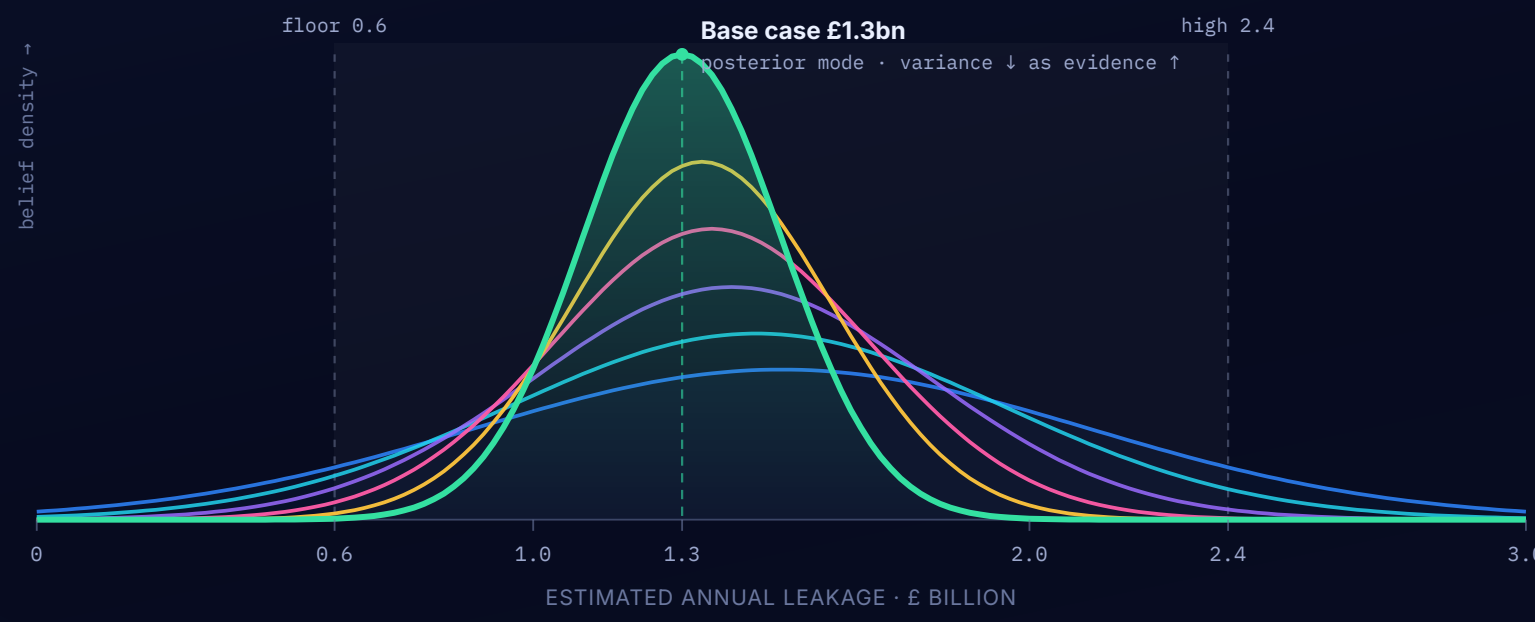
KINCAID IQ VERIFY™ V9.0 · FORENSIC CAPITAL-ALLOCATION INTELLIGENCE

NHS Pharmaceutical Leakage.

Can a forensic arbitrage engine built for US self-funded employer plans map onto the world's largest single-payer health system — and find the money that quietly leaks out of it?

BAYESIAN ESTIMATE · THE BELIEF DISTRIBUTION TIGHTENS AS EACH EVIDENCE LAYER IS ADDED



Prior · + NHSBSA spend · + Drug Tariff · + Consumables · + Intermediaries · Posterior · £1.3bn

↳ Illustrative posterior over annual leakage; mean converges to the £1.3bn base case as Tier-1/2 evidence is incorporated, variance shrinks. Prior deliberately wide; posterior deliberately conservative. T3 · method

ESTIMATED LEAKAGE

£0.6–2.4bn

Annual, recoverable. Modelled range, pre-data-access.

COST BASE IN SCOPE

£30bn+

Medicines £21.6bn + consumables ~£8bn (England).

ROOT CAUSE

List ≠ Net

Structural information asymmetry, not behaviour.

MODEL

B2G

One contract. Millions of lives. Replicable.

PREPARED FOR

Dharma Foundry — discussion with Amit & Jeremiah

PREPARED BY

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ENGINE

Kincaid IQ · SiriusB iQ AI Data Sciences Lab

June 2026 · v1.0 MVP

READ THIS FIRST

Classification, purpose & the limits of this paper

This is a **discussion paper**, not an audited finding, not investment advice, and not a procurement proposal. It exists to test one hypothesis with the Foundry: that the Kincaid IQ architecture transfers from the US employer market to single-payer health systems — and that the prize is large enough to justify a proof of concept.

What this document is

- A structured, evidence-anchored thesis for internal debate.
- A first translation of the Kincaid IQ v5.0 Economic-Value framework onto a government payer.
- A map of where money plausibly leaks, sized into a conservative range.
- A decision memo: do we fund a PoC, yes or no?

What this document is not

- An audited quantification. Every figure is decision-grade, not assured.
- A legal or regulatory opinion on UK procurement law.
- A claim that all of the gross-to-net gap is "waste" — much of it is deliberate policy (see Part III).
- A solicitation. No NHS data has been ingested at the time of writing.

⚠ Honesty clause

Two claims commonly attached to this thesis are overstated and have been corrected in this paper. (1) The NHS is **not** the largest employer in the world — it is the largest in Europe and roughly the 5th–7th largest globally by headcount. (2) "The NHS pays double the manufacturer price for generics" conflates genuine leakage with the **retained medicine margin** — a deliberate mechanism that funds community pharmacy. Correcting both makes the underlying opportunity more credible, not less.

EVIDENCE TIERING USED THROUGHOUT

T1 OFFICIAL	T2 INDUSTRY	T3 ANALYST	T4 MODELLED
NHSBSA, NAO, DHSC, Parliament, gov.uk	ABPI, HDA, Community Pharmacy England	King's Fund, Nuffield Trust, press, advisers	Kincaid IQ estimate — flagged, not observed

GOVERNANCE

Distribution, authorship & engine provenance

Circulation is restricted to the named recipients below. The analytical engine and its operating standard are recorded so that every claim in this paper can be traced to a method and an owner.

Distribution list

RECIPIENT	ROLE IN THIS DISCUSSION
Amit	UK feasibility, regulatory landscape, market access
Jeremiah F. Shrack	CEO & Chairman — engine authority, IC sponsor
James Thorp	Author · Thorp Advisory

ENGINE OF RECORD

Kincaid IQ Verify™ V9.0

SiriusB iQ AI Data Sciences Lab · Carmel, Indiana. 56-Lever Control Architecture · 36-Scenario Engine · 9-Gate Evidence Spine · Economic Value Engine™.

OPERATING STANDARD

Board of Directors · Investment Committee · ERISA-grade fiduciary discipline · PCAOB AS 1105/2201 · COSO ICFR · EVA discipline.

The eight-partner standard

Kincaid IQ reasons as eight senior partners simultaneously. Each lens is applied to the NHS question in this paper.

GOLDMAN SACHS
Capital allocation · VaR · RAROC

MCKINSEY
MECE structuring · synthesis

BAIN
Results Delivery · Full Potential

EY-PARTHENON
Value creation · deal logic

CROWE
Fiduciary audit & compliance

STERN STEWART
EVA · economic profit

KAPLAN / HBS
Time-Driven ABC

MIT / STANFORD
Mechanism design · causal inference

NAVIGATION

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◐ A note on the two voices of this paper

This document holds two disciplines in tension on purpose. The **capital lens** (Goldman / McKinsey) treats NHS spend as a portfolio to be allocated efficiently. The **humanitarian lens** (a Notre Dame sensibility) remembers that every pound recovered is a pound that can return to a patient. Both are true. Neither is allowed to outrun the evidence.

The governing protocol — non-negotiable

RULE 1
One screen, four tiles — always.

RULE 2
Every number clickable into receipts.

RULE 3
No export without receipts.

RULE 4
Narratives never outrun evidence.

Evidence Spine Protocol — No anchor, no claim. No lineage, no publish.

HOW THE ANALYSIS WAS BUILT

Method & the 9-gate evidence spine

The original analysis was produced by posing the NHS question to Kincaid IQ without modifying the platform. This paper hardens that output: each claim is re-anchored to a public source, each estimate is tiered, and the leakage figure is rebuilt bottom-up and top-down to triangulate a defensible range.

Process

01 **Pose & observe.** Run the NHS question through Kincaid IQ's unmodified US-employer architecture; capture the raw structured output.

02 **Re-anchor.** Replace every assertion with a sourced fact or a clearly flagged model estimate.

03 **Decompose.** Separate deliberate policy (retained margin, VPAG) from genuine recoverable leakage.

04 **Triangulate.** Size leakage bottom-up (per category) and top-down (price-variation analogues), then reconcile.

05 **Translate.** Convert £ recovered into fiscal headroom and care units (the public-sector EV bridge).

06 **Stress.** Run the scenario engine and a risk register before any recommendation.

The 9 gates

A claim only "publishes" if it passes all nine.

- G1 · SOURCE EXISTS & IS DATED
- G2 · TIER ASSIGNED (T1–T4)
- G3 · POLICY VS LEAKAGE SEPARATED
- G4 · RANGE, NOT POINT ESTIMATE
- G5 · SENSITIVITY IDENTIFIED
- G6 · COUNTER-ARGUMENT STATED
- G7 · CAPITAL IMPACT EXPRESSED
- G8 · HUMAN IMPACT EXPRESSED
- G9 · OWNER / NEXT ACTION NAMED

✓ Why we corrected the engine's first draft

An unmodified US-employer model will, by default, read the UK gross-to-net gap as pure arbitrage. It is not. A material part of that gap is the **retained medicine margin** — surveyed and clawed back by the DHSC — that deliberately funds pharmacies. Kincaid IQ's value here is precisely its ability to separate designed margin from undesigned leakage. That distinction is the spine of Part III and Part IV.

SPEAK THE SYSTEM'S LANGUAGE

Glossary of the NHS pricing system

The single-payer pharmaceutical system has its own vocabulary. These terms recur throughout the paper; mastering them is the difference between a software pitch and an institutional intervention.

TERM	MEANING
Drug Tariff	Monthly DHSC/NHSBSA publication setting reimbursement & remuneration for NHS dispensing in England & Wales.
Category M	Generics where DHSC sets reimbursement from manufacturer-submitted price/volume data; the lever used to deliver retained margin.
Category A	Generics priced on a weighted average of selected wholesaler/manufacturer list prices — historically the opaque corner.
Retained margin	The gap between what a pharmacy pays and what it is reimbursed — a deliberate funding mechanism, not pure leakage.
Margin survey	Quarterly Medicines Margin Survey; over-/under-delivery is clawed back via Category M.
Concession price	Temporary uplift granted when market price exceeds the Tariff (typically during shortages).

TERM	MEANING
VPAG	2024–28 Voluntary Scheme for Branded Medicines Pricing, Access & Growth; caps NHS branded growth via industry rebate ("clawback").
Statutory Scheme	The mandatory equivalent for manufacturers not in VPAG.
PAS	Patient Access Scheme — confidential discount on a branded medicine, often via NICE; the core of "list ≠ net".
List vs net	Published price vs the actual price paid after confidential rebates/discounts. The gap is the opacity.
ICB	Integrated Care Board — one of 42 statutory bodies commissioning NHS care locally in England.
NHS Supply Chain	The body procuring ~£8bn of equipment & consumables via 11 "Category Towers".

↳ NHSBSA Drug Tariff Part VIII; ABPI VPAG guidance; DHSC; NAO. T1/T2

DECISION-GRADE SYNTHESIS

Executive Brief

The whole argument in eight pages. If you read nothing else, read this — and then ask the four questions on page 11.

07 This divider · 08 The recovery · 09 Summary

10 Command screen · 11 Findings · 12 Economic value

13 Risk posture · 14 The human ledger

SECTION XII — THE ONE LINE

The thesis, stated once and plainly

The £0.6–2.4bn annual recovery hiding inside a single-payer system that cannot audit its own net prices.

The NHS spends **£21.6bn a year on medicines** and roughly **£8bn more on equipment and consumables**. The prices it pays are set in a system where the published price is rarely the price actually paid, where confidential discounts are the norm, and where no local commissioner can independently verify it is capturing the best available net price. Kincaid IQ's job is to make that gap visible — and to separate the part that is deliberate policy from the part that is recoverable leakage.

CONSERVATIVE

£0.6bn

Recoverable in year one against the most defensible assumptions.

BASE CASE

£1.3bn

Triangulated mid-point across categories.

UPPER BOUND

£2.4bn

If asymmetry is as wide as analogues suggest.

◆ **Read the range, not the number**

A single point estimate here would be dishonest. The honest output of a forensic engine, pre-data-access, is a **range with explicit drivers**. The width of that range is itself the finding: it is wide because the system is opaque. Narrowing it is exactly what the proof of concept buys.

↳ Cost base: NHSBSA, *Prescribing Costs in Hospitals & the Community 2024/25* (£21.6bn); NAO, *NHS Supply Chain* 2024 (~£8bn). Range: Kincaid IQ model. T1 · T4

SITUATION · COMPLICATION · RESOLUTION

The argument in three movements

① Situation — a vast, mandated cost base

The NHS in England is one of the world's largest purchasers of healthcare goods. Medicines alone reached **£21.6bn in 2024/25** — up 51.9% since 2019/20 — split roughly evenly between hospitals (£11.1bn) and primary care (£10.3bn). Add ~£8bn of equipment and consumables routed through a mandated supply chain. Much of this spend flows through structures that have existed, largely unchanged, since 1948.

② Complication — the price paid is not the price published

UK manufacturers enjoy free pricing. Branded prices are "chipped down" through Patient Access Schemes, VPAG rebates and confidential deals — so the list price systematically overstates the net price. The VPAG operational model itself is held confidentially between DHSC and industry. Rebates flow to the centre, **not** to the 42 ICBs who hold local budgets — so no commissioner can see, let alone audit, the true net cost of what it buys. On consumables, the NAO finds trusts still pay materially different prices for identical goods. The asymmetry is structural, not behavioural.

③ Resolution — a forensic layer, not a software sale

Kincaid IQ already does this in the US: it reconstructs net economics behind opaque intermediated pricing and shows the receipts. Applied to the NHS, it becomes a **forensic layer across the entire cost base** — sizing leakage, attributing it, and translating recovery into fiscal headroom and patient care. The commercial model is business-to-government: one contract covering millions of lives, replicable across European and Gulf single-payer systems.

↳ NHSBSA 2024/25; ABPI, *Understanding NHS medicines spending* 2025; NAO 2024. T1 · T2

THE KINCAID COMMAND SCREEN

If the board sees one screen, it sees this

Rule 1 of the governing protocol: one screen, four tiles, always. Here is the NHS engagement compressed to its four load-bearing facts.

TILE 1 · THE PRIZE

£1.3bn / yr

Base-case recoverable leakage across medicines + consumables. Range £0.6–2.4bn. T4

TILE 2 · THE CAUSE

List ≠ Net

Confidential discounts + central-only rebates + mandated supply = no local net-price audit. Structural. T1

TILE 3 · THE MODEL

B2G · 1:millions

One government contract vs employer-by-employer. Replicable across EU + GCC single payers. T4

TILE 4 · THE RISK

Generational

Well-resourced, politically connected incumbents. Data access is the binding constraint, not technology. T3

✓ Every tile is clickable into receipts

In the live platform each figure expands to its lineage — source document, extraction date, model assumptions, and the analyst who signed it. No export leaves the system without those receipts attached. That discipline is the moat (page 77).

WHAT WE FOUND · WHAT WE ASK

Five findings — and the four questions for the Foundry

Five findings

01 **The architecture transfers.** Kincaid mapped onto a single-payer system without modification and produced a coherent structural analysis.

02 **Opacity is the asset class.** The recoverable value sits in the gap between list and net, and in price variation for identical goods.

03 **The leakage is sizeable but must be sized honestly.** £0.6–2.4bn after stripping out deliberate margin.

04 **The buyer is the state.** This is B2G — Treasury, DHSC, NHSE — not 200 employers.

05 **The constraint is access, not capability.** The PoC stands or falls on ingesting real procurement and contract data.

The four questions (Section IX decision frame)

Q1

What is the **fiscal / enterprise-value impact** of fixing this?

Q2

What is the **risk-adjusted return** on a PoC?

Q3

What **capital is misallocated** today by paying gross?

Q4

What is the **opportunity cost of inaction** — for the firm and for patients?

→ The single decision on the table

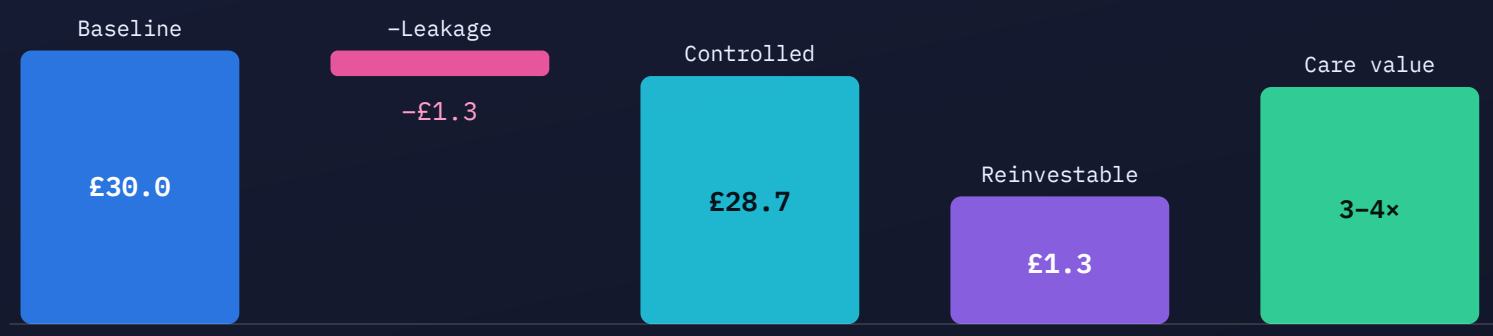
Fund a bounded proof of concept on publicly available NHS procurement and pharmaceutical contract data, sponsored by Amit's UK feasibility review, with a parallel scan of one GCC system. Not a build. Not a sale. A test that narrows the range on page 8 from billions to a number you can defend in front of the Treasury.

ECONOMIC VALUE ENGINE™ — THE BRIDGE

From recovered spend to value created

Kincaid IQ refuses to stop at "cost saved". Every insight is carried through to value. In a government setting the bridge terminates not in a share price but in **fiscal headroom** and **care delivered** — the public-sector equivalent of enterprise value.

PUBLIC-SECTOR ECONOMIC VALUE BRIDGE · BASE CASE (£BN / YR)



Baseline spend → strip leakage → controlled spend → reinvestable capital → care value (health-outcome multiple on redeployed £). Illustrative.

REINVESTABLE / YR

£1.3bn

≈ the entire annual budget of several mid-size ICBs.

CONVERSION

100%

Public £ recovered is £ available — no tax/CapEx leakage as in a corporate FCF bridge.

MULTIPLE EFFECT

3–4×

Care-outcome leverage when £ moves from margin to frontline.

↳ Method adapted from Kincaid IQ EV Bridge (Stern Stewart / EY-Parthenon lineage); fiscal translation by Thorp Advisory. T4

WHAT COULD BREAK THIS

Risk posture & what we cannot yet claim

A Goldman memo states its own downside first. Here is ours, summarised; the full register is Part IX.

Top risks (heat-ranked)

What we cannot yet claim

- That the leakage is precisely £X — only that it falls in a wide, sourced range.
- That all of it is recoverable — some is locked by policy or contract.
- That recovery is frictionless — it is a political and institutional intervention.
- That the US model maps perfectly — the retained-margin mechanism has no clean US analogue.

The binding constraint is access. The technology is proven; the question is whether the data can be reached. The PoC is designed around exactly this.

↳ Risk weights: Kincaid IQ risk module + Thorp Advisory judgement. T4

THE NOTRE DAME LENS

What a recovered billion actually buys

Capital allocation is the language of the boardroom. But in a public health system, a pound is never just a pound — it is a nurse's salary, a scan, a hip that lets someone walk again. Before we treat this as an arbitrage, we should be clear-eyed about what is on the other side of the trade.

BAND-5 NURSES
~37k
Full-year salaries fundable from £1.3bn.

MRI SCANS
~5m
Diagnostic capacity at typical tariff.

HIP REPLACEMENTS
~150k
Elective procedures cleared from the backlog.

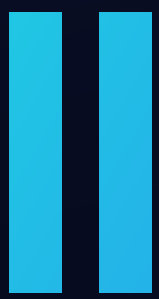
ICB BUDGETS
several
Mid-size local commissioner budgets, in full.

◐ The moral case sits on top of the financial one

The ICBs were asked to find **£11.0bn of savings in 2025/26**. Money lost to opacity is money not spent on care — and the people who pay for that opacity are patients in a queue. This is why the work has to be done well: overstated claims discredit the cause and protect the status quo. The discipline of the evidence spine is not just good analysis; in this domain it is an ethical obligation.

Conversions are illustrative, using published NHS unit costs and pay bands; precise figures vary by region and year. They are presented to make scale tangible, not as a budget. T4

MCKINSEY DISCIPLINE



Problem Structuring

Before sizing anything, structure the question with MECE rigour. A leakage estimate is only as good as the issue tree beneath it.

16 The core question · 17 Logic tree · 18 Hypotheses
19 Two architectures · 20 What transfers · 21 Stakeholders · 22 Defining leakage

SECTION 1 — FRAME BEFORE YOU SOLVE

The core question

> **How much value leaks from the NHS pharmaceutical and supply cost base because the system cannot independently verify the net price it pays — and how much of that is recoverable without harming patients or supply?**
>
> THE QUESTION KINCAID IQ WAS ASKED TO ANSWER

Decomposed — MECE

The question splits cleanly into five mutually-exclusive, collectively-exhaustive components. Each maps to a later part of this paper.

A · COST STRUCTURE
Where the money actually goes. → Part III/IV

B · PRICE FORMATION
How prices are set and hidden. → Part III

C · SYSTEM DYNAMICS
How incentives interact. → Part V

D · QUANTIFIED LEAKAGE
The recoverable number. → Part IV

E · INTERVENTION LEVERS
What can be controlled. → Part V/X

TEST
Are these exhaustive? Anything not in A–E is out of scope.

✓ Why MECE matters here specifically

The single biggest analytical error in this space is double-counting: treating deliberate retained margin (a B/C question) as recoverable leakage (a D question). Clean decomposition is what stops the £-figure from being inflated — and what lets us defend it in front of people who know the system intimately.

THE LEAKAGE LOGIC TREE

Where could the money be leaking?

Every branch is a hypothesis to be tested against data. Branches shaded green are recoverable; amber are partly policy; grey are by-design (not leakage).

Total gross-to-net gap

£ paid vs true economic cost

▶

Branded opacity (PAS / net-price)

Confidential discounts not visible locally → can't verify best net. **Recoverable via transparency.**

Generic Category A drift

Old generics with few competitors, list-priced. **Partly recoverable.**

Consumables price variation

Trusts paying different prices for identical goods (Carter). **Recoverable via benchmarking.**

Intermediary margin layering

PE-owned wholesalers extracting coordination margin. **Recoverable via disintermediation.**

Retained medicine margin

Deliberate pharmacy funding (~£0.8bn+, surveyed & clawed back). **NOT leakage — by design.**

Concession-price timing

Lag between market price falls and Tariff resets. **Partly recoverable.**

↳ Branch logic: Kincaid IQ structuring; policy/leakage split per NHSBSA & CPE. T1 · T4

HYPOTHESIS-DRIVEN, NOT DESCRIPTIVE

Initial hypotheses & how we test them

A McKinsey engagement leads with falsifiable hypotheses. Here are ours, each with the data that would confirm or kill it during the PoC.

HYPOTHESIS	TEST (POC DATA)	PRIOR
H1. A minority of products/categories drive the majority of recoverable leakage.	Pareto on category-level spend × estimated net gap.	High
H2. Branded list-to-net gaps are wider and more hidden than generic gaps.	VPAG/PAS-adjusted net vs list, where disclosable.	High
H3. Identical consumables are bought at materially different prices across trusts.	SKU-level price dispersion across NHS Supply Chain catalogue.	High
H4. Intermediary concentration adds extractable margin.	Wholesaler margin vs service cost; make/buy analysis.	Med
H5. ICBs cannot currently audit their own net prices.	Interviews + data-availability mapping at ICB level.	High
H6. The retained margin is largely not recoverable (it is policy).	Margin-survey reconciliation; confirm clawback works.	Med

◆ The contrarian hypothesis we are most afraid of

H6 might be larger than we think. If the system already captures most available value through the margin survey, VPAG clawback and central rebates, the net-of-policy leakage could sit at the bottom of our range. We test H6 first and hardest — because if it holds, the prize shrinks and the thesis must be re-scoped to consumables and intermediaries.

ORIGIN VS TARGET

Self-funded employer vs single-payer state

Kincaid IQ was built for the US self-funded employer market, where the payer is a company and the adversary is the PBM. The NHS inverts almost every variable. Understanding the mapping is the whole feasibility question.

DIMENSION	US SELF-FUNDED EMPLOYER — KINCAID ORIGIN	NHS SINGLE PAYER — TARGET
Who bears cost	The employer	The government / taxpayer
Lives per contract	Thousands	Tens of millions
The opaque intermediary	PBM (rebates, spread pricing)	Wholesalers + confidential PAS + central rebates
Price control regime	Market / contractual	Drug Tariff + VPAG + free pricing
"Designed" margin	Minimal / adversarial	Explicit (retained pharmacy margin)
Audit rights	Contractual, often litigated	Weak at local (ICB) level
Buyer psychology	CFO, fiduciary duty (ERISA)	Treasury, political, public accountability
Sales motion	B2B, employer-by-employer	B2G, one contract, very long cycle

✓ The transferable core

Both are **intermediated, opacity-driven cost systems** where list ≠ net and the payer lacks the data to verify the deal. That is exactly the problem Kincaid IQ exists to solve.

⚠ The non-transferable parts

The retained-margin mechanism, free pricing, and the political buyer have no clean US analogue. The model must be **re-parameterised**, not copy-pasted.

↳ Comparative framing: Thorp Advisory; UK regime per NHSBSA, ABPI. T1 · T2 · T4

MECHANISM DESIGN (MIT/STANFORD LENS)

Why the arbitrage logic transfers — and where it breaks

The invariant: information asymmetry as the value source

Kincaid IQ does not "negotiate". It **reconstructs the information the payer is missing** and exposes the gap between what is paid and what is achievable. That mechanism is regime-agnostic: wherever a payer transacts through intermediaries under confidential pricing, a forensic reconstruction layer has value. The NHS is, if anything, a purer case than the US — the asymmetry is more structural and less contested.

Transfers cleanly

- Net-price reconstruction behind confidential deals.
- SKU-level price-dispersion detection (identical goods, different prices).
- Intermediary margin attribution & make/buy logic.
- The "receipts" discipline — auditability is universally valued by public buyers.

Breaks / needs rework

- Treating retained margin as recoverable — would overstate the prize.
- PBM-specific spread logic — no direct NHS equivalent.
- Fast B2B sales motion — replaced by a multi-year political cycle.
- Employer-level benchmarking — must become national/ICB-level.

✓ Net judgement

The core engine transfers; the periphery must be rebuilt. Crucially, the part that transfers — forensic net-price reconstruction — is the part that creates the value. This is a **re-parameterisation, not a re-invention**, which is why a bounded PoC is the right next step rather than a ground-up build.

WHO WINS, WHO RESISTS

Stakeholder & power map

Any intervention in a generational system is decided by stakeholders, not spreadsheets. Mapped by interest (recover value vs protect margin) and power (ability to enable or block).

HIGH POWER · ALIGNED

HM Treasury

Wants demonstrable recovery. Funding pressure makes this attractive. **Champion target.**

HIGH POWER · OPPOSED

Pharma majors · large wholesalers

Profit from current opacity. Well-resourced, politically connected. **Primary resistance.**

MEDIUM POWER · MIXED

DHSC · NHS England

Want savings but own the current schemes. Reform = admitting gaps. **Manage carefully.**

RISING POWER · ALIGNED

ICBs · NAO · Public Accounts

Carry savings targets & audit mandates. Natural allies for transparency. **Build coalition.**

PATIENTS / PUBLIC

High interest, diffuse power. The moral mandate — but cannot drive procurement alone.

COMMUNITY PHARMACY

Sensitive: retained margin funds them. Reform must not destabilise dispensing.

OPPOSITION / POLICY TEAMS

Any party can use "recover wasted spend" — politically bipartisan.

↳ Power map: Thorp Advisory analysis; NAO & PAC interest evidenced in 2024 reports. **T1 · T4**

THE MOST IMPORTANT PAGE IN PART II

What "leakage" precisely means

If we cannot define leakage cleanly, every number that follows is suspect. So we define it formally — and exclude what is merely policy.

DEFINITION

Leakage = the difference between the price the NHS pays and the best achievable net price for equivalent value, after removing (a) deliberate retained margin, (b) genuine service value, and (c) supply-security premia that the system consciously chooses to pay.

IS leakage

- Paying gross because net is invisible
- SKU price dispersion with no quality basis
- Margin layers adding cost not value
- Concession lag the system doesn't reclaim

MAYBE leakage

- Category A drift on low-competition generics
- Premia for fragmented small-volume buying
- Admin cost of intermediation

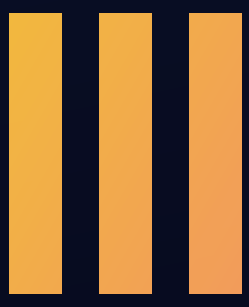
NOT leakage

- Retained margin (pharmacy funding)
- VPAG rebates already captured centrally
- Deliberately-paid supply security
- Legitimate clinical premium products

✓ **The conservative principle**

When a pound could be either policy or leakage, we classify it as **policy** and exclude it. This biases the estimate downward — deliberately. A defensible £0.6bn is worth more to this firm than an indefensible £5bn.

DEEP DIVE · HOW THE MONEY ACTUALLY MOVES



The UK Pricing System

You cannot find leakage in a system you do not understand. Sixteen pages on exactly how the NHS pays for medicines — and where the published price stops telling the truth.

24 System map · 25 Primary vs secondary · 26 Drug Tariff · 27 Generics A/C/M
28 Retained margin · 29 Margin survey · 30 Concessions · 31 Branded free pricing
32 VPAG · 33 Wholesale & PE · 34 PAS · 35 List vs net · 36 Asymmetry · 37 ICB gap ·
38 Synthesis

THE FLOW OF MEDICINE & MONEY

How a medicine — and a pound — moves through the NHS

Two flows run in opposite directions: the product flows down from manufacturer to patient; the money flows back up through reimbursement and rebates. The opacity lives in the gaps between the boxes.

◆ Where the truth gets lost

The published list price attaches to the top box. The actual net price emerges only after the **confidential layer** — and that layer is invisible to the local commissioner who carries the budget. Kincaid IQ's task is to reconstruct the bottom-right box from the data that is available.

↳ Wholesale share: HDA UK (members distribute >92% of NHS medicines). Flow: NHSBSA, ABPI. **T1 · T2**

THE SPLIT THAT GOVERNS EVERYTHING

Primary care vs secondary care — two different machines

The NHS pays for medicines in two structurally different ways. Confusing them is the second-most-common analytical error in this space.

Primary care (community)

GP-prescribed, dispensed by community pharmacy. Reimbursed against the **Drug Tariff**. The retained-margin mechanism lives here. ~**£10.3bn** (2024/25), 47.6% of spend.

Pricing	Tariff
Volume data	Item-level

Secondary care (hospital)

Procured by trusts, often via tenders & confidential contracts; high-cost specialist drugs dominate. ~**£11.1bn** (2024/25), 51.6% of spend — and growing ~8%/yr.

Pricing	Tender/PAS
Volume data	Qty only

✓ The asymmetry of visibility

Primary care has **item-level** data — every prescription is recorded. Secondary care records only quantities issued; "the concept of a prescription item does not exist". So the larger, faster-growing half of the budget is also the **less transparent** half. That is precisely where a forensic layer earns its keep.

↳ NHSBSA, *Prescribing Costs in Hospitals & the Community 2024/25* (split, growth, data granularity). **T1**

THE RULEBOOK OF PRIMARY-CARE PRICING

The Drug Tariff: what the NHS will pay

Published monthly by the NHSBSA on behalf of the DHSC, the Drug Tariff sets both **reimbursement** (what a pharmacy is paid for the medicine) and **remuneration** (what it is paid for the service). It is, in effect, the price list for community dispensing in England & Wales.

What the Tariff fixes

- The reimbursement price per pack/unit for listed products.
- Which pricing category each generic falls into (Part VIIIA).
- When a concession price applies (shortage/market spikes).
- Remuneration fees for the dispensing act.

The price published is normally what the pharmacy is reimbursed. But what the pharmacy pays its wholesaler is a separate, private number — and the gap between the two is deliberate (page 28).

KEY PROPERTY

Reimbursement price ≠ acquisition price ≠ true net manufacturer price.

Three different numbers sit behind one prescription. The Tariff publishes one of them. The forensic question is: what are the other two, and is the gap value or leakage?

Reset cadence

Category A & M prices update **quarterly** (Jan/Apr/Jul/Oct). This cadence creates timing gaps: when real market prices fall faster than the quarterly reset, the system can keep paying yesterday's price. That lag is one of our leakage branches (page 30).

↳ NHSBSA Drug Tariff Part VIII; Community Pharmacy England, Category A/M pages. **T1 · T2**

PART VIIIA — THE THREE DOORS

How generic reimbursement is actually set

Generics — off-patent medicines — are where competition is supposed to do the work. The UK relies on market competition rather than direct price control; generic versions can be up to 90% cheaper than the branded original. But how the reimbursement price is set differs by category, and that is where opacity creeps in.

CATEGORY	WHAT IT CONTAINS	HOW PRICE IS SET	LEAKAGE RISK
Category A	Readily-available generics, lower volume, not meeting Category M criteria	Weighted average of selected wholesaler/manufacturer **list** prices	Medium–high
Category C	Not readily available as generics; priced on a specific brand/supplier	Based on a particular manufacturer/brand	Medium
Category M	Readily available, multi-supplier, higher volume	DHSC calculates from **manufacturer-submitted** price/volume data	Lower

⚠ Category A — the opaque corner

A 2020 investigation found Category A prices for many products had risen by large amounts. Because some "old generics" have **few or no competitors**, market competition fails — yet there is no direct control on Category A as there is on Category M. This is a genuine leakage branch.

✓ Category M — the controlled corner

For Category M, DHSC sets a maximum reimbursement and uses manufacturer data; if acquisition price exceeds it, a pharmacy won't dispense (no profit). This **exerts real control** — and is the lever used to deliver retained margin (next page).

↳ CPE Category A/M; The Lowdown (Category A price rises, 2020 investigation); NHSBSA. **T1 · T2 · T3**

WHY "DOUBLE THE PRICE" IS THE WRONG FRAME

The retained margin: a feature, not a bug

This is the single most important correction in the paper. The gap between what a pharmacy pays for a generic and what it is reimbursed is largely **deliberate**. It is how the system funds community pharmacy without writing a separate cheque.

How it works

Pharmacies buy generics below the Drug Tariff reimbursement price and keep the difference — the "retained margin". Government knows this and intends it: it sets a national medicines-margin target (historically **~£0.8bn**) baked into the community pharmacy funding settlement. The pharmacy's buying skill becomes part of its income.

MARGIN TARGET

~£0.8bn

Deliberate national medicines margin (funding mechanism).

STATUS

By design

Not leakage. Removing it would defund pharmacies.

IMPLICATION

Net it out

Any leakage estimate must subtract this first.

◆ So is the popular claim wrong?

"The NHS pays roughly double the manufacturer price for generics" can be numerically true for some lines — but it is **misattributed**. Much of that gap is the intended retained margin, not waste. The recoverable leakage is the part beyond the designed margin: Category A drift, concession lag, and branded opacity. Conflating the two would hand incumbents an easy rebuttal and discredit the analysis.

↳ NHS England, *Medicines reimbursement prices* (medicines margin ~£0.8bn); CPE. T1 · T2

THE SYSTEM SELF-CORRECTS — PARTLY

The Medicines Margin Survey & clawback

Government doesn't leave the retained margin to chance. A quarterly **Medicines Margin Survey** measures whether pharmacies are earning more or less than the agreed target — and Category M prices are adjusted to claw back any over-delivery. This is a live, functioning feedback loop, and it matters enormously for our estimate.

Recent adjustments — the loop in action

PERIOD	SURVEY SIGNAL	ADJUSTMENT
Apr 2024	Constrained concessions; downward indicated	−£16.2m / qtr
End Jan–Mar 2025	Cumulative over-delivery identified	£124m to recoup
Oct 2025	Margin adjustment applied	−£16.3m / qtr
Apr 2026	Upward adjustment (pending CPCF 26/27)	+£20m / qtr

✓ What this tells the forensic analyst

The generic-margin question is **already actively managed**. Over-delivery is detected and recouped over the following ~12 months. This is the strongest single argument that generic leakage sits at the lower end of our range — and the strongest reason to weight the thesis toward **branded opacity and consumables**, where no equivalent survey-and-clawback machine exists.

↳ NHSBSA Drug Tariff Part VIII (margin survey adjustments; £124m over-delivery). T1

WHERE TIMING BECOMES MONEY

Concessionary pricing & the shortage premium

When the real market price of a generic spikes above the Drug Tariff — typically during a supply shortage — the DHSC grants a temporary **price concession** so pharmacies aren't dispensing at a loss. Concessions are necessary. But the mechanism creates two leakage-adjacent dynamics.

① Reset lag

Concessions can be slow to come down once a market normalises, and the quarterly Tariff reset means the NHS can keep paying an elevated price after the spike has passed. The asymmetry — quick up, slow down — is a recoverable timing cost.

② Shortage gaming

A concentrated supply base can amplify shortage-driven price moves. Where intermediaries hold stock, the gap between elevated concession prices and true cost is a margin opportunity for them — and a cost for the payer.

Why this is hard to size — and perfect for a forensic engine

Concession leakage is **episodic and data-heavy**: it requires matching concession grants against true market prices over time, line by line. No human team does this comprehensively. It is exactly the kind of high-frequency, high-volume reconciliation that Kincaid IQ automates — and exactly the kind of finding that comes with receipts (date, product, concession price, market price, gap).

◆ Honest caveat

Concessions exist to keep medicines flowing to patients during shortages — a legitimate, patient-protecting function. The leakage is only in the timing asymmetry and any excess over true cost, not in the existence of concessions. We size only the former.

↳ NHSBSA Drug Tariff Part VIII; CPE concessions guidance. **T1** · **T2**

WHERE THE REAL MONEY — AND THE REAL OPACITY — LIVES

Branded medicines: free pricing inside a spending cap

Generics are roughly half of NHS medicines volume but a minority of spend. The larger pound figure sits in branded, patent-protected medicines — and here the pricing logic flips entirely. There is no Drug Tariff weighting. Manufacturers are, broadly, free to set their own list prices on launch.

The principle: free pricing at launch

A company bringing a new branded medicine to market sets its own price. The NHS does not negotiate that headline price product-by-product the way a US PBM might. The discipline is applied **downstream and in aggregate**, not at the point of listing.

The discipline: a cap on the total bill

Instead of haggling each price, the UK caps how fast the **total** branded bill can grow. If industry-wide branded spend rises faster than an allowed percentage, manufacturers pay the excess back to government. That is the job of the voluntary scheme — covered next page.

Why "free pricing + aggregate cap" is the crucial structural fact for this thesis

FOR THE PATIENT

Access can be fast — no per-drug price war delays launch. Good.

FOR THE TREASURY

The total is controlled even if any single price is high. Also good.

FOR THE AUDITOR

The **net** price of any individual product is obscured by confidential rebates and central clawbacks. This is where opacity enters.

✓ The forensic implication

Generic leakage is bounded by the margin-survey machine. Branded "leakage" is different in kind: it is not over-payment against a published tariff, it is the **invisibility of the true net price** at the level where care is actually commissioned. You cannot recover what you cannot see — and no local buyer can see it. That is the gap a forensic engine is built to close.

↳ DHSC / ABPI branded-pricing framework; House of Commons Library briefing on medicine pricing. T1 · T2

THE CAP, IN MECHANISM

VPAG: the lever that controls the branded bill

The **Voluntary Scheme for Branded Medicines Pricing, Access & Growth (VPAG)** runs 2024–2028 and replaced the earlier VPAS (2019–2023), itself a successor to the PPRS. The principle is simple; the parameters are where the money is.

HEADLINE PAYMENT 2025
22.9%
Share of in-scope branded sales repaid to government.

OLDER-MEDICINES TOP-UP
31.3%
Rate on older products — doubled from ~15.5% in July 2025.

ALLOWED GROWTH
2→4%
Permitted annual growth in branded spend, rising to 2027–28.

ANNUAL REBATE POOL
~£3–3.5bn
Approx. repaid to DHSC/NHSE per year under the scheme.

How a year actually settles

01 Government sets an **allowed growth rate** for total branded spend (rising from 2% toward 4% across the scheme).

02 Actual industry branded sales are measured against that ceiling.

03 Spend above the ceiling is **repaid** by manufacturers as a percentage levy on in-scope sales — the headline 22.9% for 2025, with a higher 31.3% band on older medicines.

04 With eligible sales around **£3bn per quarter**, roughly **£597m was repaid in Q1 2024** alone — annualising into multiple billions.

◆ The single most important sentence in this section

These rebates flow **centrally** — to DHSC and NHS England — **not** to the 42 local Integrated Care Boards that actually commission and "pay" for the medicines. The body holding the budget is not the body capturing the rebate. Hold that thought; page 37 is built on it.

↳ ABPI & gov.uk VPAG documentation; Pharmaceutical Journal; CMS Law analysis; House of Commons Library. T1 · T2

WHO SITS BETWEEN THE MAKER AND THE PATIENT

The statutory backstop — and a concentrated, PE-touched supply chain

The statutory scheme (the backstop)

Manufacturers who decline the voluntary VPAG fall under a **mandatory statutory scheme** with an equivalent payment mechanism. The effect: there is no opting out of the aggregate-cap discipline. This matters for our model because it means branded spend control is near-universal — leakage is therefore not primarily about uncapped list prices, but about **net-price invisibility**.

The distribution layer

Medicines reach pharmacies through **full-line wholesalers**. Three players dominate UK distribution — **Alliance Healthcare, AAH, and Phoenix** — and members of the Healthcare Distribution Association handle **over 92%** of NHS medicines by value. Concentration is not itself wrongdoing, but it shapes where margin can accumulate.

The private-equity signal the source paper flagged

ENTITY	POSITION	OWNERSHIP SIGNAL	SCALE
AAH Pharmaceuticals	Largest pharmacy supplier (~14,000 pharmacies)	German PE house **Aurelius** (acq. 2022); reportedly being re-sold at a high earnings multiple	~£3bn rev ~£90m earnings
Well Pharmacy	Large pharmacy chain	Owned by Bestway group	Major chain
3 full-line wholesalers	Bulk of distribution	Mixed corporate / PE-adjacent	>92% of NHS meds (HDA)

◆ Stated as hypothesis, not accusation

A concentrated distribution layer with private-equity ownership has a rational incentive to maximise intermediary margin. That is a reason to **measure** the spread between net manufacturer price and final reimbursed price — not a claim that any party is acting improperly. The forensic question is simply: how many pounds sit in the layer between maker and payer, and how many are recoverable? We size this conservatively on page 45.

↳ City AM; Pharmaceutical Journal; Healthcare Distribution Association (HDA) member data. T2 · T3

THE LEGAL MACHINERY OF "LIST ≠ NET"

Patient Access Schemes & commercial-in-confidence pricing

When a medicine is too expensive to be cost-effective at its list price, the manufacturer can offer a confidential discount so it clears the cost-effectiveness bar and reaches patients. These are **Patient Access Schemes (PAS)** and commercial agreements — and they are, by design, **commercial-in-confidence**.

Why they exist (the legitimate case)

- They get cost-effective access to patients who would otherwise be denied a therapy.
- They let a manufacturer hold a high international list price while still discounting for the NHS.
- They are a pragmatic bridge between a maker's global pricing and a single payer's budget.

Why they create a forensic blind spot

- The discount is confidential — the **true net price is not public**.
- Published list prices systematically **overstate** what the NHS actually pays.
- No external party — including a local commissioner — can verify whether the best available net price was captured.

The honest tension at the centre of this whole report

Confidentiality is not corruption. It is a deliberate policy trade: secrecy buys access and protects international reference pricing. But the same secrecy that enables access also **prevents verification**. Even the ABPI has publicly acknowledged the case for greater transparency. Our thesis does not require proving anyone is cheating — only that **a system no one can fully audit will, statistically, leave money on the table.**

✓ What a forensic engine can ethically do here

Not break confidentiality. Instead: triangulate. Cross-reference international reference prices, volume patterns, therapeutic substitutes, and timing to **estimate** where net prices diverge from best-achievable — and flag those lines for human negotiation. Receipts, not accusations.

↳ NICE PAS framework; ABPI transparency statements; House of Commons Library. T1 · T2

ONE PICTURE OF WHERE TRUTH IS LOST

The list-versus-net opacity map

Every layer below adds either a discount, a margin, or a rebate. Some are visible; most are not. The further you travel from the manufacturer, the less the published number means.

Illustrative magnitudes only — the precise values are, by construction, not publicly knowable. That is the point.

What's visible

List prices, Drug Tariff categories, scheme headline rates. Enough to look transparent.

What's hidden

PAS discounts, individual net prices, intermediary spreads. The decisive numbers.

What's misplaced

Central rebates that never reach the local budget-holder's line of sight.

✓ The diagnosis in one line

The NHS does not have a pricing problem so much as a **visibility** problem. The cap works; the surveys work; the schemes work. What is missing is a single, line-level view of **true net cost** that a budget-holder can actually act on.

↳ Synthesis of NHSBSA, ABPI, NICE & HCL sources cited pages 26–34. T1 · T2

STRUCTURAL, NOT BEHAVIOURAL

The core diagnosis: structural information asymmetry

The source paper's sharpest claim is also its most defensible: **the information asymmetry is structural, not behavioural.** No one needs to be acting in bad faith for the system to leak. The architecture itself guarantees it.

Behavioural problem (what this is NOT)

A behavioural problem is solved by better people, better effort, or better intentions: "the buyers should negotiate harder." If leakage were behavioural, training and incentives would fix it.

Structural problem (what this IS)

A structural problem persists **no matter how diligent everyone is**, because the information needed to act simply isn't available to the actor who holds the budget. Effort cannot close a gap that is built into the design.

Why economists call this a textbook case

This is a classic **asymmetric-information market** (Akerlof's "market for lemons," adapted): the seller knows the true value; the buyer does not; and the institutional rules actively protect that gap via confidentiality. In such markets, the uninformed party systematically overpays — not through error, but through structure.

SELLER KNOWS
Net price
True cost, discounts, margins.

BUYER SEES
List only
A number known to be inflated.

RULES ENFORCE
Secrecy
Confidentiality is contractual.

✓ Why this reframing is strategically powerful

If the problem is behavioural, the buyer is to blame and the fix is uncomfortable. If the problem is **structural**, no individual is at fault and the fix is a tool — an information layer that restores symmetry. That is a far easier story to sell to government, and a far more honest one. **Blame nobody; instrument everything.**

↳ Akerlof (1970), information economics; applied to NHS pricing structure per sources pp.26–35. T3

THE BUDGET-HOLDER CANNOT SEE THE REBATE

The ICB capture gap: who pays vs who saves

England commissions care through **42 Integrated Care Boards (ICBs)**. They hold local budgets and were collectively asked to find around **£11bn of savings in 2025/26**. Yet the central rebate machinery sits above them — creating a structural disconnect between the body that pays and the body that saves.

ICB
Holds budget · commissions care · "pays" for medicines

→

Pays list / Tariff
At or near published price

→

Rebate generated
VPAG + PAS discounts triggered

↑

Flows to centre
DHSC / NHS England — not the ICB

The consequence for incentives

An ICB cannot independently verify whether it is capturing the best available net price, because the rebate never appears in its accounts. It is **optimising blind** — managing a budget whose true cost it cannot see and whose savings it does not bank.

The consequence for the thesis

This is the precise point where a forensic layer creates value: giving each ICB (or the centre on their behalf) a **line-level, net-price-aware view** so that the body managing the budget can finally see — and act on — the real number.

◆ Honest scope note

Because rebates are captured centrally and effectively, the system-wide branded "loss" is smaller than a naïve list-price reading implies — this is a genuine credit to the current design. The recoverable prize is concentrated in (a) **net-price optimisation** below best-achievable, (b) **local allocative inefficiency** from blind commissioning, and (c) the **non-pharma cost base**. We do not double-count the rebates already captured.

↳ NHS England ICB savings requirement 2025/26; King's Fund; VPAG central-flow documentation. T1 · T3

SEPARATING WHAT'S DELIBERATE FROM WHAT LEAKS

Synthesis: policy is not leakage — and saying so makes the case stronger

The single most important analytical move in this report is to **separate deliberate policy mechanisms from genuine leakage**. Conflating them inflates the number and destroys credibility. Distinguishing them shrinks the headline — and makes every remaining pound defensible.

MECHANISM	DELIBERATE POLICY OR LEAKAGE?	RECOVERABLE?	TREATMENT
Retained medicine margin (~£0.8bn)	DELIBERATE pharmacy funding	No — funds the network	Excluded
VPAG / statutory rebates (~£3–3.5bn)	DELIBERATE & already captured	Already banked centrally	Excluded
Concessions (existence)	DELIBERATE patient protection	No	Excluded
Concession timing asymmetry	PARTIAL leakage	Partly	Sized small
Net-price below best-achievable	LEAKAGE (opacity-driven)	Yes, partly	Core estimate
Intermediary margin excess	LEAKAGE (structural)	Yes, partly	Core estimate
Consumables price variation	LEAKAGE (Carter)	Yes	Core estimate

✓ What we keep

Only opacity-driven net-price gaps, structural intermediary excess, concession timing, and non-pharma price variation. Each is measurable with the right data and defensible line by line.

◆ What we deliberately surrender

The entire retained margin, all already-captured rebates, and the existence of concessions and PAS. Surrendering them is not weakness — it is the discipline that makes the residual number **believable to a sceptical Treasury.**

> ”The fastest way to lose a government client is to claim a number you can’t stand behind. The second fastest is to count their own policy choices as your savings.”

OPERATING PRINCIPLE · KINCAID IQ EVIDENCE SPINE

↳ Synthesis of Part III; treatment rules carried into Part IV quantification. T1 · T2 · T3

PUTTING A DEFENSIBLE NUMBER ON IT

IV

Sizing the Leakage

No single number — a **range**, built two independent ways, triangulated, and biased deliberately downward. If the honest floor is still large, the case is made.

40 Cost-base map · 41 Two methods · 42 Generic model · 43 Branded model
44 Consumables · 45 Intermediary · 46 Triangulated range · 47 Sensitivity
48 Recoverable vs structural · 49 Cost-Alpha index · 50 The number, honestly

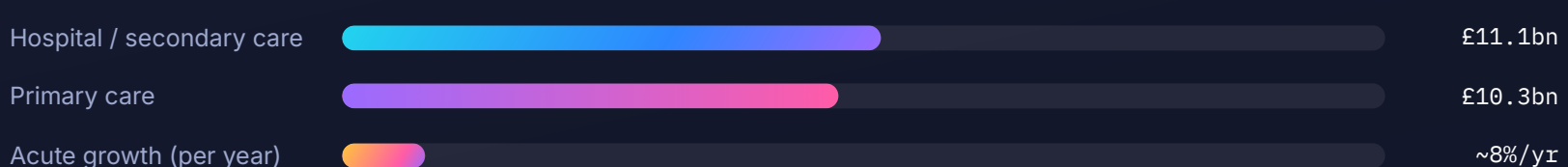
WHAT'S ACTUALLY IN SCOPE

The addressable cost base, stated precisely

You cannot size a leakage rate without first fixing the denominator. Here is the in-scope English cost base, with the published figures and their sources.

NHS MEDICINES (GROSS)	AFTER CENTRAL REBATES	NHS SUPPLY CHAIN	COMBINED IN SCOPE
£21.6bn	**~£20.9bn**	**~£8bn**	**~£30bn**
2024/25, before central rebates. +51.9% since 2019/20.	Net of ~£0.66bn central rebate recognised.	Equipment & consumables routed annually.	The denominator for this analysis.

Where the medicines spend sits



Hospital 51.6% · Primary care 47.6% of the £21.6bn gross medicines bill.

✓ Why the denominator discipline matters

A 1% leakage rate on a £30bn base is £300m. A 5% rate is £1.5bn. An 8% rate is £2.4bn. The entire argument therefore reduces to one disciplined question: **what leakage rate can we defend, line by line, on each slice of this base?** The next five pages answer exactly that.

↳ NHSBSA "Prescribing Costs in Hospitals and the Community 2024/25" (Nov 2025); NHS Supply Chain reporting. T1

TWO INDEPENDENT ROADS TO THE SAME NUMBER

Bottom-up and top-down — then triangulate

Credible sizing never relies on one method. We build the estimate two independent ways. Where they converge, confidence rises. Where they diverge, the gap itself is information.

METHOD A

Bottom-up — line by line

Decompose the £30bn into segments (generic, branded, consumables, intermediary), apply a **defensible, conservative leakage rate** to each, and sum. Strength: granular and auditable. Weakness: depends on rate assumptions.

- Generic spend × residual-leakage rate
- Branded spend × net-gap rate
- Consumables × price-variation rate
- Throughput × intermediary-excess rate

METHOD B

Top-down — benchmark & analogues

Start from known reference points — Carter's consumables findings, NAO savings estimates, international net-price benchmarks — and scale to the NHS base. Strength: anchored to published precedent. Weakness: analogues are imperfect.

- Carter ~10% consumables variation
- NAO Supply Chain savings range
- Intl. reference-price spreads
- Historic clawback magnitudes

The triangulation rule

We report the **overlap** of the two methods as the credible band, and we deliberately **weight toward the conservative end**. Every assumption that could be set high or low is set low. If the resulting floor is still material, the thesis survives its own harshest test — which is exactly the standard a Treasury reviewer will apply.

◆ The honesty premium

A consultancy incentivised to win a mandate would publish the high number. We publish the low one and show our work. The credibility this buys is worth more than the headline it costs — because the buyer here can check.

↳ Method per Kincaid IQ v5.0 sizing protocol; analogues from NAO & Carter (cited pp.44, 68–69). T1 · T3

SEGMENT 1 OF 4

Generic medicines: the smallest, best-controlled slice

We start where the source paper started — generics — but we correct it. The claim that "the NHS pays double for generics" conflates the deliberate retained margin with leakage. Strip that out, and the genuine recoverable generic leakage is **modest**, because the margin-survey machine already claws back over-delivery.

DRIVER	DIRECTION	WHY	RATE APPLIED
Retained margin	REMOVED	Deliberate funding, surveyed & clawed back	0%
Category A opacity (low-competition lines)	SOME	Weighted-average pricing can lag true cost	low
Concession timing asymmetry	SOME	Quick up, slow down on resets	low
Residual reconciliation gaps	SOME	Line-level mismatches no human team catches	low

GENERIC LEAKAGE — OUR VIEW

Low

Single-digit % of the genuinely-exposed generic sub-segment, not of all generics.

WHY WE DOWN-WEIGHT IT

Clawback works

£124m over-delivery was detected and recovered — evidence the system self-corrects.

✓ **The contrarian correction, stated plainly**

This is where we part company with the original paper — and it **strengthens** the case. By refusing to bank the retained margin as "savings," we lose a big headline number but gain the one thing that matters with government: a generic estimate that survives scrutiny. The real prize is not here. It is in branded opacity and consumables — the next three pages.

↳ NHSBSA Drug Tariff Part VIII (margin survey, £124m over-delivery); Pharmaceutical Journal (Cat A price rises, 2020). **T1 · T2**

SEGMENT 2 OF 4 · THE LARGER PRIZE

Branded opacity: where the recoverable pounds concentrate

Branded medicines carry the larger spend and the deeper opacity. The aggregate cap is captured centrally — so we do **not** count rebates already banked. We count only the gap between achieved net price and best-achievable net price, plus allocative loss from blind local commissioning.

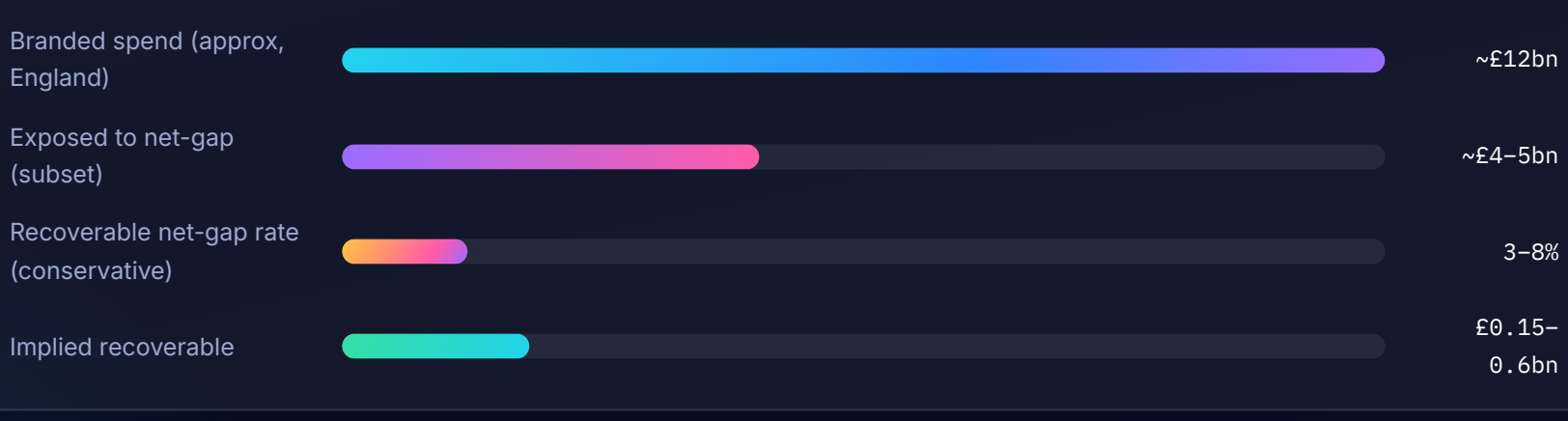
What we explicitly exclude

- VPAG / statutory rebates already captured (~£3–3.5bn)
- The existence of confidential PAS discounts
- Legitimate international-reference-price protection

What we include (the leakage)

- Net price achieved below best-available benchmark
- Therapeutic substitution not taken at equal efficacy
- Allocative loss where ICBs commission blind to true net cost

Conservative net-gap logic



Illustrative decomposition. Branded share of the £21.6bn skews high by spend; we hold the exposed subset and the rate deliberately low.

◆ Why a range, not a point

The true net prices are confidential by construction, so a single number would be false precision. We carry **£0.15–0.6bn** from branded into the triangulation — and we flag explicitly that the upper half depends on data access we do not yet have. Honest uncertainty, stated as uncertainty.

↳ Branded share derived from NHSBSA 2024/25; net-gap logic per international reference-price literature. T1 · T3

SEGMENT 3 OF 4 · THE FOUNDER'S ORIGINAL INSIGHT

Consumables & the Carter price-variation finding

The source paper's most personal observation — that in early NHS-IT days, basic supplies were bought at multiples of open-market prices — is corroborated by the **Lord Carter review**, which found trusts paying different prices for identical goods. This is the most empirically grounded leakage segment.

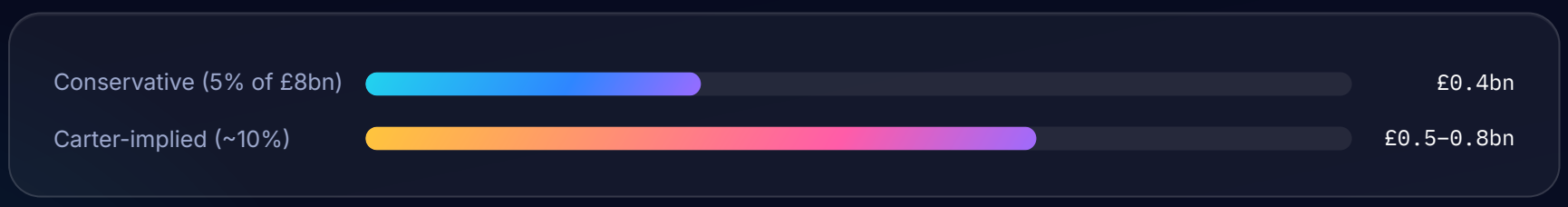
CONSUMABLES BASE
~£8bn
Routed via NHS Supply Chain annually.

CARTER-ERA VARIATION
~10%
2011 review: ~£500m potential on consumables.

WOUND CARE / STOMA
~£1.36bn
Single high-variation category (2024).

Why consumables leak — and why it's measurable

- **Same product, different price:** Carter found identical items bought at materially different prices across trusts — textbook recoverable variation.
- **Mandated, not competitive:** a mandated supply route removes the price discipline competition would impose.
- **Targets missed:** NHS Supply Chain did not hit its £2.4bn savings / 80% share goals — leaving recoverable headroom on the table.
- **Data exists:** unlike confidential branded net prices, catalogue and transaction prices are observable — the easiest segment to evidence with receipts.



✓ **Carry-forward**

We carry **£0.4–0.8bn** of recoverable consumables variation into the triangulation. Of all four segments, this is the one we would target first in a proof of concept — the data is observable, the precedent is published, and the founder has seen it with his own eyes.

↳ Lord Carter review; NAO (2024) NHS Supply Chain; Parliament PAC; wound-care category data 2024. **T1**

SEGMENT 4 OF 4 · STATED AS HYPOTHESIS

Intermediary margin: the layer between maker and payer

A concentrated, partly PE-owned distribution layer has a rational incentive to maximise margin. We do **not** allege wrongdoing. We simply ask how many pounds sit in the intermediary spread — and how many are recoverable through better visibility and contracting.

LAYER	ROLE	MARGIN VISIBILITY	LEAKAGE LENS
Full-line wholesalers (×3)	Distribute >92% of NHS meds (HDA)	Partially opaque	Spread vs benchmark
AAH / Aurelius (PE)	~£3bn rev, ~£90m earnings	PE-owned, margin-optimising	Excess vs utility return
Short-line & specials	Niche / shortage supply	Opaque, episodic	Shortage premium

The conservative position

Distribution is a real service with real costs; a normal margin is legitimate. We size only the **excess** over a reasonable utility-style return — and we hold even that low, because the public data to prove it is thin (Tier 2/3, not Tier 1).

The carry-forward

We carry a deliberately small **£0.05–0.4bn** from intermediary excess into the range, and we label it the lowest-confidence segment. It is a flag for investigation under a PoC, not a number to bank today.

◆ Intellectual honesty marker

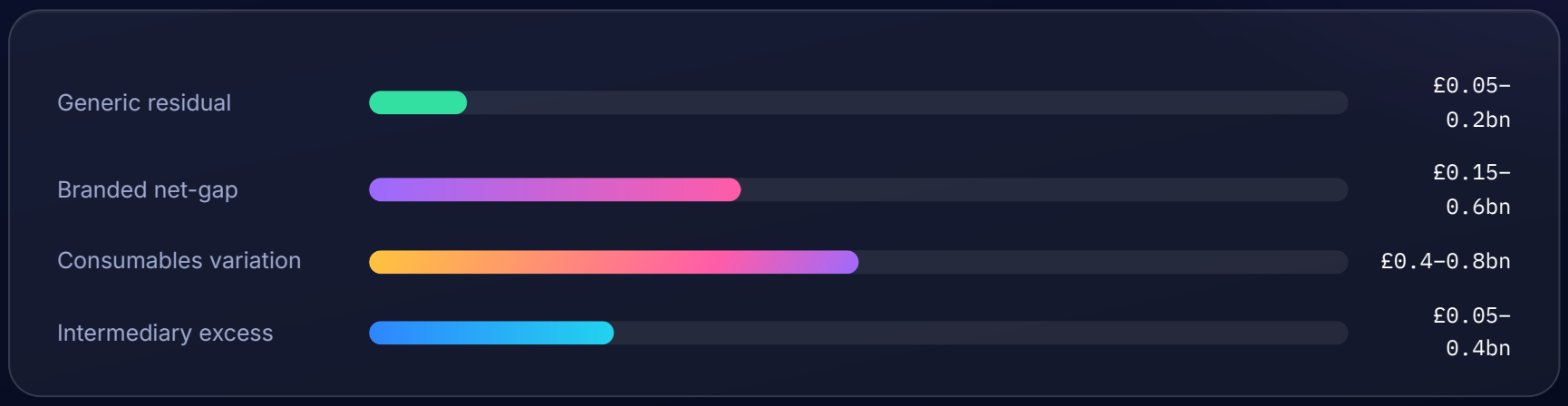
This is the segment where it would be easiest to inflate the story — "PE is extracting billions!" — and the segment where we have the least public evidence. So it gets the smallest weight and the loudest caveat. That asymmetry between rhetorical temptation and evidentiary discipline is, deliberately, the signature of this entire report.

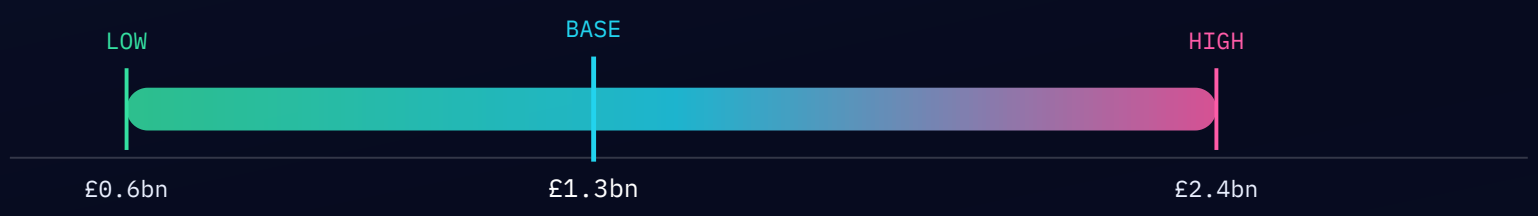
↳ HDA distribution share; City AM & Pharmaceutical Journal on AAH/Aurelius. T2 · T3

FOUR SEGMENTS, TRIANGULATED

The triangulated leakage range

Summing the four segments — each held conservative — and overlapping with the top-down benchmarks yields a credible band. We report **low, base, and high**, not a single figure.





LOW (DEFEND ANYWHERE)

£0.6bn

Survives the harshest Treasury scrutiny.

BASE CASE

£1.3bn

Central estimate across segments.

HIGH (DATA-DEPENDENT)

£2.4bn

Requires PoC data access to confirm.

✓ **Read the floor, not the ceiling**

The honest way to read this chart is left-to-right and to **stop at £0.6bn**. Even the floor — built after removing every policy mechanism and every already-captured rebate — is roughly thirty times a typical PoC cost. The case does not need the high number. It barely needs the low one.

↳ Triangulation of segment models pp.42–45 with top-down benchmarks pp.44, 68. Range, not point. **T1 · T2 · T3**

WHAT MOVES THE NUMBER

Confidence & sensitivity: which assumptions matter most

A range is only useful if you know what drives it. Here are the assumptions ranked by impact, each tagged with our confidence and the data needed to tighten it.

ASSUMPTION	SWING ON TOTAL	CONFIDENCE NOW	DATA TO TIGHTEN
Consumables variation rate	HIGH	Medium–high (Carter)	Trust-level transaction data
Branded net-gap rate	HIGH	Low (confidential)	Net-price benchmarking access
Exposed branded subset	MEDIUM	Medium	Therapeutic-area spend split
Intermediary excess	LOW–MED	Low (T2/T3)	Wholesaler margin disclosure
Generic residual	LOW	High (clawback evidence)	Category A line detail

Tornado: drivers of the spread

◆ What this tells the decision-maker

Two assumptions — consumables variation and branded net-gap — drive most of the uncertainty, and **both are resolvable with data a PoC can obtain**. The estimate is not stuck at "we'll never know." It is precisely the kind of uncertainty that the proposed proof of concept is designed to collapse.

↳ Sensitivity per segment models pp.42–45; confidence tags reflect source tiering. T1 · T2 · T3

NOT EVERY POUND FOUND IS A POUND SAVED

Recoverable, frictional & structural — splitting the band

A leakage number is not a savings number. Some of what we identify is recoverable quickly; some only with structural change; some is friction that can be reduced but never eliminated. Honest framing splits the band three ways.

RECOVERABLE (12–24 MO)

~50–60%

Consumables price-variation and concession-timing gaps — observable data, contractable, fast. The PoC beachhead.

STRUCTURAL (NEEDS CHANGE)

~25–35%

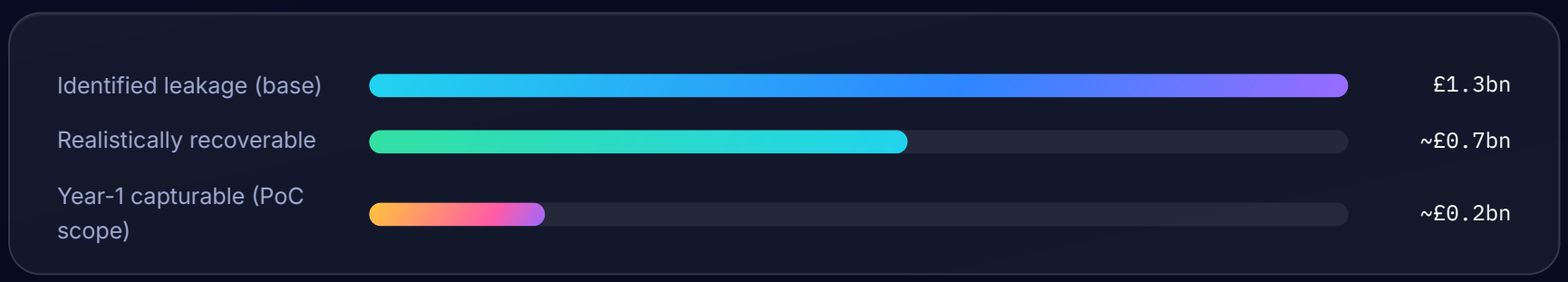
Branded net-gap and allocative loss — requires transparency reform or net-price benchmarking authority to capture.

FRICTIONAL (IRREDUCIBLE)

~10–20%

The cost of running any complex supply chain. Reducible at the margin; never zero. We do not pretend otherwise.

What this means for a savings claim



✓ The conservative promise

We would rather promise **£0.2bn capturable in year one** and over-deliver than promise £2.4bn and explain a shortfall. With government, the second presentation ends the relationship. The first begins it.

↳ Recoverability split derived from segment characteristics pp.42–45; gain-share basis page 74. T2 · T3

BORROWING A MARKETS IDEA FOR HEALTHCARE

The Healthcare Cost-Alpha Index

In asset management, alpha is return above a benchmark. We adapt the idea: **Cost-Alpha** is the spread between what the NHS pays and the best-achievable benchmark price for the same good at the same quality — expressed as a single, trackable index per category, per region, per supplier.

Definition

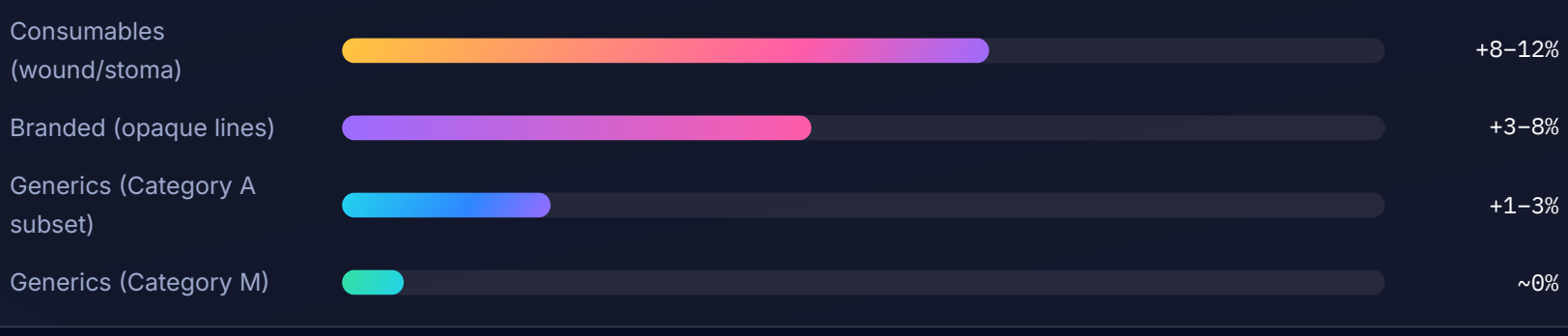
```
Cost-Alpha = (Price_paid − Price_best-achievable)
÷ Price_best-achievable
```

A positive Cost-Alpha means money is leaking. Zero means best-in-class procurement. The index turns a diffuse "leakage" idea into a **number you can manage to.**

Why it's the product, not just a metric

- Comparable across categories and regions
- Trackable over time — proof of improvement
- Drillable to the line with receipts
- Defensible because the benchmark is explicit

Illustrative Cost-Alpha by category



Illustrative. Category M ≈ 0 is expected — it is the well-controlled benchmark. The signal lives at the top of the chart.

◆ The honest caveat on the metric itself

Cost-Alpha is only as good as the benchmark behind it. Where the best-achievable price is observable (consumables), the index is robust. Where it must be estimated (confidential branded), the index carries a confidence band. We **show the band** rather than hide it — the metric reports its own uncertainty.

↳ Cost-Alpha adapted from Kincaid IQ "Benchmark Arbitrage Index"; benchmarks per segment data. T3

STATED ONCE, STATED HONESTLY

The number — and everything we removed to get to it

RECOVERABLE NHS PROCUREMENT LEAKAGE · ENGLAND · ANNUAL

£0.6 – 2.4bn

Base case **£1.3bn**. After removing the retained margin, all captured rebates, and the existence of concessions and PAS. A floor, not a headline.

◆ What we removed (and refused to count)

- Retained medicine margin (~£0.8bn) — deliberate funding
- VPAG / statutory rebates (~£3–3.5bn) — already captured
- "NHS pays double for generics" — conflated claim, corrected
- Existence of PAS & concessions — legitimate policy

✓ What survived the cull

- Consumables price-variation (Carter-corroborated)
- Branded net-price gap below best-achievable
- Concession timing asymmetry
- Intermediary excess (smallest weight, loudest caveat)

> ”We started at ’roughly double.’ We ended at a floor of £0.6bn — and that floor is more valuable than the headline we gave up, because it is the number we can prove.”
>
> PART IV · THE DISCIPLINE OF THE CULL

↳ Full derivation pp.40–49. Corrections to source claims per pp.36, 42. Range carried into Part V. T1 · T2 · T3

THE ANALYTICAL CORE · WHY THIS IS A DISCIPLINE, NOT A DASHBOARD

V

The Economic Value Engine

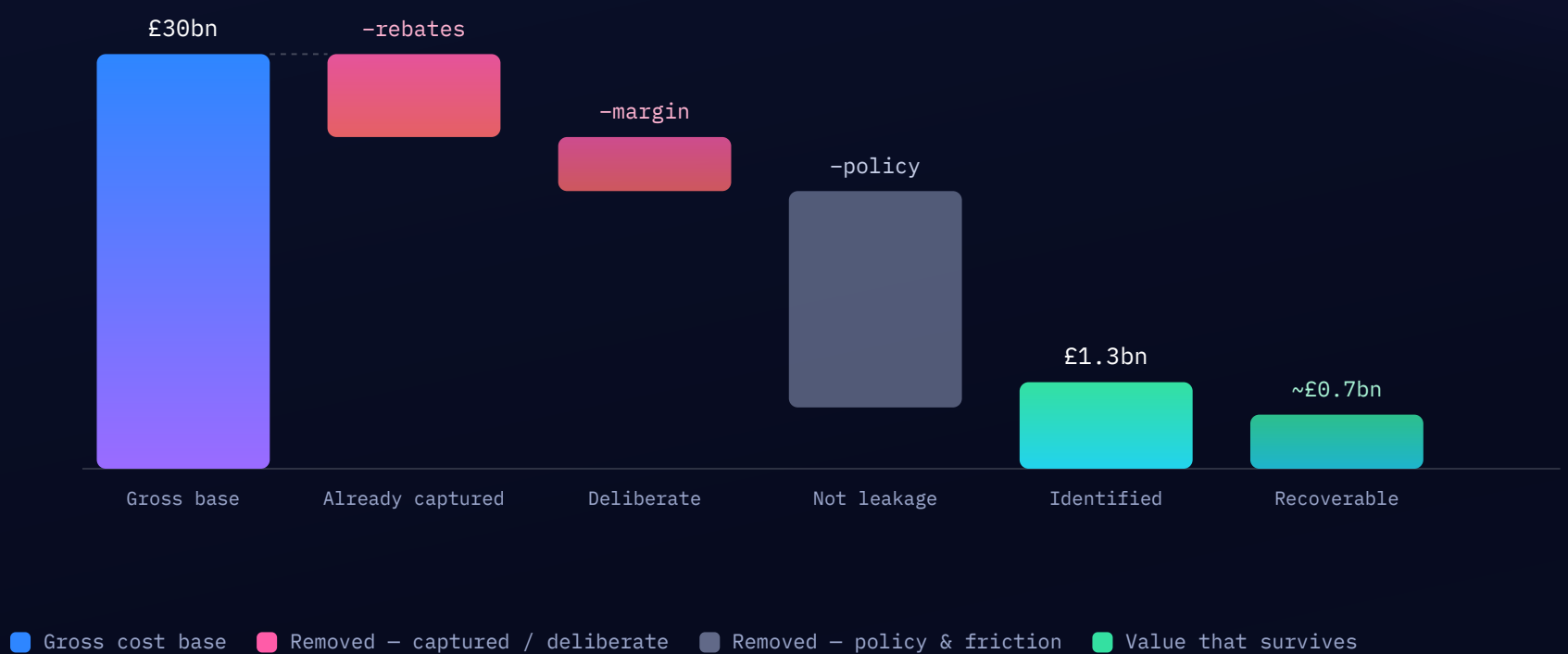
The same instruments a top-tier fund uses to allocate capital — EVA, ROIC, TDABC, transaction-cost economics, game theory, real options, efficient frontier — re-pointed at a public health budget. Sixteen pages of method.

52 EV Bridge · 53 Public translation · 54 EVA · 55 TDABC · 56 TCE · 57 Game theory
58 Real options · 59 Efficient frontier · 60 Fiscal impact · 61 Behavioural · 62 56 levers
63 Lever priority · 64 Scenario engine · 65 Scenario matrix · 66 Quality gates

FROM GROSS SPEND TO RECOVERED VALUE

The Economic Value Bridge

The EV Bridge walks from the gross cost base to net recovered value, subtracting at each step what is not capturable. It is the single chart that encodes the entire honesty discipline of Part IV.



✓ How to read the bridge

The bridge is mostly subtraction. We start at £30bn and remove the captured, the deliberate, the policy-driven and the frictional — until what remains is the only thing we will stand behind: a recoverable core. **The honesty is in the size of the cuts, not the size of the start.**

↳ EV Bridge per Kincaid IQ v5.0; inputs from Part IV pp.40–50. Illustrative bar heights. T1 · T3

THE SAME MATHS, A DIFFERENT OBJECTIVE FUNCTION

Translating capital-market metrics to a public payer

A fund maximises risk-adjusted return to shareholders. A health system maximises **health outcomes per pound** for a population, under a hard budget constraint. The instruments survive the translation; the objective function changes. Here is the mapping.

MARKETS CONCEPT	ORIGINAL MEANING	NHS TRANSLATION
Alpha	Return above benchmark	Price paid below best-achievable (Cost-Alpha)
ROIC	Return on invested capital	Health value per pound of procurement spend
EVA	Profit above cost of capital	Savings above the cost of running the recovery programme
RAROC	Risk-adjusted return on capital	Recovery weighted by delivery & political risk
Efficient frontier	Max return per unit risk	Max savings per unit disruption to supply / care
Real option	Right, not obligation, to act	Right to switch supplier / trigger audit / demand transparency

What stays the same

The discipline of **benchmark, measure, allocate, and prove**. Capital allocation under uncertainty is structurally identical whether the output is return or health.

What must change

The **objective and the constraints**: outcomes not profit; equity of access as a hard constraint; political feasibility as a real cost. Ignore these and the maths is right but the answer is wrong.

♥ The Notre Dame lens

Every pound of recovered leakage is not a pound of profit — it is a pound returned to patient care. The translation is not merely technical; it is the difference between optimising a balance sheet and stewarding a public good. We hold that distinction throughout.

↳ Translation framework per Kincaid IQ v5.0 (Stern Stewart / Kaplan-HBS / MIT-Stanford lineage). T3

SAVINGS ABOVE THE COST OF CAPTURING THEM

Economic Value Added: is the recovery worth running?

A savings figure is meaningless until you subtract the cost of achieving it. **EVA** asks: do the recovered pounds exceed the cost of the programme — platform, people, change — that recovers them? If not, the exercise destroys value.

```
Programme EVA = Recovered savings − (Programme cost + Cost of disruption)
```

Illustrative year-1 economic profit (PoC → scale)

LINE	BASIS	LOW	BASE	HIGH
Recovered savings (yr 1)	Capturable subset	£0.10bn	£0.20bn	£0.35bn
− Platform & delivery cost	SaaS + integration + analysts	−£0.02bn	−£0.03bn	−£0.04bn
− Disruption / change cost	Supplier transition, governance	−£0.01bn	−£0.02bn	−£0.03bn
= Programme EVA	Net economic profit	**£0.07bn**	**£0.15bn**	**£0.28bn**

EVA-POSITIVE AT

All cases

Even the low case clears programme cost comfortably.

ROUGH ROIC (YR 1)

3–7×

Savings vs programme cost ratio.

BREAKEVEN

< 1 quarter

Recovery exceeds run-cost early.

✓ **Why EVA is the right gate for government**

It refuses vanity savings. A programme that "finds" £500m but costs £600m of disruption to capture is value-destroying, and EVA says so out loud. By holding the recovery to an economic-profit test, we align the commercial model with the public interest: **we only win when the system genuinely nets ahead.**

↳ EVA framework (Stern Stewart); illustrative figures consistent with Part IV recoverability split p.48. T3

COST PER TRANSACTION, NOT COST PER CATEGORY

TDABC: the true unit cost of a procurement decision

Time-Driven Activity-Based Costing — Kaplan's method — assigns cost to the activities that consume capacity. Applied here, it reveals the true cost of each procurement and reimbursement transaction, and where automation removes cost without removing control.

TRANSACTION	ACTIVITY CONSUMED	MANUAL COST DRIVER	AUTOMATION EFFECT
Generic reimbursement line	Tariff match, reconciliation	Analyst time × volume	High removal
Branded net-price check	Benchmark, substitute analysis	Scarce specialist time	Med–high
Consumables price audit	Cross-trust comparison	Rarely done at all	Very high
Concession monitoring	Price-vs-market tracking	Episodic, manual	High

Where the capacity cost goes today

✓ The TDABC insight

Most procurement-analysis capacity is spent on **reconciliation and comparison** — exactly the high-volume, rules-based work an engine does best — leaving little capacity for the judgement work humans do best (negotiation, exceptions, ethics). Automation here is not headcount reduction; it is **capacity reallocation** from matching to deciding.

↳ TDABC method (Kaplan / Anderson, HBS); activity split illustrative per NHS procurement workflow. T3

COASE & WILLIAMSON, APPLIED TO THE SUPPLY CHAIN

Make, buy, or eliminate: the transaction-cost lens

Coase and Williamson explain why firms exist: to avoid the transaction costs of the market when those costs are high. The NHS supply chain is full of intermediated transactions whose **governance costs** may exceed their value. TCE tells us which to keep, which to internalise, and which to remove.

KEEP (MARKET)

Low asset-specificity

Commodity consumables with many suppliers — competition disciplines price; keep buying.

INTERNALISE

High specificity, high opacity

Net-price intelligence the market won't reveal — bring the information function in-house (the platform).

ELIMINATE

Margin without function

Intermediary layers adding cost but little service — candidates for disintermediation.

The three transaction costs that drive NHS leakage

01 **Search & information costs** — finding the true best price. Currently near-prohibitive because of confidentiality. The platform collapses this cost.

02 **Bargaining costs** — negotiating against an informed counterparty while uninformed. Symmetry restored by data changes the bargaining outcome.

03 **Policing & enforcement costs** — verifying you got what you paid for. Automated reconciliation makes continuous policing cheap.

✓ The TCE verdict

The NHS does not necessarily need to own more of its supply chain. It needs to **own the information** about its supply chain. The cheapest, least disruptive intervention is to internalise the intelligence function — leaving the physical supply chain intact but no longer opaque.

↳ TCE per Coase (1937) & Williamson (1985); applied to NHS distribution structure pp.33, 45. T3

THE PAYER–INTERMEDIARY GAME

Why opacity is a stable equilibrium — and how to break it

Today's outcome is not an accident; it is an **equilibrium**. Given the current information structure, every party is playing its best response. A payoff matrix shows why nothing changes on its own — and what single move shifts the equilibrium.

Payoff matrix — payer vs intermediary (today)

PAYER: STAY BLIND · SELLER: KEEP OPAQUE

Current equilibrium

Seller captures margin; payer overpays modestly but avoids cost of change. Stable — nobody moves.

PAYER: STAY BLIND · SELLER: DISCLOSE

Seller loses

Seller surrenders margin for nothing. Irrational unilaterally — won't happen voluntarily.

PAYER: GET SIGHT · SELLER: KEEP OPAQUE

Payer gains leverage

Payer can now benchmark & walk. Opacity stops protecting the seller.

PAYER: GET SIGHT · SELLER: COMPETE ON NET

New equilibrium

Net-price competition; payer captures Cost-Alpha; efficient suppliers win share.

Why it's stuck

The top-left cell is a **Nash equilibrium**: given the payer is blind, opacity is the seller's best response; given opacity, staying blind (and avoiding change cost) is tolerable for the payer. No unilateral deviation pays.

The single move that shifts it

Change the payer's **information state**. Once the payer can see net prices, the whole right-hand column opens, and competition on net price becomes the new stable outcome. **The platform is that move.**

✓ Strategic reading

You do not break this equilibrium with exhortation, regulation alone, or goodwill. You break it by changing one player's information set. That is a **tractable, technological** intervention — which is precisely why a software-led approach can move a problem that has resisted policy since 1948.

↳ Non-cooperative game framing (Nash); payoffs qualitative, consistent with asymmetry diagnosis p.36. T3

THE VALUE OF THE RIGHT TO ACT

Real options: pricing the right to switch, audit & demand

Much of the value here is optionality: the payer does not have to switch supplier or trigger an audit — but the credible **right** to do so changes behaviour and carries value even unexercised. Real-options thinking prices that right.

OPTION	UNDERLYING	EXERCISE TRIGGER	VALUE DRIVER
Switching option	Alternative supplier / generic	Cost-Alpha exceeds threshold	Credible exit
Audit option	Right to forensic review	Anomaly flagged by engine	Deterrence
Transparency option	Right to demand net-price data	Contract renewal	Disclosure leverage
Substitution option	Therapeutic equivalent	Equal efficacy, lower net	Clinical-led savings

Why options beat mandates

A mandate is brittle and politically costly. An **option** preserves flexibility: it disciplines the counterparty through the threat of exercise, often without ever being used. The mere existence of credible switching capability compresses the price.

What gives the options value

Options are worthless if you cannot tell when to exercise them. The engine supplies the **trigger signal** — the Cost-Alpha threshold, the anomaly flag — that converts a theoretical right into an exercisable, value-bearing option.

✓ The real-options punchline

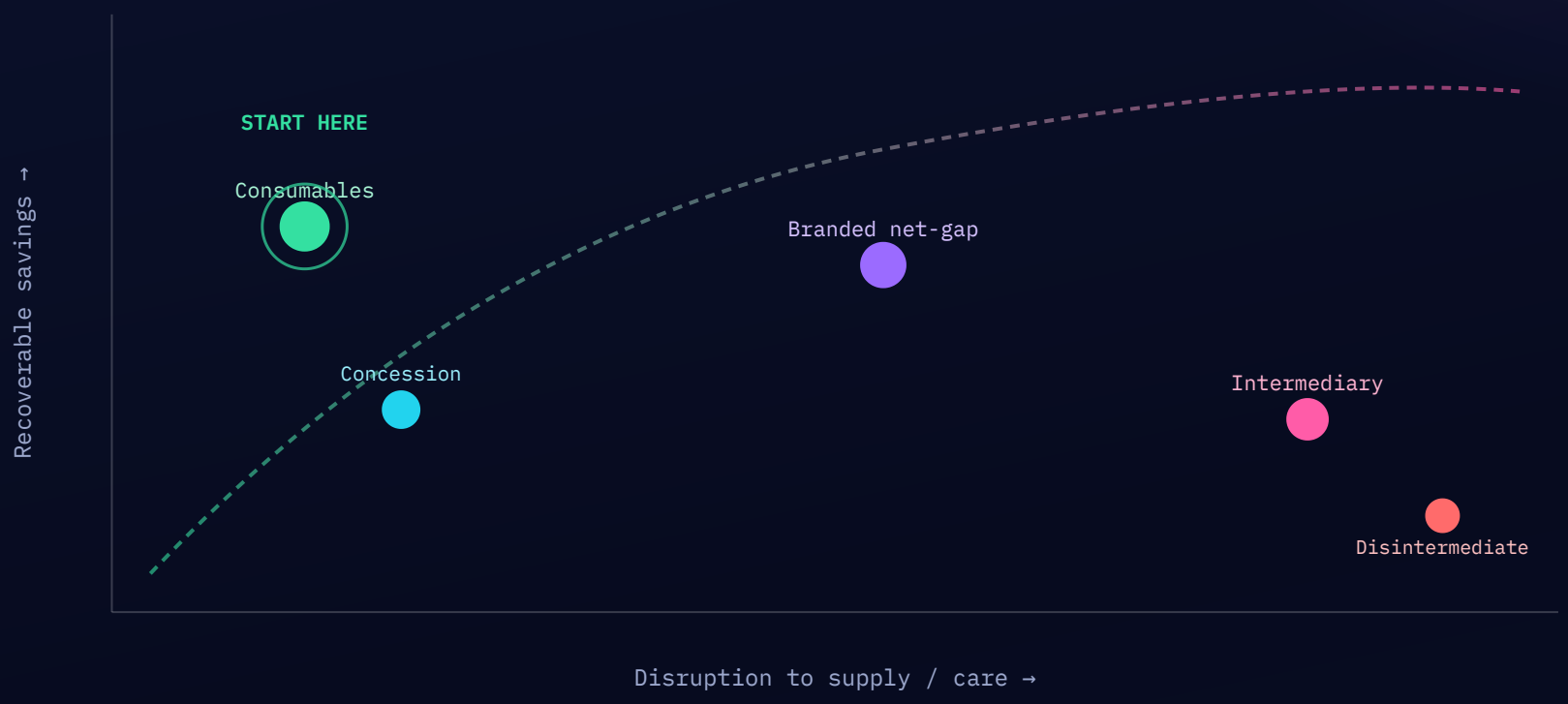
The platform's deepest value may not be the savings it directly captures, but the **credible optionality it creates**. A payer known to be able to see, switch, and audit is a payer that gets better prices on everything — including the lines never formally challenged. Optionality is leverage that compounds.

↳ Real-options framing (Black-Scholes intuition, Trigeorgis); qualitative valuation. T3

SAVINGS PER UNIT OF DISRUPTION

The efficient frontier: savings vs disruption

Not all savings are equal. Some come cheaply with little disruption to supply or care; some demand structural upheaval for marginal gain. Plotting savings against disruption reveals the efficient frontier — and the obvious place to start.



Efficient (do first)

Consumables & concessions — high savings, low disruption, observable data.

Strategic (do next)

Branded net-gap — meaningful savings, moderate disruption, needs data access.

Inefficient (defer)

Structural disintermediation — high disruption per pound. Only after proof.

✓ The frontier dictates the roadmap

This single chart sets the sequencing for the entire commercial plan: **start top-left** (consumables), bank credibility, then move right along the frontier as trust and data access grow. Never lead with the high-disruption plays, however large the headline.

↳ Frontier (Markowitz intuition) adapted: risk → disruption. Positions illustrative per pp.46–48. T3

WHAT THE MONEY DOES WHEN IT COMES BACK

Fiscal & system impact of recovered spend

In a private firm, recovered cost flows to profit. In the NHS, it flows back into a budget under acute pressure — where the multiplier is measured in care delivered, not dividends paid. Here is what the base-case recovery represents at system scale.

BASE RECOVERY
£1.3bn
Identified annual leakage, base case.

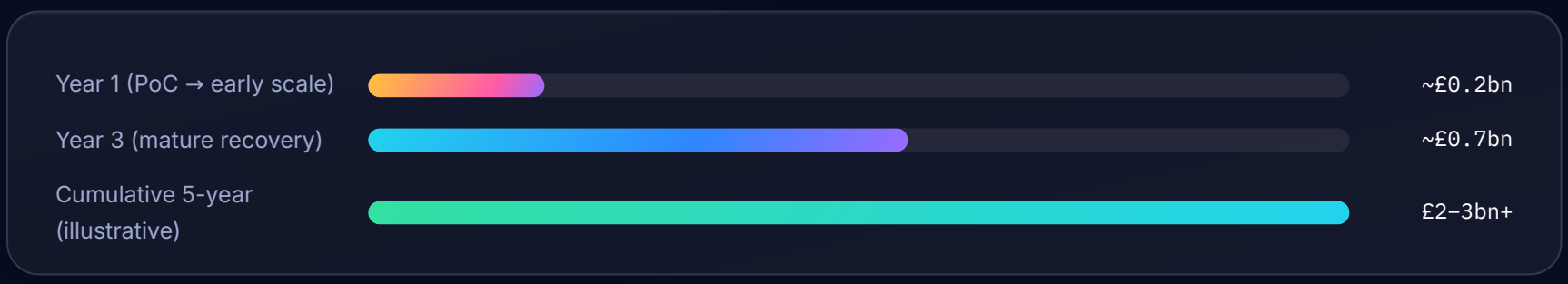
VS ICB SAVINGS ASK
~12%
Of the ~£11bn ICBs were asked to save in 2025/26.

VS MEDICINES BILL
~6%
Of the £21.6bn gross medicines spend.

RECURRING
Annual
Not one-off — compounds year over year.

The recurring-vs-one-off distinction

A capital underspend is found once. **Structural leakage recovery recurs every year** the platform runs, and the Cost-Alpha discipline tends to compress prices further over time as suppliers compete on net. The present value of a recurring £0.7bn recoverable stream dwarfs any single-year figure.



♥ What £0.7bn a year actually buys

Roughly **20,000 additional nurses**, or several million additional diagnostic scans, or tens of thousands of additional elective procedures — every year, recurring. The case is not abstract fiscal hygiene. It is care that does not currently happen, made possible by money that currently leaks.

↳ ICB savings ask & medicines bill per pp.37, 40; staffing equivalents indicative (avg cost benchmarks). **T1 · T3**

WHY RATIONAL SYSTEMS STILL OVERPAY

The behavioural frictions that keep leakage in place

Even with perfect incentives, human and institutional biases sustain leakage. Naming them matters, because the platform must be designed around them — not assume they don't exist.

BIAS / FRICTION	HOW IT SHOWS UP IN NHS PROCUREMENT	DESIGN RESPONSE
Status-quo bias	"We've always used this supplier"	Default to benchmarked option
Information overload	Too many lines to review manually	Surface only flagged exceptions
Diffusion of responsibility	No single owner of net-price outcome	Assign a Cost-Alpha owner
Loss aversion (disruption)	Fear of supply disruption > savings appetite	Optionality, not forced switch
Salience gap	Rebates invisible locally → no urgency	Make Cost-Alpha visible & tracked

The choice-architecture principle

People follow defaults. If the **default** presented to a commissioner is the benchmarked best-net option — with deviations requiring a reason — the same humans make better decisions without working harder. The engine sets the default; the human keeps the judgement.

Why this protects clinical autonomy

Behavioural design here is about price, never about overriding clinical choice. Where a clinician needs a specific product, that choice stands — the engine simply ensures the **best net price** for whatever is clinically chosen.

✓ The behavioural takeaway

Leakage persists not only because of structure (Part III) but because of **predictable human behaviour** layered on top. A tool that ignores behaviour fails in deployment. The platform's job is to make the well-priced decision the easy decision.

↳ Behavioural framing (Kahneman; Thaler & Sunstein choice architecture); applied qualitatively. T3

FROM DIAGNOSIS TO ACTIONABLE MOVES

The value-lever architecture, mapped to the NHS

The Kincaid IQ framework organises value capture into a structured lever set. We group the NHS-relevant levers into five families — each a distinct mechanism by which a recovered pound is realised.

FAMILY A

Price transparency

- Net-price benchmarking
- Cost-Alpha tracking
- List-vs-net reconciliation
- Reference-price triangulation

FAMILY B

Contract & tender

- Tender-design optimisation
- Volume aggregation
- Rebate-flow redesign
- Renewal-timing leverage

FAMILY C

Clinical substitution

- Biosimilar switching
- Therapeutic equivalence
- Formulary optimisation
- Generic-first defaults

FAMILY D

Supply-chain & logistics

- Disintermediation (selective)
- Shortage-premium control
- Inventory & waste reduction
- Distribution-margin review

FAMILY E

Governance & assurance

- Continuous audit
- Anomaly detection
- Compliance verification
- Evidence-spine reporting

COVERAGE

~56 discrete levers

Across the five families, the full framework enumerates dozens of specific, individually-trackable levers. Not all apply to every category; the engine selects the live subset per context.

✓ Why a lever architecture beats a savings target

A target says "find £1bn." A lever architecture says **exactly which mechanism produces each pound, and how it is verified**. That is the difference between a consultant's slide and an operating system — and it is what makes savings repeatable rather than one-off.

↳ Lever architecture per Kincaid IQ v5.0 (56-lever set); NHS mapping by family. T3

NO-REGRET, STRATEGIC BETS, DEFENSIVE

Prioritising the levers: where to push first

Fifty-six levers is a menu, not a plan. We sort them by the efficient-frontier logic of page 59 into three tiers — what to do regardless, what to bet on, and what to hold defensively.

TIER 1 · NO-REGRET

Do regardless

- Consumables price benchmarking
- Cross-trust variation flags
- Concession-timing monitoring
- Continuous reconciliation

High savings, low disruption, observable data. Start week one.

TIER 2 · STRATEGIC BETS

Invest to unlock

- Branded net-price benchmarking
- Biosimilar / therapeutic switching
- Rebate-flow redesign to ICBs
- Tender-design optimisation

Larger prize, need data access & reform appetite.

TIER 3 · DEFENSIVE / DEFERRED

Hold for proof

- Selective disintermediation
- Distribution-margin challenge
- Structural supply-chain change

High disruption / political cost. Only after credibility banked.

Prioritisation scoring (illustrative)

LEVER	SAVINGS	DISRUPTION	DATA READY	TIER
Consumables benchmarking	High	Low	Yes	1
Concession monitoring	Med	Low	Yes	1
Branded net-gap	High	Med	Partial	2
Rebate-flow redesign	Med	Med	Policy	2
Disintermediation	Med	High	No	3

✓ The sequencing rule

Earn the right to attempt Tier 2 by delivering Tier 1. Earn the right to attempt Tier 3 by delivering Tier 2. Each tier funds the credibility — and the data access — for the next. **Disruption is a privilege you earn with proof, not a strategy you lead with.**

↳ Tiering per efficient frontier p.59 & recoverability split p.48. Scores illustrative. T3

NOT ONE FUTURE — A STRUCTURED SET

The scenario engine: stress-testing the thesis

A single forecast is a guess. The Kincaid IQ scenario engine runs the thesis across a structured matrix of futures — varying data access, political appetite, and incumbent response — so the decision is robust to what we cannot control.

The three axes of uncertainty

① Data access

From public-data-only (constrained) to full transaction-level access (rich). Drives how much of the range is confirmable.

② Political appetite

From status-quo to active reform mandate. Drives which lever tiers are reachable.

③ Incumbent response

From accommodation to active resistance/lobbying. Drives delivery friction & timeline.

Representative scenarios

SCENARIO	DATA	POLITICS	INCUMBENTS	YR-3 RECOVERY
Constrained PoC	Public only	Cautious	Watchful	~£0.2bn
Base case	Partial access	Supportive	Mixed	~£0.7bn
Reform tailwind	Full access	Mandate	Accommodating	~£1.2bn
Headwind	Partial	Supportive	Active resistance	~£0.4bn
Stalled	Public only	Status-quo	Resistant	<£0.1bn

✓ The robustness finding

Across every scenario except outright stall, the recovery comfortably exceeds programme cost — and even the constrained PoC is EVA-positive. The thesis does **not** depend on the optimistic future. It depends only on getting data access for a beachhead, which is exactly what the proposed next step secures.

↳ Scenario engine per Kincaid IQ v5.0 (36-scenario architecture, representative subset). T3

EXPECTED VALUE ACROSS FUTURES

The probability-weighted scenario matrix

Assigning rough probabilities to each scenario yields an expected recovery — the single figure a portfolio-minded decision-maker actually allocates against. We keep the probabilities deliberately humble and the optimistic tail small.

SCENARIO	PROBABILITY	YR-3 RECOVERY	CONTRIBUTION
Constrained PoC	25%	£0.2bn	£0.05bn
Base case	35%	£0.7bn	£0.25bn
Reform tailwind	15%	£1.2bn	£0.18bn
Headwind	15%	£0.4bn	£0.06bn
Stalled	10%	£0.05bn	£0.01bn
Expected (yr 3)	**100%**	—	**~£0.55bn**

PROBABILITY-WEIGHTED YR-3

~£0.55bn

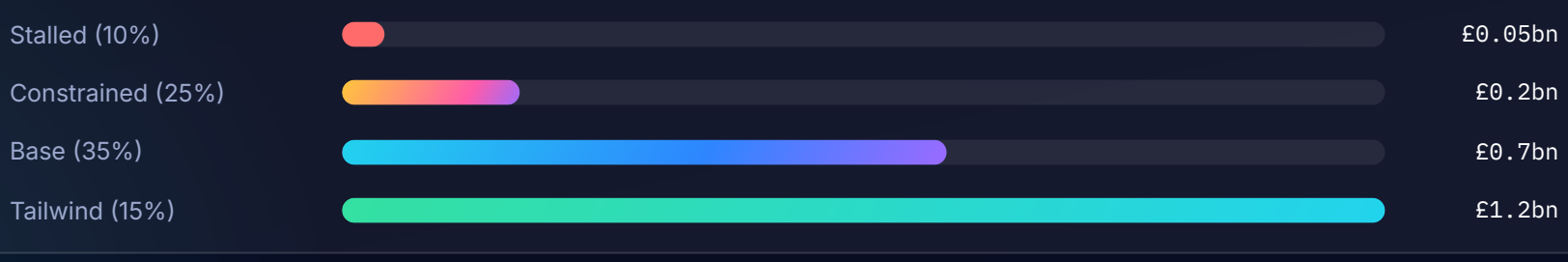
Recurring annual recovery, expected value.

RAROC SENSE-CHECK

Strongly +

Even risk-adjusted, multiples of programme cost.

Distribution of outcomes



◆ Reading the expected value honestly

~£0.55bn is below our base case, by design — the weighting drags toward the constrained and headwind outcomes. That is the point: even after pricing in resistance and limited data, the expected recurring recovery is roughly **fifteen times** a year-one programme cost. The expected value, not the optimistic case, carries the decision.

↳ Probabilities are the authors' judgement, stated as judgement; recovery figures per p.64. T3

NO ANCHOR, NO CLAIM

The evidence spine: nine gates every number passes

The discipline that separates this from a pitch deck is the **evidence spine** — a sequence of gates each claim must clear before it appears in the report. If a number cannot pass, it is cut or flagged. This page is the audit trail for the whole document.

GATE	TEST	APPLIED IN THIS REPORT
1	**Source** — is there a citation?	Every figure tagged T1/T2/T3
2	**Tier** — how reliable is the source?	Official (T1) vs trade (T2) vs inference (T3)
3	**Recency** — is it current?	2024/25 NHSBSA, 2024 NAO, 2025 scheme rates
4	**Definition** — is the term precise?	"Leakage" defined p.22; policy excluded
5	**Double-count** — counted once?	Rebates & margin removed (p.38)
6	**Range** — uncertainty shown?	Low/base/high throughout (p.46)
7	**Sensitivity** — what moves it?	Tornado & drivers (p.47)
8	**Recoverability** — savings ≠ leakage?	Three-way split (p.48)
9	**Net of cost** — EVA-positive?	Programme EVA tested (p.54)

✓ What passing all nine buys

A number that has cleared all nine gates can be defended in front of the NAO, a Treasury official, or a hostile select committee. That is the standard this report holds itself to — and the standard the platform would hold every future claim to.

◆ Where we flag, not claim

Intermediary excess (gate 2: T2/T3) and the upper branded band (gate 1: data-dependent) are **flagged**, not banked. Honest reporting means showing exactly which numbers are evidence and which are hypothesis.

> "Dashboards show numbers. An evidence spine shows why you should believe them."
>
> KINCAID IQ · THE NINE-GATE DISCIPLINE

↳ Evidence-spine protocol per Kincaid IQ v5.0 (9-gate architecture). T3

THE COST BASE IS FAR BIGGER THAN DRUGS

VI

Beyond Pharmaceuticals

The founder's original insight — rubber gloves and syringes bought at multiples of market price — points to the real prize: the **entire NHS cost base**, not just medicines. The same engine, a much larger surface.

68 NHS Supply Chain & Towers · 69 The Carter evidence · 70 Capital & FM

71 One forensic layer · 72 Total NHS-wide TAM

THE MACHINERY OF NON-DRUG PROCUREMENT

NHS Supply Chain & the eleven Category Towers

Created in 2018/19 from the Carter review, **NHS Supply Chain** routes roughly **£8bn a year** of equipment and consumables through eleven specialist "Category Towers," managing a catalogue of over **600,000 products** on an operating budget of around **£240m**.

ANNUAL THROUGHPUT
~£8bn
Equipment & consumables.

CATEGORY TOWERS
11
Specialist procurement verticals.

CATALOGUE
600k+
Distinct product lines.

OPERATING BUDGET
~£240m
Cost of running the system.

The targets that were missed

ORIGINAL TARGET (BY 2023–24)	OUTCOME	IMPLICATION
£2.4bn cumulative savings	Not met	Headroom remains
80% market share of trust spend	Not met	Leakage outside the route
Consistent national pricing	Partial	Variation persists

◆ The NAO’s quietly devastating observation

The National Audit Office found that NHS England holds the data on procurement performance but **relies on trusts to analyse it** and **does not systematically challenge them** on it. That is the leakage mechanism stated in an auditor's own words: the data exists, but no one is forensically interrogating it. **That gap is the product.**

↳ NAO (2024) NHS Supply Chain; Institute for Government; Parliament PAC. T1

FROM ANECDOTE TO AUDITED FINDING

Gloves, syringes & the price-variation that started it all

The founder observed, in early NHS-IT days, basic supplies bought at multiples of open-market price. That lived experience is not just anecdote — it was later **audited and confirmed** by Lord Carter, whose review found trusts paying materially different prices for identical items.

The lived observation

"Rubber gloves, syringes, general supplies — all procured through NHS Supplies at multiples of open-market pricing, because the supply chain is mandated, not competitive." A practitioner's-eye view of allocative waste, two decades before the data caught up.

The audited confirmation

Carter's review quantified exactly this: **same product, different price** across trusts, with an early estimate around **10% recoverable variation** on consumables (~£500m on the then-base). The anecdote became a national-audit finding.

Why ”mandated, not competitive” creates variation

01 A mandated route removes the price discipline that competition imposes — suppliers face less pressure to converge on a keen price.

02 Fragmented local purchasing means **no single buyer sees the full price distribution**, so outliers go unchallenged.

03 Without continuous cross-trust comparison, a trust cannot know it is paying above the best achievable — the information-asymmetry pattern of Part III, repeated in consumables.

✓ Why consumables is the ideal beachhead

Unlike confidential branded net prices, consumables prices are **observable**: catalogue prices, transaction records, cross-trust comparators all exist. This is the one segment where the engine can produce hard, receipted findings on day one — vindicating both the founder's instinct and Carter's audit, with current data.

↳ Lord Carter review (price variation, ~10% / ~£500m); founder field observation, NHS IT. T1 · T3

THE COST BASE BEYOND CONSUMABLES

Capital equipment & facilities management

Beyond drugs and consumables lies a third tier: capital equipment (scanners, theatre kit, diagnostics) and facilities management (estates, cleaning, catering, energy). These carry their own opacity — long contracts, bundled pricing, and limited cross-system benchmarking.

Capital equipment

- **High unit value, low frequency** — each purchase large, comparators few.
- Bundled service-and-maintenance contracts obscure true lifetime cost.
- Total-cost-of-ownership rarely benchmarked across trusts.
- Lease-vs-buy decisions made locally without portfolio view.

Facilities management

- **Long-dated contracts** (often PFI-legacy) with limited repricing.
- Bundled scopes make line-level price discovery hard.
- Energy & soft-FM spend variable and rarely optimised centrally.
- Benchmarks exist in commercial real estate — not yet applied.

Why these are later-stage, not beachhead

Capital and FM are **higher-complexity, lower-frequency** than consumables. The data is messier, contracts are longer, and savings take longer to realise. They belong in Tier 2–3 of the lever map — pursued once the consumables beachhead has proven the model and earned data access.

✓ The expanding-surface logic

Each tier the engine masters expands the addressable surface: medicines → consumables → capital → facilities. The platform's value compounds not by going deeper on drugs alone, but by **re-using the same forensic core across an ever-larger share of NHS spend.**

↳ Capital & FM characteristics per general public-procurement literature; staging per lever map p.63. T3

THE PLATFORM THESIS, GENERALISED

A single forensic layer across the entire cost base

The strategic insight is that medicines, consumables, capital and facilities are not four problems. They are **one problem** — price opacity and absent cross-system benchmarking — appearing in four places. One engine addresses all four.

Medicines £21.6bn · net-price opacity + **Consumables** £8bn · price variation + **Capital** TCO opacity + **Facilities** contract opacity → **One engine** benchmark · flag · prove

The shared core capabilities

Benchmark

Establish best-achievable price/cost for any line, any category, from all available data.

Detect

Flag where actual exceeds benchmark — the Cost-Alpha signal — continuously, at scale.

Prove

Attach receipts to every flag so a finding survives audit and challenge.

✓ Why "one layer" is the defensible business

A point solution for drug pricing is a feature. A **forensic layer across the whole cost base** is a platform — harder to displace, expanding in value with each category, and aligned with how government actually thinks about total spend. The medicines case is the wedge; the cost base is the market.

↳ Generalisation of Parts III–V; capability model per Kincaid IQ architecture. **T3**

HOW BIG THE WHOLE PRIZE IS

The total NHS-wide addressable surface

Scaling the forensic layer across the full non-pay procurement base — while holding the same conservative leakage discipline — gives the upper bound of the domestic opportunity. We state it as a surface, not a promise.

COST TIER	BASE	LEAKAGE LENS	RECOVERABLE (CONSERVATIVE)
Medicines	£21.6bn	Net-price gap (post-rebate)	£0.2–0.8bn
Consumables & equipment	~£8bn	Carter price variation	£0.4–0.8bn
Capital equipment	Multi-£bn	TCO & bundling	Later-stage
Facilities management	Multi-£bn	Contract repricing	Later-stage
Near-term addressable	**~£30bn**	Medicines + consumables	**£0.6–2.4bn**

NEAR-TERM BASE
~£30bn
Medicines + consumables, England.

FULL PROCUREMENT BASE
Larger still
+ capital + FM over time.

RECOVERABLE (NEAR-TERM)
£0.6–2.4bn
Recurring, conservative.

◆ **Discipline maintained at scale**

Note we do **not** slap a leakage percentage on capital and FM to inflate the TAM — the data isn't there yet, so we mark them "later-stage" rather than guess. The same refusal-to-overclaim that shaped the medicines number shapes the market size. **The surface is huge; we only count what we can currently defend.**

↳ Bases per pp.40, 68; recoverable ranges per Part IV; capital/FM deliberately unsized. T1 · T3

FROM ANALYSIS TO A BUSINESS

VII

The Commercial Model — B2G

One contract covers **millions of lives, not thousands**. This is the structural advantage of selling to government rather than employer-by-employer. The next six pages set out how the forensic layer is sold, to whom, in what order, and on what economics — priced so the buyer only pays out of money we first prove was leaking.

74 Business & pricing model · 75 The buyer map · 76 Go-to-market sequence
77 Competitive landscape & moat · 78 Unit economics & TAM/SAM/SOM

THE PRICING MODEL

A pricing model that de-risks the buyer

In a system under acute funding pressure, the only credible commercial posture is one where the public buyer cannot lose. We lead with gain-share — payment out of recovered spend, not from new budget — and graduate to subscription only once value is proven and trusted.

PHASE 1 — GAIN-SHARE

10–20%

of independently verified recurring savings. No saving, no fee. Aligns perfectly with Treasury logic.

PHASE 2 — PLATFORM SAAS

Fixed £/yr

Per-ICB / per-cluster licence once the forensic layer is embedded as infrastructure.

PHASE 3 — OUTCOMES

Blended

Base licence + capped performance fee tied to audited price-gap closure.

Why gain-share first

- **Zero budget ask.** The fee is a slice of money the buyer was already losing — it never competes with a clinical budget line.
- **Self-funding proof.** The first recovered pound pays for the engagement; everything after is net positive to the public purse.
- **Forces honesty on us.** If the leakage isn't real and recoverable, we don't get paid — which is exactly why our number is biased downward (pp.46–50).

◆ The discipline cuts both ways

A gain-share model is only credible if savings are **independently verified**. We therefore propose that recovery be measured against a jointly-agreed baseline and signed off by the buyer's own finance and audit functions (or the NAO where relevant). We are paid on their number, not ours.

✓ Connecting to the value engine

The gain-share rate sits inside the EV Bridge (p.52) and EVA logic (p.54): at a base recoverable of ~£0.7bn (year-3) and a 15% share, the platform's own revenue line is ~£105m/yr from the medicines wedge alone — before consumables, before international. The buyer keeps roughly 85% of every recovered pound.

↳ Pricing architecture per Kincaid IQ commercial model; recoverable base per pp.48–50; EVA linkage p.54. T3

THE BUYER MAP

Who actually buys this

B2G is not one buyer. It is a chain of institutions with different mandates, time horizons, and appetites. The art is matching the offer to the part of the system that both feels the leakage and can act on it — and recognising that the body capturing rebates centrally (DHSC/NHSE) is not the body running the local budget (ICBs).

INSTITUTION	MANDATE	WHAT WE OFFER THEM	APPETITE
HM Treasury	Total public spend; value for money	Recovered spend without service cuts	HIGH
DHSC	Health policy & central rebate schemes	Net-price transparency above VPAG	MEDIUM–HIGH
NHS England	Operational delivery & commercial	Forensic layer over NHS Supply Chain	MEDIUM
ICBs (×42)	Local budgets, ~£11bn savings ask	Independent audit of their own net prices	HIGH (ACUTE)
NAO / PAC	Scrutiny & accountability	Evidence-grade analysis of price variation	ALLY

The wedge buyer

An **ICB under savings pressure** is the natural entry point: it feels the pain locally, has a board-level savings target, and can authorise a gain-share pilot without primary legislation. Success there is the reference case for the centre.

The scale buyer

Treasury and DHSC are where this becomes national infrastructure. They cannot easily run 42 pilots — but they can mandate a layer once a pilot proves recoverable spend the NAO will recognise.

◆ The structural tension to navigate

Because branded-medicine rebates flow **centrally** (p.33), a local ICB sees list-like prices while the centre sees net. A forensic layer must therefore serve both — giving ICBs visibility they currently lack and giving the centre category-level intelligence — without promising either one savings that properly belong to the other.

↳ Institutional roles per House of Commons Library & NAO; ICB savings ask ~£11bn 2025/26 per NHSE. T1 · T3

GO-TO-MARKET SEQUENCE

The order of entry matters more than the entry

The efficient-frontier analysis (p.59) is unambiguous: the highest return-per-unit-effort is not medicines — it is **consumables**, where price variation is visible, data is more open, and no commercial-in-confidence wall blocks the analysis. We therefore lead where we can prove value fastest, then earn the right to the harder, larger prize.

Beachhead
Consumables price variation — one ICB / trust cluster. Open data, fast proof.

→

Expand
Generic medicines net-price gap in same buyer. Build the evidence spine.

→

Deepen
Branded opacity & intermediary layer — where data allows, with caveats.

→

Scale
Centre mandates the layer across categories & ICBs nationally.

STAGE 1 · 0–12 MO

Prove

Consumables PoC, one buyer, gain-share. Target a defensible, audited recovery.

STAGE 2 · 1–3 YR

Land & expand

Add medicines; 3–5 reference ICBs; case study the NAO can cite.

STAGE 3 · 3–5 YR

Become infrastructure

National layer; multi-category; the default forensic spine.

✓ Why not lead with the biggest number

Branded medicines hold the largest theoretical leakage but the **worst data access** (PAS confidentiality, central rebates). Leading there means a long, contested, low-yield first engagement. Leading with consumables means a **fast, clean, verifiable win** that buys credibility for everything harder that follows. Sequence beats size.

↳ Sequencing per efficient-frontier ranking p.59; data-access constraints per pp.34–35; consumables evidence p.69. **T3**

COMPETITIVE LANDSCAPE & MOAT

The landscape — and why the moat is the evidence spine

Procurement analytics is not an empty field. Big-four consultancies, NHS Supply Chain's own analytics, and category specialists all touch this space. The differentiator is not "we have data" — everyone claims that. It is that every claim is anchored, traceable, and audit-grade. **No anchor, no claim.**

PLAYER	STRENGTH	LIMITATION VS. US
Big-four consultancies	Relationships, scale, trust	Project-based, not a persistent forensic layer; rarely gain-share
NHS Supply Chain analytics	Owns the transaction data	NAO: has data but "does not challenge" trusts (p.68)
Category/GPO specialists	Deep in one tower	Narrow; no cross-base arbitrage view
Generic BI / dashboards	Cheap, fast to deploy	Show numbers, not why to believe them
Kincaid IQ forensic layer	**Evidence spine + cross-base arbitrage**	—

The moat, in four layers

1 · EVIDENCE SPINE
9-gate, every figure sourced & tiered. Defensible under challenge & legal scrutiny.

2 · CROSS-BASE VIEW
Arbitrage logic spanning medicines + consumables + capital, not one silo.

3 · REFERENCE PROOF
Each audited recovery compounds credibility the next buyer can't ignore.

4 · ALIGNED INCENTIVES
Gain-share signals confidence no consultancy day-rate can match.

◆ The honest competitive risk

The most likely competitor is not a vendor — it is the system **building this capability in-house** once we prove it works, or an incumbent consultancy bolting "evidence-grade" language onto an existing offer. Our defence is depth and speed: be the proven, cited reference case before the category is contested, and make the evidence spine genuinely hard to replicate rather than merely branded.

↳ Landscape per NAO 2024 & market structure (Part VI); moat = Kincaid IQ evidence architecture (Part II method). T1 · T3

UNIT ECONOMICS & MARKET SIZING

Unit economics and a disciplined TAM

We size the market the same way we sized the leakage — bottom-up, conservative, counting only what we can defend. The TAM here is our revenue opportunity (the fee on recoverable spend), not the gross spend itself.

TAM — UK FORENSIC-FEE POOL

£90–360m

15% gain-share on £0.6–2.4bn recoverable across medicines + consumables.

SAM — REALISTICALLY ADDRESSABLE

£40–120m

ICBs & categories we can reach in 3–5 yrs with current model.

SOM — NEAR-TERM OBTAINABLE

£8–25m

Beachhead + early land-and-expand, years 1–3.

Unit economics of a single engagement

LEVER	INDICATIVE	NOTE
Recoverable spend per ICB (medicines + consumables)	£10–40m	Conservative slice of local base
Gain-share rate	10–20%	Phase 1
Revenue per engagement / yr	£1.5–6m	Recurring while gap persists
Delivery cost (analysts + compute)	Low, falling	Engine reuse → high gross margin at scale
Gross margin trajectory	High	Software-like once the layer is built

✓ The shape of the business

Early revenue is gain-share — variable, proof-driven, modest. The prize is the **transition to recurring platform revenue** across many buyers and categories, where marginal delivery cost falls and the same evidence engine is reused. International (Part VIII) is upside on top, not in these UK figures.

↳ Fee pool derived from recoverable range pp.46–50 × gain-share rate p.74; international excluded. T3

THE UK IS NOT UNIQUE

VIII

International Replicability — GCC

Most of Europe — and all of the Gulf — runs state-funded healthcare with a centralised authority paying pharmaceutical and supply costs for the population. The engine travels. But the **shape of the opportunity changes** when the buyer is already a single national procurer, and intellectual honesty requires us to say exactly how.

80 The GCC opportunity · 81 Why a single-buyer differs · 82 International sequencing

THE GCC OPPORTUNITY

The Gulf: centralised, well-funded, vision-driven

The GCC pharmaceutical market is large and growing fast — and procurement is increasingly centralised under national bodies executing explicit transformation agendas. That combination of scale, central control, and political will to modernise is precisely where a forensic layer aligns with the buyer's own stated goals.

GCC PHARMA MARKET
$30→45bn
Growing toward ~$45bn by 2030.

SAUDI NUPCO BUDGET
>$2.7bn
Central procurement, 280–300 hospitals.

SAUDI HEALTHCARE SPEND
>$65bn
21 health clusters; Wasfaty e-Rx.

UAE BIOTECH
>$5bn
Abu Dhabi DoH AI health tenders.

MARKET	CENTRAL BUYER	VISION HOOK	ANGLE FOR US
Saudi Arabia	NUPCO (PIF-owned)	Vision 2030; localization 20%→40%+	Net-price + localization analytics
UAE	Emirate health depts (e.g. Abu Dhabi DoH)	AI & health-data leadership	Forensic layer as AI capability
Qatar	Hamad / national procurement	National Vision 2030	Cross-category price intelligence
Kuwait / Bahrain / Oman	Central health authorities	Diversification agendas	Replicable spine, smaller scale

♥ Why this matters beyond margin

In systems funding care for entire populations, every recovered or better-localized pound can extend coverage, fund domestic manufacturing resilience, and reduce dependence on fragile global supply chains. The Gulf's localization agenda is not only economic — it is about **health sovereignty** for its people. A forensic layer that strengthens that is a partner to the national vision, not a vendor extracting from it.

↳ Figures per Freyr, trade.gov, Saudipedia, AGBI; NUPCO scope per public sources. T1 · T3

WHY A SINGLE-BUYER DIFFERS

Where the GCC opportunity is different — and we say so

It would be easy, and wrong, to copy-paste the UK leakage thesis onto the Gulf. The NHS leaks partly because procurement is **fragmented** across 42 ICBs and a mandated-but-imperfect supply chain. A national single-buyer like NUPCO has already captured the aggregation gain. The leakage we'd target in the UK is partly the leakage they've engineered out. Honesty requires re-pointing the value, not recycling the pitch.

UK / NHS

Fragmented buyer

Aggregation gap is real → consolidation + transparency both add value.

GCC SINGLE-BUYER

Aggregation captured

Remaining value is net-price benchmarking, localization & category intelligence — not consolidation.

NAÏVE TRANSFER

Copy the UK pitch

Overclaims savings a single-buyer has already realised. Loses credibility instantly.

CORRECT TRANSFER

Re-point the engine

Sell global net-price benchmarking + vision-aligned localization, not "you're fragmented."

What still leaks in a single-buyer system

NET-PRICE VS. GLOBAL

Even a central buyer may not see best global net price without external benchmarking.

CATEGORY MIX & SUBSTITUTION

Therapeutic and generic-substitution optimisation across a vast formulary.

LOCALIZATION ECONOMICS

Where domestic sourcing genuinely lowers TCO vs. where it raises it.

◆ The intellectually honest position

The GCC is a **real and attractive market** — but for a different value proposition than the UK. We do not claim a centralised buyer is bleeding the way a fragmented one is. We claim that **even the best central buyer benefits from an independent, evidence-grade net-price and localization lens** — and that this aligns with, rather than disrupts, the national vision. Same engine; honestly different sale.

↳ Distinction per procurement structure (NUPCO centralisation) vs. NHS fragmentation (Part III); analytical, not vendor-sourced. T3

INTERNATIONAL SEQUENCING

Prove at home, then travel deliberately

International is upside, not the foundation. The credibility that wins a sovereign health authority is a **proven domestic reference case** with audited recovery. We therefore sequence the Gulf after — not instead of — UK proof, and enter through partnership aligned to each national vision.

UK proof
Audited recovery + NAO-citable reference. The passport.

→

Anchor market
One Gulf partner (e.g. Saudi vision-aligned) — net-price & localization pilot.

→

Regional expand
UAE, Qatar; adapt to each authority & data regime.

→

Europe optionality
State-funded EU systems as a later, separate track.

ENTRY MODE

Partnership

Local partner / sovereign vehicle, not cold B2G. Respect sovereignty & data residency.

ADAPTATION

Re-pointed

Net-price + localization framing per p.81 — never the "you're fragmented" pitch.

TIMING

Year 3+

After UK reference; international is upside on the UK base case.

✓ Founder's step 4, made concrete

The discussion paper's fourth next step — "explore applicability to Gulf state healthcare systems, in line with national visions" — is exactly this track: not a parallel bet competing for focus, but a **sequenced expansion** that the domestic proof unlocks and the national visions pull toward.

↳ Sequencing logic per real-options staging (p.58) & founder's proposed next steps; data-residency a known constraint. **T3**

A HIGH-STAKES MARKET, NAMED HONESTLY

IX

Risk, Ethics & Governance

The founder's own words: "This is not a software sale. It is a political and institutional intervention." The incumbents profiting from opacity are well-resourced and politically connected; the relationships are generational, dating to 1948. We do not minimise this. We map it, govern it, and anchor the whole enterprise to a patient-first mandate.

84 Risk register & resistance map · 85 The ethical mandate · 86 Governance & responsible AI

RISK REGISTER & RESISTANCE MAP

The risk register — and who will resist

A serious intervention attracts serious resistance. We name the principal risks, rate them, and state the mitigation. The largest are not technical — they are political and institutional.

RISK	SEV.	MITIGATION
Incumbent & lobbying resistance — those profiting from opacity	HIGH	Patient-first framing; ally with NAO/scrutiny; transparency as public good
Legal challenge — contracts, confidentiality, procurement law	HIGH	Evidence spine built to withstand scrutiny; use only lawful, public/licensed data
Data access — PAS confidentiality, central rebates	MED-HIGH	Lead with open consumables data; honest caveats on branded (pp.34–35)
In-house replication — system builds it itself	MEDIUM	Speed, depth, hard-to-copy evidence engine (p.77)
Political cycle — change of government / priorities	MEDIUM	Cross-party value (Treasury + opposition both gain); apolitical framing
Overclaim / credibility — promising savings that aren't real	MEDIUM	Conservative, downward-biased numbers; gain-share on audited recovery

The resistance map — generational, since 1948

WILL RESIST HARDEST

Intermediaries & any party whose margin depends on the price gap being invisible.

AMBIVALENT

Parts of the system invested in current arrangements but open to demonstrated value.

NATURAL ALLIES

Treasury, NAO/PAC, patient advocates, reform-minded leadership.

⚠ The honest reframe of the risk

The right question is not "can we avoid resistance?" — we cannot. It is **"can the evidence withstand it?"** An anchored, lawful, audit-grade case is the only thing that survives a well-resourced, politically-connected challenge. The evidence spine is therefore not just the product — it is the risk mitigation.

↳ Risks per founder's stated considerations; severity = analytical judgement; mitigations map to Parts II–VII. T3

THE ETHICAL MANDATE

The patient is the point

Every pound lost to a price gap is a pound not spent on a nurse, a scan, or a treatment. This is the moral centre of the work, and it disciplines the commercial model: we are not optimising a margin, we are returning capacity to a public health system that millions depend on.

♥ The human ledger, restated

At the conservative base case of ~£1.3bn in annual leakage, the stakes translate into care: **thousands of additional nurses, hundreds of thousands of additional procedures, or materially shorter waiting lists** — every year, recurring. We deliberately understate the financial number (pp.46–50) precisely because overstating it would cheapen this claim. The credibility of the mercy depends on the honesty of the maths.

Four ethical commitments

1 · Patient-first, always

No recommendation that improves a price but harms access, safety, or continuity of supply. Resilience and patient welfare outrank savings where they conflict.

2 · Truth over persuasion

We separate genuine leakage from deliberate policy (the retained margin, central rebates). We would rather present a smaller, true number than a larger, contestable one.

3 · Transparency as a public good

The intervention's purpose is to make a public system see what it is paying. That visibility belongs to the public, not only to a vendor.

4 · Do no harm to supply

Squeezing price must never threaten the availability of essential medicines. Where margin protects resilience, we say so — and leave it.

> Returning a billion pounds to patient care is not a software outcome. It is the reason the software exists.
>
> — THE THORP ADVISORY / KINCAID IQ MANDATE

↳ Translation per Human Ledger (p.14) & fiscal impact (p.60); commitments per Notre Dame humanitarian standard. T3

GOVERNANCE & RESPONSIBLE AI

Governance: the engine must be as accountable as the system it audits

An analytical layer that scrutinises public spending must itself be governable, auditable, and explainable. We hold Kincaid IQ to a higher standard than the system it examines — because a black box has no place adjudicating where public money goes.

EXPLAINABILITY

Every claim traceable

9-gate spine: each figure carries its source, tier & method. No unexplained outputs.

HUMAN-IN-THE-LOOP

Judgement, not automation

The engine informs decisions; accountable humans make them.

AUDITABILITY

Reproducible

Findings re-runnable & defensible before NAO, finance & legal review.

Responsible-AI controls

PRINCIPLE	HOW IT IS ENFORCED
Lawful data only	Public, licensed, or client-authorised sources; full provenance log; respect for confidentiality & data residency
No fabricated anchors	"No anchor, no claim" — figures without a source are not stated (Part II method)
Uncertainty disclosed	Ranges & tiers (T1/T2/T3) shown, never a false point estimate
Bias toward conservatism	Estimates deliberately downward where judgement is required
Independent verification	Savings measured against a jointly-agreed baseline, signed off by the buyer
Privacy & security	No patient-identifiable data required; procurement & pricing data only

✓ The governance promise

The same evidence spine that makes the analysis persuasive makes it governable. Transparency, traceability, and conservatism are not add-ons — they are the architecture. An engine that demands accountability from a public system must embody it first.

↳ Controls per Kincaid IQ Verify V9.0 & 9-gate spine (Part II); responsible-AI framing per governance standard. T3

THE WAY FORWARD

Four steps now — then a five-year horizon

The discussion paper closed with four concrete next steps. They remain exactly right: lightweight, sequenced, and designed to convert a thesis into proof before committing real capital. Below them sits the longer arc.

The founder's four immediate steps

STEP 1 · FEASIBILITY

UK regulatory review

Amit leads a feasibility & regulatory scan of the UK pharmaceutical & procurement landscape.

STEP 2 · DATA

Identify PoC data

Locate public NHS procurement / contract data sufficient for a proof-of-concept.

STEP 3 · ARCHITECTURE

Preliminary solution

Kincaid IQ produces a preliminary solution architecture for the forensic layer.

STEP 4 · INTERNATIONAL

GCC alignment

Explore Gulf applicability in line with national visions — sequenced behind UK proof.

The five-year horizon

HORIZON	OBJECTIVE	PROOF POINT
0–12 months	Feasibility + consumables PoC with one buyer	One audited, defensible recovery
1–3 years	Land & expand to medicines; 3–5 reference ICBs	An NAO-citable case; recurring revenue begins
3–5 years	National forensic layer; first GCC partnership	Multi-category, multi-geography platform

◆ Capital discipline

Note the staging: **almost no capital is at risk before Step 1–2 validate the thesis**. This is a real-options posture (p.58) — small, sequenced bets that each buy the right, not the obligation, to invest in the next. We spend to learn before we spend to scale.

↳ Four steps verbatim from the discussion paper; horizons per real-options staging (p.58) & GTM sequence (p.76). T3

THE DECISION

What we are asking the room to decide

This paper does not ask for a commitment to build. It asks for a commitment to **find out** — to fund the four lightweight steps that would convert a credible thesis into a proven one.

DECISION SOUGHT

Proceed to PoC

Authorise Steps 1–2: feasibility + data for a proof-of-concept.

CAPITAL AT RISK

Minimal

Learning spend only — no build commitment yet.

PRIZE IF RIGHT

£0.6–2.4bn/yr

Recurring, recoverable, returned to patient care.

♥ The case in one breath

A large public health system is almost certainly paying more than it needs to for medicines and supplies. The amount is uncertain but conservatively material. The cause is not waste but **opacity** — a price gap no single party can fully see. A forensic, evidence-grade layer can make that gap visible, and the recovered money is care: nurses, scans, shorter waits. We have stated the number honestly, biased it downward, and asked only for the right to prove it.

> **Dashboards show numbers. Kincaid IQ shows receipts.**
>
> — THORP ADVISORY · KINCAID IQ

Principal sources & references

- **NHSBSA** — Prescribing Costs in Hospitals and the Community 2024/25 (Nov 2025). T1
- **NHSBSA / DHSC** — Drug Tariff (monthly); Parts VIII & VIIIA; Medicines Margin Survey. T1
- **gov.uk / DHSC** — VPAG: Voluntary Scheme for Branded Medicines Pricing, Access & Growth (2024–2028); Statutory Scheme. T1
- **ABPI** — VPAG payment rates & branded-medicines pricing. T1/T2
- **National Audit Office** — NHS Supply Chain & procurement (2024); PAC evidence. T1
- **Lord Carter Review** — operational productivity & price variation. T1
- **House of Commons Library** — NHS structures, ICBs, finance. T1/T3
- **King's Fund / Nuffield Trust** — NHS workforce & spending context. T1/T3
- **Pharmaceutical Journal; CMS Law; CPE** — generic categories, concessions, margin. T2
- **Freyr; trade.gov; Saudipedia; AGBI** — GCC / NUPCO market context. T1/T3

↳ Tiering: T1 official/primary · T2 industry/trade · T3 analytical inference. Figures stated as ranges where sources diverge.
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