Alternative European Healthcare Perspective July 2025

Roger Steer

There are a range of issues to report on in July: the continued drag on the world economy triggered by Trump; the diversion of resources to war-making; the publication (and pre-publication) of the NHS Plan; and my attendance at the Mare Conference in Amsterdam, where planning was a major theme. As usual I produce a summary from around Europe and other sources of interest.

Trump continues to flood the zone

I was at the Mare conference in Amsterdam at the same time as the NATO summit took place. NATO declared it was committed to spending 5% of GDP on defence (although the fine print reveals this as 3.5% defence and 1.5% on infrastructure and industry). This is good news for the arms manufacturers and Scunthorpe, but it could mean that in the UK there will be less for the NHS. Apparently NHS England has taken to warning the NHS that there will be less for the NHS as Britain has to spend more on armaments and dire warnings have accompanied reports of early overspending.

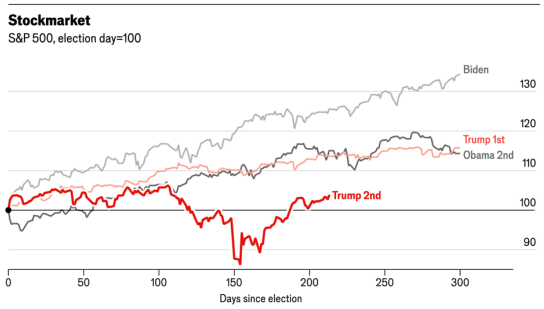
The other good news for arms manufacturers was the escalation of the wars in the Middle East. At a dinner hosted by the Amsterdam University of Applied Science (AUAS) I was talking to an Iranian member of the department whose family was having to evacuate Tehran. She was happy that Trump had imposed a 'peace' the day before. But at the conference Caitlin Procter's presentation (Centre on Conflict, Development and Peacebuilding, Geneva Graduate Institute) on Gaza, *We still have the Sea* gives less cause for optimism. As I write now, rumours are of a further bombing campaign in Iran (thankfully unfounded) while the genocide proceeds in Gaza.

In Ukraine there is still no sign of a lasting peace with Starmer, NATO and the EU committed in the long haul to fighting Russia to the last Ukrainian because President Trump doesn't want to.

In the UK there is still uncertainty over whether steel products from Sheffield will be subject to zero, 10, 25 or 50% tariffs (according to Radio 4 of 30 June).

Crucially for Trump his so-called Big Beautiful Bill, amounting to a massive cut in rich people's taxes and cuts to welfare (including $1trn to Medicaid), has managed to pass (with the vice-President's casting vote.

But not without a fierce struggle and a major spat with Elon Musk. This is filtering through to the markets as the chart shows.

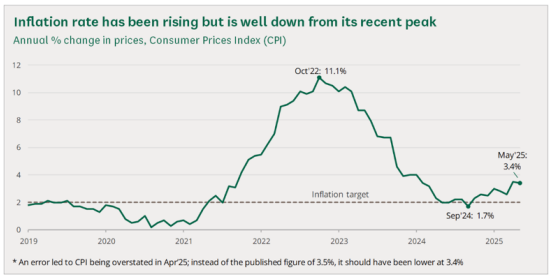


What is the impact on the UK economy?

All this is starting to take its toll on the UK economy and Rachel Reeves' calculations (and peace of mind). According to the FT, real disposable income is dropping.

Growth is faltering.

Inflation and interest remain higher than fore



cast.

UK interest rates are now 2.25% more than that in the EU and running 0.5% more than the best-case assumptions of the Treasury for 2025/26 with inflation set to exceed the 2.5% assumption.

See the following references for more detail on these charts. https://assets.publishing.service.gov.uk/media/685271097f8c3d2cbb1ec5cc/forecomp_june.pdf

https://commonslibrary.parliament.uk/research-briefings/sn02802/

https://commonslibrary.parliament.uk/research-briefings/sn02792/

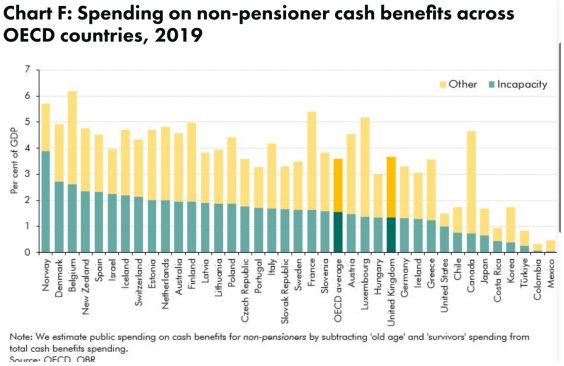
https://www.imf.org/external/datamapper/NGDP_RPCH@WEO/OEMDC/ADVEC/WEOWORLD

Starmer staked his government's reputation on 'growth, growth, growth' but, in an article for the FT, he is reminded by the incoming Director of the OBR that he has other objectives, like armaments and green energy. I fear that will be lost on the country who continue to lose faith.

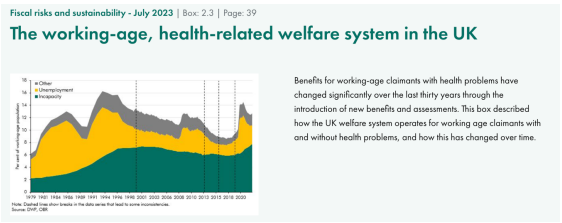
Wilful Blindness

As I write the Labour Government is struggling to dress up cutting benefits for the disabled (and has had to backtrack on its plans) but has managed to get a relatively benign reception to its 'new' NHS 10-year plan. The Government seems incapable of recognising that the UK needs to do more for the disabled and more for the sick and older people.

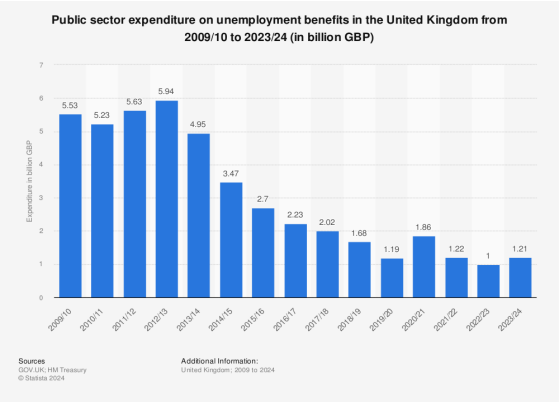
I have provided the comparative figures with Europe in the past few months, but it is well worth repeating. The UK is not generous in its support to disabled people compared to other rich European countries (see April 2025 newsletter).



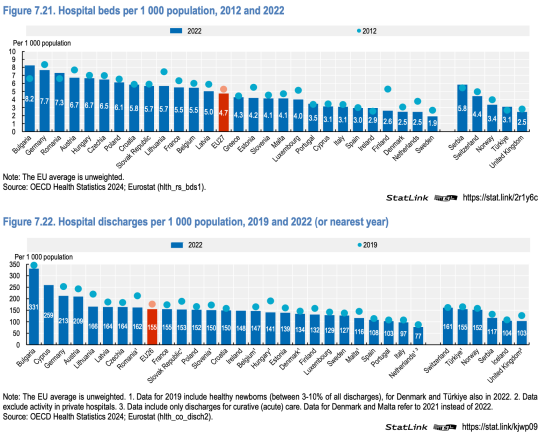
The Office for Budget Responsibility had explained that the recent blip in working age claimants was partly due to the increase in pension age for women meaning the numbers in the category of working age benefit receivers grew.



The other factor, the surge in disabling mental illness in the young, is something occurring in all European countries. Cutting access to benefits is only likely to increase anxiety. Cutting access to social media may be more constructive. And providing more not less help to the unemployed.



The UK provides far less healthcare than other European Countries (see February 2025 newsletter).



Of interest are the figures for the Netherlands where hospital beds are at a similar level to the UK and discharges are far less, but Netherlands performance is driven by high levels of social provision, compulsory social care insurance, good housing and high spending. It doesn't come on the cheap (see the discussion in January and February 2022 newsletters and below in discussion of social care)

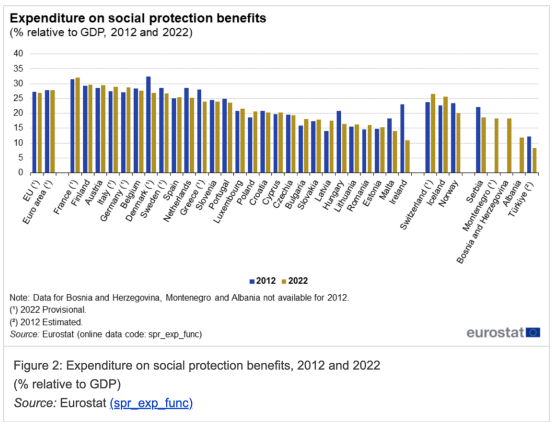
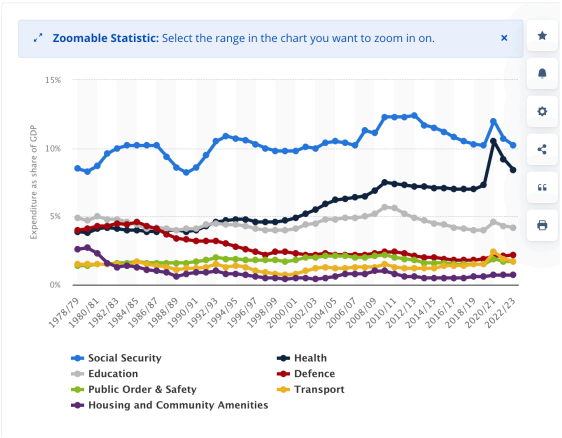
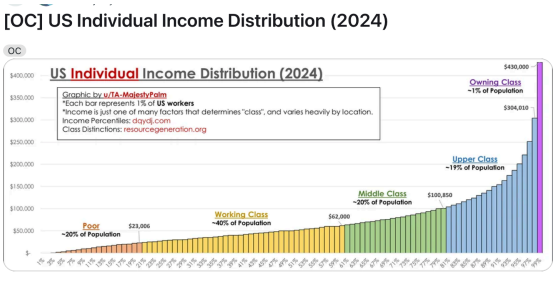


Figure 2: Expenditure on social protection benefits, 2012 and 2022 (% relative to GDP)
Source: Eurostat (spr_exp_func)

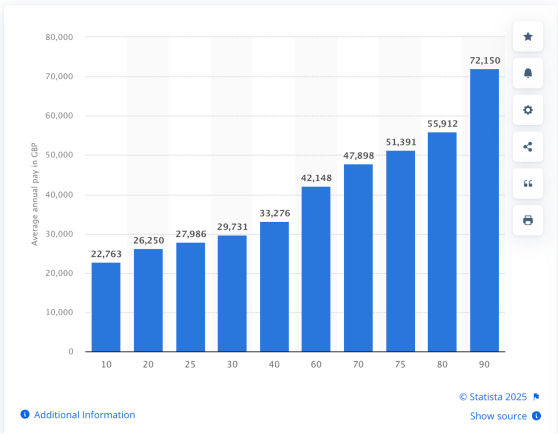
UK expenditure on social security is far less than in comparable European countries (according to Statistica).



As always, the UK is trying to provide European standards of health and social care at US levels of taxation (and callous indifference to the plight of the underclass).



Whereas in the UK, inequality is less and pay is lower.



The UK provides less Social care places.

Fig 1: Key metrics across Europe's seven largest care home markets

	Germany	France	UK	Italy	Belgium	Spain	Netherlands
Care Homes	13,500	7,400	10,800*	5,400	8,300	5,600	4,900
Beds	900,000	595,000	414,000*	321,000	150,000	385,000	123,000
Beds per 1,000 people aged 65+	54	48	42	19	66	43	71
Total market size (€bn)	€ 35.80	€ 26.20	€ 21.80	€ 14.50	€ 8.30	€ 5.70	€ 3.10
Private market size (€bn)	€ 14.30	€ 6.00	€ 17.80	€ 3.50	€ 2.70	€ 1.40	€ 0.50
% of market that is private	40%	23%	82%	24%	33%	24%	15%
Market consolidation (top 5 operators)	11%	17%	13%	8%	25%	13%	5%

*refers to England

Source Savills using Healthcare Business International, various company websites

The number of social care beds per 1,000 population compared to our countries is at most half and is almost a quarter of those in the Netherlands. This would be a good place to start taking action before contemplating further reductions in care provided, on the spurious basis sickness can be prevented quickly or more money saved by using IT, despite all evidence pointing otherwise.

I am not the only one saying this. Thea Stein, Director of the Nuffield Foundation, has said much the same in her FT article on the 10-year plan,

> *The plan has a crucial weakness in assuming this approach will save money and help restore the NHS to financial sustainability. There is no evidence for this.*

Planning -lessons From Amsterdam

As mentioned earlier I attended and presented to the Mare Conference held in Amsterdam in June. After all there is more to life than the NHS. Maritime Spatial Planning (MSP) was a major theme, and I was struck by how you can read directly across from the promises and failures of MSP to the promises and failures of NHS planning. The keynote presentation from Professor Wesley Flannery, Queens University Belfast, seemed to me to have particular relevance to the NHS.

Maritime Spatial Planning was designed to overcome a narrow sectoral focus. Previously planning had taken place in isolated sectors: Seas, Ports, Fishing, Infrastructure investment, Food Security, Housing, Trade, Local Government etc. The promise was that an integrated approach encompassing all sectors would lead to better planning. The same logic has been applied to integrated healthcare, long accused of living in silos and avoiding coordination with housing, education, the benefits system, public health, social care and the private sector.

The logic may be good, but the practice remains sticky. Planning is supposed to be participatory, addressing all the socio-political issues and focussed on managing the latent conflicts. In practice it has become about legitimisation of top-down policies, focussed on the narrow technical solutions sought by major vested interests intent on silencing opposition. Thus, participation and involvement of marginal groups and the public is tokenistic, partial and late; the planning process is taken to be compliance with a technical process, which is lacking a future orientation and in which the previous objectives of major stakeholders persist and are reasserted.

Technological solutions are misapplied in ways that over-generalise complex issues, which obscure rather than resolve complex issues, which fail to map the complex cultural, professional and identity issues and for which there is little evidence the proposed solutions work.

Conflict is managed by preventing discussion of other issues that should feature in plans: it perpetuates the existing winners and losers of the process, and it silences debate about how benefits should be realised and by whom.

Various models had been proposed for a better system: the utilitarian; (the greatest good for the

greatest number); the justice-oriented approach (commitment to a democratic process and the equitable distribution of costs and benefits); the communicative school (where efforts are made to ignore prejudice, and encourage a genuine dialogue in search of a common good); and the elitist school (which defines the public interest as something determined for the public by the political elite). In a straw poll most members of the audience saw the elitist model as predominant.

More could be done to produce and use alternative knowledge and to foster greater stakeholder capacity to engage with planning processes (see empowerus-project.eu).

The conclusion was that there had been a large gap between MSP theory and practice, that opportunities did exist to make it better through forward-looking, just and participatory processes that could guide the allocation of rights and obligations in the public interest and be supported by community building initiatives to ensure all stakeholders can participate in and benefit from planning.

The mood was however cynical with most attendees concerned about renewals of their short-term academic contracts and lack of job prospects. But the new HORIZON round of EU-funded research programmes are giving hope (even to UK participants -now allowed to participate since December 2023). The only problem is that the infrastructure in the UK to deal with this has been partially lost.

The conference covered a lot more: from the collapse of fishing stocks despite years of carefully managed quotas; the sheer size of the investments planned in offshore wind energy; the effects of climate change; the way small-scale producers are being crushed by industrial fishing interests; and, the way the future of trade and ports are being affected by the Chinese Belt and Roads programme (and Maritime Silk Road).

It would take an obtuse attitude not to see the relevance to the Wes Streeting's 10-year NHS Plan.

Planning -lessons for Wes Streeting

A great deal of time and effort was taken to prepare the ground for the launch of the NHS 10-year plan. The so-called three shifts have been drummed into us. But while the debate remained at this abstract level everyone was waiting for the detail before reaching a definitive judgement.

This hadn't stopped Helen Whately, Conservative shadow minister for Work and Pensions, on the Trevor Phillips show, from summing up 14 years of Labour opposition and a year in office as leading to nothing more than 'hiding the crisps'.

Pace MSP planning discussed above there is a disavowal of attempting to demonstrate an integrated health plan for the nation. There will be no planning for social care, for housing, education, a joined-up benefits system or for the capital spending to deal with the structural problems within the NHS (although options will be explored). The constraints of 'affordability' have been allowed to set limits to the planning. There is also a tokenistic response to weak levels of involvement and participation. This is Wes Streeting's plan with little input from the NHS; and as for patients....

The editor of the HSJ has said the plan has failed to justify its claims with evidence and a compelling business case. Well, we can make up our own minds. I suspect that events will drive the progress of plans for the future.

Thus, we have several versions of the 10-year plan:

- The Prime Minister's version which highlights neighbourhood care. Or the big misdirection by which I mean he is directing attention away from the more controversial elements..
- The executive summary which highlights the plan as a response to Darzi, or as about neighbourhood healthcare but drops its bombshells buried on page 7-10 : yet another reorganisation ,back to targets and terror, and accountable care organisations by the back door.

- The full version which is mainly good-hearted waffle until you get to the last ten pages pgs. 130-140. And which concludes with Wes Streeting's caveat:

> *This transformation will take time, so this is unashamedly a 10 Year Health Plan. The scale of transformation over 10 years will require us to test, learn and grow as we implement, in line with the Government's public service reform principles. The pace of delivering the commitments over the full 10 years of the Plan will be subject to future decisions outside the scope of this Plan, for example through planning guidance rounds, future government Spending Reviews or wider changes in economic and fiscal circumstances.*

Quite.

- The easy-to-read version which avoids the controversial proposals and is intended for the general public and journalists.

For my own part I am struck not so much by the audacity (there is bold talk of the five big bets with other people's money on new technology), as by the incoherence. My criticism of Streeting's plans is that these are plans we have all seen before; but with another NHS dis-reorganisation thrown in.

Who has not heard of cutting acute beds to invest in community care, promoting prevention as a long-term tactic, or the salesman's offers of technological transformation, at a price. As in the movie Back to the Future somehow the ability to look into the future all too often results in reliving the past.

This plan will reduce capacity just as the NHS needs extra capacity and investment. It has too readily accepted fiscal constraints that in the past have resulted in the NHS lagging in investment and performance compared to Europe. The plan continues in a long tradition of exaggerating the short-term effect of massive diversion of NHS resources into technology. Who remembers the 'paperless office' or NPfIT? The plan also extends the scheme to get more for less from the workforce.

The claim is made that 'm*ore care in the community is cheaper and more effective than care in hospitals*' without of course any evidence – because of course what evidence there is shows the contrary. You cannot readily provide acute care in the community. More often than not, as Matt Sutton has revealed many times, community care is complementary, not a substitute.

Furthermore, the desire to save money and increase productivity is simply assumed by imposing cuts: hence '*For the next 3 years we have set the NHS a target to deliver a 2% year on year productivity gain*'.

The better option would be to use investment and paying for increased activity to boost productivity. Acute trusts are already facing 6/7% efficiency targets in 2025/26. Attempts to squeeze further efficiencies are more likely to lead to more blockages and unforeseen consequences. Apparently, the latest problem is a massive shortage of clinical coders leading to backlogs in coding and trusts either losing a lot of money or not knowing how they are performing.

The tactic seems to be to beat people into submission; thus, '*Restore financial discipline by ending the practice of providing additional funding to cover deficits*' is all very well in theory but my experience of trying that trick in Kings College Hospital in the eighties is the chaos it causes is greater than the discipline it invokes.

As for the suggestion that more planning is the answer to planning problems; thus, '*All organisations to prepare robust and realistic five-year plans, demonstrating how financial sustainability will be secured over the medium term*' is merely a washing of the hands at the centre where the power to do stuff is concentrated.

And punishing the wounded thus: '*Payment for poor-quality care will be withheld, and high-quality care will attract a bonus'* will serve to increase inequalities and reward the best endowed already.

Whoever slipped in, '*Introduce multi-year budgets and require NHS organisations to reserve at least 3% of annual spend for one-time investments in service transformation, to help translate innovations into practice more rapidly*' can only be under contract from the consultancy firms who specialise in this sort of thing. See the Big-Con.

The assertion that '*While the NHS will need investment in the future, it is now self-evident that more money alone has not always led to better care*' does not take us very far. No one has ever claimed more money is the only requirement, but it certainly helps, as the experience of the Clarke reforms of the late 80s and the Blair reforms of the 90s show: a big surge in performance accompanied a big surge in spending.

The adoption of '*Move from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes. We will also test the development of "year of care" payments starting in financial year 2026 to 2027*' ignores the German and French experience of moving away from tariffs to negotiation as a means of achieving change.

And '*Ensure all trusts have the authority to retain 100% of receipts from the disposal of land assets they own and are able to use the proceeds from disposals across multiple financial years*' risks reinforcing existing inequalities.

And despite the fact that PFI has by now been thoroughly discredited; 'Develop a business case for the use of Public Private Partnership (PPP) for Neighbourhood Health Centres, ahead of a final decision at the autumn budget' risks repeating the problems of LIFT: expensive solutions that GPs resist.

And wouldn't it be easier for the Treasury or a National Investment Bank to '*Explore a new mechanism for the NHS to access low risk pension capital*'.

As for, '*In the longer-term, move to a new NHS financial model, where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for each individual, as well as how well they involve people in the design of their care, not solely on whether they provide episodic instances of care on demand*', this risks being another muddying of the waters encouraging gaming and the spending of a lot of money for little in return.

P140 of the Plan provides a final sop to the Treasury: thus,

> *There is no more important obligation on each generation than to ensure the sustainability of the health service for those that follow. That means the answer to every challenge the NHS faces cannot simply be more money, especially when more money is a fiscal fantasy. We believe a world class healthcare service can only be achieved through investment and reform. We will adopt an unwavering focus on value: investment will drive economic growth, productivity and better use of the taxpayer pound. For some in the NHS, that will mean some new realities. It will mean the era of deficits being not only tolerated but rewarded, are over. It will mean incentives reward health creation and excellence, not maintenance of a failing status quo. But there will also be opportunities: autonomy for the best performers to retain surpluses to invest in transformation and access to new sources of finance for capital transformation. By 2035, we will have created a new model of care in the NHS founded on a platform of financial sustainability and high-quality care.*

This is merely virtue signalling. It reeks of insincerity. Wes Streeting's puppet-masters must be laughing up their Armani sleeves.

NHS insiders however will be alive to the next reorganisation. The crux of the Plan is in the detail on the new Operating Model (pps 75-84) and the final ten pages on Finance. It's going to be a battle between Commissioners, Providers, and the nascent Accountable Care Organisation (ACOs) or 'Integrated Care Organisations' (ICOs) for leadership (and the plum jobs) of the new system. A rider had had to be inserted that '*they will always and only ever be NHS organisations*'. But we all know that international ACOs from the US, and the past employer of the DHSC Permanent Secretary, will be licking their lips at the sub-contracting opportunities that will be on offer.

Let's see what the public reaction is but I fear the people will not be alert to the significance of this amidst all the other stuff going on. Certainly, as I

write this newsletter most of the parliamentary and general media response all seeks to be positive.

For many however it is the culmination of all the worst fears of Simon Stevens's Sustainability and Transformation Plans (STPs) of 2016. It marks further steps towards the Americanisation of the NHS. The claims that management companies/ organisations can act as intermediaries, acting as negotiators of contracts with government agencies and providers and generate benefits for all is belied by experience in the USA. And dressing them up as NHS Integrated Care Organisations in the UK risks creating super-sized monopolies, enforcing contracts and encouraging gaming to live with the obsessive illusion that healthcare can be planned to the pound. It will alienate professional staff, reduce capacity even more, increase waiting lists and bolster the two-tier market.

I've said it many times: only the UK manages by strict cash limits. It prioritises control above planning; there is a better way of planning and managing following European models rather than Anglo-Saxon models.

More will emerge in due course. Stay vigilant.

Round up of other European Healthcare Issues

The European Observatory has highlighted significant reports on Long-Term Care and on Primary Care.

The Long-Term Care report was discussed in my May newsletter and at the time I said it would act as a benchmark for NHS plans. Given that the NHS Plan ignores long-term care until Baroness Casey presents sometime in the future this is a major flaw. The Netherlands can get away with lower numbers of acute beds because it has almost four times as many social care beds per capita, Any NHS plans to divert acute care without increased community care and facilities is doomed.

The Primary Care report highlights an article that looks at 12 European healthcare systems including the NHS and reveals that the UK already has an advanced primary care system. (see the table below). It is not clear that the UK system is inferior or under-resourced given its geography, GP numbers or mix between primary and other medical workforce. It does however reveal the crucial role of the gatekeeping function in differentiating systems and provides this linked article and reference.

Gatekeeping

The most obvious way to bring primary care upfront is to forbid patients' direct access to specialists. The PCP is thereby empowered with a gatekeeping role. Patients can access specialised care only after the PCP has issued a referral. The WHO has stressed the importance of the gatekeeping system as an organisational model to structure health care. Gatekeeping is typical of the health care systems in Denmark, Finland, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, and the UK; whereas Austria, Belgium, France, Germany, Greece, Iceland, Luxembourg, Sweden, and Switzerland allow free access to most medical specialists.
Empirical comparisons between gatekeeping systems and systems with free access to specialists repeatedly report the following three effects. Gatekeeping decreases patients' satisfaction, even though it earns a better acceptance in countries where specialists are in short supply as in the UK. Also, gatekeeping is significantly associated with a lower utilisation of health services and lower expenditures.

To appreciate the influence of gatekeeping on the utilisation of medical services and on the resulting expenditure, it is important to understand the possible relationships between gatekeeping, medical utilisation, and medical expenses.

Gatekeeping is primarily meant to limit the use of expensive specialist services to the necessary cases only and to avoid them for patients needing primary care only.

Therefore, a decrease in utilisation and expenses can reflect an efficient use of medical services only if it decreases unnecessary visits to specialists.

Empirical evidence on unnecessary care under free access to specialists is therefore needed to support this relationship; otherwise it is admitted to think that gatekeeping can cause a decrease in necessary specialised care too.

Another aspect of the relationship between gatekeeping versus free access, utilisation, and expenses is selection.

Gatekeeping in the public system coexists with free access in the private sector in countries such as Spain and the UK whereas they coexist in the private sector in Switzerland and in the USA. When both gatekeeping and free access systems coexist, the authors expect gatekeeping to attract members who are healthier on average than the free access system does. This selection process would automatically result in lower medical utilization and expenses for the gatekeeping system, independently of a possible gain in efficiency. Limited evidence is available about the existing efficiency effect, once the selection bias is accounted for.

The effects of gatekeeping versus free access are also dependent on the financial incentives they are associated with. For example, gatekeeping is often associated with PCPs' financial incentives to limit referrals to specialists, whereas system with free access provides generally little incentives of this kind.

Therefore, the lower medical utilisation and costs observed in gatekeeping systems might be due to the financial incentives rather than to the gatekeeping barrier itself. The empirical literature on gatekeeping versus direct access to specialised care so far has not disentangled the effect of both patients' and PCPs' financial incentives from the effects of constrained access to specialists.

It helps to explain that strengthening primary care has a function in the UK of strengthening the gatekeeper function. It is difficult to understand how this will improve healthcare when its whole mission is to limit access to scarce specialist services.

Thus, the development of Neighbourhood Health systems being trailed as the answer may well be an incentive for disgruntled patients to divert to A&E and to be late to present with severe illness. If on the other hand Neighbourhood centres speed up delivery of primary care and speed the referral process it will increase the pressure on acute care, not reduce it, which will require more capacity ,not less.

Table 1. Primary care features in 12 countries with patient registration, most recent OECD data.

Jurisdictions	Health system type[1]	Main type of GP-led primary care[2]	Current health spending (per capita, USD PPP)[3]	Public or compulsory expenditure (% THE) [3]	Number of GPs per 1000[3]	Ratio of primary care physicians to all physicians[3]
Netherlands	ESHI	Private group	5765	82.7	0.73	23.9
United Kingdom	NHS	Private group+	4653	77.8	0.75	26.0
Israel	ESHI	Public clinics	2932	64.7	0.29	8.1
Sweden	NHS	Public clinics+	5782	85.2	0.64	14.9
Ireland	NHI	Private group+	5276	74.3	0.84	24.8
Denmark	NHS	Private group	5568	83.8	0.60	22.4
Italy	NHI	Private group+	3649	74.1	0.71	17.7
Switzerland	SHI	Private group	7732	64.5	0.71	18.7
Norway	NHS	Private group	6647	85.4	0.79	16.1
Canada (all)	NHI	Private group	5418	70.4	1.33	47.6
France	ESHI	Private group	5376	83.7	0.89	28.0
Germany	SHI	Solo	6646	85.0	0.71	16.5

Notes: Countries are sorted by year of introduction of primary care registration (see Table2). + refers to private group or clinic practices involving health disciplines beyond GPs. It should be noted that there is a significant discrepancy between the OECD figures and Israel's Ministry of Health figures for the number of GPs per 1000 (0.6) and the ratio of primary care physicians to all physicians (13.1)

The proof of the pudding will be in the eating, but it is by no means clear that enforcing a strengthened gatekeeper function will be the key to satisfying patients.

Euronews reports concerns about US outbreaks of bird-flu in cattle. Intensive rearing practices make animals susceptible to infection and there are calls for heightened restrictions on US imports and public health vigilance.

The other big news is the heatwaves prevalent across Europe. Take precautions when travelling.

Meanwhile divisions are emerging amongst the EU nations on how to divvy up EU funds. Horror is spreading that the poorer countries want more. The reaction is best summed up in this clip from Oliver Twist. Apologies for being off message. Plainly this reflects the new NHS Operating Model.

At which point I will leave further comment to next month.

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