

The brain we are not talking about

Neurological disease, NHS capacity and the commercial question the industry keeps avoiding.



Doddie Weir. Rob Burrow. Ed Slater. Lewis Moody.

Four rugby players. Four diagnoses of motor neurone disease. Two have died. Two are living with it now. The fundraising and awareness these men and their families have generated is extraordinary -- millions raised, government research commitments secured, a condition that most people had never heard of now part of the national conversation.

MND deserves every pound and every headline it receives. It is progressive, incurable and pitiless. There is no good version of the diagnosis.

But the scale of what neurological disease does to this country, when you pull back from the one condition everyone can now name, is of an entirely different order.

The full picture

At least one in six people in England is living with a neurological condition. The total economic cost to the UK is estimated at £96 billion annually, with evidence that more than £30 billion of that could be saved each year through better access to care (Economist Impact, 2024). Dementia affects close to one million people, is the leading cause of death in England, and yet more than a third of those living with it have no formal diagnosis. Spending on dementia diagnosis and treatment accounts for just 1.4% of the total cost the condition generates.

Parkinson's, the fastest growing neurological condition globally, affects 166,000 people in the UK with someone new diagnosed every twenty minutes -- and an estimated 20,000 more living with it

undiagnosed because the NHS diagnostic pathway has not recovered from the pandemic.

Migraine affects around 10 million people -- more common than diabetes, asthma and epilepsy combined, according to The Migraine Trust, and the second largest cause of years lived with disability globally. It costs the UK economy an estimated £9 billion a year. For decades it was dismissed as inconvenient rather than disabling. Epilepsy affects around 600,000 people in England, of whom roughly 180,000 do not achieve adequate seizure control and face impaired quality of life and elevated mortality risk, including sudden unexpected death -- a cause of death that remains under-acknowledged.

And MND, devastating and irreversible, affects around 5,000 people at any one time.

None of this is a competition. Each of these conditions causes suffering that cannot be ranked. But the disparity between the public attention neurological conditions attract and the burden they actually impose shapes research funding, political priority and commercial investment in ways that affect everyone living with any of them.

A system that is swamped, not indifferent

The NHS is not failing neurological patients through lack of care. It is overwhelmed by demand that has grown faster than capacity could match, in a specialty that lacks the political visibility of cancer or cardiac services.

The NHS has between 1.1 and 1.8 consultant neurologists per 100,000 population against a European median of 6.6. No UK region meets the minimum recommended by the Association of British Neurologists. The neurology waiting list stood at 219,000 patients in January 2026, with only 57% starting treatment within 18 weeks against a government target of 65%. There is no nationally consistent service framework setting expectations for neurological care pathways, workforce or access. And a documented phenomenon called neurophobia -- a reluctance among medical students to enter the specialty because it is perceived as uniquely complex -- has made recruitment harder for decades, compounding every other pressure in the system.

The innovation arriving -- and the administration question nobody is asking loudly enough

The neurological pipeline is genuinely exciting for the first time in a long time. But the nature of much of what is arriving presents a challenge the industry has been slow to confront honestly.

A significant proportion of new treatments reaching the market in neurology are not oral therapies. They are intravenous infusions, subcutaneous injections requiring clinic attendance, or complex device-based interventions. Each places demands on a system already at its limit.

For Alzheimer's, the first treatments able to slow cognitive decline in early-stage disease received MHRA licences in recent years. Neither was recommended by NICE, the assessed benefit considered

insufficient relative to risk and cost. That is an honest appraisal of the current evidence. But these are also intravenous therapies requiring regular hospital infusions, specialist monitoring and MRI surveillance. Delivering them at the scale dementia demands would require memory clinic and neurology infrastructure that simply does not exist. There have been no oral disease-modifying treatments approved for Alzheimer's in the NHS since the early 2000s. The cupboard has been bare for over twenty years, and the next generation is arriving in forms the system is not yet equipped to deliver.

For Parkinson's, specialist injectable and device therapies for advanced disease offer real benefit -- but require trained clinicians to initiate, monitor and adjust. Continuous intestinal delivery of dopaminergic therapy, deep brain stimulation and focused ultrasound are not treatments a stretched GP can deploy. Digital monitoring tools enabling remote assessment of motor fluctuations represent a more deployable model, but consistent NHS adoption remains elusive.

For migraine, the CGRP monoclonal antibodies approved for prevention are self-injectable -- reducing the clinical burden considerably once established. But the intravenous formulation, eptinezumab, given by quarterly infusion in a clinical setting, requires infusion chair time and nursing capacity already under pressure. Oral CGRP receptor antagonists, now approved for both acute treatment and prevention, are the most deployable option and prescriptions have risen sharply. All of these still require specialist initiation through pathways that in too many parts of the country remain poorly resourced, inconsistently implemented and invisible to the GPs managing the vast majority of migraine.

For MND, a targeted gene-silencing therapy for a specific inherited form of the disease received MHRA authorisation -- the first to address a genetic cause directly. It requires regular clinic attendance. For a condition with specialist centres already at capacity, even a small patient population creates real delivery challenges.

The question is not whether the innovation exists

Treatment after treatment is arriving in a form that requires specialist clinical infrastructure to deliver, into a specialty with less infrastructure per patient than almost any comparable country.

NICE approval is not the bottleneck. It never has been in neurology. The bottleneck is the clinical pathway that has to exist before a treatment can move from guidance document to patient.

Understanding that gap -- before launch, not after -- is the work. It means asking honestly whether your administration route is compatible with current NHS capacity, and if not, what infrastructure needs to be built alongside the product. It means working with NHS partners on service design as part of the commercial plan, not as an afterthought. It means developing real-world evidence commissioners can use to justify investment. And it means being honest about the inequality dimension -- the populations most burdened by neurological disease are consistently the least likely to be identified, referred and

reached.

The men and women who have campaigned publicly around neurological conditions -- some while facing their own diagnosis, some in memory of those they have lost -- have moved science, funding and politics in ways that matter. The baton they have handed on is not only about funding research. It is about making sure that when the research works, it reaches the people who need it.

That starts not at launch, but at the commercial design stage, with one honest question: can the NHS actually deliver this, and if not, what are we going to do about it?

Growth-iQ works with pharma and med-tech companies developing and commercialising products in neurology and other complex NHS therapeutic areas.

If you are working to close the gap between a treatment that works and a system that can deliver it, it is worth a conversation. **hello@growth-iq.group**

References

Neurological Alliance and Association of British Neurologists, State of the UK Neurology Workforce, January 2026
Neurological Alliance, NHS Waiting Times Data January 2026, March 2026
Economist Impact, Neurology Crisis Costing the UK £96bn, February 2024
Alzheimer's Society / Carnall Farrar, The Economic Impact of Dementia, 2024
Alzheimer's Society, Response to NHS Dementia Diagnosis Target Removal, October 2025
Parkinson's UK, New Parkinson's Prevalence Data, Movement Disorders Clinical Practice, October 2025
The Migraine Trust, State of the Migraine Nation -- Impact Rapid Review
The Pharmacist, Prescriptions for New Migraine Pills Triple in One Year, February 2026
Global Burden of Disease Study 2021, Lancet Neurology, March 2024
MND Association, MND Statistics
NHS England, RTT Waiting Times Data, January 2026