Alternative European Healthcare Perspectives August 2025

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After the fanfare comes the denouement.

It's true of Trump's tariffs, cost-cutting and peace deals; it's true of the EU budget presented by Ursula von der Leyen intended to make the EU more competitive and reverse its relative decline; and its true of the NHS ten-year plan.

In the meantime, other issues have arisen: neo-natal and maternity care; Rachel Reeve's Mansion House speech; and disunity within Europe.

The newsletter for August provides an update on all these issues as well as a summary from around Europe and other sources of interest.

Trump's impact on healthcare

Most attention in the world is focussed on trying to cope with the arbitrary and economically destructive aspects of the new tariffs being imposed by President Trump: on Canada and Mexico, a 35% tariff is threatened by 1 August; on the EU the 30% tariff threat has now been reduced to 15%; on China tariffs are 55% on imports to the US and China levies 32% tariffs the other way.

As a reaction, Mexico and Canada are rerouting trade routes; the EU had a plan (although they have now accepted 15%); and the latest on the US-China negotiations is that tariffs are reducing, but talks are ongoing.

Peace in the Middle East and Ukraine meanwhile looks ever more remote and the death toll mounts daily, particularly in Gaza, where accusations of anti-Semitism for anyone criticising the Israeli government are wearing a bit thin.

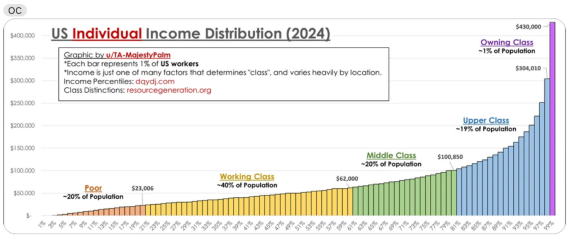
Our attention is focussed on healthcare, and it is no surprise that the latest announcements in the Trump Bill passed on 4 July is that Medicaid and other measures to help the poor in the US gain access to healthcare are being reduced substantially.

The main measures are summarised here, divided into five main categories:

1. Withdrawing Medicaid from all who cannot document their work, education or child rearing duties for young children. This will start in 2027.
2. Provider taxes used to supplement Medicaid will be abolished from 2027 onwards resulting in likely closures of rural services operating on thin margins.
3. Those enrolled on Obamacare-subsidised insurance arrangements are to be required to re-enrol, and the process made more onerous.
4. Those on Medicaid will be required to pay more to see a doctor.
5. Some immigrants will lose access to subsidised healthcare.

Last month I attached a chart on the income distribution in the US and the numbers of people that are uninsured or unable to afford healthcare in the US population. There are about 25m people without health insurance and a much higher figure with inadequate health insurance. See this report on the state of health Insurance in the USA. One in four are inadequately insured and one in three skip medications because of the costs.

[OC] US Individual Income Distribution (2024)



It is to be noted however that measures are to be staggered in effect. It will make the mid -term elections for the House of Representatives and the Senate more crucial for their implementation.

Judging by the furore about the links of Trump to Epstein many are starting to cotton on that Trump is a major threat to their livelihoods and welfare; and as unpleasant as was obvious to many from the outset.

The EU budget

This Politico article summarises the process by which Ursula von der Leyen presented her next long-term (2028-34) €1.8trn euro budget in July. It's not an easy task to get agreement amongst 27 countries of widely different ideological perspectives and economic circumstances. But adopting a secretive process restricted to an inner circle has alienated many, even of her supporters.

The statement from the EU commission on the Budget provides a very long summary. It makes the discussions about black holes in the UK finances seem trivial by comparison. There is to be a 400bn Crisis Fund; a 175bn R&D fund, a 131bn defence fund, 200bn to fund countries applying to join, 100bn for Ukraine etc.

More controversially there will be some new European taxes:

- **EU Emissions Trading System (ETS):** targeted adjustment of the revenues generated from ETS1 go to the EU budget. Expected to generate around EUR 9.6 billion annually, on average.
- **Carbon border adjustment mechanism (CBAM):** targeted adjustment of the revenues generated from CBAM go to the EU budget. Expected to generate around EUR 1.4 billion annually, on average.
- **An own resource based on non-collected e-waste** through the application of a uniform rate to the weight of non-collected e-waste. Expected to generate around EUR 15 billion annually, on average.
- **A tobacco excise duty own resource**, based on the application of a rate on the Member State-specific minimum excise duty rate levied on tobacco products. Expected to generate around EUR 11.2 billion annually, on average.
- **A Corporate Resource for Europe (CORE),** amounting to an annual

> lump-sum contribution from companies, other than small and medium-sized companies, operating and selling in the EU with a net annual turnover of at least EUR 100 million. Expected to generate around EUR 6.8 billion annually, on average.

What does this mean for individual nations? You have to go the budget fact sheets. It seems that those that pay in the most also get a lot back. Poland however is the largest beneficiary and many of the benefits are to be linked to adherence to EU laws and processes. Hungary has been warned.

The European Social Fund Plus will contribute to promote equal opportunities for all, to support strong social safety nets, foster social inclusion, intergenerational fairness and fight poverty.

Key priorities and focus areas for the ESF+ in 2028-34 are:

1. **Social inclusion and equality**
2. **Skills and education**
3. **Employment**
4. **Social innovation**
5. **Specific needs of vulnerable groups**
6. **Adaptability**
7. **Independent fund with own dedicated budget**

The ESF+ will function through a **partnership principle** involving collaboration between national and regional authorities, social partners, and civil society organizations. There will be a **shared management model** where the European Commission, member states, and other relevant actors share responsibility for its implementation. Member States will develop **partnership plans** outlining how they will use ESF+ resources to address their specific social needs and priorities. The ESF+ will provide **targeted support** to address specific challenges, such as youth unemployment, child poverty, and the integration of marginalised groups. The ESF+ will be designed to be **accessible and inclusive**, ensuring that it reaches all those in need, regardless of their background or circumstances.

But there is no mention of a final figure, because the last budget (€141bn) was raided for 50bn euros to pay for Ukraine. Healthcare has well and truly been relegated. A further breakdown will be released soon. In other words, the haggling continues.

The NHS 10-year plan

In trying to bring the threads together the best summary is provided by Andy Cowper in his excellent Health Policy Insight.

Thus,

> *Reactions to the NHS Ten-Year Plan might best be described as studiedly polite from organisations who have or want contracts with the Department For Health But Social Care, and sceptical-to-damning from almost everybody else.*

The Health Select Committee in holding the Secretary of State and temporary Chief Executive to account were similarly united in their desire to keep hopes of a future

ministerial career intact and from a conservative perspective were only too happy to support the same magical solutions to the ills of the NHS as they had in office and which has led to the crisis we have today. Even the Chair in her concluding remarks felt the Committee had been 'pussycats'. Quite.

Nonetheless some commentators have had the courage to put their heads above the parapet. Steve Black of the HSJ, not a commentator I usually support, as he's too keen on selling his data collection expertise, and the supposed enlightenment it delivers, but I agree completely with him on this.

As he says,

> *The plan misses the urgent need to fix the current problems.*
>
> *The plan would have been a great deal better had it stated up front that nothing in it was intended to fix the big problems the NHS has today (eg long waits in crowded accident and emergency departments, the long waiting lists for elective treatment and poor access to GPs). Then nobody would have seen the three big shifts as a way of tackling them.*
>
> *The NHS can't start working towards the plan's goals if the current urgent problems are not solved quickly....*
>
> *The plan is certainly visionary. But the vision is untethered to reality and relies on vastly overblown claims from the marketing brochures of the worst technology snake oil salesmen. It does contain many good ideas, but their impact is diluted to insignificance by an overwhelming failure to* focus *and a huge number of bad or purely fantastical proposals.*

I mentioned others last month that were quick to point to the lack of evidence in support of the plans; more have added their criticisms.

The Lowdown is disappointed with the extent of investment in Public Health, How do promises on prevention of illness measure up; Jess Morley's *I Think I've Seen This Film Before, and I Didn't Like the Ending* is particularly good on Apps and AI but provides a good overview. Similarly Sam Freedman's *Optimism of the will* attempts an overview and starts with this summary,

> *Like so much of what this government has done, it's ambitious and full of policies, but largely undercut by a lack of coherence and a refusal to acknowledge reality.*

The Royal College of Emergency Medicine is more specific,

> *RCEM is very disappointed by the lack of meaningful commitment to reduce 12-hour stays. Setting a target threshold of no more than 10% of people staying more than 12 hours represents a failure to meaningfully grip this problem. The proportion of 12 hours stays in 2024 was about 10% and several times worse than before the pandemic.*
>
> *Furthermore, the direction to maintain the four-hour access*

standard at a lower level of 78% is also harmful. Setting the threshold this low has perverse and unintended consequences.

[Same Day Emergency Care] cannot be a substitute for fully functioning EDs and must not be used to mask underlying capacity shortfalls. Investment is required in both workforce and diagnostic infrastructure to ensure these services are safe, effective, and consistently available.

The failure to solve the social care problem and downplaying the hope for more resources effectively dooms the NHS Plan.

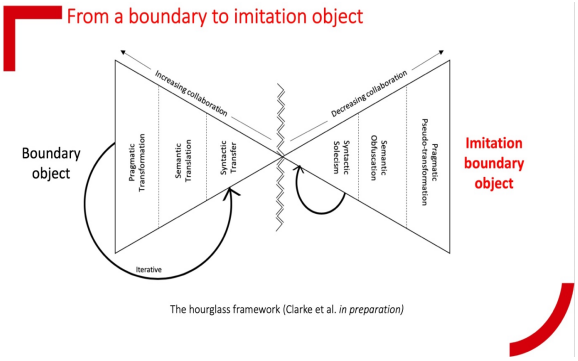
The issue for me however is why government and policy-makers believe and promote ideas that have such a lack of traction and plausibility. It is in fields of comedy and the outer reaches of social theory perhaps that I have found the most inciteful revelations.

The first is the Armando Iannucci (and Marina Hyde) podcast in a recent episode of Strong Message Here: Delivering for Ordinary People (16 June). It's all worth listening to but the discussion after 18mins 50seconds on auto antonyms or words that mean their opposite, spoke to me.

For example prevention can mean both stopping someone providing healthcare and investing more in something that is meant to reduce the demand for healthcare. Shifting from spending on acute healthcare can mean spending more on community care or cutting spending on acute care, as either complimentary or as a substitute for acute healthcare. Spending more on technology for the NHS can mean spend spending less on healthcare itself. Change can mean literally anything. Assisted Dying can mean accelerated killing.

In other words, a concerted effort is being made by politicians to keep us confused.

Which brings me to this diagram, which I took from a presentation made to the 2023 MARE Conference in Amsterdam on planning.



To help in the interpretation of this you have to understand the NHS ten-year plan as a boundary object in social theory terms, which is seeking to be transformed into a set of policies to be copied and implemented.

The left-hand side of the diagram is the official version of how things get done whereas the right hand is what tends to happen in practice. In other words, things breakdown in the meaning of words, meaning of policies and the need to present pseudo transformation plans.

It all leads to a world where managing the NHS becomes how best to deny healthcare and delay healthcare.

All of which seems to fit Wes Streeting. Plainly he thinks he is good at this. Some suggest he is the leading candidate to replace Starmer as the next Labour Leader and be a potential Prime Minister. Blimey.

Neo-natal and maternity care

This seems to have emerged as the issue of the day demonstrating the breakdown of the NHS and the inability of the NHS to sort out its own problems. The Guardian has highlighted the costs of maternity failings at £27bn in outstanding legal cases.

> *The Department of Health and Social Care said it had inherited "an unacceptable situation where too many families are suffering from botched care" and the NHS is "paying billions for its mistakes, rather than fixing them". It added "We are committed to breaking that cycle and providing mothers and babies with safe, compassionate care once and for all."*
> *NHS England said it was taking immediate steps to strengthen maternity services, including closer oversight of under-performing trusts. It added, "We recognise that too many women and families are not receiving the high-quality maternity care they deserve, and we are committed to changing this."*
>
> *NHS Resolution said "The high cost of compensation arising in maternity comes from a small number of very serious incidents resulting in brain injury to a baby at birth. These incidents are devastating for families and reflect the need to make provision for lifelong and complex care needs."*

None of this is new. The equation made in the past was that the costs of solving the problem represents an insuperable financial barrier. But Wes Streeting has commissioned a review to report in December on failings in the services.

As someone involved in reviewing NHS reconfiguration plans in a variety of settings across the country common themes can be identified that are not there in other countries:

- The UK leads in the delivery of industrialised maternity services based on baby factories and technical efficiency. This leads to accessibility problems and delays in presentation.
- This in turn leads to higher-than-average rates of inductions and caesarean births.
- Professional hierarchy is a problem in UK care . This can only be solved by spreading expertise not concentrating expertise.
- Professional resistance amongst doctors is high as they like large departments with high numbers of junior staff who can be delegated more responsibilities.
- Other countries have less contested methods of dealing with medical accidents speeding resolution.
- The UK leads in adopting managerialism rather than professionalism to manage issues. This adopts simplistic solutions to complex problems.

The truth is that the UK is not as good as the best in Europe, but it is a lot better than the US. Or maybe they bury their accidents – if this extract from the ONS is anything to go by (the red square is the UK and the red triangle the US).

3.2. Ranking Countries by Childhood Mortality

One way to rank the success of pediatric care is to compare childhood mortality. United Nations mortality data [45] for neonates, infants, age 1-11 months, 1-4, 5-9, 10-14 and 15-19 in 200 countries was averaged over the 3 years 2020 to 2022 and ranked for each group with 1 for lowest and 200 for highest mortality. The individual ranks were then summed across the 7 age groups, and this is shown in Figure 1. Hence, the minimum score is 7 while the maximum score is 1400.

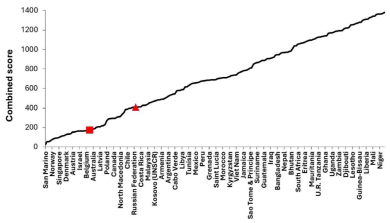
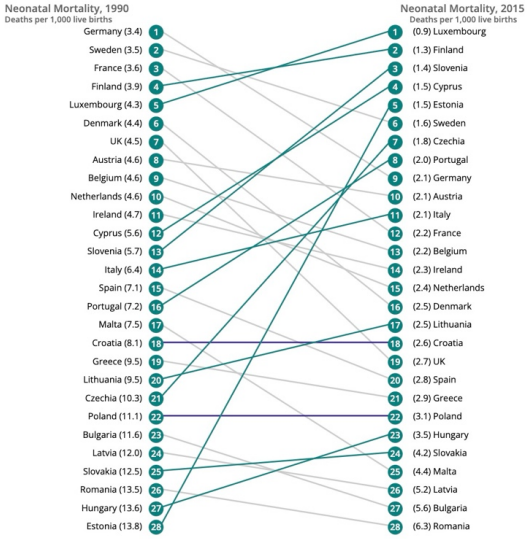


Figure 1. Ranked score of combined childhood mortality across 7 age bands for 200 world countries. Data from [45].

And although neonatal mortality rates are improving everywhere the UK hasn't improved as much as the best in Europe.

Neonatal mortality rankings, European Union countries, 1990 to 2015



But I fear that the price of success in eliminating some errors is producing unintended consequences. Lives that were previously lost are now being saved, but the lives of the saved increases the numbers of lives blighted with brain injuries, blindness and other handicaps, and with massive care needs.

No fault compensation schemes can mitigate the (outrageous) legal costs but only at the expense of total costs.

Who in the DHSC is responsible for commissioning care for the numbers of damaged babies in the system? My experience of Commissioning at the SHA level was that it was a case of desperately searching for placements not strategic commissioning.

Can the market be allowed to supply NHS needs for such services? Will not the market lead to shortages and price gauging and unethical behaviour. Again, I recall issues about the use of chemical coshes in private homes; NHS staff being unwilling to do this themselves.

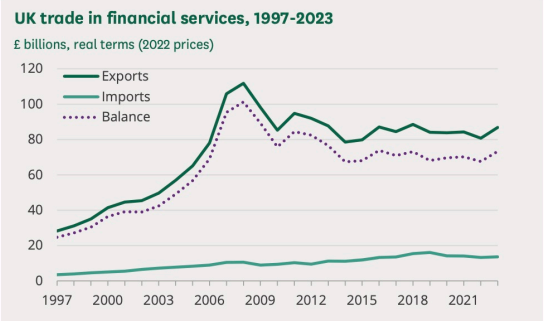
Do the ethical issues surrounding assisted dying include young babies and profoundly handicapped individuals?

We will all await the results of the review in December, but the first question should be how do other countries deal with this issue?

6 Rachel Reeves's Mansion House speech

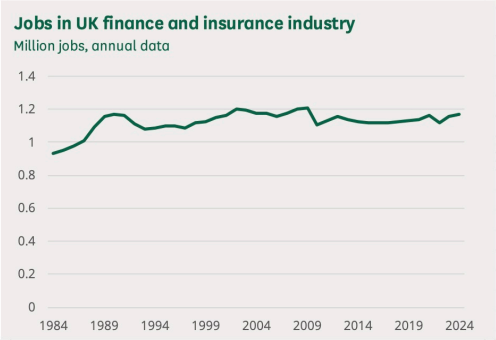
It hasn't been a good month for Rachel Reeves, and she seems to be doubling down on faith that the deregulation and pro-financial services approaches will unlock economic growth. Her Mansion House Speech, hailed as taking the boot off the neck of business by enabling banks to loosen bank lending for mortgages and encouraging retail investment in stocks and shares, risks reliving the financial crisis of 2007/9.

This Parliamentary Briefing on Financial Services published in 2024 shows why there is still residual nostalgia by Blairites for those days.



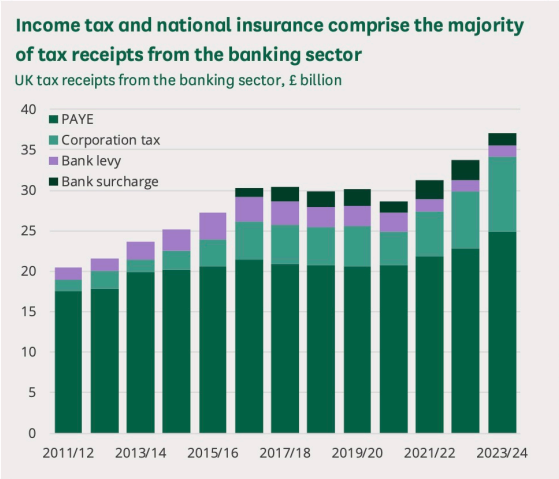
Source: ONS series S2FP and S2FQ

But it never created jobs.



Source: ONS, Workforce jobs data, via NOMIS database, 16 July 2024, Financial and insurance activities, SIC Section K.

And we shouldn't expect a boom in tax receipts.



Source: HMRC, PAYE and Corporate Tax receipts from the banking sector (2024)

Lest we forget the banks still owe us £450bn from the 2007/9 banking collapse.

All the talk of a black hole in government finances tends to forget where the biggest black hole lies. Just as Gordon Brown's reputation sunk after his Mansion House Speech with the 'end of boom and bust' it may be that Rachel Reeves will be best remembered for encouraging people to take out mortgages they cannot afford and to invest in stocks and shares before the next crash.

This is desperate stuff and intended to restore confidence before she raises taxes in the Autumn. But she is both boxing herself into a corner with the Business Secretary seemingly ruling out wealth taxes, even though independent commentators such as Richard Murphy have consistently identified ample opportunities to extract taxes from those that have enriched themselves over the last fifteen years.

Examples of such measures are:

1. Restricting pension tax relief to the basic rate of income tax, regardless of the individual's higher tax bracket
2. Eliminating the current reduction in national insurance for higher earners
3. Investment income surcharge on income from investments, dividends, rents, and capital gains
4. Impose VAT on financial services
5. Investing in HMRC to improve tax collection.

There may even be a little left for the NHS and the ten-year plan.

Disunity in Europe

If readers think I'm being harsh on Reeves it would be only fair to say that things are not a bed of roses in Europe; and Trump is not making her task any easier.

Simon Nixon in Byline Times asks the question of whether Europe can emerge from the current crisis stronger. The article is paywalled so I will give you the gist.

Three problems have been identified for Europe: defence, the economy and the Euro.

Defence: Nixon points out that Europe already spends more than twice as much on defence as Russia, and that European Nato members have more than 2 million troops, more than the 1.3m of the USA and the 1.3-1.5m of Russia. Thus, the issue is not the size of the budgets and armies committed but to the efficiency of the spending. The problem is that for all the talk of European unity, in practice there are a series of national champions leading to over a dozen types of battle tanks and highly fragmented supply lines.

There needs to be a united plan, including the UK. And there needs to be agreement on how it could be financed without causing higher taxes and cuts to welfare budgets. The risk is that there will still be inadequate arms and disgruntled voters, likely to be more sympathetic to Putin and right -wing parties.

The economy: European GDP per head is 30% of the US and productivity runs at 80% of the US. No large companies have emerged in Europe as start-ups in the last 50 years. The truth is that the EU remains disunited. For example, there are 43 groups running 102 telephone networks in Europe whereas in the US there are just three. There are 27 market regulators in Europe and one in the US. The reason is that progress in implementing a single market has been stalled by protectionist governments. The IMF has calculated that internal barriers to trade are the equivalent to a 45% tariff on goods and 110% on services.

On **the Euro** as a credible alternative to the dollar Nixon says the omens are not good. If it were, borrowing costs would be lower and the resilience of the economy improved. But it requires more opportunities for global investors to buy euro-denominated stocks and the issuance of common EU debt.

There has been a reluctance of low indebted countries to agree to this despite the average debt in Europe being 89%, whereas it's 124% in the US, 225% in Japan and 96% in the UK.

It is only by boosting a dynamic, fast growing, secure and prosperous EU will the people of Europe and the UK thrive. It sounds unlikely to many, as other articles in the By-Line Times suggest and the experience of setting the next EU budget bears out. Macron has been the European champion for more Europe but his tenure as French President is fast waning.

Our hopes are pinned on the new German Chancellor who seems more relaxed about more borrowing. Who would have thought it?

Round up of other issues

In the UK the new bright idea is to look to mayors and strategic authorities to bring things together. The linked report discusses, *A new health duty for mayors and strategic authorities: getting it right*. It's well worth reading if only for the revelation that the roots of self-deception lie deep in UK culture. The results from efforts so far appear paltry and claims of success unlikely to have been caused by the factors claimed. For example, it is more likely that improvements in life expectancy in Manchester are not directly due to Andy Burnham.

Passing responsibilities to cash starved local authorities with very limited fiscal and borrowing powers looks like a Treasury strategy rather than one genuinely designed to promote welfare or investment.

But read the new Manchester strategy and decide for yourself. This article attributes Manchester's success to investment in public transport. See also this recent report promoting place-based care. It's not what we do but how we do things apparently.

The linked article from the BMJ raises the risk that efforts to improve Neighbourhood Care will be at the expense of existing GPs, whose premises are being allowed to wither. I along with many wondered where the Prime Minister's new enthusiasm for Neighbourhood Care has come from. It was the only thing he wanted to talk about in his preface to the recent 10-year plan. Luckily, I've been sorting through my books in storage and came across the 2004 edition of *Towards a 21st Century Health System: the contributions and promise of Prepaid Group Practice* by Alain Enthoven and Laura Tollen.

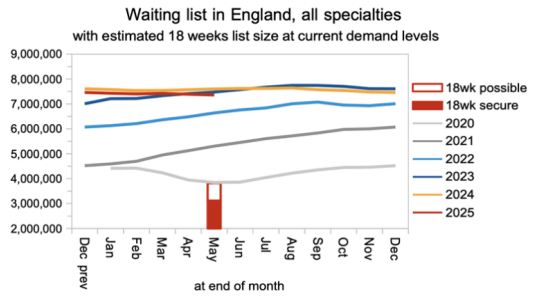
I would direct you to the Foreword by William Roper who, after casually dismissing the previous claims of the health maintenance organisations as not providing enough consumer choice, wholeheartedly supports prepaid group practices (PGPs) as the future.

After accusing employers of foisting 'managed care' on employees in the 1990s, which provoked a backlash, and which led HMOs to focus on mergers, claims systems, marketing and other non-health related concerns, he advocates investing time, energy and resources in improving care. He claims three things must happen for PGPs to do well:

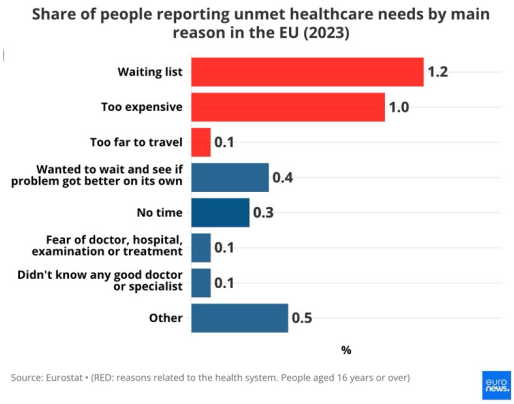
- *Throughout the healthcare system, we must improve our ability to document performance (quality and cost).*
- *PGPs must then establish a clear and consequential performance advantage; and,*
- *Employers and other payers must reward switching or leaving the security of an existing physician relationship for something new and different. None of these steps is easy.*

Which raises the question on Neighbourhood Care: where is the evidence of performance advantage? Most of such care gets delivered in local GP practices in Europe.

If this chart from the HSJ is anything to go by, the latest news on UK **waiting lists** is not good despite efforts to spin this as being on track to reduce waiting lists by the end of the Parliament.



Unmet health needs are not unknown in Europe but it is nowhere near this scale. The UK figure would be around 10%.



Waiting lists seem designed to support the private market in the UK. It is not a feature of a well-designed health system. While I support incentives for reducing waiting lists and waiting times this article suggests that administrative means and gaming the system are what NHS leaders have in mind. Disgraceful. It could only happen in Britain.

The Lancet has reviewed the benefits of new drugs and concluded that the costs outweigh the benefits. My suspicious mind inclines me to believe that the shortages of drugs have been contrived to get over this problem.

Which adds to the significance of this report on Personalised Medicine from the European Health Observatory. Judging by the linked summary to this report we, and Europe, are still in a position of being a long way from being able to deliver personalised medicine and the risk is of diversion of resources into new drugs of little benefit.

The Kings Fund asks What we can Learn from Scotland? Personally, I would wish that the Kings Fund asked the question of what we can learn from Europe rather than from looking inwards or towards the US. There is a lot to be learnt if this story from France is anything to go by. The story is of a woman with cancer receiving much better care in France than she had been receiving in the UK. It appears in the French newspaper for ex-pats in France, Connexion.

The Nuffield Trust looks at the topical and important issue of doctors' earnings but somehow excludes the earnings from private practice and from working for agencies. It is somehow regarded as impolite in the UK to mention this. But it can render international comparisons meaningless. This article is 25 years old! Why is it so difficult to address this issue?

The good news is that Euronews and the Lancet are reporting that the benefits of walking to our health can be achieved at 7000 steps per day. Which is a consolation for those of us missing the 10,000 steps target.

Me, I am plodding on.

Database of editions of Alternative European Healthcare Perspectives 2025

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.