# comment

"On the assisted dying debate my only real, honest answer is, 'I don't know'" **MATT MORGAN**
"Medicalising exercise, including parkrun, is a retrograde step" **MARGARET McCARTNEY**
**PLUS** The cost of Trump's cuts on health and science

**PRIMARY COLOUR** Helen Salisbury

# New incentives for GPs to ask for advice

The waiting list for hospital appointments sits at 7.4 million, with three million patients waiting more than 18 weeks. Reducing unnecessary hospital visits is clearly one way of helping to create a more functional health service.

This idea isn't new, and many schemes over the years have sought to reduce demand by dissuading GPs from making referrals. The latest proposal is to incentivise GPs to seek "advice and guidance" from consultant colleagues. GPs will be paid a nominal fee of £20 for each request for advice submitted, under a system that in theory started on 1 April, although how we code and claim is still not clear.

GPs would appreciate better communication and more efficient routes to enable them to ask questions such as, "Should I be worried about this skin lesion?" or "What would you try next for this complicated patient with treatment resistant hypertension?" However, if the reply is an instruction to do five further investigations and try two medicines, titrating each according to ongoing monitoring, this has moved from receiving advice to being given instructions, as if the GP is a resident doctor in the community. In these cases, a more appropriate response could be to turn the advice request into a referral, so the consultant's team takes on the work. The overtones of paternalism in the word "guidance" suggest a hierarchy rather than equal but separate areas of expertise.

At a recent local meeting between GPs and consultants it became obvious there are two main stumbling blocks to efficient expansion of the "advice and guidance" scheme. One is that each hospital department has set up its own system: some offer email advice lines; some have an option to request advice through the (incredibly user unfriendly) electronic referral system also known as Choose and Book; and some specialties hide their contact details so well it's almost impossible to reach them. As a GP, I waste time trying to find out who to ask and how to do it, and I sometimes just end up referring the patient on. Easily accessible, reliably updated contact information is a basic requirement for any advice and guidance scheme to work.

The second major problem, which has been a recurrent theme in our GP/consultant meetings, is the lack of appropriate tech to support the communication. The electronic referral system doesn't "talk" to the patient record, either in hospital or at the surgery, which results in a lot of copying and pasting, which is time consuming and error prone. Some GPs are fortunate enough to use a system that embeds emails to colleagues and their responses directly into the patient record, but this isn't available to all.

There's a tension between hospitals' need to cut waiting lists and the responsibilities of GPs whose patients are demanding a specialist opinion. I'm fully aware of my gatekeeper role, and when I let someone through that gate it's for good reasons.

In my optimistic moments I hope increased communication with consultants, through advice requests, will reduce waiting lists. More pessimistically, I worry it may increase friction without achieving its aim.

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I'm fully aware of my gatekeeper role, and when I let someone through that gate it's for good reasons

**CRITICAL THINKING**

Matt Morgan

# Sitting on our hands is sometimes the best option

I've been sitting on my hands on the topic of assisted dying. Not because I'm scared, or irritated, or confused. I've purposely not spoken out owing to something much more serious.

Because of my writing, I'm often expected to have opinions on everything that touches medicine. Talks that I give often end with a tough question, such as, "Should we experiment on animals?" or "Is the NHS broken?" And I love these tough questions—although I still prefer tough answers, "No" or "Yes."

But it's also OK not to have an opinion on some, or even many, issues involving medicine. In today's fractured world, where small streams of difference swell to gulfs of conflict, I'd argue that it's essential not to have an opinion on things that are "not for you." And to say so. Or to say nothing. Hubris can be deadly.

On assisted dying, it's not even that I don't have opinions. I do. I have loads. Too many. They're jumbled throughout parts of my brain, surfacing when I think of patients from the past or about my own future health; when I talk to overseas colleagues working in places where assisted dying is well established; or at times when simply discussing assisted dying would be a disaster.

The main reason I've kept quiet about whether we should allow assisted dying is that my only real, honest answer is, "I don't know." And that's OK, too.

In my world of critical care, the need for assisted dying is vanishingly rare. Patients are so unwell that, if their best interests are no longer served by medical interventions that prolong death and not life, withdrawing life sustaining treatments will overwhelmingly result in a so called "good death." Not always, but almost. And although I go to work intending to save a life, sometimes saving a death is more important.

So, I'm extremely understanding of people with chronic disease or disability who talk of pain, distress, or a lack of dignity. But equally, I don't meet these people during their home lives, I don't talk with them before they're critically ill, and I don't treat them in their community to see their joy or pain during a normal week.

I want to stay fiercely neutral. And this is not a cop-out

I'm not an expert in palliative care: I don't understand the advances in pain management and support at the end of life for people who are not critically ill but are dying.

## Temporary custodians

I want to stay fiercely neutral. And this is not a cop-out. This instead does as Aneurin Bevan recommended: "The purpose of power is to give it away." I don't even think that assisted dying is a particularly medical question. Of course, it needs to be informed by the science and humanity of those who do care for such people.

But "care" is a broad church, with doctors occupying a narrow pew. The question of assisted dying is often framed as a medical dilemma, but in truth it's no more a clinical issue than the decision to print a book is a question of paper manufacturing.

Medicine may provide the means, the prognosis, much care, and the relief of suffering, but it doesn't own the moral, philosophical, or human weight of the decision itself. So, a balance struck in the current discourse between medical voices and those from the rest of life should be encouraged, as long as it's done with good intentions. It's a matter of autonomy, of the boundaries of state power, and of what it means to live a life that truly is one's own.

Doctors have a role as temporary custodians and guides for the body and for the person who inhabits that body during life and death. But they are not, and should not be, the sole authors of life's final page. And so, in truth, "I don't know"—and please read these medical words knowing that they are but a tiny fraction of what's written on a much bigger page.

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**OPINION** Margaret McCartney

# Prescribing parkrun: medicalising a walk in the park

The National Academy for Social Prescribing has recently announced that more than 1800 general practices have joined "the parkrun practice initiative," saying that this has "proven highly effective in promoting preventative care, particularly for patients facing barriers to physical activity." And so, GPs are now "prescribing parkrun" for their patients.

Parkrun is an exceptional phenomenon. I wrote about it in *The BMJ* in 2015. At that time, 50 000 or so people were taking part weekly. Essentially, it's an organised, timed, and free 5 km run, jog, walk, or wheel on Saturday mornings—in parks, on beaches, or on trails around the world but mainly in the UK, where it originated. I love parkrun and believe that it can make a real difference to public health.

It's free, outdoors, community focused, and easy to join in: all good things. Parkrun has some paid staff, but the work of setting up, timing, and processing results is done by local volunteer teams. Around 200 000 people now take part each week.

But "prescribing"? Prescribing encapsulates power and command: "I have the authority to prescribe, and you must follow my orders." Parkrun, at its origin, was something to recommend or invite interested parties to; it involved word of mouth, personal recommendation, and organic growth. The fact that volunteers are necessary to make it tick means that it's an enterprise that belongs to no one and to everyone. The atmosphere of cheer is always uplifting.

Turning parkrun into a prescription makes it less about pleasure and fun, more like work and compliance. This approach doesn't support patient autonomy or embedding social resources for a community. Instead, it grapples with gatekeeping and—literally—medicalises a walk in the park.

## Commercial sponsors

What evidence is there to support GPs having to "prescribe" parkrun? I've long been concerned about overmedicalisation, and it's tempting to evangelise about the non-pharmacological interventions that we know can often benefit patients far more than drugs can. But we must be wary of false dawns and exaggeration.

Prescribing parkrun is not a "simple, cost effective solution for sustainability, improving wellbeing, reducing loneliness, and disease prevention." Some people may get all these advantages, regularly attend, and enjoy the benefits that come with socialising, fresh air, and friendly venues for exercise. But 43% of people who register for parkrun don't attend, 22% participate only once, and people who describe themselves as physically inactive are less likely to return.

**Turning parkrun into a prescription makes it less about fun, more like work**

## Why prescribe exercise?

Prescribing is for drugs that are, in general, deemed too dangerous for the public to have direct access to. Are we really meant to encourage people to consider exercise in the same domain? And we need a far better term than "non-pharmacological interventions." The social and community resources that benefit humans are true preventive medicine, and they shouldn't need anyone to engage with a doctor to receive them, whether it's decent housing, active transport, or affordable childcare. Nor is social prescribing a slam-dunk: evidence is limited and often poor quality.

The Royal College of General Practitioners' approval for "prescribing" parkrun could be considered catnip to commercial opportunities. Sponsors include Vitality, an insurance company that tells customers to speak to their GP to find out whether having one of its annual health checks is "right for you." Supporters include the manufacturer of an anti-inflammatory gel and a "global hydration partner" that makes electrolyte drinks.

A previous "partnership" was with Healthspan, a vitamin supplier. The Advertising Standards Authority told Healthspan to change its health claims for supplements (personal communication, 2018) after parkrun's newsletter went out offering discounts for Healthspan's vitamins and links to its website. Sponsors have access to "a range of digital inventory for which they pay a commercial rights fee."

I still go to parkrun. But partnerships risk commercial opportunism, and medicalising exercise is a retrograde step. Resources should belong to the community, not to doctors.

Margaret McCartney, GP, Glasgow

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MIGSTOCK/ALAMY

# Counting the cost of Trump's presidency—just three months in

The ramifications of the president's drive to cut jobs in health and welfare programmes are being felt by federal workers, but it's the sick and poor who will really suffer

**OPINION** Esther Choo

## A sad week for public health

Recently it was National Public Health Week in the US and perhaps the saddest one in the 70 years of this celebration. President Donald Trump's administration enacted mass firings, or a "reduction in force," at agencies that form the scaffolding of US public health. This action continued the attacks on science and health that have quickly become a signature of the new presidency.

The scope and depth of the cuts are vast, including the Centers for Disease Control and Prevention, the National Institutes of Health, the US Food and Drug Administration, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, and many other offices.

Collectively, these cuts impair functions that are vital to society, harming services that help to ensure the safety of new medications, devices, food, and other products; detect and respond swiftly to new health threats, including outbreaks, epidemics, and pandemics; maintain decades of data for the prevalence of key health conditions; ensure our living and working environments are safe; improve the quality, safety, and efficiency of healthcare delivery; understand and eliminate health inequalities; run organ donation and transplantation systems; and support children and families in poverty.

These reductions were not paper cuts, they were jugular lacerations. Some consequences will take years to materialise, but others will be felt swiftly by the people kept afloat by government services. The Administration for Community Living, for example, lost 40% to 50% of its staff; it runs Meals on Wheels, which delivers more than 200 million meals a year to two million older people and people with disabilities. Cuts at the Administration for Children and Families threaten Head Start, a federally funded early education programme for families living in poverty. Both operate in all 50 states.

Robert F Kennedy Jr, the secretary of health and human services, has said he is dedicated to tackling chronic disease. However, the National Center for Chronic Disease Prevention and Health Promotion was among the bodies that were gutted, affecting activities related to Alzheimer's disease, arthritis, epilepsy, lupus, and chronic disease education and awareness. Across agencies, work on HIV/AIDS, hepatitis, tuberculosis, mental health, cancers, and substance use disorders has been decimated or sharply curtailed.

The firings, led by Elon Musk's Department of Government Efficiency, were chaotic and disorganised. Employees found out they were fired by getting locked out of their offices or email accounts. Some workers needed to be rehired within days because they had been fired accidentally or the implications had not been anticipated. Little was planned or divulged about the purported reorganisations and even the most basic of questions about them remain unanswered.

If you ask the average American what the cuts mean for them, they may not be able to articulate it. That is because these agencies and the public servants in them were doing what public health does best: working quietly in the background, keeping Americans safe and healthy.

Esther Choo, professor, Oregon Health and Science University, Portland

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**OPINION** Joan Alker

## Medicaid cuts may leave clinicians with untenable choices

On 13 February 2025, a few hours after the US Senate confirmed Robert F Kennedy Jr as secretary of health and human services, President Trump issued an executive order establishing a "Make America Healthy Again" (MAHA) Commission.

The same day the US House Budget Committee voted to progress a bill that targets Medicaid with the biggest share of cuts to finance Trump's agenda of border security and tax cuts. The House budget proposal includes at least $880bn (£674bn) in Medicaid cuts—about 11% of federal funding over the 10 year period.

Medicaid is the largest publicly funded source of health insurance coverage, covering 79 million people. By comparison Medicare covers 68 million people. Medicaid is a federal-state matching programme with the majority of funding (69%) coming from the federal government. States run the programme with federal rules and options. Medicaid is the only source of public financing for long term care—a daunting task with an ageing population. It is the largest source of coverage for mental health and substance use disorder services and is the primary insurer for close to half of children and births.

Medicaid is disproportionately important for people living in rural communities where provider shortages are acute and hospitals are operating on thinner margins. Federal Medicaid funding is the largest source of funding going to state governments ($588bn in state fiscal year 2024).

A demonstration against the Federal cuts in Manhattan, New York, last month

ERIK MCGREGOR/LIGHTROCKET/GETTY IMAGES

Large cuts to Medicaid would be devastating to a system that on a per capita basis has been growing more slowly than other payers in the system. Unlike the federal government, states are required to balance their budgets. States would have no choice but to cut eligibility, benefits, and/or provider reimbursement affecting physicians' ability to accept Medicaid patients. The outcome of this debate is critical for people covered by Medicaid and providers who serve them.

A policy that was a feature of Trump's first administration (although largely struck down by the courts) is the imposition of work requirements as a condition of Medicaid eligibility. Originally this was through voluntary agreements with willing states, but this time around Congress is considering a mandate on all states to impose these requirements nationwide. States that do not comply will face the loss of significant federal funds.

A common feature of work reporting requirement policies is a list of exemptions. These exemptions typically include one for persons who are "physically or mentally disabled." The question arises as to who will make the determination—and there is a real possibility that clinicians will be tasked with this.

And herein lies a critical issue that may arise for clinicians in the context of congressional action and Kennedy's "MAHA" agenda. They may be asked to make judgments about their patient's health and behaviours that have the consequence of cutting their patients off from health insurance, limit benefits, or raise costs for "non-compliant" low income patients. Placing a condition on benefits and eligibility for Medicaid on compliance with a set of government proscribed preferred behaviours is likely to place physicians in the position of violating their ethical obligations to their patients.

**Taking away health insurance or limiting benefits as a punishment is unacceptable**

We've seen a preview of this movie. During the second President Bush's tenure in 2007, the state of West Virginia received federal permission to limit benefits if a patient was deemed non-compliant with a proscribed list of "healthy behaviours." Many in the medical community were deeply concerned at being asked to make this determination.

Trump's MAHA executive order raises the question of whether the federal government uses carrots or sticks to encourage healthy behaviours—a worthy goal but hard to accomplish. Taking away people's health insurance or limiting their benefits as a punishment is unacceptable and ineffective. Clinicians may be asked to "inform" on their patients. Substantial cuts to Medicaid will limit access to care for many of the most vulnerable populations in the United States.

Joan Alker, executive director and research professor, McCourt School of Public Policy, Georgetown University

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**OPINION** Liz Salmi and colleagues

# Cutting public commentary threatens science and health

Since the passage of the US Administrative Procedures Act of 1946, public commentary has remained a cornerstone of US policy making, establishing transparent procedures with which federal agencies must comply. Public comment is not a bureaucratic formality: it's part of a process designed to ensure accountability in policy making.

That's why a proposal by the US health secretary, Robert F Kennedy Jr, to eliminate public comment requirements for key decisions in the Department of Health and Human Services (HHS) is so alarming.

If implemented, this change would strip away a critical mechanism that invites patients, care partners, healthcare professionals, and advocacy organisations to weigh in on policies that directly affect them. Removing the formal mechanism will permit policies to be formulated unilaterally behind closed doors.

Publicly informed rule making is not a symbolic exercise: it has effected positive change over many decades. For example, resistance to transparency in pricing by drug companies moved the US to enact the Sunshine Act, which requires disclosure of payments and gifts from drug companies given to physicians and teaching hospitals. Another powerful example is the process leading to the nationwide adoption of fully transparent medical records.

Public comment matters because it forces agencies to listen to the people most affected by their decisions, not just to those with primarily political or economic interests.

If Kennedy's proposal progresses, there will be fewer checks on corporate influence, fewer opportunities for patients and care partners to speak up, and weaker accountability for policies shaping healthcare access, costs, and quality. Policies would likely favour industry interests, often at the expense of patients.

At a time when trust in science and public health is already under immense pressure, we must not abandon public comment. The pandemic showed how misinformation can spread when governments fail to communicate openly with the public. Moving now to restrict public input into health policy decisions would further deepen scepticism and erode trust.

The ability to participate in regulatory decision making is not a privilege: it's a legal requirement and a fundamental right in a democratic society. Those who believe in open, accountable governance must be clear that public input in health policy is not just important but is essential.

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Jan Walker, associate professor of medicine

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# LETTERS Selected from rapid responses on bmj.com

## EFFECT OF TRUMP WHITE HOUSE ON HEALTHCARE

### Reforming DEI to prioritise evidence

The movement to dismantle diversity, equity, and inclusion (DEI) initiatives in healthcare threatens to reverse decades of progress towards tackling systemic inequities that harm marginalised patients and providers. But criticism of DEI efforts should not justify abandoning the mission altogether. Instead, the solution lies in reforming DEI to prioritise evidence based strategies. Studies show that racial concordance between patients and physicians improves trust, communication, and adherence to treatment plans, directly enhancing clinical outcomes. Yet only 2.8% of physicians are black women, a stark under-representation that perpetuates inequities (Opinion, 8-15 February).

Too often, DEI initiatives rely on superficial workshops led by facilitators lacking clinical expertise. Effective DEI requires clinician-educators with dual expertise in anti-racist pedagogy and medical practice. Workshops led by physicians can show how implicit biases affect treatment decisions, offering actionable strategies to mitigate harm. Such training must be integrated into clinical workflows, ensuring relevance to daily responsibilities. Moreover, institutions must move beyond tokenising marginalised people. Although lived experience is valuable, DEI leadership requires formal training in organisational change, behavioural psychology, and bias mitigation. Hiring leaders with this expertise ensures interventions are both culturally informed and evidence based.

To counter claims that DEI is "performative," institutions must tie initiatives to measurable health outcomes. Black patients experience disproportionately lower hypertension control rates, contributing to higher rates of stroke and heart disease, for example. DEI programmes should prioritise closing this gap through targeted interventions: community partnerships to expand screenings, culturally tailored education materials, and bias aware clinical protocols. Rigorous evaluation, tracking metrics like screening rates, medication adherence, and disparity trends, is essential to show impact.

The case for DEI is not about political correctness, it is about rectifying systemic failures that harm patients and providers alike. Diversity and merit are not mutually exclusive. Reform, not abandonment, is the path forward.

**Sonali Sharma, researcher, Vancouver; Elsie T Nguyen, associate professor of radiology, Toronto; Kevin Ibach, clinical instructor, Vancouver; Tracey Hillier, associate professor, Edmonton; Charlotte J Yong-Hing, clinical associate professor, Vancouver**

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## TACKLING MATERNAL DEATHS IN BLACK WOMEN

### Racialised health inequalities are unacceptable

The inequalities in outcomes for pregnant women and babies from black and Asian backgrounds have been improving, but they still persist (Feature, 22 February–1 March).

Across Scotland, we are fortunate to have organisations—such as Amma Birth Companions and KWISA, Women of African Descent in Scotland—advocating for and amplifying the voices of women and families from racialised and marginalised communities. We must continue to listen carefully and enable meaningful feedback and participation.

The Scottish government lists tackling racialised health inequalities in maternity care as a specific planning priority in its guidance for NHS boards in 2025-26. Boards will therefore be expected to report on progress towards both developing and delivering actions in maternity services in their anti-racism plans.

Disparities in outcomes and experiences for women and babies from minority ethnic communities are unacceptable. It is incumbent on us to understand those inequalities and identify meaningful action to tackle them.

**C Albert Yeung, consultant in dental public health, Bothwell**
**Karen Conduit-Turner, public health registrar specialty trainee year 4, Dundee**

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## IMPROVING GYNAECOLOGY EXPERIENCES

### Women need trauma informed care

The need for shared decision making and informed consent in gynaecology is not new (Opinion, online 21 February). But progress is glacially slow.

The gaslighting of women in gynaecological settings is commonplace; severely painful, invasive procedures, for example, are described as causing "discomfort" or "mild cramping." The Royal College of Obstetricians and Gynaecologists green top guideline on outpatient hysteroscopy underplays the severe pain endured by one in three patients, advising against the routine use of local anaesthetic and opposing the use of sedation.

A full discussion of risks, benefits, and alternatives, including analgesia and anaesthesia, should accompany any gynaecological procedure. I would go one step further: many women will have suffered sexual or domestic abuse, obstetric violence, or birth trauma, so intimate examinations and procedures may provoke embarrassment, anxiety, distress, and often long term trauma. Providing trauma informed care would be a further step in the right direction.

**Valerie E Humphreys, retired former head of law school, Birmingham**

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## HIV IN PRIMARY CARE

### Preferred antiretroviral drugs

Singh and colleagues answer questions on managing HIV in primary care (Practice pointer, 8-15 February). Although they are are right that HIV-2 infections are observed mainly in people with links to West Africa, HIV-1 is probably still more common in many countries in that region, although data on HIV-2 prevalence are limited.

Regarding antiretroviral therapy, although indinavir is a protease inhibitor, it has been avoided for more than a decade owing to its toxicity; boosted darunavir is preferred. Similarly, although efavirenz is a well known non-nucleoside reverse transcriptase inhibitor, it is often avoided for patients naive to treatment owing to central nervous system toxicity, with doravirine being preferred.

Dual oral treatment is increasingly common, such as a nucleoside reverse transcriptase inhibitor (lamivudine) plus an integrase inhibitor (dolutegravir). Injectable treatments are increasingly available, consisting of an integrase inhibitor (cabotegravir) paired with a non-nucleoside reverse transcriptase inhibitor (rilpivirine) administered every two months.

**Daniel Bradshaw, consultant virology and sexual health, London**

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## SUPPORTING DOCTORS FACING BURNOUT

### Northern Ireland needs a practitioner health service

Wilkinson brings the challenges of burnout and mental ill health faced by doctors into sharp focus (Feature, 25 January). In Northern Ireland, we look with envy at the NHS Practitioner Health service in England. We don't have a commissioned, confidential mental health service for clinicians.

Clinicians in Northern Ireland are not immune to burnout, mental illness, or addiction. Our work is beyond challenging, in a region with the longest waiting lists and the highest levels of deprivation in the UK. We have the highest prescribing rates of antidepressants in the UK, which is thought to be due to the devastating 30 year long conflict. Many of our staff have been exposed to these same traumas, compounded by the moral distress and injury caused by working in a healthcare system under interminable pressure.

The introduction of a practitioner health service for clinicians in Northern Ireland must be urgently addressed by our commissioners.

**Emma Murtagh, vice chair, RCGP Northern Ireland**
**Ursula Mason, chair, RCGP Northern Ireland**

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### System-wide reform to tackle root causes of burnout

Burnout has become a systemic failure demanding urgent reform. Rising burnout rates stem from workplace inefficiencies, overwhelming workloads, and role fragmentation rather than individual shortcomings. Interventions such as NHS Practitioner Health offer valuable psychological support but do not tackle the root causes. Coaching and peer support help doctors cope, but they fail to resolve the systemic pressures driving them to exhaustion.

AI is a largely untapped resource for reducing cognitive burden and administrative overload. AI tools could streamline workflows, improve decision support, and allow doctors to focus on complex, high value clinical work—ultimately enhancing both patient outcomes and physician job satisfaction. Integrating AI solutions could reduce the root causes of burnout.

Burnout cannot be solved by individual resilience alone. Meaningful change requires system-wide reforms—streamlining workforce structures, leveraging AI to reduce workload, and fostering a culture that supports physician wellbeing. Without these changes, burnout will remain a persistent and worsening crisis.

**Peter R McGhee, locum senior house officer, Maidstone and Tunbridge Wells NHS Trust**

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## GP IMPRISONED FOR CLIMATE ACTIVISM

### Climate activists should be applauded

Smith acknowledges the admiration that many of us hold for those who make huge sacrifices by acting in line with their conscience (Opinion, online 20 February). But we must avoid framing climate activists as acting on "their beliefs" rather than decades of climate science. This narrative has been exploited by the GMC as part of its justification for suspending doctors.

Smith expresses scepticism about the effectiveness of civil disobedience, but research has shown that it leads to greater support for more moderate climate organisations. We are already seeing a shift in things once deemed radical becoming normalised.

Health institutions ought to use their privilege and power to proudly, publicly, and courageously applaud climate activists as the true advocates for public health. They should vociferously challenge the GMC's suspension of those who care so deeply about patient health that they are willing to pay such a heavy price for all our sakes.

**Rammina Yassaie, senior lecturer in leadership, Sheffield**

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## SLOWDOWN IN LIFE EXPECTANCY

### Social inequalities can kill

After generations of improvement, progress on life expectancy has stalled (News online, 20 February). The situation is even more alarming if one looks at not just survival times but also "disability-free" life expectancy. Covid-19 greatly increased the proportion of adults living with disability.

Policy makers seem reluctant to mention inequalities in relation to the new prevention agenda. Life expectancy stalled after 2011. In 2012 Andrew Lansley passed a Health and Social Care Act that drove reorganisation of almost every part of the health system and introduced national chaos to public health and social care for at least a year. Since 2020 many older people have died from covid-19, especially those in disadvantaged ethnic groups, deprived neighbourhoods, and places with limited community assets like public transport or housing.

In terms of inequalities, many voters in 2024 wanted change—will better social justice and citizen empowerment enable the government's prevention aspirations to become reality?

**Woody Caan, retired professor of public health, Duxford**

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## TACKLING OBESITY

### Learn from failures in tobacco control

The government's tepid response to the House of Lords Food, Diet, and Obesity Committee report on the obesity crisis is concerning (This Week, 8-15 February), particularly its refusal to exclude food companies from policy discussions.

The government's reluctance to introduce evidence based regulation, preferring instead "voluntary action" from industry, echoes past failures in tobacco control that cost so many lives. This approach ignores how industry messaging—derived from a tried and tested playbook—emphasises personal responsibility while undermining structural interventions to protect public health, downplays evidence of harm, and primes itself as part of the solution.

We cannot afford to have such delays with obesity. Every year adds to the toll of cardiovascular disease, putting a strain on NHS services and, most importantly, cutting short lives in our most deprived communities. The government must learn from the decades' long tobacco control debacle and act decisively in the public health interest.

**Chelsea C Omeni-Nzewuihe, internal medical doctor, Camberley**

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**ANALYSIS**

# Vision 2050: a revolution in academic medicine for better health for all

The chairs of the BMJ Commission on the Future of Academic Medicine set out principles for transforming their sector and to help improve population and planetary health

Academic medicine is in urgent need of a revolution,[1] now more than ever following recent attacks on it in the US.[2 3] Academic medicine brings together science, humanities, social science, health, and social care to improve the health and wellbeing of people and planet in an equitable manner.

For decades, its role has been to train doctors who have led on generating research and provide services to improve health outcomes in a growing global population.[4] Some countries such as France, Germany, and India offer domestic students free or minimal tuition fees. However, the past decade of rising costs of publicly and privately funded medical education in many countries disproportionately favours a minority of students who can fund themselves through medical training.[5] These students then pursue a clinical career to repay their debt rather than entering academic medicine, where salaries are often lower.

Alongside an academic workforce crisis there are challenges to research funding. The bulk of academic medical research increasingly takes place within institutes of biomedicine or technology, whose funders and industry partners prioritise technological advances that promise financial profit. This can result in scientific censorship and disinvestment in unprofitable interventions with potential to improve population health.

These shifts mean that the goals and success measures of academic medicine are no longer aligned with improving health and wellbeing outcomes in the population. The misalignment has negatively affected the morale of clinical academics, who are under increasing pressure to bring in large research grants to universities. They have been struggling to do this alongside teaching workloads and delivering health services that are already stretched and insufficient to meet the population's health needs. Few academic medical institutions devote attention towards talent development to build academic capacity and nurture progression of clinical academic careers.

In addition, the entire process of applying for funding, producing research, and publishing has not kept pace with the speed at which new health threats emerge or technology has advanced. Thus, much of the research that is generated is not used, or is seen as irrelevant by the people who have the greatest health needs. Importantly, major medical advances with proved benefit, such as vaccines, are being rejected or mistrusted by the public, and now even by senior officials in the US and elsewhere.

**Success measures are no longer aligned with improving health**

These longstanding problems are exacerbated by the policies of the current US administration. These have resulted in loss of funding and academic workforce, destruction of data, and restricted freedom of speech, creating fear, despair, and anger among the global academic community and increasing public mistrust of science.[3 6] The BMJ Commission on the Future of Academic Medicine began before this abrupt change and focuses on the longstanding issues. Nevertheless, it is clear that many of the principles discussed here are being bluntly disregarded, and this will have negative consequences for academia and the population without strong challenge.[2]

Our 2024 *BMJ* editorial laid out a list of historical misalignments, siloed thinking, and challenges within academic and health service structures and pathways that have led to the current crisis within academic medicine.[1] The recent global health shocks from pandemics, wars, and geopolitical conflicts have added to a widening health gap between rich and poor, between and within countries, underscoring the need to do radically better.[7 8]

In this, the first in a series of papers from the BMJ commission, we examine progress and failures against reforms to academic medicine that were envisaged at the start of the 21st century. We propose five core principles intended to realign the goals of academic medicine and health institutions towards population and planetary health improvement.

## Progress and failures in the past 25 years

Two decades ago, the International Campaign for Revitalising Academic Medicine (ICRAM) identified key reforms needed for academic medicine.[9] It developed five scenarios—"Academic Inc" (a privately funded model of academic medicine), "reformation" (dissolution of academic institutions and absorption into mainstream health care), "in the public eye" (populism), "global partnership," and "fully engaged" (multidisciplinary and stakeholder led academic medicine)—and identified key instabilities that would need to be secured for positive change. Not surprisingly many of the "instabilities" identified 20 years ago remain today, although some progress can be identified. Here we consider the relevance of the five scenarios to our mission to provide a new vision for academic medicine.

## Corporatisation and globalisation

The ICRAM group correctly predicted rising private investment from an international pool of industry competitors, particularly in technical and digital innovation.[11] Leaders of academic medicine institutions have prioritised technological advances that can be commodified for profit over services that improve population health. Many of these new technologies focus on the health problems of wealthier people and countries. They offer limited population health gain and are likely to increase inequities. An important reason for this is that research is increasingly done in specialised powerful research institutions with links to big pharma

and biotechnology, inevitably influenced by their drive for profits. Public health research is much less generously funded than even clinical research, accounting for just 9% ($2.84bn) of the $30bn spent on healthcare research globally a year.[12]

Corporatisation and globalisation have also led to an uncontrolled increase in private medical and educational faculties and new medical schools that has intensified competition for students. In India, nearly half of medical school places are now privately funded and their high cost—up to $115 000 in total—denies access to less privileged students.[13] Similarly, the reduction in public funding for higher education has led universities in high income countries to rely more on overseas students and introduce or increase fees for domestic students, widening the educational attainment gap between rich and poor domestic students.

## Reformation

The reformation scenario accurately depicted shifts of teaching, research, and improvement science from universities to team led activity in point-of-care clinical settings. Teamwork and multidisciplinary working are increasingly accepted in clinical medicine globally. However, services, specialty and subspecialty medicine remain fragmented and need better integration with communities, as seen during the covid-19 pandemic.[14]

The medical workforce globally came under intense pressure to deliver services while producing research in a crisis situation. Many people experienced intense burnout, which has resulted in high attrition rates. The drive to specialise has meant it is increasingly difficult for academics to be competent in all areas, and academics are often forced to choose between research or teaching and training. Financial pressures have reduced the number of tenured academic positions, and many universities now expect staff to bring in the equivalent of their salary costs in research grants, lowering morale and resulting in clinical academics opting for the security of permanent clinical roles.

**Media platforms enhance knowledge exchange, but reliable science communication has yet to be achieved**

Within academic medicine, a persisting culture of competition and elitism prevails. Universities and academic medicine institutions reward individuals whose metrics show the highest research income and number of high impact publications and citations rather than recognising that team science and collaboration can improve scientific rigour.[15] These criteria are used for academic promotion and have reinforced gender and racial inequalities in recruitment, pay, and career progression and retention of clinical academics.[16]

## Celebrity culture and populism

The third scenario of popular "public eye" culture in academic medicine has increased exponentially through global digital technologies and social networks. A lack of regulation was correctly predicted to lead to disinformation and erosion of public trust in health systems, professions, and science. Populism, celebrity, and influencer culture were accelerated by social media platforms such as TikTok, X, and YouTube. Although media platforms enhance rapid knowledge exchange, the goal of reliable science communication has yet to be achieved.

## Global academic partnerships

Despite rising educational attainment worldwide, ICRAMs vision of a global academic partnership for health equity appears to have failed. The high cost of international fees has introduced selection bias towards educating students from wealthier families and nations, further widening the gap for talent development between high income countries and low and middle income countries.[5-13] International students experience many hurdles and may struggle to learn in a second language (usually English) with stringent curriculums in a culture that is not their own. Logistical difficulties in obtaining visas for medical and specialty training are also increasing. Educational institutions and teaching staff need an increasingly broader skill set, supported by sufficient funding, to support students and trainees to learn and assess competencies from diverse multicultural groups effectively.

## Widespread engagement

The scenario of development of new institutions integrating widespread voices has not materialised. Some funders mandate consultation with patients and the public in grant applications to ensure relevance, but this remains sporadic and can be tokenistic. Community engagement where researchers are invested in ascertaining meaningful input throughout the research process often takes time and effort but can be critical to addressing population needs and for improving the sustainability and acceptability of clinical interventions and population health initiatives.

## Unforeseen changes

The past 25 years have also seen major geopolitical changes, including a global polycrisis of pandemics, austerity, conflicts and displacement, and extreme weather patterns and climate disasters, that are widening the global health divide.

The covid-19 pandemic revealed the fragility of even the best health and social care systems when faced with disasters.[14] It also showed the reluctance of high income countries and the pharmaceutical industry to share vaccine technologies and covid-19 treatments equitably.

The scale and impact of technological advances and digital innovation (including artificial intelligence (AI)) are much greater, however. Technology is transforming how societies are structured and function, and rapidly affecting how medicine and care are delivered. AI will continue to evolve and become embedded in everyday patient care (diagnosis, treatment planning, and communications). Education is also likely to become increasingly virtual.

Table 1 | Recommendations for action on the five principles to revolutionalise academic medicine by 2050

| Recommendations |
|---|
| **Principle 1: Focus on health outcomes of populations and the planet** |
| Develop a global health security agenda to protect, promote, and preserve the health of people and the planet<br>Health, research, and social care institutions show how human and planetary health are part of their vision and strategic plans |
| Training prioritises primary health physicians willing to work in community settings and unhealthy environments where there is the highest need |
| **Principle 2: Align goals of academic medicine and health systems** |
| University and clinical academic goals align with those of the health systems and health professionals<br>Improve working conditions and pay structures for clinical academics<br>Universities' performance indicators prioritise quality of teaching and health and societal impact of generated knowledge<br>Academic performance is rewarded for team approaches rather than individual star performance<br>Interdisciplinary and transdisciplinary knowledge exchange, education, and training should occur between academic and health professions, across different health professional and non-medical professions |
| **Principle 3: Embed ethics, participation, and relevance** |
| Disinvestment needed for health harming industry (tobacco, food, fossil fuel, gambling)<br>Investment in sustainable interventions and health systems<br>Medical education and training includes awareness and understanding of social and commercial determinants of health and the importance of public health in addressing detrimental impacts on health |
| Develop ongoing dialogue between stakeholders and the public to identify common health and social care outcomes valued by society |
| Bring skills in community engagement, social science, and humanities into medical curriculums |
| **Principle 4: Deliver equitable health outcomes** |
| Public and private funding for research expands beyond illness management to considerations of health, wellbeing, and prevention for the whole population with explicit mention of how interventions will improve equity |
| A culture of equality and service should be promoted and modelled among medical students and academic staff during their passage through the university (courses, seminars, group working) |
| Public sector funding to ensure access to medical education exists for all<br>Academic capacity building globally to support regions and countries and under-represented disciplines that need investment to avoid "brain drain" |
| **Principle 5: Have real world impact** |
| Research is timely, responsive, evaluated, and shared in the real world<br>Researchers work more closely with stakeholders and health authorities to apply research to care pathways and close the implementation gap |

## Vision 2050

A new set of principles is required if academic medicine is to support improving health and wellbeing oucomes for people and the planet. By aligning goals of academic medicine to those of health services and community voices, tackling health inequalities, and ensuring science is applied to make positive changes, academic medicine can show the way to better health for population and planet.[19] We propose five underpinning principles that should underwrite academic medicine globally for today and the future, irrespective of current disruptive sociopolitical views (table 1).

## Focus on health outcomes of populations and the planet

The effects of climate change and conflicts are intensifying threats to population health. Both trends are forcing mass migrations. Chronic diseases are more prevalent as a result of increasing life expectancy, driven by the aggressive marketing of ultraprocessed foods and drinks, tobacco, and alcohol. Increased air pollution is leading to cancers, respiratory conditions, and other diseases. Hence, by 2050 medical institutions will focus research and teaching on preventing diseases, reducing healthcare costs, tackling social determinants of health, including climate change, and improving overall population health.

Research funders and health systems will have human and planetary health as part of their vision. They will support high quality studies that focus on health and wellbeing outcomes and prioritisation of cost effective and high value interventions, including those that embrace new technologies and sources of data, for better clinical and policy decision making, especially for the neglected and deprived communities. Financial incentives and corporatisation that now drive the academic medicine agenda will be challenged, particularly where they may harm health.

## Align goals of academic medicine and health systems

By 2050 we envisage that the mission of university and academics will align with that of the health service and health professionals and public health practitioners to improve health outcomes. Central to this is building a fulfilling and sustainable career structure for the next generation of medical academics. This will require strong leadership and integration of education, training, and knowledge exchange between academic and health professions. Importantly, it will require public sector funding to enable access to medical education and better working conditions and pay structures for clinical academics that reward effort, which will ultimately build academic capacity and reduce inequalities in the medical workforce.[16]

A culture of unhealthy competition between academic medical institutions will shift towards rewarding collaboration and ultimately improve the quality of science and speed of its delivery and application. The covid-19 pandemic has shown this is possible when leaders come together.

By 2025, academic promotion will no longer be linked exclusively to performance indicators and instead will move to encourage collaborative teamwork. Universities will broaden staff performance indicators beyond academic publication in peer reviewed science journals, placing more emphasis on student and staff research and teaching quality and experience.[21] Research and teaching teamwork will be promoted in many institutions, and grant funding for translational teamworking will grow over the years. The transdisciplinary approach will enable the complex problems driving the ill health of people and the planet to be addressed more effectively.[22]

## Ethics, participation, and relevance

In our vision 2050, citizens, patients, communities, and health professionals will co-create ethical research agendas around key questions relevant to addressing their health. For years, community and stakeholder engagement has been tokenistic or omitted altogether. Without this engagement, patients and end users may reject changes or interventions they perceive have been imposed or do not recognise as fit for purpose.

Knowledge exchange and participative, non-patronising, illustrative public consultation is not only an important ethical principle, it is vital for improving the relevance, applicability, and sustainability of interventions. It is essential for increasing health literacy and combating misinformation, which is an increasing threat to societal health.

## Deliver equitable health outcomes

Our equity principle envisages that everyone will have access to timely health information and care regardless of where they live or their personal wealth. This is in line with the central promise of the United Nation's Agenda for Sustainable Development for 2030 to not only "leave no one behind" but also end discrimination and exclusion along lines of

Table 2 | Academic medicine now and in 2050

| 2025 | 2050 |
|---|---|
| **Public and private funding focuses on new and often costly technologies that benefit a minority** | **Science is focused on improving health outcomes in the population and planet** |
| Medical graduates and specialists are not necessarily aligned with current and future societal healthcare needs | Academic medical workforce matches health needs of current and future populations |
| Insufficient training on social and commercial determinants of health and the importance of public health | Medical education and training includes awareness and understanding of social and commercial determinants of health and the importance of public health in addressing detrimental effects on health |
| Insufficient training of primary healthcare physicians willing to work in community settings with high levels of disadvantage | Training prioritises primary health physicians willing to work in community settings and unhealthy environments, where there is the highest need |
| **Widening rift between universities and health systems** | **Goals of academic medicine and health systems are aligned** |
| Financial pressures and constraints in higher education negatively affect research and education leaving little time for teaching, resulting in patchy learning and poor pastoral care for students | Health and academic medicine institutions have adequate funding and infrastructure including a trained workforce, technology, and resource to achieve their goals |
| Universities' performance indicators are focused on individual gain, and reputations are built on academic publication in peer reviewed science journals | Universities' performance indicators prioritise quality of teaching and health and societal impact of generated knowledge |
| A focus on individual performance drives unhealthy competition | Academic performance is rewarded for team approaches rather than individual star performance |
| There is job insecurity and glass ceilings in career structures with stark racial and gender inequalities that drive apart clinicians and those working in academic medical careers | A sustainable clinical academic career structure with improved pay and working conditions and inclusive culture |
| **Science is unethical, irrelevant, or ignored** | **Academic medicine is rapid, responsive, and relevant** |
| Science that is celebrated in academic circles is too slow, lacks application to improving health outcomes through practice or policy or is perceived as irrelevant to practice and ignored or rejected by patients and the public | Academic medicine is participatory with co-creation of research with patient and public stakeholders from inception to implementation. Research dissemination is speedy and has timely effect on health outcomes and is sustainable in the real world, Cost effectiveness and impact studies will aid in better defining strategies that can actually reduce healthcare costs |
| Avoidable waste in medical research is fuelled by scientists pressed for funding, who consistently conclude more research (and funds) are needed | Interventions are sustainable. New health interventions and policy do not harm people or the environment |
| **Widening gap in health and access to healthcare** | **The health gap is closed** |
| Funding of research is inequitable globally | Public and private funding for research focuses on health and prevention for the whole population and on interventions that will reduce health inequality |
| Globalisation and rising costs of medical education favour the wealthy and have created a brain drain from poorer nations | Investment for growth in academic medical capacity globally to support regions and countries and under-represented disciplines that need investment to avoid brain drain |

**Promoting a culture of equality and service among medical students during their university training is vital**

race, gender, and other forms of identity.[24] Despite recent progress, 15% of the world's population still lacks access to essential health services and disaggregated data are often unavailable on race and ethnicity. In 2050, academic medicine will help deliver information on equity of health outcomes within and between countries. Addressing this will require a strong focus on better data and interventions to mitigate the social and environmental drivers of poor health.[25]

Medical students and trainees will have a strong appreciation of the power of the social and commercial determinants of health. Promoting a culture of equality and service among medical students during their university training is vital, as is the need for more community based training and less emphasis on highly specialised medicine to encourage more of the workforce into primary care and public health roles. Investment in academic medical capacity is needed globally to support regions and countries and under-represented disciplines to reverse the effect of the brain drain of health professionals from regions where they are most needed.

By 2050, institutional processes will be fair and reduce current inequalities in academic recruitment, representation, and academic career progression, including for women and people in minority groups. This will require the international academic community to stand up to defend basic principles of humanity against the economic, transactional mode of dealing with profound human suffering currently being promoted in the US.

## Have real world impact

In our vision 2025, people, health, and social care systems will benefit from academic medicine in a timely way. While many effective interventions are not implemented, others are not evaluated and too many studies conclude "more research is needed" to demonstrate reproducibility. This leads to avoidable waste.[26]

We strongly recommend funders increase support for policy and practice relevant research to care pathways that close the implementation gap. Universities will work closer with healthcare authorities to address and solve the highly complex issues of contemporary societies, apply research to care pathways, and close the implementation gap.

## Advancing health for everyone

Our vision for 2050 is first and foremost about working with other stakeholders to promote the health and wellbeing of people and the planet and will require a revolution to resuscitate our current broken system (table 2). Achieving this will require a focus on the needs of a planet ailing from the pressures of climate change and an ageing population facing a heavy burden from chronic disease, both of which are increasing inequities.

Research provides the evidence to underpin efforts to improve health and health equity. Strengthening human capacity through training the next generation of health scientists and leaders becomes ever more vital. Hence, the crux of our vision will be talent development across the globe to create a sustainable career structure for those in academia but also to improve capability across the medical and health professions.

When resources are in short supply, the need to better understand the fundamental drivers of health and to improve knowledge on the effectiveness and cost effectiveness of clinical and policy decisions, become more important, not less. Consideration of the social and commercial determinants will be vital to inform health services, target actions to reduce health inequities, and improve health and wellbeing outcomes.

Finally, our vision is that academic medicine, in its broadest possible definition, will drive positive change and no longer be an abstract concept that is misaligned with what matters to patients and the public.

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**OPINION** Victor Adebowale, Parveen Kumar, and Liam Smeeth

# Will scrapping NHS England lead to better health and healthcare?

The announcement that NHS England (NHSE) will be scrapped may have surprised the mainstream media, but for many insiders there were indications of the direction of travel. The absence of any serious defence from political parties suggests this move was overdue.

The proposed 50% job cuts across NHSE and the Department of Health and Social Care (DHSC) appear arbitrary—more of a political signal than a feasible strategy. However, cuts are inevitable. At its onset NHSE's mission was wide and included driving the delivery of safe and high quality healthcare for all; supporting NHS staff with training, data, and tools; and delivering value for money. The key concerns in getting rid of NHSE are what gets eliminated, what remains, and how resulting gaps will be tackled. Where will the "slack" be taken up, and duplication avoided, in an already stretched system within the DHSC?

Integrated care boards (ICBs) will experience the most significant administrative cutbacks—as much as 50%, which follows the 30% cuts to running costs they had already been required to make by 2026. A major concern is that such cuts could undermine the community services that help reduce demand on acute hospitals. Acute and other provider trusts will not be spared the pain as they have been asked to cut their corporate costs.

ICBs were born into a storm and have faced constant upheaval since. Many ICBs were established through a "lift and shift TUPE" process from previous structures, meaning there was little opportunity for intentional organisational design. A more planned strategic approach may identify some areas where streamlining and reducing duplication could be beneficial without harming services.

Historically, NHSE has never functioned as a true quango. Due to its political significance, governments have always maintained a hands-on approach despite what previous health secretary Andrew Lansley intended. Perhaps inevitably, ministers have exercised considerable control, ensuring NHSE remained far from independent. The appointment of James Mackey as interim chief executive is strong. A crucial aspect of his leadership will be ensuring his team remains connected with the broader organisation.

A major concern is that these reforms may simply replicate the status quo, with improved execution rather than meaningful transformation. There is also apprehension the acute sector will continue to be prioritised while primary care, mental health, and community services remain underfunded. Historically, commitments to these areas have been more about reducing hospital pressures, not improving overall health outcomes.

Furthermore, the DHSC faces the daunting challenge of dismantling more than a decade of entrenched practices and institutional culture. This is no small feat and should not be underestimated. Meanwhile, the impact on the workforce remains a critical issue. Employees are understandably anxious, particularly given the current economic climate, where job security is a major concern. Clarity is needed on the NHS's unique role in healthcare and how the new structures will be designed to fulfil that role effectively.

If the principle that organisational structure should follow function is to be upheld, then proceeding with these changes before the publication of the NHS 10 year plan seems illogical. This decision appears politically driven—an attention grabbing announcement influenced by wide dissatisfaction expressed during the DHSC's engagement exercise, in which many called for NHSE's removal.

**A major concern is that these reforms may simply replicate the status quo**

Despite these risks, there are potential opportunities. Greater local autonomy may allow regions to implement what works best for them. Clearer delineation of roles between the central, regional, and local levels could improve efficiency. Additionally, there may be increased scope for local innovation and scalable partnerships, with a central body that can learn from and improve the entire system. A shift in power and funding from acute hospital trusts to primary care, community, and prevention initiatives could also emerge, though the extent of this remains uncertain.

The BMJ Commission on the Future of the NHS has suggested a health focused oversight body akin to the Office for Budget Responsibility. While this could provide valuable accountability, the current political climate, which favours reducing quangos, may render this unlikely.

For this transition to be successful, the right leadership team is essential. Wes Streeting, health secretary, has identified three key shifts: from hospitals to the community, from analogue to digital, and from treatment to prevention. Achieving these objectives will require a primary care expert with the authority to drive transformation, alongside a leader skilled in system change and people management. A digital leader with deep expertise and influence will be necessary to modernise healthcare delivery. A surgical lead will be needed to prioritise and ensure high quality elective care, while a finance leader must understand that financial figures reflect behaviours rather than dictate them.

Additionally, an acute sector leader must be committed to population health and aware of broader dynamics. The leadership team as a whole must be aligned around a clear vision, values, and strategy, inspiring and learning from the wider NHS and social care system. The appointment of Penny Dash as NHSE's chair is therefore a welcome step given her experience across public health, medicine, management, and as a chair of an ICB. It is hoped her leadership will support the NHS to embrace the potential of system working.

The outcome of this reorganisation remains uncertain, but its success will depend on whether it leads to genuine improvements in health and healthcare delivery or simply reinforces existing inefficiencies under a different guise.

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# Reparative justice and COP29

Climate policy needs to take a reparative stance

At the 2024 UN climate change conference (COP 29), developed nations pledged $300bn in climate finance annually to support “an insurance policy for humanity.”[1] This falls far short of the trillions required to enable vulnerable nations to adapt to the increasingly severe impacts of climate change.[2]

COP 29 failed to meaningfully address the systemic inequities that underpin the climate crisis.

The most vulnerable nations are being offered paltry sums that are disproportionate to both the loss and damage endured and their contribution to the climate crisis. An example is the 2022 floods in Pakistan, which affected more than 33 million people, destroyed or damaged over two million homes, and resulted in the deaths of more than 1700 people.[4] Rainfall in two of the hardest hit provinces was around 75% more intense than it would have been had the climate not warmed by 1.2°C.[5] Juxtapose the $30bn in damages and economic losses that were estimated to have been caused by the floods[4] with the $5.75tn (£4.5tn; €5.2tn) that the UK is calculated to owe Pakistan in reparations,[6] and the misdirection and gaslighting at play in climate finance negotiations.

A reparative approach is needed to address place specific vulnerabilities to climate change that are, for the most part, artefacts of systematic racism,[7] exploitative colonialism,[8-11] purposeful underdevelopment,[12 13] and illicit financial flows.[14] Today, demands for reparations for historical and present harms—from chattel slavery to colonial land theft to genocide—are proliferating globally.[10] Evidence substantiating the moral, legal, economic, historical, ecological, and political basis for such claims is manifold, as are the possible modes of redress.[11-14]

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**Climate finance often prioritises interests of donor countries and corporations**

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And while full reparations will take decades, if not more, to pay off—the $45tn owed by the UK to South Asia is 13 times the country’s annual GDP, for example—debt cancellation can serve as an initial, impactful step towards freeing up resources in low and middle income countries to fund public health, poverty reduction, climate adaptation schemes, and transitions to clean energy.[15]

By contrast, climate finance, as conceived at COP, often prioritises the interests of donor countries and multinational corporations over the genuine needs of communities on the frontlines of climate change. For example, projects to reduce emissions from deforestation and forest degradation in developing countries, financed by climate funds from Norway and other donors, aim to reduce deforestation and enhance carbon sinks in countries such as Brazil and the Democratic Republic of the Congo. These projects allow donor countries to claim carbon offsets while maintaining high domestic emissions, thus externalising environmental costs. Meanwhile, forest dependent communities face restrictions on land use and economic activities.[16] What is described as “support” in official terms is, in practice, a vehicle for extending fossil fuel based economic growth by focusing on carbon sequestration instead of phasing out oil, gas, and coal, while simultaneously maintaining the disposability of ethnic groups most affected by climate devastation.

## A fairer response

True climate justice demands that we shift the conversation from the failed model of development aid to a reparative stance for climate policy.[17-19] This would entail direct, unconditional financing to communities most affected by climate change, enabling them to lead their own adaptation and mitigation efforts as well as recovering from climate impacts. For example, after the 2022 floods in Pakistan, rather than receiving grants, compensation or reparations, the country was obliged to take out $1.3bn in loans, adding to an already critical debt crisis.

In this context, COP 29’s compromise on climate finance can be seen as a perpetuation of the neoliberal status quo instead of a meaningful step towards justice. Until the systemic problems are solved through reparations that address the legacies of enslavement, colonialism, and genocide[21]—for example, the Brattle report calculated that the US, Britain, France, Portugal, and Spain owe over $100tn for transatlantic chattel slavery in the Americas and the Caribbean[22]—the promise of climate finance will remain an empty gesture, and the world will continue towards climate apartheid.

To take a truly reparative stance for climate change policy, the global community must move beyond superficial compromises and embrace a bold vision of redistributive justice. Only then can we hope to address the root causes of vulnerability and chart a path towards a truly sustainable and just world.

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