around it, while the Magenta Book ensures evaluation is not an afterthought.

For a trust developing a five-case business case, in practice this means: Green Book for the strategic and economic cases, Aqua Book for the underlying analytical modelling (demand forecasts, financial projections), Orange Book for the risk register feeding into the management case, Commercial Playbooks for procurement strategy in the commercial case, Teal Book once the scheme moves to delivery, and Magenta Book for the evaluation plan that should now be designed in at the OBC stage rather than bolted on afterwards.

The NHP (New Hospitals Programme) case is instructive here too: much of the criticism from the NAO and PAC maps directly onto failures across several of these books simultaneously — Green Book-compliant appraisal not being completed before commitment, Teal Book delivery principles not being followed (workforce vacancies, contingency under-provisioning), and Orange Book risk management arguably failing given the scale of underestimated costs.

Thus, according to the Project Management Office,

> *The Green Book now makes the strategic case feel more explicit and practical: case for change, theory of change, SMART objectives, BAU and strategic fit are all right up front. In other words, before teams jump into the numbers, they are expected to be clear about the outcome they are trying to create, and how intervention is supposed to get there.*
>
> *It matters because while many problems are surfaced(!) in projects delivery, the root causes can often be tracked back to fuzzy intent, over-optimistic assumptions, unclear success measures, or poorly defined options. The Green Book now leans harder(!) into that discipline.*
>
> *It also challenges the assumption that a single project can deliver transformational change. Anyone who has witnessed a single CRM or ERP implementation project that promised "Business Transformation" will appreciate the stance taken here. Paragraph 4.29 notes that Transformational change requires multiple projects or programmes, with multiple 'tipping point'.*

With the New Hospitals Building programme or many of the other 'Transformation' plans that have appeared over the last twenty years this is closing the door after the horse has bolted.

And, adding to the difficulties of presenting a business case in the first place (or rather making it more difficult to get away with a dodgy options appraisal and the presentation of a 'gold-plated' option as a fait accompli).

For the outstanding projects in the NHP it may spell the death knell.

"In France, planning and design consume about **10% to 15%** of the total budget. In the UK NHS ecosystem, pure design fees align closely with France, but broader pre-construction "soft costs" regularly escalate to **15% to 25%** due to a more heavily bureaucratised business-case approval process. [1]" Source NHS Property Services.

I suggest the French argue out disputes before the project is committed to rather than it being treated as in the UK, a way of getting one over the Treasury.

The by-election result

We all know the result: Andy Burnham won. My take is that his success is still resting on a vote of a third of the electorate, and tactical voting by the Greens and Liberal Democrats (who were neck and neck with Count Binface and the Monster Raving Loony Party). The price may be in measures to introduce proportional representation before the next election, which Burnham had previously supported and which the Liberal Democrats will now be expecting.

We now know however that the result has gone far beyond Makerfield. Labour MPs see this as a chance to retain their seats and have flocked to both stand beside Burnham and to ditch Starmer. Following the Prime Minister's resignation it's looking like a coronation.

The key problem is that we have only a vague idea from Burnham of what the plan is. This seems to be a prevailing theme in UK politics if recent articles in the Guardian and BBC documentaries are anything to go by. Andy Cowper notes that all the prospective candidates for Prime Minister had little to say about the NHS.

A clue though emerged on the same day in the publication of a policy paper The Productive State. by Mainstream, the Labour Group that has been the vehicle for Burnham's leadership ambitions. I asked AI for a summary and posed questions as to what that could mean for the country. Here is the full discussion.

The paper identifies the problem as too many companies extracting value out of the economy by means of rents and poor value for money, especially in the utilities.

Whether this is sufficient as both an analysis and as a sketch of a government programme no doubt we will find out in due course. From my perspective it doesn't take an international perspective. Doing something about the international frameworks that govern state aid, accounting standards and the normative rules on government investment will take time and allies. Overpromising and underdelivering don't get us far.

But it's a start. Much will depend on who replaces Rachel Reeves.

Round up of other issues catching my eye

Obituary for Michael Thompson

The above discussion links nicely to an item in the press marking the death of Michael Thompson an anthropologist with a gift for cutting through the verbiage of

social theory. He is best known for Rubbish theory and the theory of Plural rationality.

It applies neatly to the NHS at present...

Rubbish Theory & Plural Rationality Applied to NHS Planning

Thompson's 1979 theory argues objects, and by extension policies and institutions, move between three value categories rather than simply declining over time. **Transient** objects lose value progressively (most policies presumed to have a shelf life). **Durable** objects hold or increase value (entrenched institutions, professional traditions). **Rubbish** is the crucial third category — things that fall *out* of the value system entirely, becoming invisible to decision-makers, yet retain latent potential to be rediscovered and recategorized as durable once again. The transition from rubbish back to durable is rarely smooth or rational; it tends to depend on who has the power to "see" value where others see waste.

NHS applications:

- **Policy cycling**: Integrated care, community-based models, and bed-based rehabilitation have repeatedly been established wisdom, then defunded and abandoned as outdated, then rediscovered as evidence accumulated. Today's Integrated Care Systems closely echo the 1970s Area Health Authorities — essentially the same model, recategorised as innovation rather than recognised as recovery.
- **Estate and infrastructure**: Victorian and post-war NHS buildings were frequently written off as inefficient and costly. Under different pressures — housing shortages, community health priorities, heritage protection — the same buildings get revalued as durable community assets worth retaining rather than demolishing.
- **Workforce roles**: Nurse prescribing, paramedic-led home visits, and pharmacist-led minor ailment schemes were once seen as downgrading professional standards. They are now mainstream advanced practice, demonstrating how "rubbish" ideas about role boundaries can be rehabilitated when workforce pressure makes them necessary.

- **Management implication**: Organisations should deliberately maintain a "rubbish bank" — a structured institutional memory of discarded approaches, including *why* they were discarded — rather than treating abandonment as final. This allows faster cheaper redeployment of proven models instead of expensive reinvention from scratch.

Theory of Plural Rationality (Cultural Theory)

Developed by Mary Douglas and extended by Thompson and Aaron Wildavsky, this theory holds that there are four irreducible ways of organising social life, distinguished by **grid** (how much external rules constrain individuals) and **group** (how strong collective boundaries and identity are). Crucially, no single rationality is sufficient on its own — durable institutions require genuine tension between the three legitimate, competing logics:

- **Hierarchy** (high grid, high group): values order, expertise, rules, and centralised planning. Strength: coordination, safety, long time-horizon investment. Risk: rigidity, slow adaptation, managerial bloat.
- **Egalitarianism** (low grid, high group): values fairness, participation, and equity. Strength: legitimacy, inclusion, challenge to entrenched power. Risk: decision-making paralysis, difficulty scaling beyond small groups.
- **Individualism** (low grid, low group): values competition, markets, and innovation. Strength: efficiency, entrepreneurial adaptation. Risk: cherry-picking profitable activity, gaming of targets, worsening inequality.
- **Fatalism** (high grid, low group): not a model to aim for, but a diagnostic warning sign — passivity and disengagement that emerges when the other three rationalities have failed to include someone.

NHS applications:

The NHS's history can be read as a series of swings between dominant rationalities rather than a stable balance. From 1948 to the 1980s, *hierarchy* dominated — top-down regional planning and clinical paternalism. From the 1990s through the 2000s, *individualism*

surged — internal markets, NHS Trusts, PFI financing, patient choice agendas, and target-driven management. From the 2010s onward, attempts at an *egalitarian* correction — co-production, patient-centred care, a renewed focus on health inequalities — have largely been grafted onto an individualist market architecture rather than genuinely integrated, producing incoherence rather than balance.

Each rationality has a clear, legitimate role: hierarchy is essential for national clinical standards, safety regulation, and emergency/pandemic response; egalitarianism is essential for addressing health inequalities, community co-design, and democratic accountability; individualism is essential for innovation, research commercialisation, and efficient provider diversity. The danger is not any one rationality but the dominance of one at the expense of the others.

Fatalism shows up concretely: patients disengaging from services and presenting late via emergency care, or staff becoming cynical and burnt out, both signal that the system has stopped functioning as a genuine pluralist institution and has excluded people from meaningful participation in any of the three legitimate logics.

Synthesis

The NHS's best-functioning moments — arguably the creation of NICE, the Cancer Waiting Times framework, the COVID vaccine rollout — succeeded precisely because they combined hierarchical coordination, egalitarian equity commitments, and individualist innovation simultaneously, rather than relying on one logic alone. Thompson calls this a "clumsy solution": messier and harder to manage than a single-rationality approach, but far more resilient because it doesn't silence any of the legitimate perspectives.

The two theories connect directly: when a policy or model becomes "rubbish," it is worth asking *which rationality discarded it* and whether a different rationality would value it differently. Often what hierarchy abandons as inefficient, egalitarianism would value for its inclusiveness, or what individualism dismisses as unprofitable, hierarchy would value for its safety net function. Genuine NHS planning should treat policy rubbish not as settled waste but as a contested category, continuously open to reassessment

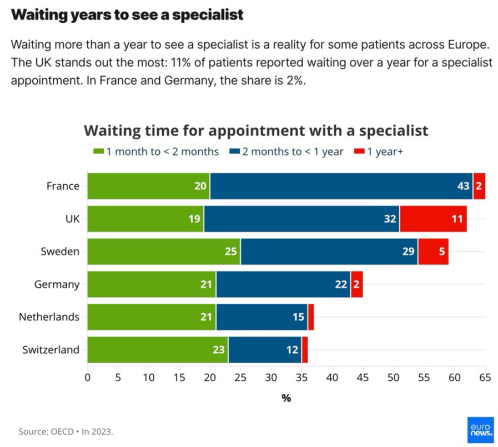
from competing legitimate viewpoints.

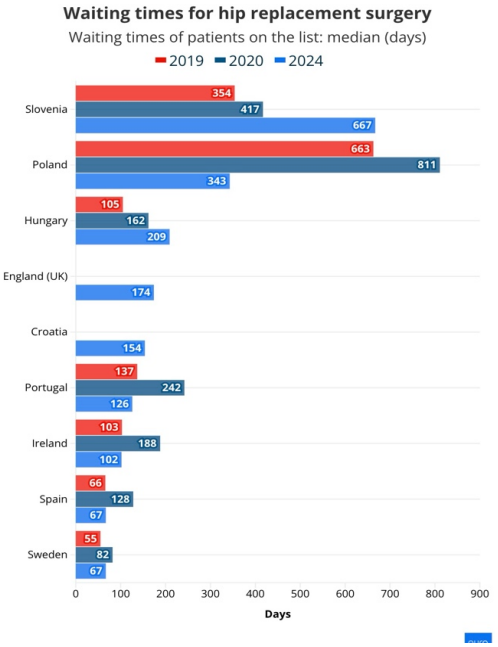
My advice to the New Health Secretary of State James Murray was to take a look at the Alternative NHS Plan linked to my last newsletter. He might also want to become familiar with the works of Michael Thompson. It might save him a lot of heartache.

But he better get cracking. He might not be in post long.

Euronews highlights that waiting times is not just a UK issue.

Although the UK leads Europe, not in a good way, waiting times are becoming more of a problem in Europe. So, it's not just in the UK that things are not as good as they should be. Indeed, Michael Gove put his finger on the issue by noting that Keir Starmer was more popular as leader than Macron in France and Merz in Germany.





Something to take comfort in, in these trying times.

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.
June	James Murray; A new NHS plan; book reviews; private equity in social care; Palliative care; Paying for Healthcare. Planning in Europe and the
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
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