THE RATIONAL POLICY-MAKER'S

GUIDE TO REBUILDING THE NHS

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FOREWORD

Our new government is right to stress that it faces profound challenges on many fronts: economically and in the cost-of-living crisis; in the state of public services; and in the international arena to a degree unprecedented since 1945. These challenges are greater than those which faced the 1997-2010 New Labour government, and the need for national renewal about which Sir Keir Starmer has repeatedly spoken is correspondingly greater.

Rebuilding the NHS is one of the most important of these challenges. Lord Darzi's report (2024) laid bare the extent of the damage the NHS has sustained since 2010. The New Labour government did succeed in turning around the NHS, though not from such a low base or against the backdrop of so much else that needs rebuilding. There is much we can learn from their experience.

This report is timely and practical: it shows how far the 1997-2010 government was able to rebuild the NHS. It shows what it got right and what it got wrong. And it shows why there was success despite some mis-steps. It is also challenging: it suggests that, to succeed today, the government's radical words are followed by no less radical action, and that effectiveness hangs on being more joined up - both within the NHS and in the departments congruent to it - than the British state has managed before.

My hope is that policy-makers will take this report's findings to heart as they build on what has been a good beginning, and that we shall see courageous and rational policy on health and beyond.

To coin a phrase: This Time No Mistakes

Will Hutton

Author of ***The State We're In***
and ***This Time No Mistakes***

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1. EXECUTIVE SUMMARY

The government has pledged a decade of national renewal. When citizens are asked for their most pressing concerns, the answers they give are consistent: the top issue is the cost-of-living crisis, and the second is the crisis in the National Health Service. Tackling the NHS crisis is a critical part of national renewal.

The 1997-2010 Labour government also inherited an NHS in crisis and succeeded in turning it around. This time the job is more difficult because the UK faces many simultaneous crises – not least a chronically weak economy – and there are many other pressing areas in which renewal is also needed. The government has set out three important shifts[1] it intends to drive in rebuilding the NHS: from analogue to digital; from hospital to community; and from sickness to prevention. Most experts agree with the direction of these three shifts, but they do not constitute a complete strategy for rebuilding the NHS.

This report argues that, despite the additional challenges, the government *can* rebuild the NHS but that, as it has very little room for error, it will have to learn from the experiences of its last term, act systemically and avoid some tempting pitfalls along the way:

- The 1997-2010 Labour government delivered a huge improvement in NHS performance – this government must learn from that experience and replicate that success (see Section 2);

- The 1997-2010 government also instigated some questionable initiatives which need scrutiny (see Section 3);

- The reason the last Labour government was successful is that it succeeded in getting right many of the most important factors, in particular, funding, prevention and tackling the social determinants of ill health – this government must do the same (see Section 4).

Since the new government faces a tougher challenge than the 1997-2010 government, it can and must also learn from Attlee's government about how to deliver in times of great stress.

As the Health Secretary[2] said last year, *"We have done this before. When we were last in office, we worked hand in hand with NHS staff to deliver the shortest waits and highest patient satisfaction in history. We did it before, and together we will do it again."* This report explains how to make that aspiration a reality.

[1] (Department of Health and Social Care, 2024)
[2] (Streeting, 2024)

2. THE 1997-2010 GOVERNMENT OVERSAW A HUGE IMPROVEMENT IN NHS PERFORMANCE

This section of the report explores the success of the last Labour government in turning around the performance of the NHS: it covers what we mean by healthcare system performance, what outputs and outcomes Labour managed to deliver from 1997-2010, how citizens reacted, how that stacked up against other leading healthcare systems and – perhaps most importantly – *what caused the improvement.*

ASSESSING HEALTHCARE SYSTEM PERFORMANCE

To understand that achievement, we need to think carefully about what we, as citizens, can expect from the healthcare system, and what outcomes we want to see.

There are three things we can reasonably ask of our healthcare system:

1. We can ask it to be **effective,** providing good quality in the *outputs* (healthcare services) it delivers – for example, when we are ill, do we receive high-quality care?

2. We would like it to be **efficient**, which means that it delivers those outputs that we want for a reasonable level of *input*, which in this case is money;

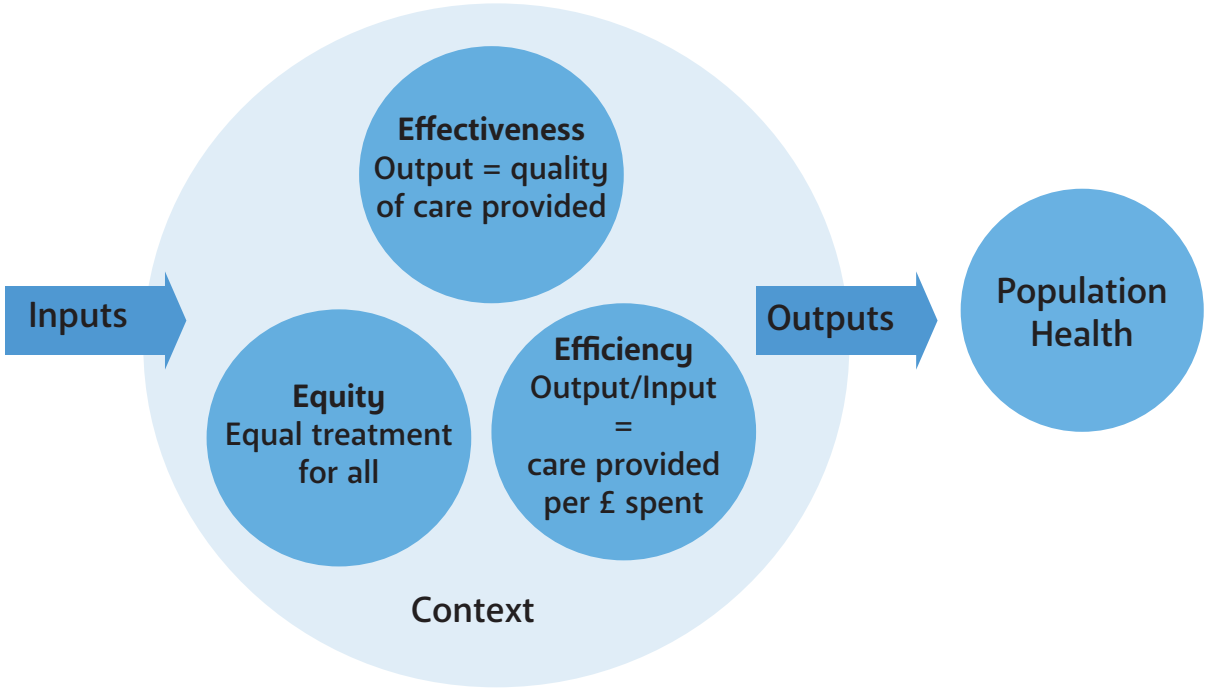
3. And we want it to be **equitable** in the care it delivers – the level of care we receive should depend on medical need not on whether we are wealthy or perceived to be important.

Those are the three things *within the control of a healthcare system,* but they are not the only things citizens care about. In particular, we care very much about outcomes (is the population healthy? what is our life expectancy?) although these are not all within the gift of the health system, often being determined by factors beyond its control.

The USA, for example, has the lowest life expectancy in the OECD, but the main reason for this does not lie within their poorly-performing healthcare system (although it *is* without question an extremely poor healthcare system[3]). The main reason for the low life-expectancy in the USA is that so many Americans die before they reach the age of 45 as a result of gun-related deaths, automobile accidents and drug overdoses . So, context is important in determining outcomes. And, of course, no matter how efficient a system is, it cannot produce the outputs required if the inputs are too low.

A meaningful assessment of health system performance therefore needs to take into account all the factors set out in Figure 1 below.

Figure 1: Analysing health system performance



[3] (Commonwealth Fund, 2014)
[4] (Burn-Murdoch, How disadvantage became deadly in America, 2023)

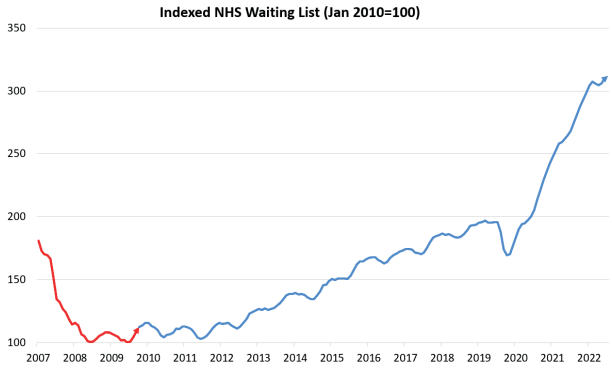
OUTPUTS AND OUTCOMES

Figure 2 below summarises the outputs and outcomes under the last part of the previous Labour government and the most recent Conservative government.

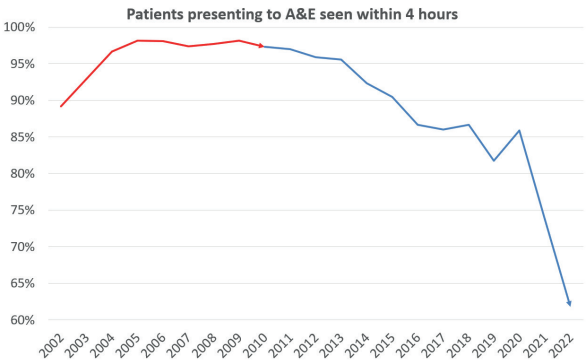
In terms of outputs directly controllable by the NHS, between 1997-2010 there was a large improvement: waiting lists fell dramatically (and have since risen dramatically), and emergency admissions seen within 4 hours rose to well over 95% (and have since fallen back dramatically).

In terms of outcomes, the picture was less rosy: we remained within the bounds of our peer countries under the last Labour government, but were never among the best; and our performance has since drifted below that of almost all our peers.

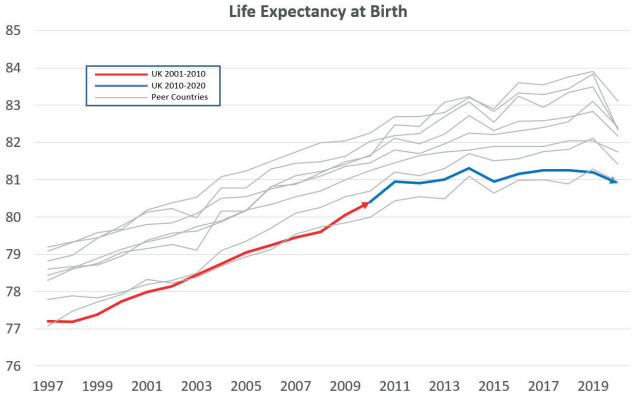
Figure 2: NHS performance over time



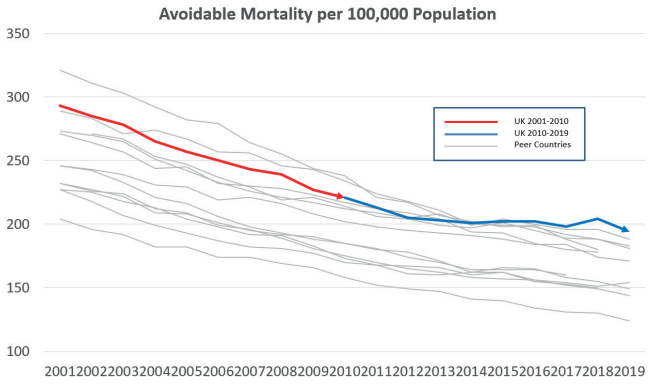
Source: NHS England and NHS Improvement: monthly RTT data collection



Source: A&E performance and emergency activity annual time series



Source: OECD.stat



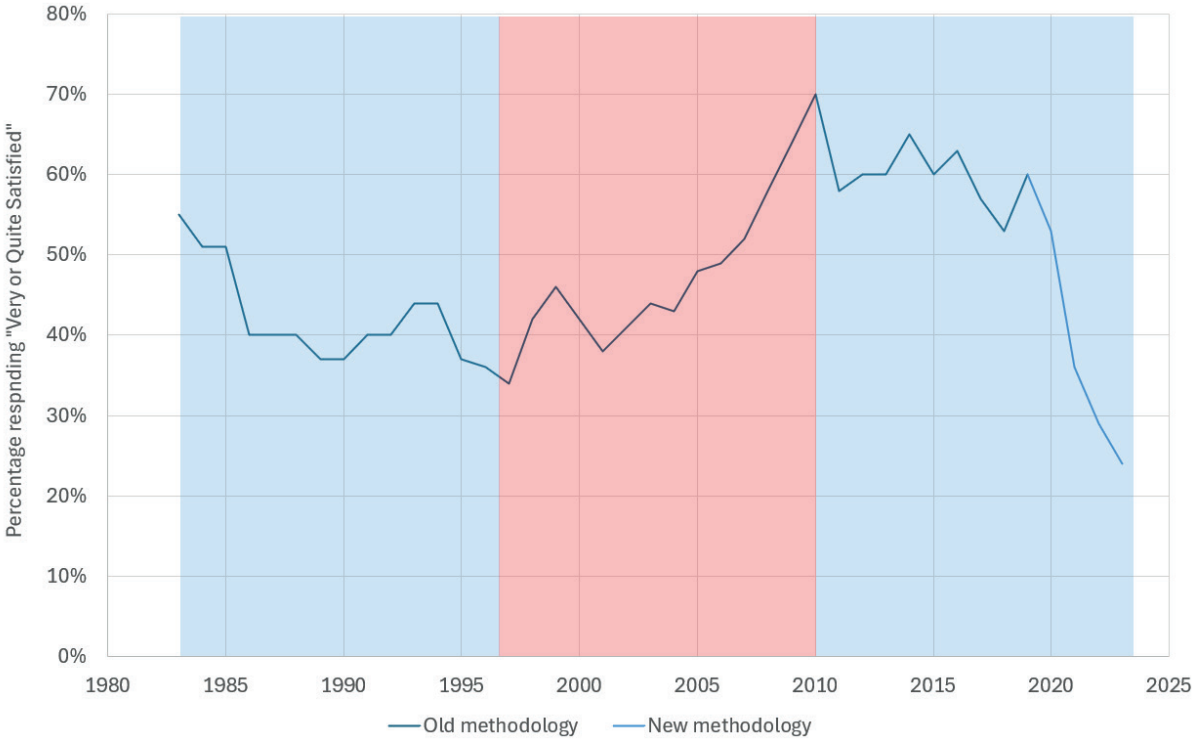
Source: OECD.stat

Nevertheless, the overall picture is clear: the performance of the NHS improved dramatically under the last Labour government.

PUBLIC SATISFACTION

This improvement was recognised by the public: satisfaction with performance of the NHS[5], which had fallen by 1997 to what was then an all-time low, rose to an all-time high by the year 2010, before declining slowly during the 2010s and more swiftly in the early 2020s.

Figure 3: Public satisfaction with the NHS over time



Source: British Social Attitudes survey

The statistics were reflected, in other words, in the public's perception of performance. Relative to the past, the NHS was now performing well again. Which leads us to consider how it stacked up against other countries' systems.

INTERNATIONAL COMPARISONS

There are many organisations which carry out international comparisons of healthcare systems. Of those, one of the best known – and one which addresses all the issues of efficiency, effectiveness and equity – is the Commonwealth Fund. (For more on the range of benchmarks available, and how comprehensive is the Commonwealth Fund assessment methodology, see *The Rational Policy-maker's Guide to the NHS*[6].)

[5] (Jeffries, Wellings, Morris, Dayan, & Lobont, 2024)
[6] (The 99% Organisation, 2023)

Figure 4, below, shows the results of the Commonwealth Fund assessment published in 2014, based on data from the early 2010s.

Figure 4: Commonwealth Fund assessment from early 2010s

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS: Top 2* / Middle / Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National* Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data*, 2013 (Paris: OECD, Nov. 2013).

Source: (Commonwealth Fund, 2014)

As the chart shows, the NHS scored extremely well on the quality of care it provided. It also had intrinsic advantages in both equity and efficiency which have been reflected in its rankings.

In terms of equity, the NHS being (still largely) free at the point of use and funded by progressive taxation is the best system yet devised to ensure that access is determined by need not wealth.[7]

Healthcare is expensive, and in countries such as the UK with high levels of income inequality , most people could not afford to fund their own healthcare. This remains true even though the UK has a very efficient system. A study in the British Medical Journal[8] concluded that:

[7] (OECD, 2023)
[8] (Papanicolas, Mossialos, Gundersen , Woskie, & Jha, 2019)

"The UK spent the least per capita on healthcare in 2017 compared with all other countries studied ... and spending was growing at slightly lower levels (0.02% of gross domestic product in the previous four years, compared with a mean of 0.07%)."

Nevertheless, the average cost per person for healthcare in the UK in 2021 was over $5,000 (roughly £4,000)[9], which would put it out of reach for many families. Median household disposable income (income after taxes) fell in 2022[10] to £32,300. Even assuming that an insurance-based system would reduce the tax burden, most families with children could not afford to pay a premium of £16,000[11] for health insurance.

On efficiency, as the NHS is cheaper than most other systems, it scores well on that dimension, too. Indeed, there is no country which has been consistently more efficient than the UK. One reason for this is its enormous economies of scale, in particular, the monopsony[12] buying power the NHS exercises. The UK pays around 40% of what the US pays[13] for the same drugs, for example:

"The United Kingdom, France, and Italy generally have the lowest prices among the comparison countries for all drugs and for brand-name originator, biologic, and nonbiologic drugs separately."

The one area where the NHS did not score well is, as we have already shown, on outcomes – and that is largely because of the high rates of poverty and inequality[14] in the UK.

Overall, in the early 2010s, the NHS was ranked best of the advanced healthcare systems analysed by the Commonwealth Fund. So there was a huge improvement, showing up in outputs, recognised by citizens, and comparing well with systems in other developed countries.

We now turn to the question of what caused that improvement.

[9] (OECD, 2023)
[10] (Office for National Statistics, 2023)
[11] For a household of two adults with two children
[12] Monopsony is to buying what monopoly is to selling: if you are the only buyer, or even just vastly bigger than those trying to sell to you, you have tremendous bargaining power
[13] (Mulcahy, et al., 2021)
[14] (Burn-Murdoch, Britain and the US are poor societies with some very rich people, 2022) (OECD, 2023)

THE SOURCE OF THE IMPROVEMENT

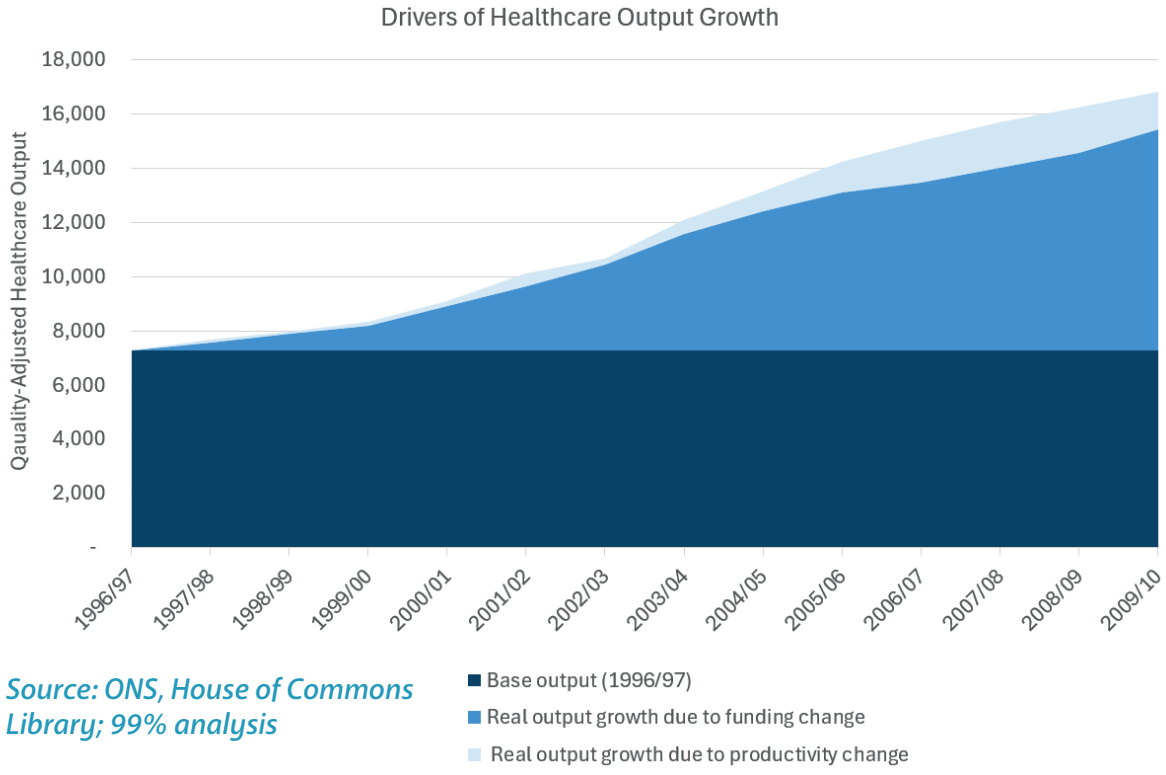
It is important to consider what it was that drove the improvement in the NHS under the last Labour government. During the period 1997-2010, under the Health Secretaries Frank Dobson, Alan Milburn, John Reid, Patricia Hewitt, Alan Johnson and Andy Burnham, there were numerous initiatives introduced to improve NHS performance. Disentangling exactly which of their initiatives were successful is difficult – but it is relatively easy to split the initiatives into two broad classes and assess their contributions to the improvements:

1. Increases in NHS funding;
2. Other improvements.

The ONS provides data on healthcare efficiency (which they call 'productivity adjusted for quality of care')[15] – i.e. how much healthcare was delivered per £ spent in each year. If the total amount of healthcare delivered doubled because there were twice as many hospitals and twice as many doctors and nurses, etc – in other words because funding doubled – that would be a 100% improvement in output, but a 0% improvement in efficiency. If funding remained constant, but the total amount of healthcare delivered rose by 10%, that would be a 10% increase in output driven by a 10% improvement in efficiency.

This enables us to derive the following picture.

Figure 5: Drivers of growth in healthcare output



Source: ONS, House of Commons Library; 99% analysis

[15] (ONS, 2024)

The graph shows that the more than doubling in volume of healthcare output delivered during the period 1997-2010 was overwhelmingly (more than 85%) driven by the increase in funding provided. While some of the improvement related to efficiency improvement, this was below what we should have expected based on normal rates of efficiency improvement. This means that in aggregate, the initiatives which were intended to boost efficiency above normal rates of improvement did not do so – they were collectively slightly negative, though some may have been successful.

It *is* clear that the improved funding of the NHS was the main driver of the success of the 1997-2010 government; and the new government's decision to increase NHS funding is therefore likely to bear fruit as long as it is both adequate and sustained.

It is not clear which of the many reforms introduced over the 1997-2010 period were successful. Possibly, all were; it is f*ar more likely that some were significant successes and others significant failures. It is important that we understand which reforms were helpful, and which were detrimental.*

3. THE 1997-2010 GOVERNMENT INSTIGATED SOME INITIATIVES WHICH NEED SCRUTINY

The overall picture from 1997-2010 is one of a successful turnaround of the NHS from a low base, but as noted in Section 2, it is likely that some of the individual initiatives introduced by the last Labour government were unhelpful. While it is not 100% clear which initiatives were successful and which were not, there are good reasons to suspect that the following initiatives were counter-productive:

- The Private Finance Initiative;
- Lack of rigour in target-setting, leading to distortions of priorities;
- Use of public funds to build private sector capacity.

There were also major issues which the 1997-2010 government did not tackle – notably Social Care.

To succeed this time, the government must skilfully avoid the pitfalls of the past.

THE PRIVATE FINANCE INITIATIVE

The Private Finance Initiative (PFI) was introduced as a way of getting NHS financing off the public books by getting the private sector to do the borrowing. Most PFI contracts had three elements: a financing element, a construction element and an operating element.

In brief, the problem is that all three elements were flawed, the first unavoidably so:

- Getting the financing off the books was an accounting sleight-of-hand that did not reduce the government's financial liabilities – in fact it increased them, as it was bound to do, because the government can borrow more cheaply than any private sector organisation: we are still paying the price;

- There is nothing wrong in principle with using private sector construction companies, but when very long-term contracts have been signed and are hard to break, and requirements change (as they will), a skilled contractor will extract a huge price for contract changes;

• Many facilities management tasks were contracted out to the private sector; however, in practice, the main 'efficiency' the private sector offered was poorer terms and conditions for their employees, and again, even small changes such as fitting a shelf could become exorbitantly expensive.

Appendix 1 explains in detail how this happened and summarises the reasons that led the National Audit Office[16] to conclude that PFI was poor value for money.

TARGETS DISTORTING PRIORITIES

No organisation can run without measurement; but it is easy to destroy an organisation by getting measurement wrong. For over half a century, management scientists have been wrestling with the problem of how to measure and manage success. As V F Ridgway[17] wrote,

> *"In all the studies mentioned above, the inadequacy of a single measure of performance is evident. Whether this is a measure of an employee at the working level or a measure of management, attention is directed away from the overall goal."*

And he concluded that,

> *"Quantitative performance measurements – whether single, multiple or composite [can] have undesirable consequences for overall organizational performance."*

In healthcare, of course, overall performance is what counts – the effects of anything less than very careful design and use of performance measures can be dangerous. The following problems have materialised due to careless design or implementation of targets:

• **'Gaming'** – for example[18] emergency departments could move patients to unsuitable accommodation just before the 4-hour waiting time targets might be breached;

[16] (National Audit Office, 2018)
[17] (Ridgway, 1956)
[18] (Edwards & Black, Targets: unintended and unanticipated effects, 2023)

• **Over-working of staff** – the scandal at the mid-Staffordshire hospital has been attributed to an excessive focus on achieving the targets to become a Foundation Trust. The Healthcare Commission found[19] that management had made

"cutbacks to staffing and services in order to make millions of pounds' worth of surplus at the end of each year"

and that this understaffing had resulted in poor care and high mortality rates amongst patients;

• **Hitting the target but missing the bigger picture** – today, the field of ophthalmology is one in which a blunt focus on waiting lists could have a catastrophic effect. Evidence suggests that over-focus on waiting lists could be leading to an apparent improvement in some key performance indicators at the expense of creating serious health risks for the UK population.

This last issue is explored in detail in Appendix 3; very briefly, some eye conditions are relatively simple, and their treatments are quick and cheap to perform (many cataract operations would fit this description); other conditions are more complex and require much more expensive and demanding treatment. If reducing waiting lists were the *only* consideration, then prioritising the simpler cases and farming them out to private sector cataract factories would be effective.

Medically, however, it would be a disaster as leaving untreated more complex conditions like glaucoma and macular degeneration can lead to permanent blindness unless treated quickly. Moreover, there is a risk that the private sector, having an incentive to maximise demand, may treat unnecessary simple cases at the expense of essential complex ones, leading to what the President of the Royal College of Ophthalmology[20] described as patients with *"very mild cataracts getting surgery at the expense of other patients going blind."*

[19] (Business Live, 2013)
[20] (Greenwood, 2024)

USING PUBLIC FUNDS TO BUILD PRIVATE SECTOR CAPACITY

Any government has a choice about where to invest. In the case of health, it can choose to invest in building NHS capacity or to invest in creating private sector capacity. There are reasons in principle to expect that building NHS capacity would be preferable, and these are confirmed by practical experience.

There are three arguments in principle that suggest that investing in private sector capacity will be sub-optimal.

First, there are economies of scale (bigger organisations tend to be more efficient) in many industries[21] including healthcare, such as the monopsony buying power of the NHS referred to in Section 2. It therefore makes sense to invest in organisations which have large scale, rather than those which do not.

In addition, there are elements of a private sector cost base which the NHS need not incur such as a required profit margin and sales and marketing costs.

Perhaps most importantly, there is an inevitable and damaging tension[22] between a company's legal duty to maximise shareholder value[23] and the objectives of the NHS to maximise the health of the population.

Practical experience leads to the same conclusion. Historically, most health investment went into the NHS, but in late 2002, the government decided to fund several independent sector treatment centres (ISTCs) to treat NHS patients who required relatively straightforward elective or diagnostic procedures. The reasons given for doing so included increasing elective capacity available to the NHS to reduce waiting lists and times; reducing the spot purchase price in the private sector; increasing patient choice within the NHS; encouraging best practice and innovation; and stimulating reform within the NHS through competition.

The degree to which these objectives were met was assessed in 2006 by the House of Commons Health Committee[24]. The Committee concluded that there were serious grounds to believe that investing in the NHS would have provided better integration and greater value-for-money:

[21] (Blinder, Canetti, Lebow, & Rudd, 1988) (Lee, 1999)
[22] (The 99% Organisation, 2024)
[23] (Barker, 2019)
[24] (Health Committee, 2006)

"There are major benefits from separating elective and emergency care in treatment centres. Such centres should continue to be built where there is a need and where the decision to build the centre has been agreed with the local health community following Section 11 consultation. ***We are not, however, convinced that ISTCs provide better value for money than other options such as more NHS Treatment Centres, greater use of NHS facilities out–of–hours or partnership arrangements such as those at Redwood. All these options would more readily secure integration and may be cheaper.****"*

Recent research by Oxford University[25]during the Conservative government 2010-2024 adds significant concerns about the health outcomes of choosing private sector provision when a public sector alternative is possible. The conclusion was,

"The privatisation of the NHS in England, through the outsourcing of services to for-profit companies, consistently increased in 2013–20. ***Private sector outsourcing corresponded with significantly increased rates of treatable mortality****, potentially as a result of a decline in the quality of health-care services."*

[25] (Goodair & Reeves, 2022) (Goodair & Reeves, The effect of health-care privatisation on the quality of care, 2024)

FAILING TO TACKLE SOCIAL CARE

In July 2011, the Commission on Funding of Care and Support[26] produced its assessment of the state of care in the UK and how it should be funded ('The Dilnot Report'). The report concluded that care funding in the UK was not fit for purpose: it was confusing, unfair and unsustainable. People were unable to plan to meet their future care needs or to protect themselves against very high care costs. They recommended that the government introduce a fairer system that shared the costs between individuals and the state.

There has been no improvement since then. The 2010-2024 government repeatedly postponed action on care, and the new government has done the same. Meanwhile, as Caroline Abrahams[27], the Director of Age UK put it, *"the care system has gone from merely creaking to a state of near collapse in some places."*

This has huge financial consequences for individuals – which many are unable to bear – and it also has a serious knock-on effect on the NHS. More than half[28] of delayed discharges from hospitals relate to patients awaiting a solution to care or rehabilitation, and this increases waiting lists for treatment, reduces NHS productivity and harms the health of the population.

While this is a sin of omission, rather than commission, it is one which should be addressed.

[26] (Dilnot, Warner, & Williams, 2011)
[27] (Whannel, 2024)
[28] (NHS England, 2025)

AVOIDING THE PITFALLS IN FUTURE

It is to its credit that this government is taking NHS funding more seriously than any since 2010. It is vital, however, that it learns all the lessons of the past, as the room for error is far less now.

While there is no comprehensive assessment of all the initiatives undertaken under the 1997-2010 government, it is clear from Section 2 that in aggregate they had a negligible impact and likely that some, including PFI, insufficiently careful use of targets and performance measures and using public money to increase private capacity may well have been significantly negative in impact.

The government should therefore encourage rigorous investigation by Britain's leading universities of which reforms produced improvements, and which were counter-productive, the National Institute for Clinical Excellence (NICE) should be asked to assess new initiatives before launch and the NAO should be responsible for assessing which initiatives have lived up to their promises so that policy errors can be quickly rectified.

Lord Darzi's report[29]concluded that,

"the NHS is in critical condition, but its vital signs are strong."

A patient in critical condition needs very careful handling; the same is true for an organisation. We must avoid the pitfalls.

[29](Darzi, 2024)

4. THE 1997-2010 GOVERNMENT SUCCEEDED BECAUSE IT GOT THE KEY THINGS RIGHT

Despite these missteps, overall, the 1997-2010 government was good news for the NHS and for patients. They were not perfect, as Section 3 showed, but they did get the most important things right:

- They recognised and acted on the need to address previous under-funding;
- They made significant progress in addressing the social determinants of ill-health; and
- They had a sound approach to prevention and public health.

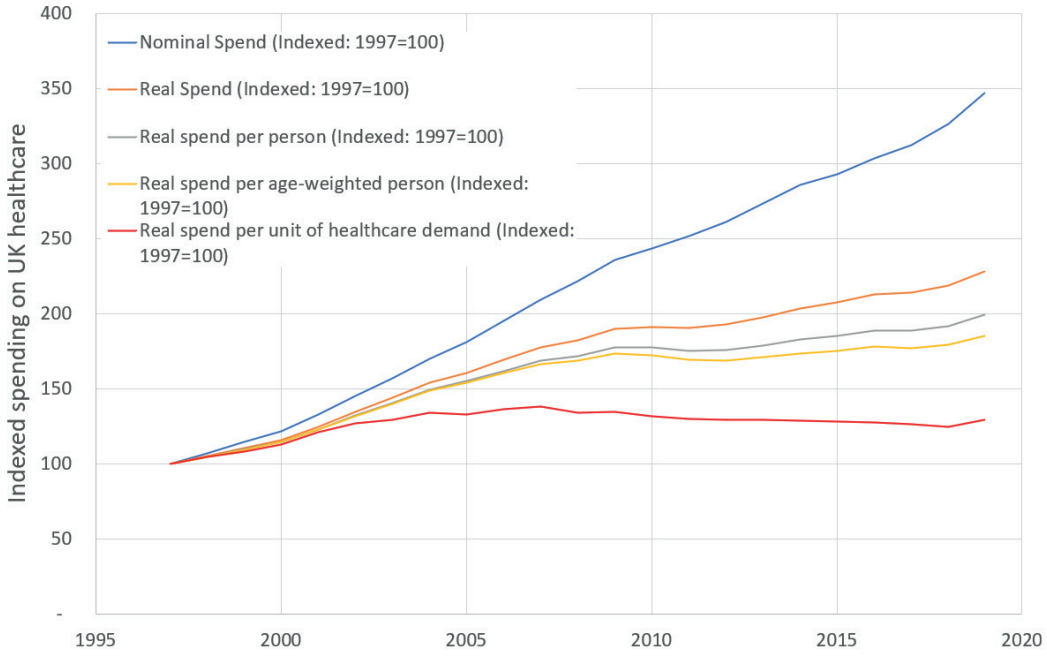
FUNDING TO MEET NEED

The 2010-2024 government repeatedly claimed that it was 'spending more than ever before on the NHS', but that is true only if you ignore the impact of inflation, a growing population, an ageing population and a population with increasing rates of ill health.

Of course, £1 in 2010 went *much* further towards meeting the needs of the UK population than £1 does in 2025. A rational policy maker would *not* ignore those other factors.

If we focus on the bottom line in figure 6, the line which *does* take these factors into account, we see that whereas we had been *increasingly* able to meet need until the Global Financial Crisis struck, the NHS has been *decreasingly* able to meet need since then. And the results since 2010 reflect that.

Figure 6: NHS Funding vs Need over time



Source: ONS, OBR, NHS Digital; 99% analysis

It is not sufficient merely to spend more than last year, we must spend *enough to meet need* – the 1997-2010 government recognised that and acted accordingly.

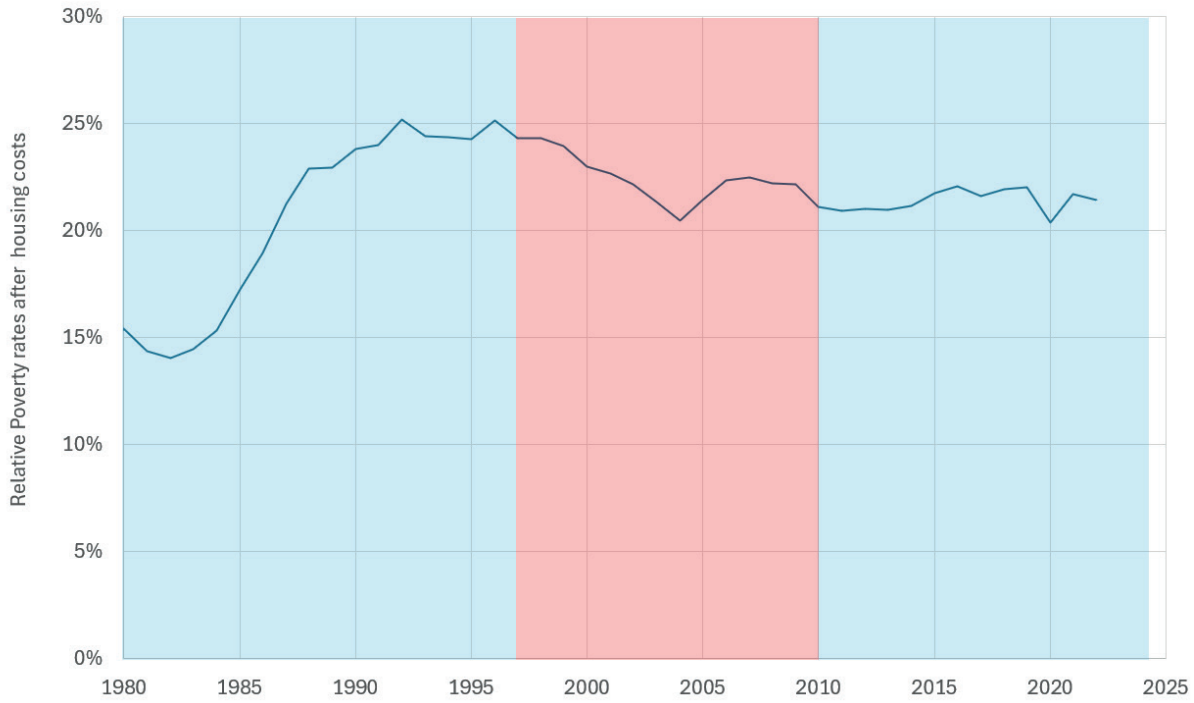
ADDRESSING THE SOCIAL DETERMINANTS OF ILL-HEALTH

The link between deprivation and lifestyle factors causing illness – i.e. between poverty and morbidity – has been demonstrated by the work of Sir Michael Marmot[30]and others. If you are poor, you are more likely to live in poor quality housing (or even to be homeless), to experience higher levels of stress, to have a poorer diet and to have less opportunity for health-giving activities. As a result, you are far more likely to suffer from ill-health.

Relative poverty had been rising fast from 1980-1987, but then it declined under the 1997-2010 government, and remained static after 2010[31](figure 7).

[30](Marmot, Allen, Boyce, Goldblatt, & Morrison, 2020) (Marmot, Fair society, healthy lives : the Marmot Review: strategic review of health inequalities in England post-2010, 2010)
[31](IFS, 2024)

Figure 7: Change in Poverty Rate over time



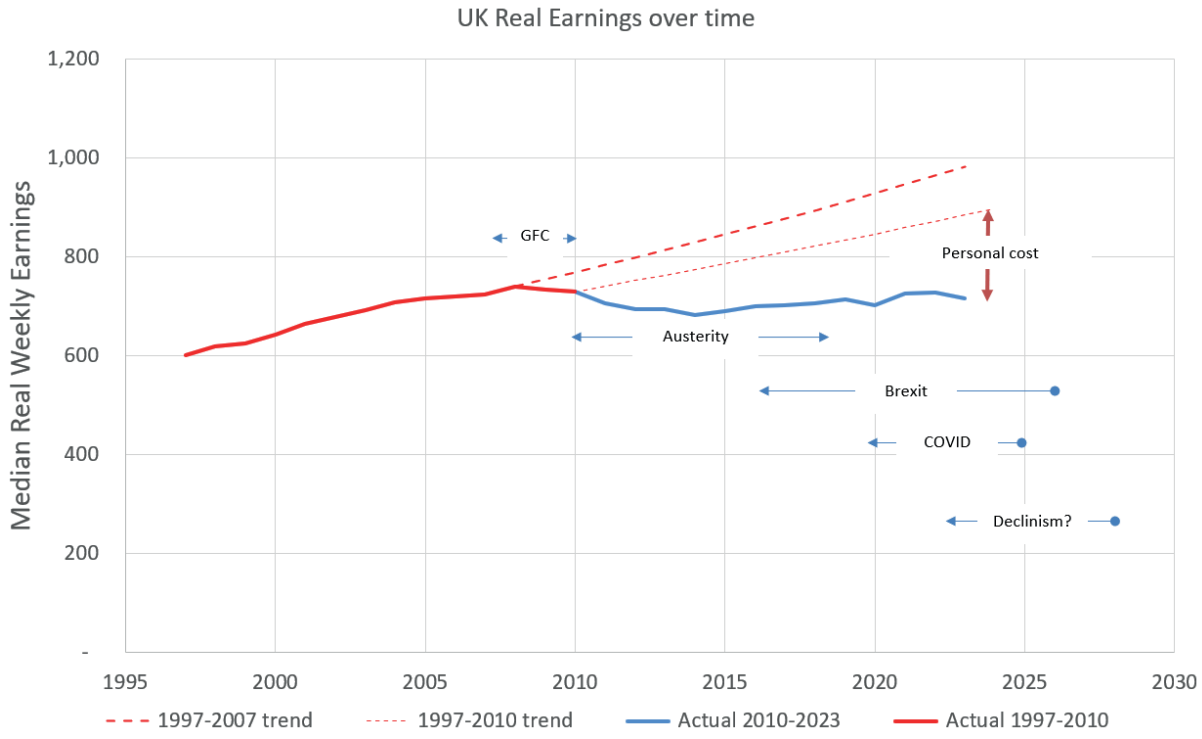
Source: IFS; 99% analysis

Figure 8 shows real (adjusted for inflation) median earnings over time. The median earner – the person in the middle of the earnings spectrum – can buy less today with their earnings than they could in 2008. In other words, normal people are poorer.

And since relative poverty is defined in terms of median earnings (you are in relative poverty if you earn less than 60% of the median), to reduce relative poverty when earnings are rising means a significant *decrease* in real-terms poverty.

Conversely, static relative poverty during a period when median earnings are falling means an *increase* in real-terms poverty – which is what we have seen since 2010.

Figure 8: Real Median Earnings



Source: ONS, OBR; 99% analysis

So, as well as funding the NHS in line with need, the last Labour government tackled some of the social determinants of ill-health.

Extra funding targeted health and education, children and pensioners. The evidence shows improvements in many socio-economic outcomes, progress towards greater equality on many dimensions including early childhood development and school education – key determinants of social equity. Labour set up 3,500 Sure Start Children's Centres[32], provided free early education for all three- and four-year-olds, and more affordable and higher quality childcare. The school workforce was boosted by 48,000 extra FTE teachers resulting in large falls in pupil-teacher ratios. The gap between the exam results of poorer and richer pupils was reduced as school attainment rose.

Greater funding at local authority level created improvements to social housing, neighbourhood management, policing, nurseries, health centres, parks, youth clubs, playgrounds and schools. The poorest neighbourhoods saw falls in unemployment rates, crime, litter, and vandalism.

Child and pensioner poverty, while not eliminated, fell to match the levels of other groups. Income differences across the life cycle were significantly reduced between age groups.

[32](Lupton, Hills, Stewart, & Vizard, 2013)

The Nuffield Trust[33]reported:

> *'There were measurable improvements in parenting as well as children's health, behaviour, and other developmental outcomes, and some health indicators improved, such as higher life expectancy, and reduced socio-economic gaps in infant mortality.'*

While the government did not address the incomes of the super-rich or overall inequality, the improvement in many of the social determinants of health had a clear impact on outcomes.

PREVENTION AND PUBLIC HEALTH

In 2010, the incoming Coalition government published a review[34]on the state of health and wellbeing in the UK. It stated that,

> *"Vast improvements in public health have meant that the biggest threats to our lives now are diseases that usually occur later in life. The onset of diseases that occur earlier in life are at least partly linked to the way we live our lives. ... The overall disease burden of ill health does not appear to have been rising. Overall prevalence of disease has been fairly stable over the last 30 years and there is some evidence that the impact of diseases on lives has actually lessened."*

The picture today is very different: public health has been severely damaged by repeated organisational changes and by underfunding.

Prior to 2013, public health in England was the responsibility of the Health Protection Agency (HPA). The HPA's role was to provide an integrated approach to protecting public health in the UK, providing advice and information to the public, health professionals and local government; and providing emergency services, support and advice to the NHS and the Department of Health. The HPA also played a lead role in helping prepare for new and emerging health threats, such as bioterrorism or emerging virulent disease strains.

In 2013, the government replaced the HPA with an executive agency of the Department of health and Social Care, Public Health England (PHE).

[33](Lupton, Hills, Stewart, & Vizard, 2013)
[34](Department of Health , 2010)

PHE was itself abolished a few years later. The abolition of PHE was announced in 2020[35]during COVID, with the initial proposal being to combine it with NHS Test and Trace to form a National Institute for Health Protection (NIHP), under a new leadership structure headed by Conservative peer Dido Harding as interim CEO. Harding's appointment was later found to be unlawful[36]. In March 2021, it was announced that the new agency would instead be called the UK Health Security Agency, commencing on 1 April and led by Jenny Harries (formerly a regional director at PHE and Deputy Chief Medical Officer for England).

To add to the problems, the public health grant has been cut by 28%[37] on a real-terms per person basis since 2015/16, and this has tended to be greater in more deprived areas. In Blackpool, ranked as the most deprived upper tier local authority in England, the cut to the grant (including new drug and alcohol treatment and smoking services and support funding) has been one of the largest.

Prevention is extremely good value for money: both the World Health Organisation[38]and the Health Foundation[39]put the cost of prevention as about one-quarter of the cost of cure. In 2010, the state of public health was good; since then it has worsened considerably.

[35](Wikipedia, 2025)
[36](BMJ, 2022)
[37](Finch, Gazzillo, & Vriend, 2024)
[38](World Health Organisation, 2014)
[39](Finch, Gazzillo, & Vriend, 2024)

WHY THE TURNAROUND FROM 1997-2010 WORKED

The reason *why* getting these things right more than compensated for any errors the 1997-2010 government made is that *these are the key elements* of a **larger social and economic system** of which the NHS is a part.

Common sense is enough to tell us that each of the three chains of cause and effect listed below exists in the real world; but common sense alone is not enough to tell us how great the real-world impact of each one will be:

- **Chain 1: the Capacity Loop[40]:**
  - o Economic output enables economic decisions to fund;
  - o Funding drives capacity to treat;
  - o Capacity to treat (staff, technology, hospital beds, etc) drives treatment provided;
  - o Treatment provided drives rates of recovery and hence number of healthy people;
  - o Number of healthy people of working age drives economic output;
- **Chain 2: the Poverty Loop:**
  - o Economic output enables economic decisions to address poverty;
  - o Poverty drives morbidity;
  - o Morbidity drives demand for treatment;
  - o Excess demand causes untreated illness;
  - o Untreated illness drives (negatively) number of healthy people;
  - o Reduced number of healthy people of working age decreases economic output;
- **Chain 3: the Prevention Loop**
  - o Spending on prevention reduces illness;
  - o Reduced illness reduces need to treat;
  - o Reduced need to treat reduces funding requirement for treatment capacity;
  - o Reduced funding requirements facilitates adequate spending.

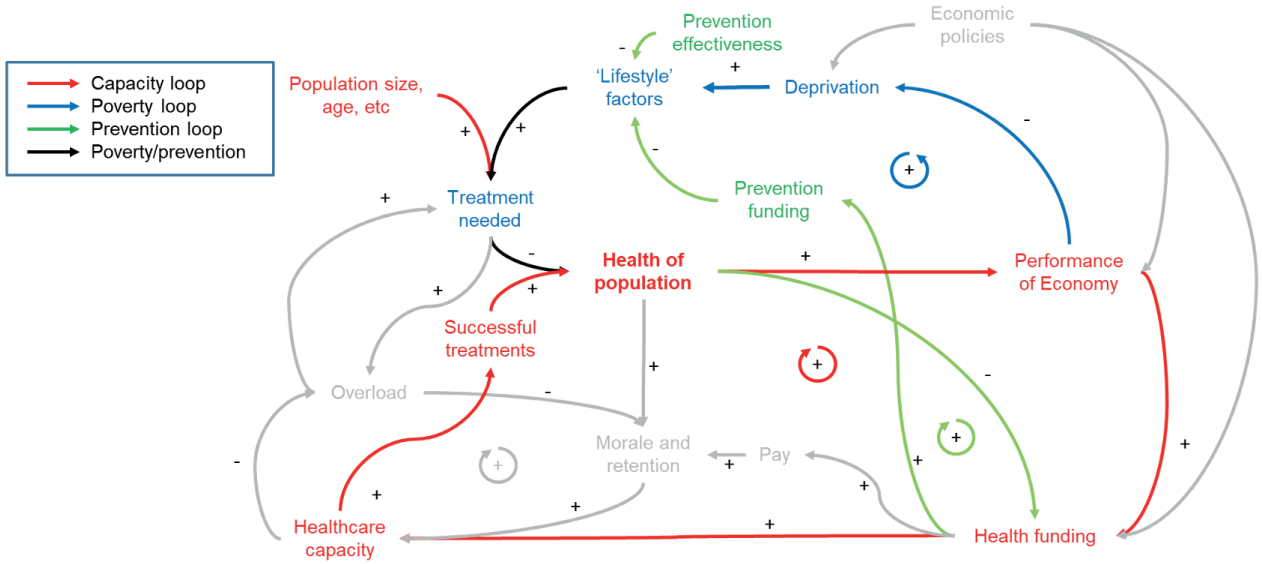
[40]The NHS Confederation and the IPPR also examined part of this loop, with similar conclusions: (CF, 2022) found that for every £1 spent on the NHS, the economy grows by £4 and (IPPR Commission on Health and Prosperity, 2023) that well over 2% of GDP has been lost due to long-term ill health.

And there are other important issues that are not part of these three loops, for example, **the overload loop:**

- Having less capacity than needed to deliver the treatment required results in staff overload; which damages
- Morale and retention; which affects
- Workforce capacity and productivity.

When we put the capacity, poverty and prevention loops together, we start to see the complexity. The diagram below shows a simplified picture of the cause-and-effect relationships between the healthcare system and the wider economy. It looks complex because it is.

Figure 9: Interactions between Health and the Economy



Source: See pp53-59 of The Rational Policy-maker's Guide to the NHS

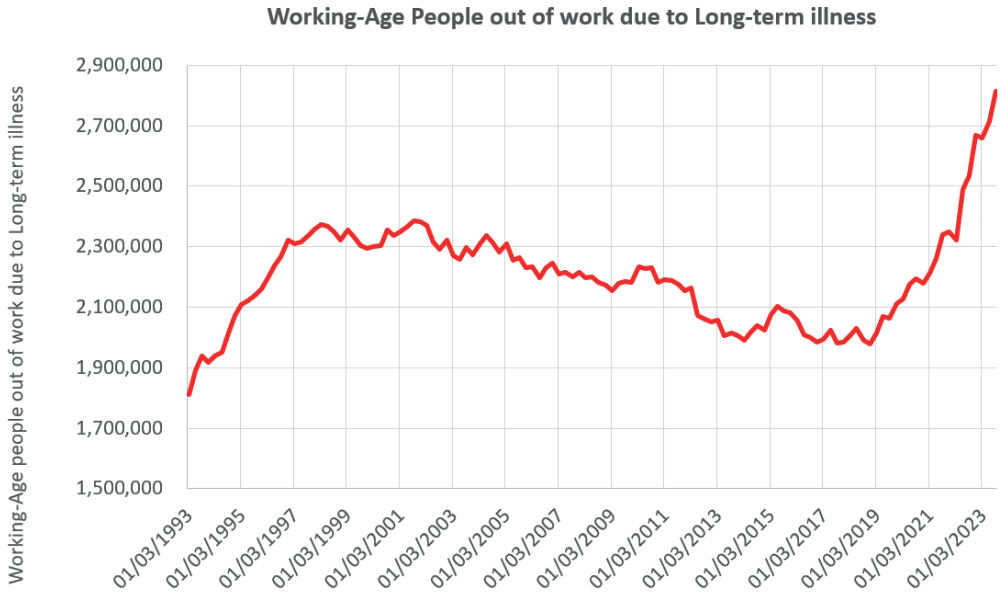
Each individual cause-and-effect link above is easy to understand: either there is a positive[41]relationship (in which case the cause and effect increase and decrease together) or there is a *negative* one (in which case an increase in the cause produces a decrease in the effect). The link between 'Successful treatments' and 'Health of the population', for example, is a positive one: the *more* 'Successful treatments', the *greater* the 'Health of the population'. The link between 'Prevention Effectiveness' and 'Lifestyle factors' causing illness is negative: the *more* effective the prevention spending, the *fewer* people will fall ill.

[41] In this paragraph, the words 'positive' and 'negative' refer to the nature of the relationship; they do not imply that one is good and the other bad.

The discipline of System Dynamics[42] developed from the 1950s onwards precisely to help policy-makers deal with this kind of complexity and reach sound conclusions in areas where common sense alone will not suffice. In our previous report[43], we used a System Dynamics model based on Figure 9 which shows both that a strong economy becomes impossible without a healthy population (so an underfunded healthcare system has huge cost to the wider economy) and that the cost of meeting demand will (even with an aging population) be a stable % of GDP (as long as morbidity within age groups does not continually increase[44] and therapeutic inflation is contained).

In that report, we concluded that if the NHS were allowed to fail, the UK economy would fail with it. Recent data suggests that this is correct.

Figure 10: How the Economy is suffering from the NHS crisis



Source: NHS, ONS; 99% analysis

In summary, the 1997-2010 government succeeded in turning around the NHS because they got some key things right:

- They funded the NHS in line with need;
- They had a reasonably effective approach to public health;
- They made good progress in addressing the social determinants of ill-health.

These should be the key learnings for today's government.

[42] (System Dynamics Society, 2023)
[43] (The 99% Organisation, 2023)
[44] This requires both action on the social determinants of ill-health and a sound preventive strategy, e.g. to protect the population against COVID and other public health risks

5. HOW THIS GOVERNMENT CAN SUCCEED

It is clear what needs to happen to rebuild the NHS. It must be made to happen – the consequences of allowing the NHS to fail, medically, economically and politically are too grave to be contemplated as an option.

The question is how it can be made to happen, given all the other challenges facing the government:

- When governments have decided that they must succeed, they find ways to do so – even when that means taking uncomfortable decisions;
- Successfully rebuilding the NHS – and other aspects of national renewal – will require joined-up government;
- As argued earlier, the government must learn from what works.

WHY THE GOVERNMENT MUST SUCCEED ON THE NHS

Imagine if what has happened to NHS dentistry were to happen to the rest of the NHS.

Regional health inequalities would worsen, many people would be unable to get treatment for non-emergency procedures and A&E demand would rise correspondingly[45], medical bankruptcies would become more common[46], and many people would postpone getting medical attention or resort to do-it-yourself treatments which can lead to life-threatening conditions[47]and ill-health and avoidable mortality would rise.

The health consequences are obvious, and morally unacceptable. The economic consequences would also be dramatic – Figure 10 showed the impact of the existing NHS crisis on the workforce. The former Deputy Governor of the Bank of England, Andy Haldane estimated[48]that the cost to the UK economy is already £150 billion per annum. But that is nothing compared with the cost of such an NHS failure: as our previous report[49]showed, if the NHS were allowed to fail in such a way, the UK economy would fail with it.

The long-term political consequences for the UK of such a double failure would be unthinkable.The UK cannot afford the government to fail on the NHS. It is not an option to be considered.

[45](Stiebahl, 2025)
[46]In the UK, currently, medical bankruptcies run at under 10%; in the US they run at over 66% (World Population Review, 2025)
[47](British Dental Association, 2024)
[48](Haldane, 2023)
[49](The 99% Organisation, 2023)

PLANNING TO SUCCEED - AS ATTLEE DID

When failure is not an option, governments find ways to succeed. Often this means taking actions more radical than those they would normally consider.

Before the Second World war, the idea of a British government introducing a compulsory lending scheme, driving debt up to over 250% of GDP, rationing food and other essentials and introducing a top rate of income tax of over 90% would have been inconceivable. But after Churchill's famous *"we shall never surrender"* speech[50], the question was no longer, *can we afford to win the war?* but *how shall we pay for it?* A question answered by Keynes[51]. Without taking these actions, it is unlikely that Britain would have held out against the axis powers.

After the Second World War, Attlee's government would have had plenty of excuses for non-delivery: as mentioned earlier, at the end of the Second World War, Government debt to GDP stood at over 250%; in addition, the cost of servicing that debt was over 5% of GDP; more than half of national income had been diverted to the war effort and over 5 million people mobilised into the Armed Forces; some 5% of national wealth had been destroyed, and 1% of the population lost (and the equivalent figures were even worse in some other countries). Under such circumstances, a major increase in public spending would normally be considered unthinkable. Nevertheless, in 1948, at a time when the ratio of government debt to GDP was still over 200%, Attlee's government founded the NHS. Also in 1948, it passed the National Assistance Act, which abolished the poor law system and established a social safety net to protect the poorest and most vulnerable, completing the work of the National Insurance Act of 1946. Without these actions, the conditions of the poorest and most vulnerable in the UK would today be at best like the poorest in the US[52] – and probably worse.

Although it is already clear from the early stages of the COVID Inquiry that the Johnson/Sunak government handled the pandemic badly[53], they got at least one thing right. Once ministers understood that without a lockdown, hundreds of thousands of UK citizens would die needlessly, they found a way to fund a furlough scheme. At that time government debt stood at around 85% of GDP. From Cameron onwards, Prime Ministers had been arguing that such debt was dangerously high and there was *"no magic money tree"*[54], so there was no way of funding UK public services adequately.

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[50] (Churchill, 1940)
[51] (Keynes, 1940)
[52] In the US, 1.2% of the population survive on under $3.65 per day; in the UK, the figure is 0.5% (World Population Review, 2025)
[53] (Hallett, 2024)
[54] (Cameron, 2010)

Surely, then, it would be impossible suddenly to find a spare £70 billion[55] to pay for a furlough scheme? In fact, no: the UK became the first country[56] to use money creation by its central bank to finance the furlough scheme directly. Without that action, hundreds of thousands would have died at home, without proper medical support as the NHS was already close to being overwhelmed[57], people with other conditions would have been crowded out, public order might have broken down, and the economy would be in a far worse condition even than it is today.

When failure is not an option, governments can find a way to succeed.

DELIVERING JOINED-UP GOVERNMENT – A DEPARTMENT FOR NATIONAL STRATEGY

The government faces serious challenges, well beyond the NHS. And they are interconnected. As Section 2 explained, health outcomes are determined by factors well outside the control of the NHS – the health system cannot pick up the pieces of a broken country; and as Section 3 showed, the dependency works the other way, too – the rest of the economy cannot succeed without a healthy workforce. As well as being prepared to act radically, delivering renewal will require a capability for joined-up thinking and action.

Every major business has a strategy department whose job it is to step back from the detail, look at the big picture and the long term and develop a sound response to the challenges it faces.

China[58] and Singapore[59] have long-term plans for their countries, using a range of systems thinking and other techniques to assess the trade-offs involved. They have been remarkably successful in achieving their aims. The UK, however, does not have a department for national strategy. So the first step would be the creation of a Department for National Strategy. Importantly, this should not be part of the Treasury.

And since, as a saying attributed to Sun-Tzu points out, "Strategy without tactics is the slowest route to victory. Tactics without strategy is the noise before defeat," there also needs to be a powerful department capable of ensuring that the tactics are consistent with the strategy: i.e. that the national strategy is translated into operational plans, that these plans are resourced and coordinated, and that they deliver. That would require an expanded role for the Cabinet Office, working with the other departments of state.

[55] (Francis-Devine, Powell, & Clark, 2021)
[56] (Giles & Georgiades, 2020)
[57] (Fong, Summers, & Cook, 2024)
[58] (Valchev, 2021)
[59] (Chiam, 2021)

A full exploration of the issues beyond the NHS is outside the scope of this report: our next report will cover them in detail.

LEARNING FROM WHAT WORKS

Section 1 showed that there was subnormal growth in NHS efficiency between 1997-2010 despite all the initiatives undertaken during that period. The improvement in healthcare output was overwhelmingly down to proper funding. Section 2 explained that at least some of the 1997-2010 initiatives are likely to have *reduced efficiency*. In addition to the actions set out in Section 3, rebuilding the NHS sustainably will require a steady improvement in efficiency over time, and that in turn will require learning from what works.

There is no shortage of ideas[60] for efficiency improvement and anecdotal evidence of successful initiatives.

The problem is that, even for businesses, learning from what works is difficult: it means accepting that some things did not work. No project manager, director or sponsor wants to admit that his/her project failed, and the politically powerful can cover up failure. Even pilot projects whose objective was to test an idea may be deemed successful for political reasons.

In the public sector, where scrutiny is higher and criticism more intense, this issue is even more difficult. There are, however, two initiatives the government could undertake to address the problem.

First, as suggested in Section 2, it could encourage Britain's leading universities to look retrospectively at improvement initiatives between 2010-2024 – that is 14 years' worth of learning, which would not be politically damaging.

Secondly, it could create a stream of competitive pilots, assess them rigorously and pick (and celebrate) the winner. In 2019, for example,[61] three economists shared the economic equivalent of the Nobel Prize for their work developing rigorous ways of assessing poverty-reduction programmes, equivalent to the randomised control trials used to test drugs.

We are used to evidence-based medicine; now we can have evidence-based policy.

[60] (The Bevan Commission, 2025)
[61] (The Nobel Prize, 2025)

CONCLUSION

This government faces huge challenges in rebuilding the NHS. They are challenges it must not duck. To succeed, it will need to challenge its own orthodoxy, it will need to build a genuine capability for joined-up government, and it will have to learn from what works.

All of this is possible. The alternative is failure: for the government and for the country.

APPENDICES

Appendix 1: The Private Finance Initiative

- History of the Private Finance Initiative
- How did PFI work?
- PFI's key features
- Issues with PFI
- Conclusion

Appendix 2: How Opthalmology can suffer from an excessive focus on waiting lits

- The nature of eye diseases
- Direct impact on patients
- Wider impact of excessive focus on simpler cases
- Conclusion

Appendix 3: Contributors

Appendix 4: Bibliography

APPENDIX 1:
THE PRIVATE FINANCE INITIATIVE

The Private Finance Initiative (PFI) was conceived by the 1992-1997 Conservative Government, but the majority of PFI schemes were delivered during 1997-2010. PFI was abandoned in 2018 when it was deemed poor value for money. In July 2024 Lord Mandelson lobbied the incoming Labour Government for a new, improved, version of PFI to support the Government's ambition for growth and to fund much needed infrastructure.

This appendix is drawn mainly from a National Audit Office (NAO) report[62] and explains to MPs who may not be familiar with the details of PFI why, however much it might be 'improved' from the original concept, PFI will always be poor value for money and should not be used to fund public infrastructure.

HISTORY OF THE PRIVATE FINANCE INITIATIVE

PFI was introduced in 1992 against the backdrop of the Maastricht Treaty which provided for European Economic and Monetary Union (EMU). To participate in EMU, EU member states were required to keep public debt below a certain threshold, and PFI was a mechanism to take debt off the government balance sheet and so meet the Maastricht convergence criteria. In 1997 two months after Labour Party took office, the Health Secretary, Alan Milburn, announced[63] that *"when there is a limited amount of public-sector capital available, as there is, it's PFI or bust".*

Following the 2008 Global Financial Crisis, Parliament became increasingly critical of the PFI model and in 2013, having consulted on changes, HM Treasury launched PF2. In 2018 following a National Audit Office Report showing the UK had incurred many billions of pounds in extra costs for no clear benefit through PFIs, the Government cancelled PF2.

On 31 March 2023 (last reported information[64]) there were 669 PFI projects across the UK with a capital value of £50.2bn and an outstanding contract value of £143bn. The Department of Education and the DHSC accounted for 309 projects (46%), mainly schools and hospitals. Yearly contract expiries will increase from four in the 2023 calendar year to an expected peak of 71 in 2036 after which there will be a steep decline. From 2043 onwards there will be 5 or fewer expiries each year with the final three coming in 2048.

[62] (National Audit Office, 2018)
[63] (Monbiot, 2007)
[64] (Infrastructure and Project Authority, 2024)

HOW DID PFI WORK?

The Private Finance Initiative (PFI) was a procurement method used in the United Kingdom to deliver public infrastructure and services by leveraging private sector investment. It aimed to address the limitations of traditional public sector funding by involving private companies in the financing, construction, and operation of public projects such as hospitals, schools, roads, and prisons.

PFI'S KEY FEATURES

1. Private Sector Financing

A consortium of companies would form a Special Purpose Vehicle (SPV), normally a limited company, to bid for a PFI contract. The consortium would generally comprise a financial institution, a builder and an operator. The SPV raised the capital needed for projects, reducing the immediate financial burden on the public sector. This allowed governments to undertake large-scale infrastructure projects without significant upfront public expenditure. The SPV was funded through a mixture of equity and debt (typically 10:90 in early projects[65] increasing to 25:75 under the revised PF2 model).

2. Long-Term Contracts

PFI projects typically involved long-term contracts (often 25-30 years) between the public sector and private consortia. The private sector would design, build, finance, and operate the asset, while the public sector paid annual fees (known as "unitary charges") for the use of the facility. The annual unitary charge would usually be adjusted upward for inflation.

3. Risk Transfer

A key principle of PFI was the transfer of risks (e.g., construction delays, cost overruns, and maintenance) from the public sector to the private sector. This was intended to incentivise efficiency and innovation.

4. Service Provision

The private sector was often responsible for maintaining and managing the asset throughout the contract period, ensuring that the infrastructure remained in good condition.

[65] (National Audit Office, 2012)

ISSUES WITH PFI

1. Cost of Debt

In 2011 the House of Commons Treasury Committee[66] said, *"Private finance has always been more expensive than government borrowing, but since the financial crisis the difference between the costs has widened significantly. The cost of capital for a typical PFI project is currently over 8%—double the long-term government gilt rate of approximately 4%. The difference in finance costs means that PFI projects are significantly more expensive to fund over the life of a project. This represents a significant cost to taxpayers."*

The interest rate was fixed at the time the PFI deal was closed to give certainty to the PFI contractors and to the public body about the long-term cost of the deal. Many PFI projects were closed in 2007 and 2008 just before the global financial crisis (GFC) at interest rates of 6-8%+. However after the GFC, general interest rates were much lower, which made the PFI deals even more expensive relative to the going rate, and because public finances (annual budgets etc) are geared to the prevailing economic conditions, the annual funding into, say the NHS, did not provide for borrowing at the PFI rates of interest making the PFI infrastructure unaffordable without additional central government support. It also made the SPVs attractive investments and many of the original funders and building contractors who were thought to be invested for the long term in their projects sold their shares on. The rules for subsequent PFI projects were amended so that if SPVs were refinanced at lower interest rates, the public sector and private sector would share the benefit, though this still meant the public sector was paying over the odds compared with a publicly funded project.

2. Risk transfer

The fixed unitary payments were not payable until the construction was complete and the asset available for use. This transferred the building risk to the private sector which was incentivised to build within budget and to time. It was seen as a major benefit of PFI. However the risk transfer caused the private sector to provide substantial contingencies to cover the cost of potential overruns and delays and to make the project investable. As the cost of the risk was priced back into the deal, the risk was effectively still borne by the public sector. If the private sector completed the project on time and to budget it banked the contingency fund as extra profit.

[66] (House of Commons Treasury Committee, 2011)

3. Efficiency and Innovation

Private sector involvement was expected to bring greater efficiency, innovation, and expertise to project delivery. This often proved to be the case. The private sector did bring innovative ideas and solutions to building problems. However, the same could have been achieved through design competitions at an early stage in the project development without the commitment to long-term PFI contracts.

Furthermore, the time it takes from original concept through to completed building, of say, a hospital, can be many years. Much of this delay is due to the bureaucratic processes involved with business cases, planning, public consultation, political decisions, departmental and treasury prioritisation and approval, and procurement. Over such a long period the specification and requirements for the project may change. This can make an original and innovative design obsolete by the time it is delivered. The time delay locks in design innovation at a relatively early stage in the process, making it increasingly difficult and costly to change even if external circumstances would require otherwise. For example, design and affordability issues caused several hospitals to be opened too small because patient demand at the point of opening was different from the planning assumptions.

4. Off balance sheet finance

The use of private borrowing was supposed to enable governments to keep the public sector borrowing within agreed limits. This was, and remains, a spurious argument for several reasons:

a) Whether it was on or off-balance sheet, it was still borrowing and not recognising it as such was storing up problems. The debt still needed to be repaid, and the cost of the debt was much higher than government debt. It was like the difference between a high street bank loan and a pay day loan.

b) 'Off balance sheet' is an accounting expression typically applied to leased assets. If a company leases an asset instead of buying it outright, the lessor remains the owner. The lease rental payment is recorded by the company as a running cost and no asset or liability appears in the company's balance sheet. Over the years Generally Accepted Accounting Principles (GAAP) have changed and the party that enjoys the risk and economic benefit of the asset records it as such in its balance sheet with the outstanding lease rentals shown as a liability. For several years the Treasury did cartwheels to ensure deals remained 'off balance sheet' and the National Audit Office report[67] noted that keeping borrowing off balance sheet was deemed the priority even if this made a deal more expensive.

[67] (National Audit Office, 2018)

c) PFI deals were not bankable without a Deed of Guarantee from the Secretary of State. In the event the contracting authority was unable to pay the unitary charges, Government would underwrite the payments. This being so, it is debatable that the private sector was ever taking a risk on the asset.

d) Many argue that the UK 'balance sheet' concept is flawed because the Treasury only accounts for borrowing and does not recognise the asset that the borrowing relates to. No-one would assess the financial health of a company on this basis.

5. Service Contracts

The original PFI contracts included provision for hard and soft facilities management (FM) services. Hard services would include the maintenance of the infrastructure while the soft services might include laundry, linen, catering, portering etc. The received wisdom was that the private sector would be more efficient at running these services. It also indicated that the private sector was the economic owner of the infrastructure and therefore the deal should be accounted for off balance sheet by the public authority.

While public sector staff were transferred to the private sector under their existing terms and conditions, it was legally possible to vary the terms over time. The main 'efficiency' the private sector offered was poorer terms and conditions for their employees.

Later PFI contracts just contained the hard FM as a service. The logic was that the private contractor would maintain the asset well and hand it back to the public authority in good working order. The cost of maintenance was priced into the unitary charge and many PFI buildings were maintained to a high standard.

But there were two unintended consequences. First, it resulted in infrastructure maintenance being prioritised over other current expenditure, because the unitary charge had to be paid. When annual budgets for running public services are tight it has been the practice of public authorities to defer less urgent expenditure such as property maintenance. This of course stores up problems for the public authority in the long run, but PFI contracts took away the flexibility to do this in the short term, sometimes resulting in cuts to public services.

The second consequence is that alterations to buildings are extremely expensive. Public infrastructure like a school[68] or hospital is highly likely to require changes over the 25-30 term of a PFI contract. Even small changes, such as fitting a shelf can be exorbitantly expensive. The impact over time is that public services must adapt to the buildings rather than adapting the buildings to the services, which can impact on service quality and efficiency.

6. Contract Management

A public authority is unlikely to have great expertise in PFI: it may only ever commission one PFI deal and would usually rely on external consultants to advise. In contrast, PFI contractors often do several deals using an in-house team. This creates a knowledge imbalance, and unless the public body appoints its own in-house expert contract managers, (at additional cost), it is at a disadvantage in contract negotiations. Many PFI contracts were poorly managed by public authorities and consequently did not optimise value for money.

Furthermore, if the contract includes facilities management, the public sector employees transfer to the private contractor so the specialist knowledge for running the facilities, or managing the contract, is also lost by the public authority.

7. End of Contract

The first PFI contracts are coming to an end and there is a concern that the hand-back to the public sector will be disorderly[69]. The Financial Times reported there is considerable toxicity in the relationships between many public authorities and their PFI contractors, and the condition of an asset can be highly subjective. This is resulting in disputes. There has already been a lawsuit over a PFI contract, and it seems possible there will be many more in years to come.

[68] (Jeffries B. , 2025)
[69] (Timmins, 2024)

CONCLUSION

For a detailed briefing on all aspects of PFI we refer the reader to the Nuffield Trust's discussion paper 'Lessons from the last hospital building programme, and recommendations for the next"[70]

This short briefing has attempted to explain what PFI aspired to be and what it became. PFI was officially abandoned in 2018 because it did not give value for money and has saddled the country with a costly liability for many years to come.

With public sector borrowing constrained, and a need for investment in infrastructure to facilitate growth and to replace obsolete or dilapidated buildings, Governments may be tempted to revisit PFI, intending to learn from past mistakes.

PFI can never be more cost effective and offer better value for money than Government borrowing, and many of the mistakes made in the earlier schemes are inevitable and unavoidable.

[70] (Edwards, Lessons from the last hospital building programme, and recommendations for the next, 2020)

APPENDIX 2: HOW OPHTHALMOLOGY CAN SUFFER FROM AN EXCESSIVE FOCUS ON WAITING LISTS

A project at Edinburgh University under the supervision of Dr Nigel Goddard explored the health impact of different policies in relation to tackling waiting lists in Ophthalmology (the treatment of eye-diseases). It concluded that over-focussing on just one or two performance measures could be effective if judged solely against those measures but nonetheless have an extremely damaging impact on patient health. There are also wider implications which should have a bearing on policy.

THE NATURE OF EYE DISEASES

Eye diseases and disorders range from the relatively straightforward to the highly complex. Many cataracts are simple cases; cases with multi-morbidity (several different conditions co-existing simultaneously) and those with conditions like glaucoma, diabetic retinopathy, macular degeneration and a host of less common conditions are often complex and, if not treated quickly and effectively, can lead to permanent blindness. Most of the treatment for these complex conditions takes place in out-patient clinics and involves multiple attendances over months or years. Although there is monitoring of the number of patients awaiting an initial out-patient assessment, and political pressure to reduce this waiting list, there is little monitoring of delays to follow-up reviews and treatment, which do not commonly feature on waiting lists. Such delays can lead to permanent and irreversible loss of vision.

Cataract surgery is the commonest surgical procedure performed in the UK and globally, so a large proportion of the patients on the surgical waiting list for ophthalmology treatment are waiting for cataract surgery, and this large number also has a significant impact on the overall surgical waiting list. A focus on reduction of this component of the waiting list by diversion of a large proportion of cataract surgery to specialist independent sector treatment centres ('cataract factories') has taken place over the past decade, even though cataracts are hardly ever a cause of irreversible loss of vision in the UK.

DIRECT IMPACT ON PATIENTS

The project considered two policy options related to resource allocation to the simpler and more complex cases:

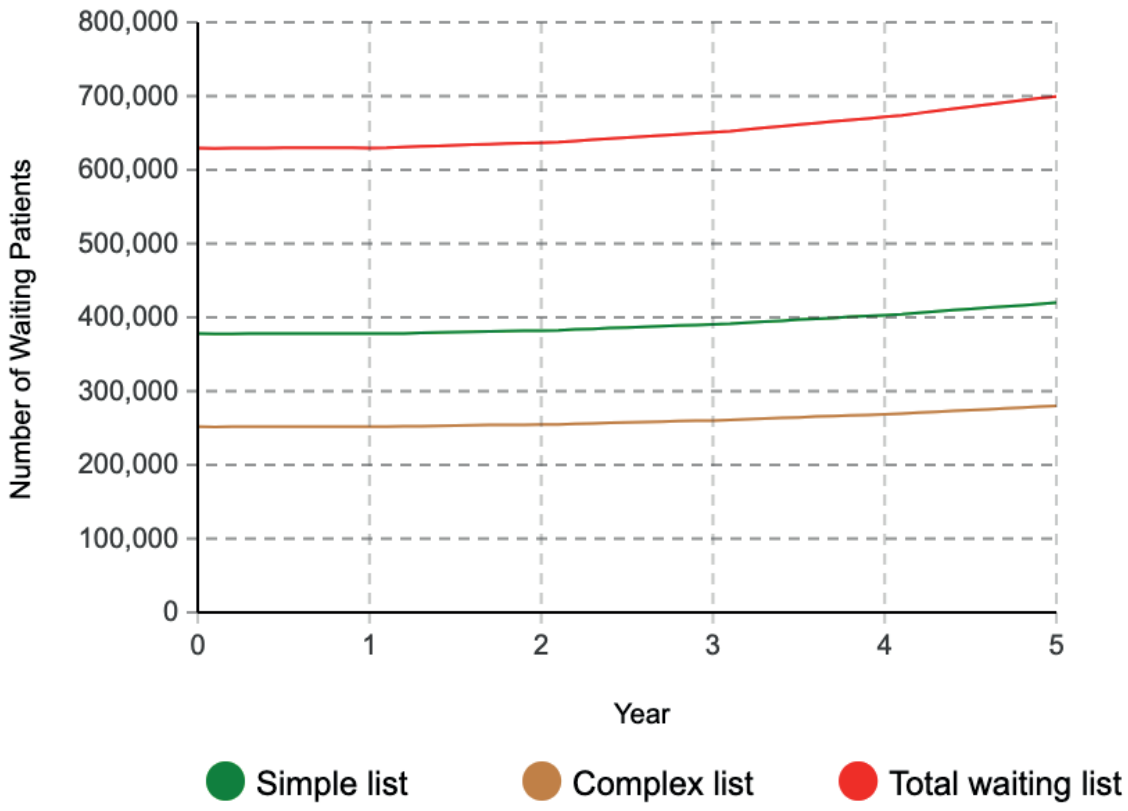
- **Option 1: Business as Usual** – this option relates to the historical resource allocation in which around 40% of the total resource is allocated to the most complex cases and 60% to the (more frequent) simple cases;

- **Option 2: Waiting List Focus** – this option prioritises containing the total waiting list by reducing the total resource allocated to the most complex cases to only 25%, leaving 75% for the simpler cases.

Option 1: Business as Usual

In this option, the performance in relation to both types of case moves together – with a gradual increase in the numbers on the waiting lists.

Figure 11: Waiting lists over time with current resource priorities



Source: Edinburgh University

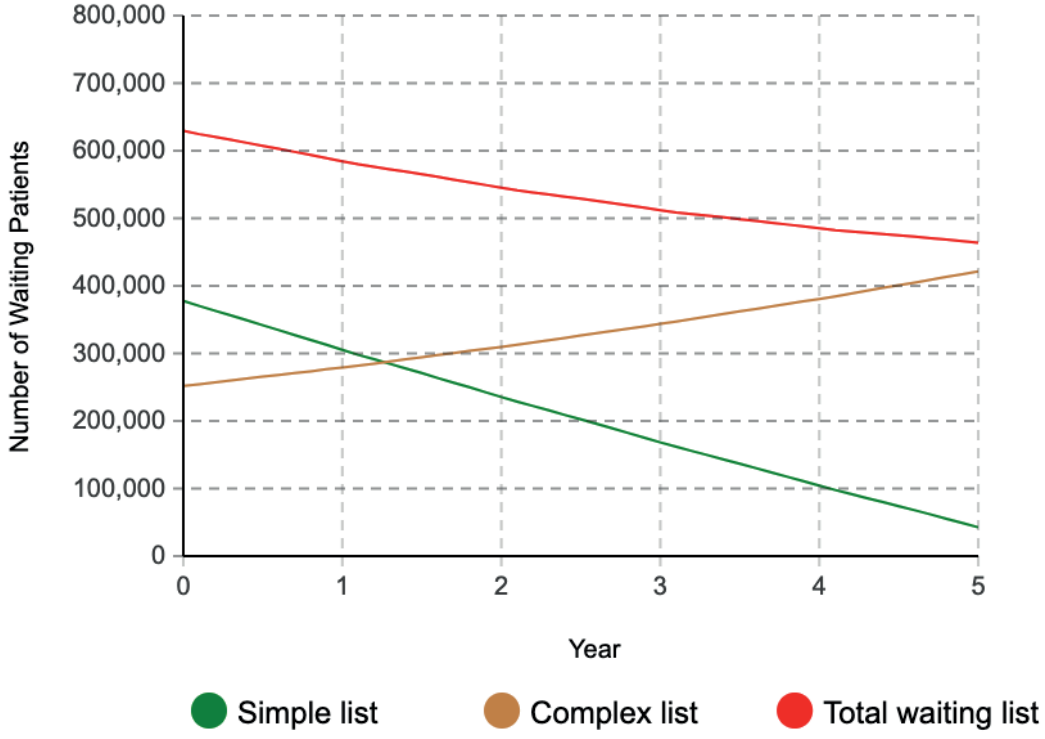
From both a medical and a total waiting list perspective, this option is less than satisfactory. In terms of the most serious cases, the number at risk of permanent blindness rises from around 250,000 to around 280,000 – an increase of 12% – while the total waiting list has continued to grow.

This makes it tempting to consider an aggressive focus on getting waiting lists down.

Option 2: Waiting List Focus

In this option, the policy is set to reduce waiting lists at all costs: 75% of the resources available are devoted to the simpler cases in order to get through the waiting list as fast as possible. The policy succeeds in this aim, but from a medical perspective is a dangerous failure.

Figure 12: Waiting lists over time with alternative priorities



Source: Edinburgh University

In this option, the total waiting list declines from around 630,000 to around 480,000 – a fall of around 25%, and the number of simpler cases plunges from around 390,000 to under 50,000 – a fall of almost 90%. Superficially, this looks like a good result, but the number of patients with complex cases, at risk of permanent blindness, rises from around 280,000 to 420,000 – an increase of 50%. The practical impact in terms of patients' health would be devastating.

That this research mirrors real-world experience is confirmed by research done by the Royal College of Ophthalmologists, which identified 169 patients suffering significant, irreversible visual loss, due to delay in treatment or review, over a twelve-month period in 2015/16. The majority of these had experienced delay in follow-up outpatient review for glaucoma, macular degeneration or diabetic retinopathy[71]. A follow-up survey is underway.

And the President of the Royal College of Ophthalmologists[72], described the impact of increasing focus on simpler procedures as being a distortion of priorities which results in some patients with *"very mild cataracts getting surgery at the expense of other patients going blind."*

WIDER IMPACT OF EXCESSIVE FOCUS ON SIMPLER CASES

Less critical than direct patient impact but important nonetheless are: the impact of such a policy on the ability to train the surgeons of tomorrow (and therefore the sustainability of ophthalmology in the UK); the impact on the financial viability of eye departments in the NHS; and the risk of provider-driven demand (demand created by the financial incentive to treat, rather than clinical need).

Impact on tomorrow's eye surgeons

The private sector providers benefit from a hidden subsidy[73] in the recruitment and training of staff:

> *"As we have noted in our previous work on the for-profit private healthcare sector, the business model of many of these clinics relies on using NHS consultants and other NHS doctors to undertake cataract operations on a free-lance basis, rather than employing them directly. This enables them to keep the costs of delivering services comparatively low compared to NHS Trusts. Compared to the NHS, private sector clinics do not contribute significant amounts to the very large costs of training ophthalmologists and other eye care staff."*

[71] (Foot & McEwen, 2017)
[72] (Greenwood, 2024)
[73] (Centre for Health and the Public Interest, 2024)

And as well as the private sector benefitting from the publicly subsidised training of the staff on which it relies, diversion of NHS provision is now having a detrimental impact on the training opportunities for the upcoming generation of eye surgeons in the NHS[74]. Trainee ophthalmologists have previously developed their skills in microsurgery through supervised operation on large numbers of patients with uncomplicated cataracts, before extending them into other kinds of less common surgery, such as corneal transplantation, glaucoma surgery and vitreo-retinal surgery. The transfer of most uncomplicated cataract surgery to the private sector has led to the loss of such training opportunities.

Some progress has been made in the last two years in arranging training placements with a couple of the independent sector providers, but less than a third of trainees had easily been able to access placements, and these are taking place towards the end of the six-year training programme, reducing the opportunity to build progressively on this surgical experience throughout their training.

Diversion of funding streams

In addition, the Centre for Health and the Public Interest (CHPI)[75] noted the destabilising effect that the transfer of more than half of all NHS-funded cataract operations to independent sector treatment centres has had on the financial resources available to fund round the clock access to emergency ophthalmology services and the treatment of conditions that can lead to permanent, irreversible, loss of vision, because under current funding arrangements, these are not funded at cost.

> *"Due to the fact that cataract surgery is a relatively routine procedure and at least in the NHS attracts a high price tag (or tariff) relative to other more complex eye treatments, cataract surgery is also deemed by those working in NHS eye care departments to be a "profitable" procedure to undertake. Throughout the course of our research we were told by a number of ophthalmologists that many NHS eye care departments use the income they receive from undertaking cataracts to cross-subsidise the costs of running emergency care and treating conditions such as glaucoma and macular degeneration as well as to treat children with complex eye care conditions. They were concerned that if their Trust lost cataract income to the private sector this would impact the financial sustainability of their eye care departments."*

[74] (The Royal College of Ophthalmologists, 2024)
[75] (Centre for Health and the Public Interest, 2024)

Clinical demand vs provider-led demand

The same study showed a large increase in the overall number of cataract operations being performed in England, and that the proportion of the NHS ophthalmology budget spent on cataract surgery has greatly increased. The natural lens of the eye will not be as clear in a sixty-year-old as in a youngster: there is no fixed level of opacity at which these aging changes would be called 'a cataract.' There is no benefit in removing the lens of the eye at an early stage and it is certainly not time-critical.

Also, one in two hundred people end up with significantly worse vision following cataract surgery, so it is not appropriate to expose a person to that risk until the cataract is beginning to prevent them from doing the things that they want or need to do.

Anecdotally there does seem to have been a lowering of the threshold at which people are being referred for consideration of cataract surgery and having the operation. There needs to be greater assurance that public funds are being used to greatest effect in reducing serious disability and not diverted to the treatment of minor levels of visual impairment. And there needs to be an awareness of the risk of provider-driven demand for cataract surgery consuming a disproportionate amount of the total budget allocated to ophthalmology.

CONCLUSION

Simple waiting-list measures do not properly capture medical priorities, and steering resource allocation based on these measures can result in serious misallocation of resources. The direct impact on patient health – patients needlessly suffering irreversible blindness – is already serious, and the sustainability of NHS eye-treatment provision could be called into question.

APPENDIX 3: CONTRIBUTORS

This paper has been produced by an all-volunteer team including: Chris Banks; David Booth; Lynne Bowers; Dr John Carlisle; Dr Shirin Eghtesadi; Dr Nigel Goddard; Dr John Lister; Professor Annabelle Mark; Professor Patricia Murray; Dr Tony O'Sullivan; Dr John Puntis; David Puttick; Vicky Sargent; Daphne Stedman; Alan Taman; Mark E Thomas (lead author); Lady Hannah Walker and Samantha Wathen. We are extremely grateful to them all for their time, and expertise; as well as to others who did not wish to have their contributions publicised.

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