How privatisation is shrinking public provision of eye surgery in England's NHS

A report on the impact of outsourcing NHS cataract surgery

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November 2025

Background
Cataract surgery is the most frequently performed surgical procedure undertaken by the NHS in England and Scotland.

The National Health Service in the UK is not a single institution. It was created by three acts of Parliament for England and Wales (1946), Scotland (1947), and Northern Ireland (1948). In 1999, the new Scottish Parliament was given devolved powers and can now make its own policies for health services. While Scotland and England have both prioritised funding to clear waiting lists in elective surgery they have taken different policy routes.

England's policy has been to direct NHS funding to the private sector through contracts transferring a range of services, including elective surgery, out of NHS. This requires using public funds intended for the NHS public hospitals. Scotland, on the other hand, has sought to grow extra capacity within the NHS with minimal outsourcing. Instead, it bought up a private hospital in 2002, renaming it the Golden Jubilee National Hospital and making it a special health authority.

In 2003, the NHS in England awarded £4.6 billion in contracts for elective surgery to the private sector with guaranteed payment for each patient referred. In 2008 a further expansion took place. Between April 2008 and March 2019, 15% (538,555) of all NHS funded cataract operations in England were undertaken in the private sector. By January 2016 around 20% of all NHS England funded cataract operations were carried out in the private sector and by January 2024 it was almost 60%. The private sector in England now performs 1.7 times more cataract operations than it was performing in 2019 and in 172 private clinics with substantial funding from the NHS.[1] In contrast, Scotland's parliament opted to build capacity in-house and not privatise services so that only 2% of NHS Scotland funded cataract procedures were carried out in the private sector by 2022/23.

The huge increase in the number of cataract operations has happened in the absence of any population based planning or national eye care strategy in England. Private providers undertake cataract surgery in purpose-built clinics. These private for-profit clinics also benefit from referrals made by high street private sector optometrists [4] which the NHS bodies that commission treatment must pay for. High street optometrists are gatekeepers to NHS funded cataract surgery and receive financial incentives (known as co-management fees) from the NHS to refer patients to private sector clinics. Companies like Specsavers and Newmedica are vertically integrating optometry and surgical services. In 2022 the top five companies providing cataract surgery to the NHS in England collectively made pretax profits of more than £100m, with SpaMedica alone earning £72m.

The policy claims

The government in England claims that the use of the private sector can increase capacity, reduce waiting times, tackle inequalities, reduce costs, and make use of innovation. We examine the first three of these claims comparing England's policy of increased use of the private sector for NHS elective surgery with Scotland's policy of keeping surgery in-house. We analysed NHS hospital data over 20 years between 1997/98 and 2018/19 for elective surgery for cataracts in three different time periods for Scotland and England.

We examined the impact on admissions, waiting times and inequalities.

Key findings

- Admission rates more than doubled in both countries between 1997 and 2019 with a concomitant fall in waiting times
- Scotland increased admission rates and reduced waiting times using public hospitals and without expanding outsourcing in contrast to England
- England has not increased in NHS in-house admissions since around 2008/9 and all expansion has taken place in the private sector
- By 2018/19, 30% of NHS funded cataracts in England were outsourced to the private sector
- In Scotland, where the decision was made in 2003 to limit private suppliers and boost NHS in-house operations, only 2% of NHS funded cataract procedures were carried out in the private sector
- Since 2009 in-house NHS admission rates have fallen in England overall and disproportionately among patients living in the poorest areas. The trend in admission rates in England has become less pro-poor unlike Scotland
- Although waiting times fell over the 22 years of the study period increasing levels of outsourcing meant that for every 1% increase in private provider share, waiting times were 2.0% higher than they should have been

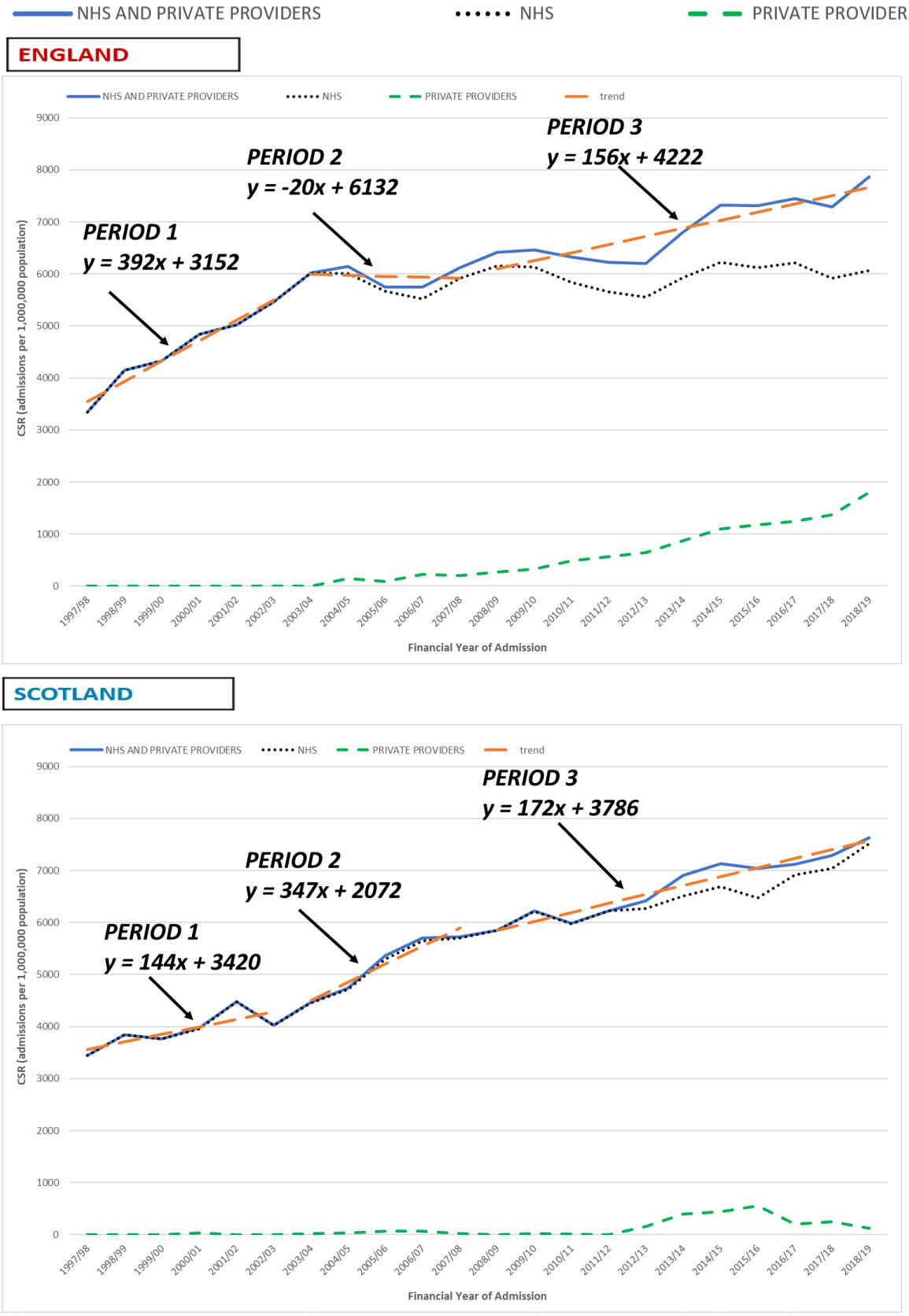
Admissions

Admission rates to the NHS in England rose sharply between 2003/04 and 2008/09, and more slowly thereafter to 2018/19 (figure 1). There has been no increase in NHS in-house provision since 2008/9 and all expansion has taken place in the private sector. The increases in English admission rates from 2008/09 onwards all occurred in the private sector. Scotland achieved equal improvements and increases in admission rates over the entire period, and largely without the involvement of private sector.

Readmissions

Readmissions are a growing source of pressure on the NHS because they often require further surgery and long stays in hospitals and use up a lot of NHS bed capacity (table 1). A "readmissions" captures any patient readmitted within 30 days for any reason following the procedure. Almost all of the readmitted patients treated by the private sector return to the NHS. From 2003/04 to 2018/19, just 46 people (0.04%) were readmitted to private facilities, compared with 103,400 going to the NHS. Of these 7,300 patients had had their first surgery in the private sector. Readmissions resulting from cataract operations performed in the private sector accounted for almost 49,000 NHS bed days between 2003/04 and 2018/19 i.e. 5.7% of all NHS cataract readmissions. As table 1 shows many of these readmissions are to other specialties in the hospital e.g. orthopaedics for fractures or cardiology and general medicine.

Figure 1. NHS England and NHS Scotland funded elective cataract operation admissions (CSR) 01 April 1997 to 31 March 2019



Kirkwood G, Pollock AM. Outsourcing NHS cataract surgery in England - a misguided policy? A comparison of waiting times and admissions in England and Scotland 1997/98 - 2018/19. In submission. 2025, figure 1a, 1b

Table 1. NHS funded elective cataract operations: 01 April 2003 - 31 March 2019:top six reasons for readmission to NHSS7 in paper P4 supplementary)

Reason for readmission	**Readmissions to the NHS by provider of origin (n)**		**Original admission bed days**	**Readmission bed days**
Mechanical, fracture	NHS	2,130	2,534	50,897
	Private	197	198	3,662
Infection	NHS	9,930	10,967	97,979
	Private	824	2,637	6,181
COPD	NHS	4,050	4,352	31,861
	Private	283	283	1,342
Soft tissue	NHS	791	842	7,612
	Private	73	267	514
Haemorrhage, haematoma, pulmonary embolism, cerebral & myocardial infarction, heart failure, stroke	NHS	3,621	5,085	58,677
	Private	272	273	3,043
Syncope and collapse	NHS	2,098	2,330	8,772
	Private	181	1,079	516
Other	NHS	73,397	82,434	549,330
	Private	5,504	5,967	33,583
Total		**103,351**	**119,248**	**853,969**

Kirkwood G, McNally R, Pollock AM. Taking advantage of the English NHS: an ecological analysis of readmissions following NHS funded elective surgery in the private sector. In submission. 2025, table S7

Waiting times

England had longer waiting times than Scotland in 1997/8 with patients waiting an average of 70 days more for an operation. Waiting times fell dramatically in both countries; by the last period of the study waiting times were still shorter in Scotland than England (table 2).

The fall in waiting times in the first period may have been due to the introduction of phacoemulsification, a procedure which enables patients to be treated faster as outpatients in clinics. A second reason for the decrease in all periods is the financial incentives which have been used as part of waiting time initiatives. NHS doctors benefit as they can supplement their NHS income by undertaking extracontractual (out of hours) duties for the NHS i.e. operating on weekends or in the evenings. They can also undertake more private practice in private clinics. Generous NHS payments to the private companies allows the private sector to pay doctors three times the overtime rate of the NHS. NHS doctors have been reducing their NHS sessions in favour of undertaking cataract surgery in the private sector and some have been setting up private clinics with equity investors. It has long been noted that NHS consultants may have perverse incentives to keep NHS waiting lists long in order to stimulate demand for their private work.[7] Supplier induced demand is a feature of marketized healthcare systems and concerns have been raised that this may result in overtreatment. While waiting times for routine cataract surgery have fallen over time, waiting lists and times for other, more complex, procedures, have increased.[8]

Table 2. Admission (n), Crude cataract surgical rates (CSRs /1,000,000) and mean waiting time(days) by period and provider. NHS England and NHS Scotland funded elective cataract operation admissions 01 April 1997 to 31 March 2019

		NHS England			NHS Scotland		
		NHS	Private Providers	All Providers	NHS	Private Providers	All Providers
Period 1	Admissions	1,335,107	1 (0.0%)	1,335,108	119,194	153 (0.1%)	119,347
Apr 1997 -	CSR	4,528	0	4,528	3,918	5	3,923
Mar 2003	Waiting time	194.7	N/A	194.7	124.8	99.2	124.8
Period 2	Admissions	1,473,694	33,458 (2.3%)	1,507,152	131,984	1,034 (0.8%)	133,018
Apr 2003 -	CSR	5,823	132	5,955	5,162	40	5,203
Mar 2008	Waiting time	93.2	56.5	92.8	100.2	80.8	100.1
Period 3	Admissions	3,547,321	538,555 (15.2%)	4,085,876	382,322	11,532 (3.0%)	393,854
Apr 2008 -	CSR	5,981	908	6,889	6,521	197	6,718
Mar 2019	Waiting time	70.3	61.4	69.3	68.7	62.2	68.5
All periods	**Admissions**	**6,356,122**	**572,014 (9.0%)**	**6,928,136**	**633,500**	**12,719 (2.0%)**	**646,219**
Apr 1997 -	**CSR**	**5,570**	**501**	**6,072**	**5,527**	**111**	**5,638**
Mar 2019	**Waiting time**	**101.8**	**61.2**	**99.2**	**85.7**	**64.2**	**85.3**

Kirkwood G, Pollock AM. Outsourcing NHS cataract surgery in England - a misguided policy? A comparison of waiting times and admissions in England and Scotland 1997/98 - 2018/19. In submission. 2025, table 1

Inequalities

The waiting time initiative had a major impact on reducing inequality in waiting times between socioeconomic groups in Scotland and England. Waiting time inequality, however is now moving in a pro-rich direction in England.

Since 2009, in-house NHS admission rates have fallen in England overall and disproportionately among patients living in the poorest areas. England has slightly longer overall waiting times than Scotland in the last period of the study and with increasing inequalities. The president of the Royal College of Ophthalmologists has warned that NHS ophthalmology risks simply becoming unavailable in poorer areas, as has happened with NHS dental care.[9] This may also be because private for profit clinics are being established in richer and more affluent areas.

Training and research

Routine surgery is essential for trainee doctors, who need to practise and develop their skills on straightforward, high volume work. Outsourcing undermines this, and private clinics rarely provide formal training. Such costs are left to the NHS.

Budgets

Budgets are under pressure because of the high costs of paying private providers. The total NHS ophthalmology budget in England increased by just half compared with a doubling in expenditure on cataracts over the same period, 2018/19 to 2022/23.[5,6] By 2022/23, the annual cost to the NHS of cataract surgery was £522m of which over half of went to the private sector. As more and more money is spent on cataracts there is less for all other eye services.

It has been estimated that just five companies alone extracted £90m in one year in interest payments and dividends from their NHS-funded cataract surgery.*[4] This is money that could have

* *The Lowdown* mentions five companies: SpaMedica, CHEC, Newmedica, Optegra, and ACES.[11]

been reinvested in the NHS, helping to ensure a sustainable service with better training and facilities.

In the NHS, the income hospitals receive for elective cataract care will cross-subsidise the costs of providing emergency treatment and more complex elective treatment including eye cancers. The diversion of resource to the private sector risks delays in managing and monitoring chronic sight-threatening eye conditions such as glaucoma and macular degeneration and destabilising hospital services. The NHS is the mainstay of clinical medical research, privatisation of services fragments the patient population as well as services and staff and undermines the ability to undertake research.[2,10]

Recent concerns that too much NHS funding has been going to routine cataract operations have led the NHS to propose tariff (price) reductions for the most routine procedures (paid to both NHS and private providers), aiming to distribute the £64m savings to other ophthalmology services (mostly in-house NHS).[12,13] This is far short of what is needed, which is to stop using the private sector and to put resource back into the NHS.

Conclusion

Since 2003, in contrast to England, Scotland has achieved the increase in NHS funded cataract admission rates and decrease in waiting times without outsourcing NHS funded surgery to the private sector and private clinics. In England, since 2008 the increase in NHS funded treatment took place in the for-profit private sector.

Since 2009, in-house NHS admission rates have fallen in England overall and disproportionately among patients living in the poorest areas. Overall, the trend in admission rates in England has become less pro-poor unlike Scotland. Despite outsourced admissions having had lower waiting times than in-house NHS admissions, increasing levels of outsourcing in England is associated with increasing waiting times.

The decision to outsource NHS funded care to private companies is having a knock-on effect on training and destabilising other vital NHS eye services within NHS hospitals. Warnings raised for over 20 years about the impact of outsourcing have been ignored by politicians and policy makers. There should be a moratorium on all further outsourcing of ophthalmology including cataract surgery. A parliamentary committee and the National Audit Office should examine the costs of outsourcing in England, profits of companies, supplementary income of NHS consultants and staff and the impact on NHS ophthalmology services more widely.

Acknowledgements: Dr James Lancaster for his assistance with this report

Endnotes

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Appendix: note by Dr Stella Hornby Eye Surgeon and Clinical Director of Ophthalmology at Oxford University Hospitals NHS Foundation Trust

personal view -summer 2023

My grandfather lost his sight in the 1990s from "wet" age-related macular degeneration which was then untreatable. A passionate reader, it made him unable to drive, isolated, and depressed. In the last 30 years ophthalmology has been transformed particularly by digital imaging and injections for medical retinal conditions. It is now the largest NHS outpatient subspecialty. However, a recent rapid and uncontrolled expansion of independent sector provision of cataract surgery is leading to major destabilisation of the NHS hospital eye services including in the Oxford hospital where I work, damaging patient safety and quality and level of services for eye care and ophthalmology training. At least 50% of all NHS cataract surgery now is undertaken in the private sector. In Oxfordshire where I work three independent treatment centres have opened in the last seven months, which has affected my department directly.

The majority of ophthalmology outpatients have long term chronic eye diseases including glaucoma and medical retina conditions (AMD and diabetic retinopathy) where patients often need multiple treatments and follow up for life to prevent blindness. In contrast patients with cataracts alone require a one-off operation which is an effective treatment. Focusing only on cataract surgery ignores the more important and "harder nut to crack" of how to deliver effective and efficient treatments for chronic eye disease. Ophthalmology services and prevention of blindness are not a priority for NHS England with its current focus on emergencies, cancer, and 65 week waits. Data on preventable sight loss is not used to commission or plan care although sight loss is expensive for the individual and for the NHS and for social care.

The impact on training for the next generation of ophthalmologists has been badly affected. The UK used to have the best training in Europe attracting trainees for fellowships from across the world, but this is no longer the case. Some 30% of ST2 ophthalmology trainees will miss their target for cataract surgery numbers. My department has had two (of 10) training posts removed recently for this reason alone. NHS England has asked us to develop models of care including cataract surgery training in partnership with the private sector providers. We have been working with two of the three ISTCs which have set up in my county recently, but contractual agreements and arrangements to bring our trainees have been lengthy, confusing and have yet to start.

One consequence of focusing on high volume low complexity cases is the deprioritisation of chronic eye care, since it is the same staff who work in the NHS and migrate to the private sector. Consultant colleagues from neighbouring trusts (most of whom trained in my department) have set up a treatment centre in Oxfordshire and have reduced their core NHS work. Moving cataract surgery off an acute trust site will not help the waiting time for non-cataract eye surgery and waiting is likely to be far more detrimental to a patient with glaucoma or retinal problem than a patient on the cataract waiting list. Furthermore, since the private sector "cherry picks" richer, easier to treat patients, they leave the complex ones to the NHS and data show that inequalities in access are growing. The case mix on NHS waiting list is correspondingly more difficult which makes it harder to achieve GIRFT targets and to identify suitable cases particularly for junior trainees.

A further consequence is that although all independent providers are required to make arrangements with the local eye emergency department to refer urgent patients if required, specialist emergency departments are being so degraded and underfunded that questions remain over staffing levels and the impact on NHS patients and services.

Commissioning is not working and NHS spending on cataract surgery is out of control. Private providers can set up in any Integrated Care System and start charging for procedures irrespective of local needs or impact on local NHS services. The cataract market is worth £500m a year and £250-300m is now being spent with ISTCs. Changes to referrals to bypass GPs and to commissioning will move money from NHS trusts in 2023/24. Patients are unaware of direct incentives or "co-management fees" paid to optometrists who refer to ISTCs. In my trust, ophthalmology has lost theatres to other specialties. There is no additional funding available to expand services for chronic eye disease whether hospital or independent sector based.

The current "blank cheque" for independent NHS cataract services is stupid and frankly unethical. Contracting and commissioning should be urgently reviewed by the Government and NHS England to keep the NHS hospital eye service viable and sustainable for the full range of eye care as well as training.

The question is whether parliament and the government is prepared to allow the hospital eye service to go the way of NHS dentistry and whether the public is prepared to pay the consequences of neglect in the epidemic of blindness which will follow.

Stella Hornby is a consultant ophthalmologist specialising in urgent and primary care ophthalmology working for acute NHS trusts for 30 years. She is Clinical Director of Ophthalmology at Oxford University Hospitals NHS Foundation Trust. She qualified in medicine from Cambridge University in 1992 and has an MD on childhood blindness in India. She has served on the RCOphth Professional Standards and Education Committees. She does not do private practice. Her partnership Primary Care Ophthalmology LLP runs courses for GPs and others to promote awareness & knowledge about eye health. Twitter: @HornbyStella

Stella Hornby went on to give evidence in September 2025 to the Oxfordshire Joint Health Overview and Scrutiny Committee in which she warned unchecked growth in private cataract surgery could destabilise NHS ophthalmology by diverting funds, impacting staff, and jeopardising training and emergency services. She called for an urgent review of private sector involvement to protect the Eye Hospital's future.

https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=148&MId=7860&Ver=4