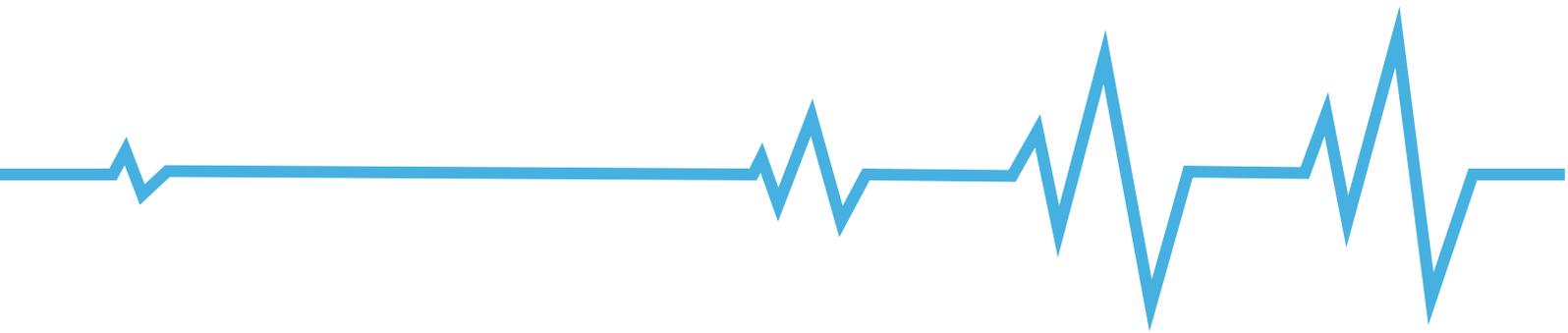


Privatisation

The Nature, Extent and Impact of Healthcare
Privatisation in the UK



NHS Working Group

Working Paper 2

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1. Executive Summary

Our report *The Rational Policy-maker's Guide to Rebuilding the NHS*¹ set out an overall strategy for how the government could learn from what the 1997-2010 government did successfully to return the NHS to its position as the developed world's best healthcare system². It also warned about repeating the mistakes of that government. This working paper looks in detail at one mistake in particular: encouraging the privatisation of the NHS.

There are those who argue that this Working Paper is not needed: there is no privatisation in UK healthcare, or if there is, it has been and remains at a low level – and in any case, privatisation is only of concern to those with an ideological opposition to the private sector.

In fact, all three of these points are fallacious, which makes it extremely important for policy makers to understand the Nature, Extent and Impact of Healthcare Privatisation in the UK:

- **There is privatisation in the UK** of at least five kinds (see Section 2) – simply pointing out that the NHS has not been sold ignores all the ways in which it *has* been privatised;
- **It is far more widespread than is generally acknowledged** – the figure which is often cited of around 7% and static represents only a tiny part of the whole picture: a more accurate summary would be to say that around 30% of the NHS has been privatised so far, and the figure is growing (see Section 3); and
- **The privatisation which has taken place harms patients and taxpayers**, and in some cases, risks undermining the long-term viability of the NHS itself (see Section 4).

For these reasons, policy-makers urgently need to understand the issues – and to drive policy change before the damage is too great to reverse (see Section 5).

¹ (The 99% Organisation, 2025)

² (Commonwealth Fund, 2014)

2. There are at least five types of healthcare privatisation

Usually when governments use the word ‘privatisation,’ they refer to selling-off public services. In this narrow sense only, the previous government was correct when it denied that NHS privatisation was taking place (*“the NHS is not for sale and never will be”*³).

There are at least four other important forms⁴ of privatisation which have been taking place, which have important implications, and which we must examine in detail.

Definition of healthcare privatisation

The World Health Organization (WHO) defined privatisation⁵ as *“a process in which non-governmental actors become increasingly involved in the financing and/or provision of healthcare services.”*

This is both a broader definition than that implicitly adopted by the last government and a more reasonable one. It would in principle be possible to privatise the entire UK healthcare system without any sale being involved. And in practice, other forms of privatisation have been happening in the UK.

Categorising the approaches to privatisation

Of course, selling-off the NHS would fall under the WHO’s definition, but so do other means of privatisation which are more common in the UK:

- Transferring public funding to private companies to provide NHS services (contracting out);
- Charging, rationing or withdrawal of NHS provision so that patients must choose between going without or paying a private sector provider for the service (throwing out or squeezing out);
- Using private finance to pay for and own NHS estates and equipment (PFI); and
- Involving the Private Sector in the management or governance of the NHS.

All four of these other forms are present in the UK health system and have significant unintended consequences for patients and for taxpayers.

Transfer of public funding to private companies to provide NHS services

Any service which is contracted-out to the private sector involves a transfer of funding from the NHS to a private supplier. This happens both with non-clinical services – eg facilities management – and with clinical services such as orthopaedics and ophthalmology. In these cases, the patient is referred to a private provider who can

³ (Hansard, 2020)

⁴ (Keep Our NHS Public, 2025)

⁵ (Muschell, 1995)

choose to offer the service if it is profitable and will be paid for it out of what would otherwise have been NHS funds.

Governments sometimes make the argument that this is not an issue for patients, who do not care about such a transfer: they simply want to be treated promptly. We shall examine this argument in detail in Section 4, but in brief the fallacy is this: one patient may indeed benefit from the private provision and be quite happy about it, but other patients (unknown to the first) may have their treatment impaired by the lack of funding and staffing resulting from the treatment of the first. This is particularly serious when the patient who is treated quickly is of lower clinical priority while the patient who is delayed is in urgent need of complex and expensive treatment. In some cases, this invisible side-effect is having serious and lasting health consequences for patients.

Charging, rationing or withdrawal of NHS provision

When the NHS withdraws or charges for part of its service, this is an immediate concern to patients. It can happen in a variety of ways. Most simply, if NHS waiting lists become too long, patients who are suffering severely have the choice between continuing to suffer – for months or even years – or paying to go private. They can be ‘squeezed out’ of the NHS. And of course if the NHS introduces or increases its charges, this can be an issue for patients, especially poorer patients, who in any case tend to suffer from lower levels of provision⁶. Similarly, when the NHS formally withdraws provision of a service, patients face the choice between paying and going without, but they have been ‘thrown out.’

Using private finance to pay for and own NHS estates and equipment

Previous governments have used private sources of finance as a way of getting around their Budgetary constraints. Inevitably, as Section 4 explains, this is more expensive than using government finance – it is an accounting sleight of hand, which pushes the problem of funding onto future governments.

Because previous forms of Private Finance Initiative (PFI), PFI 1 and PFI 2, were found to be uneconomic, the present government claims that it is not planning to use PFI, but in fact it is planning to do so under a slightly different guise. It says it has learned the lessons of the past but simultaneously courts private investors to fund its plans. This is a rhetorical sleight of hand on top of the accounting sleight of hand. And it causes enormous harm to taxpayers.

Private Sector involvement in management or governance of the NHS

Traditional GP practices were typically partnerships and therefore technically part of the Private Sector. But most of them thought and acted as though they were part of the NHS. And this arrangement worked well for decades.

⁶ (The Lancet, 2021) (Appleby & Deeming, 2001)

But with corporate providers it is different: they are not legally allowed to think this way: they have a fiduciary duty⁷ to manage the company in the interests of its members (its shareholders) and only to take due concern about the interests of patients and taxpayers.

The NHS, of course, has the reverse priorities – as it should: it is concerned first about patients and taxpayers and only takes due concern over the profits of its suppliers. This is a fundamental difference, and to the extent that corporate providers are involved in NHS governance or management, they will (because it is their legal duty to do so) seek to modify those priorities to the benefit of their shareholders and the detriment of patients and taxpayers.

Selling-off in whole or in part what was a public service

There is, of course, no denying that this constitutes a form of privatisation. Selling off is less common than the forms described above, but it has happened – eg Plasma Resources UK, a majority stake in which was sold by the Department of Health to Bain Capital, is now privately owned⁸ and run.

In Section 4, we will explore these forms of privatisation, focussing on their effects on patients and taxpayers.

⁷ (Thomson Reuters, 2023) (Barker, 2019)

⁸ (Department of Health and Social Care, 2013)

3. Privatisation is far more widespread than generally realised

One way of dismissing concerns about privatisation is simply to deny that it is happening, or at least to assert that it is at a low level and is not increasing. Detailed analysis of the data does not support that assertion.

There is a general understanding that around 7% is privatised

There is a widely-cited figure of around 7% of NHS funding being spent on the private sector, and comments like this⁹ are frequent, *“There's no detailed information on individual contracts, and while the actual figure may have increased, the percentage of overall spending has remained consistent at around 7.2%. ... These factors mean it isn't easy to get a clear picture of how much the NHS spends on private services. However, the fact that the overall spend appears to have remained static in terms of an overall percentage suggests that the figures don't provide significant evidence of NHS privatisation.”*

That figure misses out most of what is happening

If that static 7% were roughly correct, it would not be so important to assess the impact of privatisation because, even if privatisation tended to have negative consequences, it would be a minor and contained issue. Unfortunately, that is not the case – the 7% figure is a partial estimate of the extent of contracting-out. It is not complete even for contracting-out and takes no account of the other forms of privatisation.

We have analysed the data, correcting for these omissions, and get a much higher figure as a result¹⁰.

⁹ (Steele, 2025)

¹⁰ In analysing how much is delivered privately, we have treated GP practices as part of the NHS. Although technically, GP practices have often been private sector partnerships, in practice most work almost entirely for the NHS and see themselves as part of the NHS – and indeed that is how the public see them. The percentage privatised would be even larger than our analysis below indicates if we treated GPs as private sector providers.

The table below indicates what is missing.

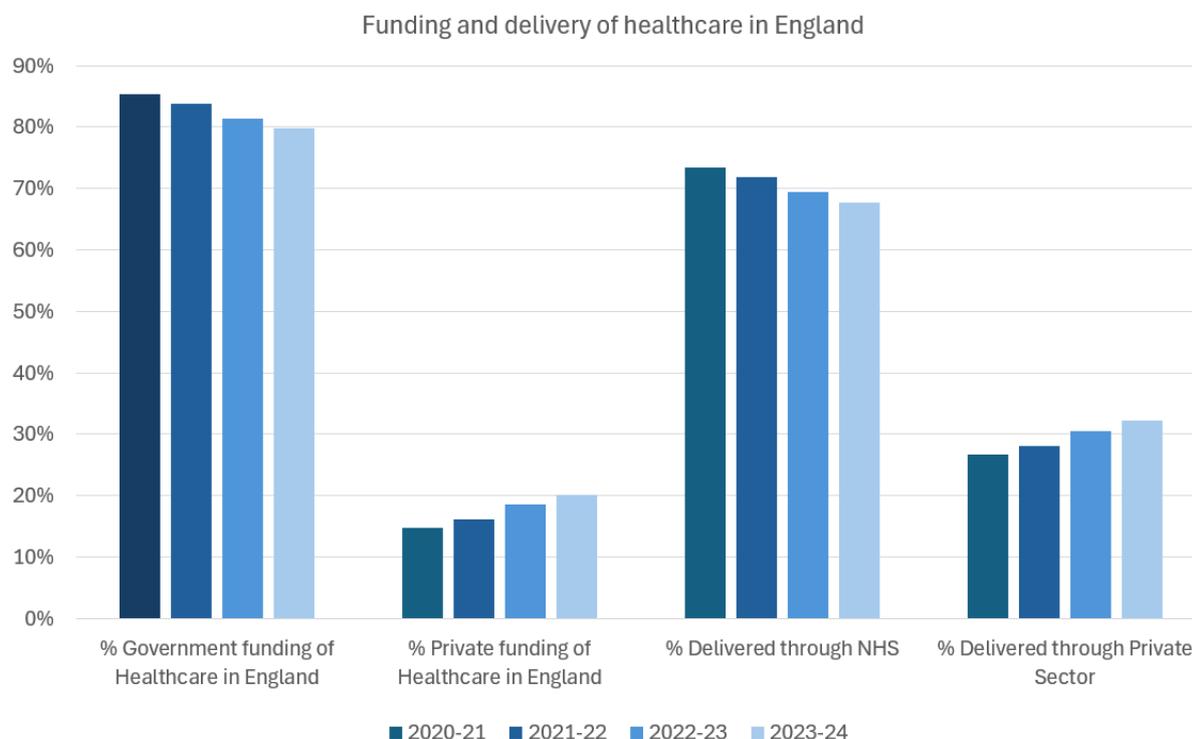
Figure 1: What is included in the 7% estimate

| Item | | In 'accepted 7%' |
|------------------------|---|------------------|
| Contracting out | | |
| | Independent Sector Providers | Y |
| | Voluntary Sector | Y |
| | Local Authorities | Y |
| | Devolved Administration | Y |
| | Other Group Bodies | Y |
| | Purchasing of healthcare from non-NHS providers by NHS providers (NHS Trusts) | N |
| | Purchasing of healthcare from non-NHS providers by NHS England | N |
| | Expenditure on Pharmaceutical Services (Boots, Lloyds Pharmacy) | N |
| | Expenditure on Ophthalmic Services (Specsavers, Vision Express) | N |
| | Expenditure on General Dental Services and Personal Dental Services | N |
| | Expenditure by NHS on social care | N |
| Squeezing out | Charging for, or rationing by lack of capacity of, NHS provision | N |
| Throwing out | Withdrawal of NHS provision from some or all patients | N |
| Selling off | Selling off part of the NHS to the corporate sector | N |

Including all forms of privatisation gives around 30%

Once we correct for these missing items, we get a quite different picture. Privatisation is far more widespread than is generally acknowledged, and it is continuing to grow.

Figure 2: Extent of privatisation over time



Source: NHS England, OECD; 99% analysis

The advent of COVID distorted the figures, both because of the huge increase in total spending and because much of what the government called ‘NHS spending’ was in reality funnelled to the private sector¹¹, but focussing on the period since, a clear trend is visible: the total amount of healthcare funded privately is around 20% and rising – and because some of what is funded publicly is nevertheless delivered privately, the percentage *delivered* privately has reached around 30% and is also rising. In some specialist areas, the figure is over 50%.

This is a quite different picture from the static 7% which is normally presented and makes it vitally important for policy-makers to understand the true costs and benefits of privatisation.

¹¹ (National Audit Office, 2020)

4. Privatisation harms patients and taxpayers

In this section we explore the principal forms of privatisation in the UK: contracting out, squeezing out, throwing out, PFI, and involvement of the private sector in NHS governance.

Approach 1: Contracting out – example: Ophthalmology

Appendix 1 explains in detail what can go wrong with contracting out, using ophthalmology as an example. 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 contracting them out to private sector cataract factories would be effective.

Medically, however, it has been a disaster: leaving complex conditions like glaucoma and macular degeneration untreated to focus on the easier cases can lead to permanent blindness. Moreover, there is a risk that the private sector, having an incentive to maximise demand, treats unnecessary simple cases at the expense of essential complex ones, leading to what the President of the Royal College of Ophthalmology¹² described as patients with “*very mild cataracts getting surgery at the expense of other patients going blind.*”

Approach 2: Squeezing out – example: Dentistry

Extent of privatisation

In principle, Dentistry remains available under the NHS, though it is not free at the point of use as the NHS generally claims to be. And, in practice, the government contract for dental services has forced many dentists to offer only private treatment. As the House of Commons Library¹³ explains,

“Under the current NHS dental contract, introduced in 2006, the provider agrees in advance to complete a set amount of dental activity per year, measured in units of dental activity (UDAs). Commissioners can ‘claw back’ money from providers that under-deliver and providers have little scope to provide more activity, even if they have the capacity and time to do so. This is why some patients are told their dentist cannot see them for an NHS appointment but can see them as a private patient.”

¹² (Greenwood, 2024)

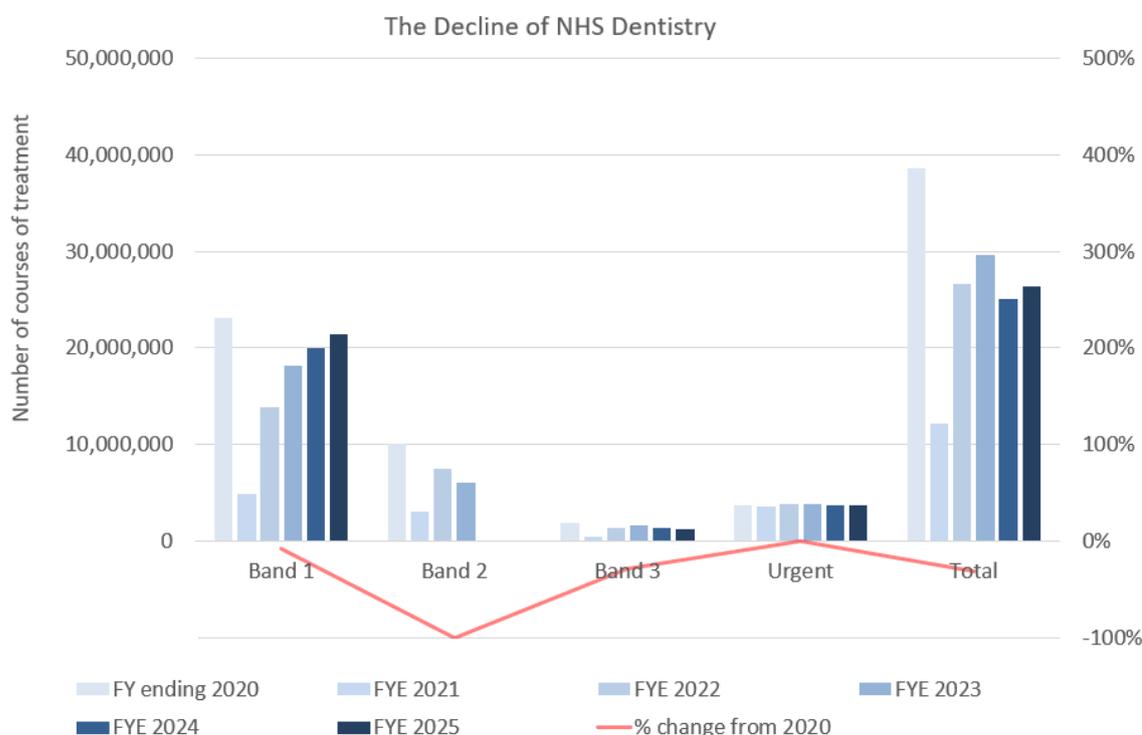
¹³ (Garratt & Danechi, 2025)

This contract has been criticised by many stakeholders¹⁴, and the government accepts that it is not optimal – but it remains in place¹⁵ and is an instructive case-study of what can go wrong.

Commenting on the continuing rapid decline in NHS provision, the Committee of Public Accounts wrote¹⁶,

“At best, current funding and contractual arrangements are only sufficient for around half of the English population to see an NHS dentist over a two-year period. In reality just 40% of adults saw an NHS dentist in the two years up to March 2024, compared to 49% in the two years prior to the Covid pandemic.”

Figure 3: Availability of NHS Dentistry over time¹⁷



Source: NHS Digital, NHS England Dental statistics

A recent report¹⁸ indicates that fewer than half of children in England now have access to an NHS dentist. In some parts of the country, termed ‘dental deserts’¹⁹, there is almost no chance of seeing an NHS dentist. This has led to significant health inequalities in dental care. For instance, in 2018-19, the number of children attending

¹⁴ (Health and Social Care Committee, 2023)

¹⁵ The contract will be tweaked, but probably not fixed, in April 2026 (The Guardian, 2025)

¹⁶ (Committee of Public Accounts, 2025)

¹⁷ See Table 6 for the meaning of the bands

¹⁸ (NHS Digital, 2022)

¹⁹ (Association of Dental Groups, 2022)

hospital for carious tooth extractions was more than three-fold higher (per 100,000 population) in the most deprived compared to the least deprived groups²⁰. In 2015-16, tooth extractions that were mostly for preventable tooth decay in children ages 0-19 cost the NHS about £50.5 million.

Impact on patients’ health and finances

While NHS dentistry is affordable to many people (but not all: because it is so far from free at the point of use), private procedures are far more expensive and are out of the reach of many. And this has profound consequences both for their finances and for their health.

Figure 4: Comparison of NHS and Private Sector Dental procedures

| Band | Example procedures | Cost under NHS (£) | Cost privately (£) |
|---------------|----------------------|--------------------|--------------------|
| Band 1 | Routine check-up | 27 | 50 |
| Band 2 | Fillings (white) | 75 | 75-100 |
| Band 2 | Root canal treatment | 75 | 400-600 |
| Band 3 | Dental crowns | 327 | 1,000 |
| Band 3 | Dental implants | 327 | 1,500 |

Source: Gentle Dental Care²¹, NHS²²

As a result, the British Dental Association reported in 2024²³ that 82% of dentists surveyed had seen patients who had attempted their own dental procedures such as “using pliers to pull out teeth, superglue on broken crowns, chewing gum as a basis for temporary fillings, and even constructing homemade dentures.”

Knock-on impact of poor dental health

Routine dental appointments are also an opportunity to look for signs of disease including mouth cancer. Oral cancer killed more than 3,000 people in 2021 - up 46% from 2,075 a decade ago.

The negative impact on wellbeing resulting from poor access to dental care, accompanied by the huge and unnecessary costs of treating preventable tooth decay, should serve as an indication of what might happen to other NHS services with increasing levels of privatisation.

²⁰ (Public Health England, 2021)

²¹ (Gentle Dental Care, 2025), (NHS, 2025)

²² (NHS, 2025)

²³ (British Dental Association, 2024)

Approach 3: Throwing out – example: Hip replacements

Extent of privatisation

The proportion of hip and knee replacements delivered privately has been rising²⁴ and is now greater than the proportion undertaken by the NHS. This is partly driven by the length of time patients have been asked to wait to have the procedure performed on the NHS and some of this has been NHS-funded, but the number having to pay privately increased from 17,000 in 2019 to almost 30,000 in 2022. As the Health Foundation commented²⁵, this *“will have had substantial financial implications for many of the patients who opted to fund their care privately.”*

But some patients have not *opted* out – they have effectively been thrown out.

The guidelines²⁶ from the National Institute for Health & Care Excellence (NICE) say,

“Healthcare professionals do not use scoring tools to identify which adults with osteoarthritis are eligible for referral for consideration of joint surgery. Evidence for the Oxford Hip and Knee scores, Knee injury and Osteoarthritis Outcome Score (KOOS), and Hip disability and Osteoarthritis Outcome Score (HOOS) showed that these numerical scales alone were unlikely to determine whether someone should have surgery, and are not recommended for making decisions on eligibility for joint surgery.”

And speaking in Parliament, Rachael Maskell quoted²⁷ David Haslam, Chair of the National Institute for Health and Care Excellence, saying that such rationing of surgery concerned him:

“He says that the NICE osteoarthritis guidelines make absolutely clear that decisions should be based on discussions between patients, clinicians and surgeons, and that issues such as smoking, obesity and so on should not be barriers to referral.”

Nevertheless, an increasing number of commissioning bodies have been using Body Mass Index (BMI) scores as a basis for rationing these procedures.

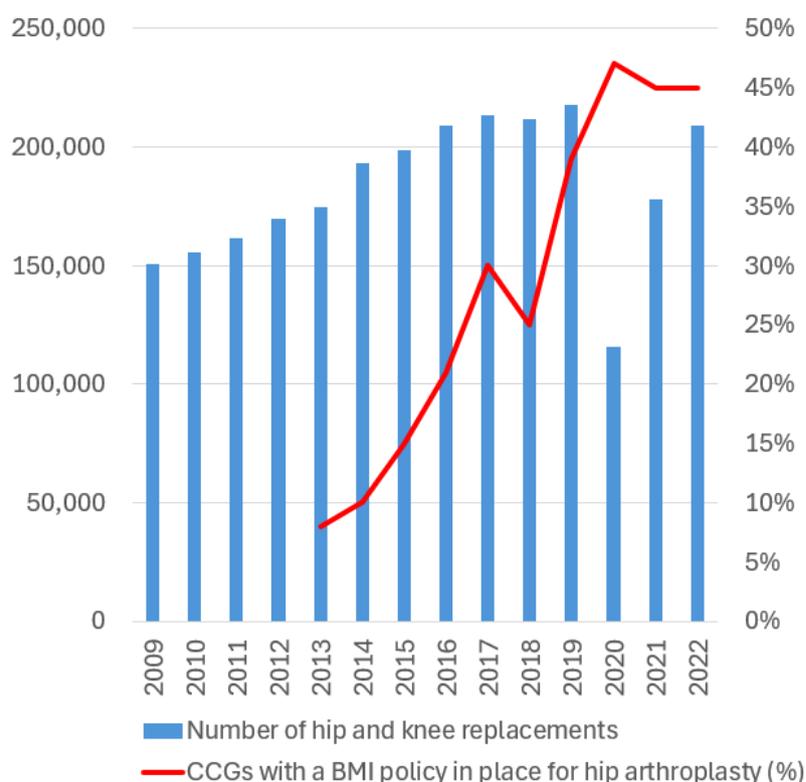
²⁴ (Plimmer, Private hospitals overtake NHS for hip and knee replacements, 2021)

²⁵ (Neville, 2024)

²⁶ (National Institute for Health and Care Excellence, 2015)

²⁷ (Hansard, 2017)

Figure 5: Hip and knee replacements



Source: BMC Health Services Research; 99% analysis

Impact on patients' health and finances

Since the cost of a hip replacement²⁸ is now around £10,000-£15,000 for a simple case and £13,000-£20,000+ for a more complex case, it is clear that being faced with an expensive private-sector solution will inevitably harm either patients' health or their finances. And of course, it is the poorer patients who suffer most.

Impact on NHS capacity and sustainability

Before 1997, all hip replacements were done by the NHS²⁹, and all surgical capacity was employed by the NHS. Now much of what was NHS capacity has been transferred – not irrevocably: most surgeons operate both within and outside the NHS – to the private sector. In effect, each procedure which is carried out privately, removes the capacity to carry out at least one procedure on the NHS. A recent study³⁰ found that,

“The introduction of private providers into the NHS is associated with a contraction in in-house NHS provision, increasing waiting times for all patients and a two-tier system operating in favour of the rich.”

²⁸ (Going Private UK, 2025)

²⁹ (Keep Our NHS Public, 2025)

³⁰ (Kirkwood & Pollock, 2025)

Approach 4: Private Finance

The Private Finance Initiative (PFI) was introduced from 1992 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 2 explains in detail how this happened and summarises the reasons that led the National Audit Office³¹ to conclude that PFI was poor value for money.

PFI can never be as cost effective and offer as good value for money as Government borrowing, and many of the mistakes made in the earlier schemes are inevitable and unavoidable. This government should not repeat the mistakes of its predecessors.

Approach 5: Corporate management / governance

Some politicians regard private sector health service providers as 'strategic partners.' Private sector providers of healthcare services naturally take a businesslike view and see the NHS as a competitor. The result of not taking a businesslike view is that the NHS is at risk of colluding in its own demise – and giving its competitors influence in NHS governance is a sure way to accelerate that problem.

Businesses are competitive

Business competition is a tough game, in which many organisations lose out and ultimately disappear. Businesses have a fiduciary duty to their shareholders (and in principle they should consider other stakeholders) but *not* to their competitors, whose interests are diametrically opposed to their own.

31 (National Audit Office, 2018)

In the world of business, a competitor is any organisation which provides products or services which you also provide yourself or want to provide (in a market you want to serve).

A business which provides or wishes to provide healthcare services in the UK sees the UK healthcare market as an opportunity and the NHS as a competitor. And it is one they would dearly like not to have to face. The UK healthcare market could offer as much as a \$28 billion profit opportunity³², if the NHS were not present.

Healthcare services businesses see NHS service provision as an obstacle to a very lucrative potential market.

Companies compete because they are legally obliged to do so

The fiduciary duties of directors mean they must grow profit

Directors of a company have legal duties. As Companies House explains³³, the first of these is not to exceed your powers; the second and possibly most important is to promote the success of the company:

*“The duty states a director must act in a way that they consider, in good faith, would be most likely to **promote the success of the company for the benefit of its members (shareholders)** as a whole. When making decisions, directors must also consider the likely consequences for various stakeholders, including employees, suppliers, customers and communities. They should also consider the impact on the environment, the reputation of the company, company success in the longer term and all of the shareholders (including minority shareholders).”*

This duty makes doing what is in the interests of shareholders the number one priority – in practice this means that directors will do whatever (within the law, and sometimes even outside³⁴) they believe will enable them to deliver most money to shareholders over time. Usually, this means growing profit as fast as possible.

This is true for UK companies and for US corporations, where there is a similar duty³⁵ on directors. (It is *not* necessarily true for all private sector businesses: traditional GP practices are private sector partnerships whose main customer is the NHS. The Partners are free to pursue goals other than profit maximisation – for example patient care³⁶ – and many see themselves as part of the NHS).

In practice this means that a healthcare company will simply walk away from unprofitable business – products, services³⁷, classes of patients or entire geographic areas³⁸ in which they cannot make a profit. The NHS, on the contrary seeks to provide a

³² (The 99% Organisation, 2021)

³³ (Barker, 2019)

³⁴ (Financial Times, 2022)

³⁵ (Thomson Reuters, 2023)

³⁶ (Oxtoby, 2016)

³⁷ (Limb, 2015)

³⁸ (Plimmer, Centene to sell GP clinics and hospitals in exit from UK market, 2023)

complete, universal service, even in high-cost areas (though it does not manage to provide a uniform level of service in all areas³⁹). This makes effective risk transfer to the private sector very difficult: the NHS cannot simply let businesses fail – it must step in to provide the services they no longer provide. Even when they do not fail, if they reject difficult to treat patients, the NHS is forced to step in, with all the costs that entails.

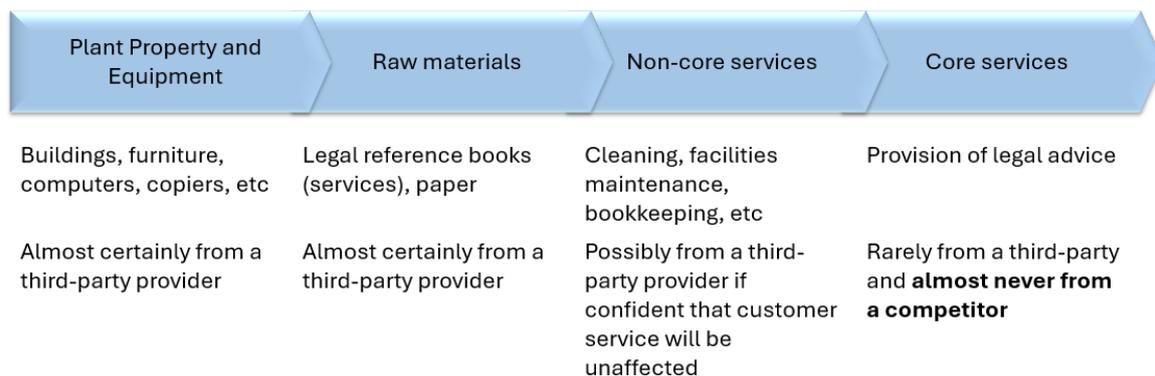
The superordinate goals of a company are to maximise value for its shareholders by growing profit; those of the NHS are to protect the health of the UK population and the public purse. These two sets of goals are in inevitable conflict.

Businesses cooperate with non-competitors but attack competitors

Businesses make a sharp distinction between the way they treat competitors and the way they treat suppliers and business partners.

Businesses are prepared to cooperate with others where doing so could be mutually beneficial, but even there they bargain hard. The diagram below shows how a professional services business – a law firm in this example – might interact with other businesses.

Figure 6: How a Professional Service Business might use Third-party providers – Law firm example



A law firm would almost certainly source its plant, property and equipment from third party providers. Similarly, it would get its raw materials: legal reference books and information services, etc, from third parties. It would also be open to sourcing non-core services from third party providers if it felt assured that it could maintain high levels of customer service. It might even subcontract specialist legal advice in areas outside its own areas of expertise⁴⁰.

What it would *not* consider doing is encouraging a direct competitor to provide legal advice in its own areas of specialism to its own clients – it would consider that commercial suicide.

³⁹ (The Lancet, 2021)

⁴⁰ For example, in a cross-border transaction between the UK and Zambia, it might engage a Zambian law firm if it lacked expertise in Zambian law.

When businesses cooperate as above, they nevertheless bargain hard to ensure that they get the best of the bargain. Bargaining power is all important in determining profitability, and relative size is important in driving bargaining power. If I go to the supermarket as an individual, I have essentially zero chance of bargaining on price with such a giant business: I have to take their price. When the supermarket wants to bargain with farmers, it is in a very strong bargaining position and will drive a very hard bargain.

In keeping with their superordinate goals, businesses treat their competitors as follows:

- They aim to **take as much market share** from them as possible;
- They **take all legal steps to weaken their competitors' positions** and to strengthen their own;
- **Only in exceptional circumstances** do they collaborate with them;
- **They never allow a competitor to use their brand;** and
- They keep their **strategic plans and management information secret** from them – they are treated as commercially sensitive information and not disclosed; and therefore;
- **competitors must be nowhere near the governance of the business.**

If health policy-makers and the NHS were to learn from business about competition, several of these points would cause material change in policy.

Mismatch of superordinate goals is fatal to governance

As the European Observatory on Health Systems and Policies⁴¹ concluded, recognising the difference between the superordinate goals of corporations and health services is of critical importance – and where these goals are incompatible, beneficial partnership is impossible:

“Making the nature of private sector collaboration explicit is an important element of planning and managing effective relationships. This entails:

- *setting out the objectives of both public and private sector actors clearly;*
- *identifying how both parties can achieve their objectives within a collaboration; and*
- *weighing up shared goals and the reasons for the private sector engagement as well as exploring other means of achieving the stated objectives.*

Goal alignment and compatibility are central considerations in working with the private sector and should be linked to appropriately targeted incentives.

Transparency and accountability are crucial in ensuring private sector contracts are governed robustly:

⁴¹ (Maresso, et al., 2023)

- *Open and transparent information is closely linked to public trust and is needed to safeguard the integrity of government bodies dispensing large amounts of public funds.*
- *Clear, transparent processes must be followed to identify and consider potential private sector partners and in justifying the choices made in awarding contracts in order to alleviate concerns about the risk of potential corruption. This is particularly critical in the area of public procurement.”*

As we pointed out above, NHS governance does not currently meet these guidelines – and without sound governance, there will not be sound decision-making.

The House of Lords described the previous government’s Health and Care Bill⁴² in this way:

“The Health and Care Bill is a clear and disturbing illustration of how much disguised legislation a Bill can contain and offends against the democratic principles of parliamentary scrutiny.”

They were particularly concerned about the Henry VIII powers the Bill planned to introduce. The Lords proposed several beneficial amendments including one to protect the integrity of Integrated Care Board (ICB) governance by ensuring that conflict of interest would not occur. The Lords wanted this protection⁴³ for the NHS:

“(4) Each integrated care board must set out in its constitution— (a) the arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the board’s decision-making processes, (b) the process by which any appointment of a member to the integrated care board or any appointment to any committee or sub-committee of the integrated care board that has a commissioning function must be made so as to avoid the appointment of anyone who would be perceived to have a conflict or potential conflict of interest, and (c) the arrangements for ensuring that no member of any committee or sub-committee of the integrated care board who has a conflict or potential conflict of interest obtains access to information that might be perceived to favour the interest or potential interest.”

The previous government objected to protecting the integrity of the ICBs’ decision-making processes and removed the teeth from that amendment:

“(4) If the constitution includes provision under this paragraph allowing committees or sub-committees to exercise commissioning functions, the constitution must— (a) provide for the members of any such committee or subcommittee to be approved or appointed by the chair of the integrated care board, and (b) prohibit the chair from approving or appointing someone as a member of any such committee or sub-

⁴² (House of Lords Delegated Powers and Regulatory Reform Committee, 2021)

⁴³ (UK Parliament, 2022)

committee (“the candidate”) if the chair considers that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.”

Restoring the Lords’ intended safeguard would be a quick win for this government.

Specifically, the NHS should ensure that healthcare service companies:

- Are not involved in NHS governance⁴⁴;
- Do not have access to commercially sensitive NHS information;
- Are not allowed to represent themselves to patients or brand⁴⁵ themselves as if they were part of the NHS
- Are not given new contracts for NHS clinical care services, or the ancillary staff needed to perform them, in competition with the NHS itself unless certain tests are met.

How to use the private sector wisely

Of course, the private sector has a vital role to play in healthcare as product and technology providers. It would not make sense for the NHS to attempt to create all its own pharmaceuticals or all its own medical technology, for example. By analogy with the law firm example above, it makes perfect sense for the NHS to make full use of what the private sector has to offer in these areas.

But using the private sector for healthcare service provision – i.e. in direct competition to the NHS itself – makes sense for patients and taxpayers only when four tests are passed:

1. **The quality of healthcare provided is at least as high as in the NHS** – if not then the hidden costs of poorer health will outweigh any potential savings
2. **The unit cost is sustainably lower than doing it in the NHS** – if not, then the money would be better spent on NHS capacity. If the private sector solution is to pay lower wages for medical staff, this will not be sustainable
3. **The private service can deliver without a hidden subsidy from the NHS** (for example if a service is only possible for the private sector to provide because it can leave the difficult / expensive cases to the NHS, that is a hidden subsidy) – if not, then Test 2 is not really passed
4. **There is genuine spare capacity in the private sector** – if not, the lack of spare private sector capacity suggests a hidden subsidy (eg in the form of training costs). If further capacity is removed from the NHS, eventually, the subsidy will cease to exist, and the costs will rise to higher than they had been under the NHS.

⁴⁴ (UK Parliament, 2022)

⁴⁵ (NHS England, 2024)

Unless all four criteria are met, private-sector ‘solutions’ will worsen the problems faced by UK healthcare. They are often not met today.

These criteria can be met, for example, when there is currently no NHS provision, if there is a treatment which can be expected to improve patient outcomes/add value. For example, proton beam therapy is a type of radiotherapy treatment using high or low energy proton beams to treat some types of cancer. Prior to being available on the NHS, NHS patients could access this treatment at private centres in the UK or abroad. In 2009, the UK government made the decision to set up a National NHS Proton Beam Therapy Service. There is now a centre at The Christie NHS Foundation Trust in Manchester, and another centre at University College London Hospital (UCLH).

Conclusion: Unwise privatisation harms patients and taxpayers

We have given several examples showing where the government should be extremely careful about expanding its use of the private sector. Empirical research more generally confirms that – at best – there are grounds for serious concerns about the quality of care provided by for-profit providers.

As a 2022 study by Ben Goodair and Aaron Reeves at Oxford University, published in *The Lancet*⁴⁶ showed, “*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.*”

A follow-up in 2024⁴⁷ which looked at the international picture concluded, “*We found that hospitals converting from public to private ownership status tended to make higher profits than public hospitals that do not convert, primarily through the selective intake of patients and reductions to staff numbers. We also found that aggregate increases in privatisation frequently corresponded with worse health outcomes for patients.*”

⁴⁶ (Goodair & Reeves, 2022)

⁴⁷ (Goodair & Reeves, The effect of health-care privatisation on the quality of care, 2024)

5. Policy implications

We have seen that privatisation can have serious effects on patients, on taxpayers and on the sustainability of the NHS itself. This means that having sound policy in this area is vital.

Implications of current trends continuing

The discussion above on governance and the mismatch of superordinate goals shows that the idea that the NHS could become just a marginal part of the UK's healthcare ecosystem with most of the services provided by the private sector would be organisationally flawed – alignment of goals is critical for the success of any organisation: trying to produce a high-performing organisation dedicated to patient care and benefit to the public purse while all its service delivery was carried out by organisations whose overarching goal is to maximise profit would be a certain recipe for failure.

And yet, this is the plan – at least according to former Health Secretary and current advisor to the government, Alan Milburn⁴⁸:

“... we've got to stop viewing the health care system in this country as being about a single institution that we happen to call the National Health Service, and instead see it as being an ecosystem of very different providers, from telcos, techcos, of course private sector providers, and at the margins, the public sector...”

The likely outcome of continuing down this path would be an unsustainably expensive NHS, spending increasingly large amounts with private suppliers who focus on the most profitable services and leave the state to pick up the pieces with the least profitable. This is part of what has happened⁴⁹ in adult social care (with underfunding being the other major issue⁵⁰).

Looking globally suggests that this pattern is widespread. As Dr John Lister wrote⁵¹:

*“Nowhere in the world can the private sector on its own sustain a **comprehensive or universal health-care system** or even a competitive market in health: it needs a combination of public subsidy to train staff with either the scope to cherry-pick the most financially lucrative patients, or public provision for the most demanding cases that will never be profitable to treat. The pattern throughout the world confirms that the private for-profit sector in particular is averse to risk and, for this reason, **unwilling to deliver full-scale emergency services or open-ended services for the chronically sick and elderly** – unless a substantial premium payment is attached, to guarantee a profit stream.”*

⁴⁸ (Anderson, 2025)

⁴⁹ (Hudson, 2016)

⁵⁰ (Goodair, McManus, Esposti, & Bach-Mortensen, 2024)

⁵¹ (Lister, 2013)

Replacing the NHS as a provider with private sector service providers would be bad both for patient care and – increasingly over time – for the public purse. It would also be exceedingly difficult to reverse.

Policy options

There are two obvious options:

- Stick to the government’s declared 10-year plan; or
- Make a radical recommitment to the fundamental principles of the NHS.

Sticking to the 10-year plan

In our previous report⁵², we compared the contents of the 10-year plan with what happened, largely successfully, under the last Labour government. The conclusion of that report was that the previous Labour government succeeded in turning around the NHS *because it had a strategically sound approach* – it got the big things right: it funded the NHS in line with need; it tackled the social determinants of ill-health; and it invested in sound prevention and public health. These big issues were the result of a sound government-wide approach.

By analysing the healthcare productivity statistics provided by the Office for National Statistics, that report also showed that productivity growth was lower under the 1997-2010 government than its long-term average: the initiatives during that period which were supposed to make the NHS more efficient and effective in fact weakened it. Notably, use of PFI, using public money to build private sector capacity and a crude approach to performance management all seemed to be tactical errors. These errors were the largely the initiatives of the previous Health Secretaries – who appear not to recognise that their efforts were counter-productive.

The 10-year plan does not replicate the strategic measures but hopes to make up for that by repeating the tactical errors of the past. It is set to fail. And, as we argued in 2023⁵³, if the NHS is allowed to fail, the UK economy will fail with it. There is no perspective, not even a purely financial one, from which that makes sense.

We are already seeing clear evidence of the harm being done to the UK economy: the economic consultancy, Oxera estimated⁵⁴ that,

“... the total economic cost of lost output among working-age people due to ill health is around £150bn per annum, equivalent to 7% of GDP, with an additional total cost to the government (in terms of lost tax income, benefits payments and costs to the NHS) of around £70bn or £1,000 per person.

⁵² (The 99% Organisation, 2025)

⁵³ (The 99% Organisation, 2023)

⁵⁴ (Catherall, 2023)

To provide a sense of scale, if the government could avoid these costs it would be possible to pay for up to 1.8m additional nurses, equivalent to more than double the current number of registered nurses in the UK.”

To provide another sense of scale, this impact is already similar to that of Brexit⁵⁵.

This is an unbearable economic cost; and it risks derailing the entire economy. It is extraordinary that current government policy is to run that risk.

Committing to the success of the NHS

The alternative is to repeat the successful strategy of the last Labour government while avoiding its tactical mistakes. This means:

1. Funding the NHS in line with need;
2. Tackling the social determinants of ill-health; and
3. Investing in sound prevention and public health.

The biggest obstacle to the proper funding of the NHS is that the current approach to fiscal rules prevents it – more generally, the current rules are incompatible with national renewal⁵⁶. This is, of course, a problem beyond the remit of the Department of Health and Social Care to fix on its own. But if it is not fixed, the NHS may fail, and with it every other aspect of this government’s programme of renewal.

Unfortunately, the same is true of the need to tackle the social determinants of ill-health. Without serious poverty-reduction, the rates of ill-health are likely to continue to rise, and the NHS will be under ever-greater strain.

Prevention is easier to tackle, and the government claims that this is a focus area. But the current plan is sorely lacking; and action on the ground is invisible. Where are the public health messages about spreading ‘flu and COVID? Where are the vaccinations for working-age people? Where is the root-cause analysis of the mental health epidemic?

Lord Darzi’s review⁵⁷ provided a good diagnosis of the problems facing the NHS. The 10-year plan provides the wrong prescription.

Immediate next steps

This paper and our report on *Rebuilding the NHS*⁵⁸ have raised serious questions about privatisation in the NHS. While there has been no comprehensive assessment of all the initiatives undertaken under the 1997-2010 government, it is clear from that report that in aggregate they had a slightly negative impact and likely that some, including PFI,

⁵⁵ (Bloom, Bunn, Mizen, Smietanka, & Thwaites, 2025)

⁵⁶ (The 99% Organisation, 2025)

⁵⁷ (Darzi, 2024)

⁵⁸ (The 99% Organisation, 2025)

insufficiently careful use of targets and performance measures and using public money to increase private capacity have been significantly negative in impact.

It would be reckless to proceed without addressing these issues. We recommend that:

- The government should encourage **rigorous but rapid investigation** by Britain's leading universities of which initiatives produced improvements, and which were counter-productive;
- the National Institute for Health and Clinical Excellence should be asked to formalise criteria along the lines of those set out in Section 4 for wise use of the private sector and to **assess proposed initiatives against these criteria before approving launch**; and
- the NAO should be responsible for assessing which initiatives have failed to live up to their promises so that **policy errors can be quickly rectified and the contracts unwound where possible**.

Lord Darzi's report⁵⁹ 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.

⁵⁹ (Darzi, 2024)

Appendices

Appendix 1: Contracting out

The principal argument for contracting out is that waiting lists are too long and contracting-out can be a way of reducing them. This ignores the side-effects of over-focus on simpler cases, which is exacerbated by contracting-out.

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 assumed to be effective if judged *solely* against those measures but nonetheless have an extremely damaging impact on patient health. There are wider implications which should have a bearing on policy in other areas.

The nature of eye diseases

Eye diseases and disorders range from the relatively straightforward to the highly complex. Many cataracts are simple cases; but 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 outpatient clinics and involves multiple attendances over months or years. Although there is monitoring of the number of patients awaiting an initial outpatient 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:

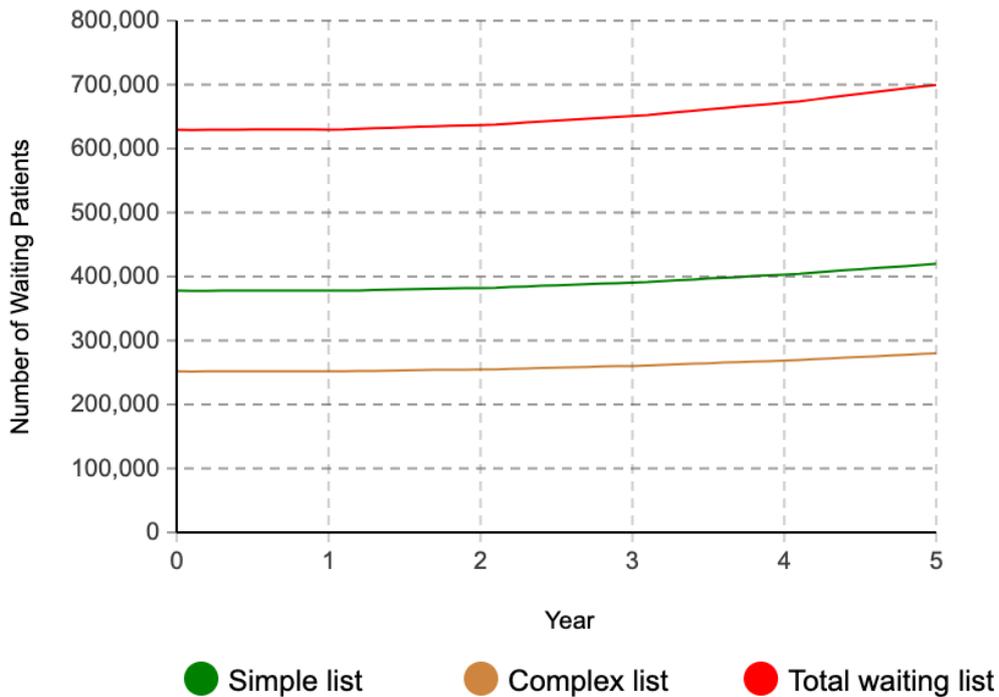
- **Option 1: Clinical focus** – this option relates to the historical resource allocation in which around 40% of the total resource is allocated to the most complex cases and 60% to the (more frequent) simple cases;

- **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 7: Waiting lists over time with current resource priorities



Source: Edinburgh University

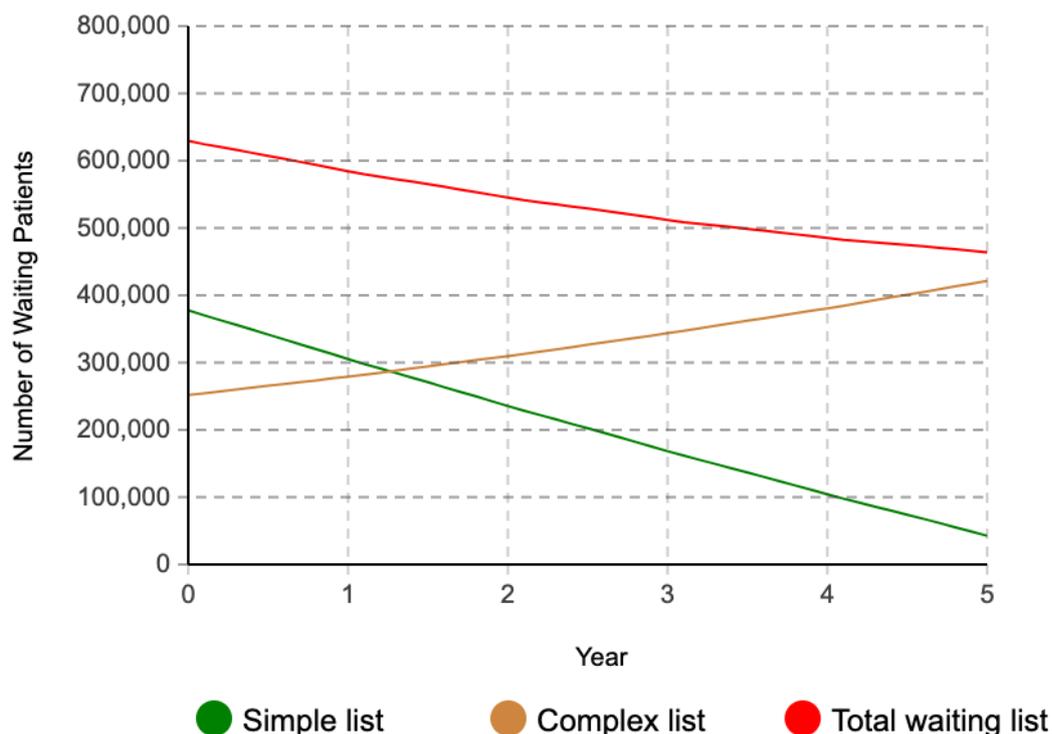
From both a medical and a total waiting list perspective, this option is less than satisfactory. In terms of the most serious cases, the number at risk of permanent blindness rises from around 250,000 to around 280,000 – an increase of 12% – while the total waiting list has continued to grow.

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 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 8: 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 serious complications up to and including 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.

The NHS surgeons who work in these cataract factories have usually reduced the number of hours in their NHS contracts, making themselves unavailable to provide as much care in their NHS departments; that care would typically be for a diverse range of conditions, many potentially blinding, painful or disabling. In their NHS work they would be expected to contribute to the training of the next generation of ophthalmologists, provide continuity of care to their existing patients, and deal with urgent and emergency care as the need arises. They cannot fulfil these functions while operating in the private sector: the consequence is the need to employ more Consultants to provide the same level of care – and often those potential consultants just aren't out there to employ.

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 retinopathy⁶⁰. A follow-up survey is underway. The President of the Royal College of Ophthalmologists⁶¹ 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 contracting-out

Less immediately 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 subsidy⁶² 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.”

Part of the public subsidy arises because most of the surgeons involved are continuing to work part-time for the NHS, which picks up the on-costs of their employment, such as annual leave, sick leave, Employer's National Insurance contributions and superannuation. None of these costs are borne by private providers, which only pay for sessions actually worked, and yet the tariff paid to the private provider is the same as to an NHS trust which carries these employment costs.

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 NHS⁶³. Trainee ophthalmologists have previously developed their skills in microsurgery through supervised operation on large numbers of patients with uncomplicated cataracts,

⁶⁰ (Foot & McEwen, 2017)

⁶¹ (Greenwood, 2024)

⁶² (Centre for Health and the Public Interest, 2024)

⁶³ (The Royal College of Ophthalmologists, 2024)

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.

There have been attempts to address this problem in the last two years by 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)⁶⁴ 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.”

Clinical demand vs provider-led demand

It is now possible for an optometrist to refer a patient directly to a ‘cataract factory’ without NHS approval. This can happen even when the cataract factory is part of the same corporation as the optometrist⁶⁵. This is provider-led demand.

The CHPI study cited above 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 younger person: there is no fixed level of opacity at which these aging changes would be called ‘a cataract.’ There is no

⁶⁴ (Centre for Health and the Public Interest, 2024)

⁶⁵ As Specsavers says, “The experts at Newmedica, part of the Specsavers family, make accessing care easy.” (Specsavers, 2025)

benefit in removing the lens of the eye at an early stage and it is certainly not time-critical.

Also, approximately 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. Nevertheless, there is anecdotal evidence of a lowering of the threshold at which people are being referred for consideration of cataract surgery and having the operation, and the greatly increased volume of these operations lends further support to that hypothesis.

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-led demand for cataract surgery consuming a disproportionate amount of the total budget allocated to ophthalmology. Since some of this 'demand' is not clinically justified, the beneficial impact on waiting lists is likely to be even less than suggested above.

Contracting-out can cause serious harm to patients and damage the NHS

Relying on contracting-out as a strategy to reduce waiting lists inevitably distorts medical priorities, and can result in serious misallocation of resources, especially when provider-led demand becomes widespread. 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. And it may not even be effective in reducing waiting lists.

Appendix 2: Private Finance

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 section is drawn mainly from a National Audit Office (NAO) report⁶⁶ 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, claimed⁶⁷ 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 information⁶⁸) 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.

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

⁶⁶ (National Audit Office, 2018)

⁶⁷ (Monbiot, 2007)

⁶⁸ (Infrastructure and Project Authority, 2024)

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 projects⁶⁹ 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 claim 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.

Issues with PFI

1. Cost of Debt

In 2011 the House of Commons Treasury Committee⁷⁰ 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*

⁶⁹ (National Audit Office, 2012)

⁷⁰ (House of Commons Treasury Committee, 2011)

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 claimed 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.

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 an 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.

Many PFI hospitals were built according to capacity assumptions of stable or reduced need, in parallel with a push to shut down many major hospitals with A&Es, assuming that care would be transferred to the community. This meant many PFI hospitals were constantly in crisis.

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 for the future. 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 report⁷¹ noted that keeping borrowing off balance sheet was deemed the priority even if this made a deal more expensive. In other words, the accounting consequences, not the economic reality were what drove PFI.
- 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

⁷¹ (National Audit Office, 2018)

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 school⁷² 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. Financial

⁷² (Jeffries B. , 2025)

squeezing of trusts often led to estates, planning and other areas of non-clinical expertise being shed, increasing the above risk of poor contract management, as well as making trusts more dependent on external consultancies

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 disorderly⁷³. 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.

Private finance has not worked and will not work

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.

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*"⁷⁴

With public sector borrowing constrained by the Chancellor's fiscal rules⁷⁵, and a need for investment in infrastructure to facilitate growth and to replace obsolete or dilapidated buildings, the government is now tempted to revisit PFI, intending to learn from past mistakes but inevitably repeating them.

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.

⁷³ (Timmins, 2024)

⁷⁴ (Edwards, 2020)

⁷⁵ (The 99% Organisation, 2025)

Appendix 3: Contributors

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