The NHS – a Suitable Case for Treatment?

Policy Exchange

The fifth part of Policy Exchange's
Policy Programme for Prosperity

Roger Bootle, Ben Ramanauskas and Ben Sweetman

Foreword by Rt Hon Sir Sajid Javid

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Foreword

by Rt Hon Sir Sajid Javid

The NHS is one of our country's most treasured and beloved national institutions - and for good reason.

It speaks to the ideals at the heart of our national life. The principle of equality - that every British citizen deserves the same access to high-quality healthcare - and the belief that we all have a responsibility for the health of our neighbours.

However, while the strength of our belief in these ideals has not wavered, our ability to deliver them is increasingly being called into question.

We live in an ageing society. Both men and women are likely to live a decade longer than they did when the NHS was founded. As our population gets older, more and more of us will live with complex long-term conditions.

In addition, high-quality healthcare is getting more sophisticated. We live in an age of incredible scientific and technological advances. People rightly expect the treatments available to them on the NHS to be cutting edge.

All of this comes at a cost. The modern-day NHS spends its original yearly budget every month. Our health budget is the size of the GDP of Portugal - and it will only grow further.

We've come to a crossroads. A serious conversation with taxpayers about how we continue funding their favourite national institution is long overdue.

We have two options.

The first is to make an active choice to continue putting more and more money into healthcare, funded by yearly tax rises and by diverting essential investment into everything from education to defence towards the NHS. The second is reforming how we do healthcare.

What we cannot afford to do is to bury our heads in the sand. While some of the new government's interventions have been very welcome - particularly Wes Streeting's focus on patient outcomes - they will not change the long-term viability of a model which does very little to adjust almost unlimited demand to the finite resources we have for healthcare provision.

This paper from Policy Exchange does exactly that. We have an almost totally socialised model for healthcare in this country. All of the funding,

the commissioning and the service provision is concentrated in the state and its agencies.

By contrast, the very best performing systems combine high levels of state subsidy, mandatory insurance, co-payments, and individual choice.

Dutch healthcare, perhaps the most highly regarded in Europe, operates along these lines. The Singaporean model, often ranked as the best in the world, does too. Both these systems deliver extremely good coverage and affordable care, but they also ask the individual to take more responsibility where they are able.

What we mustn't do is gravitate closer to the US model. American healthcare is hugely expensive, fails to cover a significant proportion of the population and results in extremely poor average outcomes.

But not every call for reform of how we fund healthcare in this country is an advocacy of US-style private health insurance. Those who label any discussion of reform as an attempt to abolish or 'sell-off' the health service are actively making it harder to preserve the parts of it that we cherish, and which continue to function well.

In the pages that follow, Policy Exchange offers a clear-sighted overview of the situation we face, and the implications for the economy unless we take action: a combination of escalating debt, higher taxes and poorer public services across the board.

They have thought carefully about the process of transformation, and have drawn on the historical experiences of a range of countries which have managed to achieve success with healthcare reform.

Ultimately, any reforms must have patient outcomes at their heart. The purpose of the National Health Service is simple: It is a means to the end of promoting the health and wellbeing of the British people.

If it is failing to do that, then the responsible politician – the one who is concerned with the national interest – must look at every option for reform.

The Government's Paper "Fit for the Future"

- The Government's paper, "Fit for the Future – The 10 Year Health Plan for England" was released just as we were completing this study.[1]Its thrust is primarily different from this paper, focussing on a variety of organisational and other changes which the Government thinks are necessary to improve NHS performance within the existing NHS funding model. By contrast, our paper majors on a comparison of healthcare systems in different countries and suggests a change in the model for financing healthcare in the UK.
- But we warmly welcome the Government's report. Indeed, it includes more than twenty policy recommendations made by Policy Exchange's Health and Social Care Unit across eight different reports published in the past four years.
- The Report is remarkably candid about the performance of the NHS and about its future, saying: "The choice is stark: reform or die". If nothing changes then it says that the NHS could become a "poor service for poor people". And in reporting on the results of a conversation over 8 months with thousands of staff and members of the public, it says" no one defends the status quo".
- And the Government's report is bold in both its analysis and its policy prescriptions. We welcome its emphasis on getting improved productivity in the NHS and the weight it places on technology, and especially AI, in achieving this. We also welcome the way the report stresses the importance of introducing incentives into the system to improve efficiency and the patient experience. And its proposals on preventative care and care centred on the community rather than hospitals exclusively have much to commend them.
- Moreover, we welcome the Report's ambitions. It says it wants the NHS to be a global leader. And it says" This Plan will transform the NHS into an engine for economic growth rather than simply a beneficiary of it". We have no quibble with that. We would differ on the desirability and feasibility of some of its proposals but our main difference is simply over the funding model. We think it is fundamentally important to reduce the burden that funding the NHS places upon the taxpayer and we do not see that this will be possible within the current funding system.

1. "Fit for the Future" – The 10 Year Health Plan for England", CP 1350, His Majesty's Stationery Office, July 2025.

Executive Summary

An assessment of relative success

- The NHS offers neither the best nor the worst healthcare in the developed world. At its best, it provides superb care but the standard is hit and miss, within both England and the other nations of the UK. At its worst, the standard of care is poor. And the average is decidedly mediocre.
- There is more to health outcomes than the effectiveness of the healthcare system. Nevertheless, it is noteworthy that in comparison with a range of countries of comparable economic development (Australia, Canada, France, Germany, the Netherlands, Singapore, Switzerland and the US), with regard to the probability of dying between the ages of 30 and 70 from cardiovascular disease, cancer, diabetes or chronic respiratory disease, the UK performs slightly worse than average.
- And on both life expectancy and healthy life expectancy, the UK comes in second to last. Only the US scores worse.
- With regard to both preventable and treatable mortality, the UK again comes in second to last, again beating only the US.
- And the average length of waiting times to receive treatment is unacceptably high. From 2008 to early 2025 the median waiting time from referral to treatment by the NHS in England has more than doubled to stand at over 14 weeks. Among our comparator countries, the UK's proportion of patients waiting over a year to see a specialist is the highest in the group.
- Against our comparator countries, the UK also performs badly on the difficulty of securing an appointment with a GP and access to GPs out of normal hours.
- Out of 19 developed countries surveyed by the King's Fund, the UK had the smallest number of CT and MRI scanners per million of the population. It also had the smallest number of hospital beds per capita in our selected sub-group of countries.

The causes

- The NHS is a behemoth. It is the largest employer in Europe with some 1.38 million full-time equivalent members of staff. Paying these employees absorbs almost half of the service's budget for current (i.e. day-to-day) spending. (The second largest employer in the UK is Tesco, with 345,000 employees.)
- Such an entity is virtually impossible to manage efficiently, and the examples of poor management and excessive bureaucracy are legion.
- Meanwhile, the Service has had to cope with an ageing and growing population, and the emergence of expensive new treatments.
- Nevertheless, the keenest debates about the failings of the NHS concern funding. It is often alleged that they are simply due to "inadequate funding" and the "cuts" imposed by Conservative and Conservative-led governments. Yet the NHS has received increases in its funding well above the inflation rate for decades. From 1955/56 to 2022/23, in real terms health spending increased by an average of 4% per annum. Over this period as a whole, real health expenditure per capita rose by about 850%.
- But there were marked differences within this period. There was a surge in health spending under Gordon Brown which had a major beneficial effect on waiting lists. In 2011/12, under the "austerity" policies of Prime Minister Cameron and Chancellor Osborne, however, in real terms NHS funding fell. It barely kept pace with the increasing numbers of people in the country. There was again a fall in 2021/22 and 2022/23, but this came after a huge increase in 2020/21.
- Yet NHS England has revealed that in 2023/24 productivity was 11% lower than its pre-pandemic level. It put 3% of this 11% down to industrial action within the Service.
- As currently structured, the NHS has an insatiable "need" for more funding. It will always be in some sort of financial crisis.
- Admittedly, in regard to the proportion of GDP spent on healthcare, the NHS is not especially expensive by international standards. Government funded current expenditure on healthcare in the UK amounts to about 9% of GDP, well below the combination of government and compulsory insurance spending in the US, which is almost 14%, followed by Germany and France at 10%. Switzerland, Canada and Australia all spend a fair bit less than the UK, but in these countries voluntary and out-of-pocket expenditures on health are higher.
- Moreover, since per unit of GDP the UK has a relatively high population and a relatively low level of productivity, the UK's spending on health per capita is fairly low by the standards of other developed countries.

- The standout exception among all developed countries is Singapore, where current spending on healthcare is only about 5% of GDP, with government spending on healthcare accounting for only 2.8% of GDP. What makes this all the more remarkable is that on most of the usual markers of successful healthcare, Singapore achieves some of the best results in the world.
- But all of these comparator countries finance their healthcare systems through a mixture of insurance, charges, co-payments and some taxpayer funding.
- Within Europe, other countries besides the UK primarily fund their healthcare systems through taxation. They include Denmark, Finland, Italy, Norway, Spain and Sweden. And their health outcomes are in general better than the UK's. On life expectancy and healthy life expectancy, with the exception of Denmark and Finland, their outcomes are almost as good as, or just about in line with, the best outcomes in our comparator group of countries – except Singapore.
- But at about 9% of GDP, the UK places the second highest burden on its taxpayers of all these developed countries for the public financing of the healthcare system. (Sweden has the highest figure.) The other largely tax-financed European countries spend much less as a share of their GDP. And within our comparator group, France, Germany, the Netherlands, Singapore and Switzerland all fall in the range 0.5-2.9% of GDP.
- This is extremely important because taxes distort economic activity, damage incentives and thereby inhibit economic growth.

The consequences

- The NHS is now so large that its failings are no longer a matter of health alone. They have important economic consequences.
- Its failings are an important (although not the only) contributor to the UK's poor productivity. Within the service itself, productivity levels are poor by international standards and have been deteriorating. Moreover, by failing adequately to achieve the best health for the UK's workers, thereby reducing their work attendance and productivity, the NHS contributes to poor UK productivity overall.
- In the three months to November 2024, 9.3 million people aged 16 to 64 were economically inactive. Of these, some 2.8 million (30%) were self-reported as having a long-term sickness. This number is up by 35% since 2019, the last year before the pandemic.
- Government funded healthcare in the UK consumes only slightly less than the whole revenue from income tax. As a share of GDP, expenditure on health has risen from 3% in 1955/56 to 9% today.

- In 1955/56 expenditure on healthcare accounted for about 8% of all government spending. Today the figure is about 18%.
- What's more, the BMJ Commission on the Future of the NHS said that, on the basis of past experience, the share of GDP spent on the NHS would double by 2058. And by 2070, more than a fifth (21%) of GDP would be spent on the NHS.
- This is simply unacceptable. Without radical reform, either other sorts of public spending would have to be squeezed or taxation would need to be increased to eye-watering levels. The latter would have a materially depressing effect on the economy by damaging incentives for individuals and businesses. It simply cannot be allowed to happen.

Possible Cures

- Some commentators and politicians argue that the key to raising the quality and of the NHS and improving health outcomes lies solely with greatly increased funding. No doubt it would be possible to improve health outcomes by pouring more money into the NHS. But money is by no means everything. After all, America spends proportionately more on healthcare than any other developed country, yet its health outcomes are about the worst.
- In any case, the amounts of extra public money necessary to have a transformatory impact on the UK's health outcomes would be eye-watering, requiring major cuts in other sorts of public expenditure and/or huge increases in taxation, which would have serious adverse economic effects.
- There are broadly three ways of trying to avoid a future economic calamity caused by huge and ever-increasing spending on healthcare: (i) increasing the use of "rationing", whereby patients are made to wait and access is squeezed;(ii) maintaining the current model but reducing its cost through a mixture of making efficiency savings, hiving off certain functions to the private sector and charging for some services; (iii) moving to an insurance-based model.
- The even greater use of rationing than at present would cause widespread consternation. And it would constitute a way of muddling through rather than any sort of solution. So, in practice, the solutions come down to a move to greater efficiency and more charging and the adoption of the insurance model. It is possible to adopt an approach that combines both.
- Keeping the present model but reducing its cost through making efficiency savings, ending national pay bargaining and charging for some treatments and/or introducing co-payments (detailed below) could bring a saving of about £13bn per annum for the

UK as a whole or about 1/2% of UK GDP. This would be helpful but on its own it would not be transformatory. Moreover, it would be a one-off measure. It would fail to deal with the problem for the public finances of ever-expanding demands for healthcare and the pressure this puts on taxpayers. Hence the case for moving to a largely insurance-based model.

- Most British people think that moving to an insurance-based model would mean adopting something like the US system, of which they do not approve. And rightly so. The American system fails to cover a significant part of the population and it is hugely expensive. Meanwhile, although some of the best healthcare in the world is available to a privileged few, average American health outcomes are extremely poor. **For all its faults, the presently structured NHS is far preferable to the American system. Under no circumstances should the UK consider moving towards the US model.**
- But other countries with some sort of insurance-based model do much better, including France, Germany, Switzerland and the Netherlands, as well as several countries outside Europe, such as Australia, Japan and Singapore. In one of the top performers, Singapore, healthy life expectancy is 5 years longer than it is in the UK.

The Ambition

- Pretty much everywhere in the world, healthcare systems are a mixture of public and private. The key lies with getting the mixture right. The proposals in this paper aim to alter the current mixture in the UK, giving more scope for market forces and reducing the burden on the taxpayer, while retaining a considerable role for the state.
- We believe that better quality healthcare with universal coverage and improved long term funding sustainability could be secured by moving from our present, entirely socialised model to a hybrid model with a significant social insurance component. This reformed healthcare system would ensure universal, affordable coverage, subsidise the cost of the care for those under the age of eighteen, those on low incomes and those with long term conditions, employ a blend of insurance premiums, annual excesses, tax contributions and copayments, and would ensure a high minimum standard of provision as well as greater choice for individuals over their healthcare.
- The ambition should be to deliver health outcomes close to the level of the best performers in our comparison group, at an overall cost no higher, or even lower, than the cost of the present UK system.

- If the government spent the same proportion of our GDP on health as the Australian government spends, this would result in a saving of about £1000 per annum per adult head of the population. If our government spent the same proportion of GDP as the Singaporean government does, this would result in a saving of about £3,200 per annum per adult head of the population. Of course, it would be ridiculous to cut healthcare spending just for the sake of it with the result that the standards of healthcare plunged. But the fact is that both Australia and Singapore deliver better average health outcomes than we do.
- Even if there were no efficiency gains as a result of the changes in the healthcare system advocated here, the switch from a largely tax-funded system to a largely insurance funded model would reduce the amount of tax absorbed by the NHS. If we shifted to a system in which the tax-payer contribution to the financing of healthcare was reduced from 9% of GDP to 4.5%, this would result in a reduction of the tax needed to pay for UK healthcare about £128 bn per annum. If this was all returned to tax payers, the result would be a reduction in the average tax paid of about £2,400 per annum.
- Admittedly, unless the reform of the financing system brought substantial real savings and efficiency improvements, this reduction in tax would be counter-balanced by an increase in NHS charges and insurance premiums. But the latter do not seriously affect incentives whereas tax rates do. Such a shift could radically improve the incentive structure of the whole economy, thereby increasing efficiency and boosting GDP.
- Making such a change is an ambitious target but it is achievable. In 2006, the Netherlands radically reshaped its healthcare system to involve more competition and greater consumer choice. The reform has been extremely successful and Dutch healthcare costs are proportionately lower than the UK, waiting lists lower and health outcomes generally better. (Admittedly, though, in common with other insurance-based systems, there is pressure for more central funding to cope with the growing cost of medical technologies and the consequences of an ageing population.)
- It would be laudable to try to replicate the success of Singapore's healthcare model but we doubt that this is a realistic ambition. The cultural differences between the UK and Singapore are so great. By contrast, the Netherlands provides a realistic template and an inspiration for the UK.
- The UK's system of social care is also in crisis with large unmet demands. Because of stringent eligibility criteria, between 2015/16 and 2022/23 the number of older people receiving community care fell by 7%, while the number receiving nursing or residential care fell by 9%.
- The only reason that the system of social care hasn't caused a

major fiscal problem is because of its different funding model. It does not aim to deliver unlimited care, free at the point of use but rather relies on rationing through means testing. Moreover, the financial cost is less obviously visible because it is borne by local authorities. But for them, the fiscal burden is considerable. Demographic trends mean that the current system's failings will become more and more apparent and the fiscal cost much larger. Social care is also in dire need of reform.

- Many advocate shifting social care onto the same funding model as the NHS. This would be a disaster. Rather, as the NHS moves towards a largely insurance-based system for medical care, the same thing should happen for social care. Indeed, there is an argument that the move to an insurance base should occur first with social care, where the current system is in dire need of reform.

Policy Recommendations

Reforms to reduce costs and improve efficiency within the existing model

- Even if the current structure of the NHS and the taxpayer funding of the system were retained, there are a number of measures that could be taken to save/raise money and thereby limit the demands on taxpayers.
- There should be a fee payable for visiting a GP. Low income groups should be exempt. If the fee were levied at £20, this measure could potentially raise about £5 bn per annum. But the introduction of a charge would also reduce the demand for GP appointments and cut back the number of missed appointments. So the total gain could be considerably greater.
- There would be a downside, however, as some patients who really needed an appointment were discouraged by the charge, with the result that serious conditions were left undiagnosed and untreated until much later. As well as the unnecessary suffering this would bring, it would also lead to the NHS having to shoulder extra costs to treat patients whose conditions could have been treated earlier more cheaply. We suspect this factor would be minor compared with the overall saving.
- The over 60s should no longer be eligible for free prescriptions. Rather, they should be treated in the same way as other citizens. Where their financial circumstances make payment for prescriptions unbearably expensive they should be exempt from payment, just as happens with other citizens with low incomes. As part of a rationalisation of prescription charges, this can potentially save up to £1bn per annum.
- Charging for more luxurious hospital accommodation could potentially raise £0.7bn.
- A reduction in the use of expensive agency staff, even if it is accompanied by some increase in regular staff, could perhaps save the NHS about £1bn net per annum.
- Centralised pay bargaining in the NHS should be abandoned, thereby allowing regional divergence in pay rates, reflecting local economic conditions. The saving to the NHS pay bill could potentially be about £2bn per annum.
- Halving administrative costs by making more and better use of

technology could save the NHS £1.4bn per annum.

- The total savings from the above measures could be about £11bn per annum for England and almost £13bn for the UK as a whole.
- Additionally, there could be more emphasis on personal responsibility (as in Singapore) and incentives throughout the healthcare system could be engineered to encourage individuals to have a stake in their own health. Fines should be levied for those who miss appointments. And we could copy Sweden in putting more emphasis on preventative healthcare: inducements could be offered for individuals to enter into preventative health schemes like screenings, smoking cessation programmes or fitness programmes.
- To relieve pressure on the NHS, the Government could make health insurance premiums tax deductible. But, depending upon take-up, this could cost about £500m per annum.
- More importantly, this might make a move to a universal insurance-based model more difficult. For under such a compulsory insurance model, premiums would not be tax-deductible. Accordingly, the adoption of such a system would lead to an increase in the effective cost of insurance for those who had already taken out medical insurance policies. This is not part of our proposals.

Shifting to a largely insurance-based system

- So there is scope to make improvements within the current system. And a saving of £11bn (£13bn for the UK as a whole) from organisational improvements and the introduction of some charges is not insignificant. But it is hardly transformatory. It amounts to less than ½% of GDP. Instead, we need to move to a system of compulsory social insurance.
- The Government should prepare the public for a radical change in the financing arrangements for the NHS. HMRC already issues a breakdown of each taxpayer's tax bill, including an estimate of what they pay towards the nation's healthcare system. This appears on each tax-payers' self-assessment on the HMRC portal. But most taxpayers do not see this. This information should be communicated to taxpayers directly.
- This would be the forerunner to a transition to a social insurance-based system of financing healthcare, involving compulsory medical insurance, of the sort widely in operation on the continent. The system would provide universal, affordable healthcare coverage, involving a basic insurance plan that can be supplemented by additional policies, and an annual deduction. Our aim should be broadly to replicate the Dutch system which has been highly successful.
- Following this model, the British system should encourage

competition among providers and insurers, with the latter acting as prudential purchasers of services on behalf of policy holders.

- This shift to an insurance-based system should be combined with the introduction of charges and co-payments, as discussed above.
- Funds from general taxation should be used to reduce the premiums of those with chronic illness and long-term healthcare needs and others who cannot afford the insurance premiums, excesses, charges and co-payments.
- And the government would regulate both insurance companies and healthcare providers.
- The aim should be to keep the name NHS. The change would mainly be about the way the system is financed. It should be presented as such to the public.
- It would be important that savings made from organising and financing the NHS differently should not be used to increase public spending elsewhere. This reform of NHS funding should be explicitly tied to a tax reduction so that taxpayers can see that there is a quid pro quo for their increased expenditure on health insurance premiums. This will be a critical part of making reform politically possible.
- In this regard, some form of NHS rebate should be issued to all citizens. It could come in the form of a voucher that could be set against income tax due.
- It will be important to avoid disruption in the transition to a new system. One way to do this would be to proceed in phases. In the first stage, Integrated Care Boards (ICBs) would be converted into insurers on a non-profit basis. Individuals would be obliged to take up insurance with their local ICB.
- In a second stage of the reform process, the ICBs would be free to come to arrangements with whatever hospitals or service providers they wanted, as long as they could guarantee the basic level of provision to their policy-holders.
- Existing hospitals should be converted into not-for-profit foundations and new specialist centres should be allowed to enter the market (under regulation).
- What's more, rather than moving the financing of social care towards the current financing model for the NHS, the funding of social care should also be put on an insurance basis. This shift could come before the move to an insurance basis for medical care.

A) The History and the Philosophy

1. Health before the National Health Service

The NHS that emerged in 1948 after the passing of the National Health Service Act in 1946 was far from being the beginning of free healthcare in the UK. One of the most famous hospitals in the world, St Bartholomew, or Barts as it is affectionately known, was built in 1123 to care for the sick poor.

In fact, the NHS's designers inherited – and sought to rationalise – a pre-existing patchwork of different providers and institutions, ranging from voluntary, religious or charitable organisations through to municipal hospitals administered by local government.

Two institutions in particular were prominent in the old system: the parish, and the church. In the case of the former, the "Old Poor Law", established in 1601 by the Poor Relief Act, made parishes the basic administrative unit responsible for the needy in an area, and introduced a distinction between "deserving" or "impotent" poor people, unable to work because of disability or infirmity, and the "undeserving", idle or vagrant. This system was funded through the rates, levied on residents of the parish.

As part of this system, the poor received healthcare within the poorhouses or workhouses, which often had infirmaries. However, the quality of care was low and patchy, and the conditions of the workhouses themselves could be dreadful. (Indeed the "New Poor Law", established in 1834 and amending the old system, was deliberately designed to make conditions in the poorhouses such that they were deter people from falling out of work.)

The church also administered hospitals on the Christian principle of giving alms to the needy. These were funded on a voluntary basis through charitable donations or bequests, instead of the rates, and entry was usually reserved for those with acute need and limited means. St Thomas's Hospital in London was originally founded on this basis in the 13th Century, and was staffed by a mixture of Augustinian monks and nuns.

Other hospitals like the Royal Free in North London were established on a charitable, non-religious basis. A "hospital almoner" would establish whether a particular person was sufficiently in need and therefore appropriate for charitable support, or whether they ought to make a contribution towards their care.

Finally, many wealthier families paid for private care, provided by surgeons or doctors who visited their homes. The hospital as an institution carried something of a stigma, particularly in Victorian Britain. Some private for-profit hospitals did exist, such as the King Edward VII Hospital in Marylebone (founded in 1899), but these were rare compared to the charitable or publicly-funded hospitals. Private surgeries were more common than private practice in voluntary hospitals.

By the early 20th century, then, there was a patchwork of voluntary hospitals funded through philanthropic donations, municipal hospitals funded through the rates, and some private healthcare provision for wealthier individuals and families.

From 1911 onwards, efforts to rationalise and standardise coverage and provision of healthcare increased. That year, David Lloyd-George's Liberal Government introduced National Insurance, a compulsory scheme for certain industries which gave access to a doctor from a local panel (although the scheme didn't cover hospital care).

A Ministry of Health was established in 1919, and began to provide a regulatory framework for healthcare providers. The Local Government Act of 1929 effectively terminated the Poor Laws, and many workhouse infirmaries or hospitals were taken over by local authorities.

The late Victorian and early Edwardian period also saw the development of mutual aid funds – community, cooperative institutions which helped to insure working people against the cost of care.

According to Isabel Hardman, by the inter-war period, not only was the health of the nation improving dramatically, thanks to sharp drops in infant and maternal death, and falling rates of death from tuberculosis and other diseases, but British healthcare was among the best in the world.[2]

It wasn't poor standards of healthcare that brought on the foundation of the NHS but rather patchy coverage. Not all areas of the country had sufficient hospitals or GPs and even in those areas that did, insurance coverage was limited to those in work and non-existent for children and women who worked in the home.

Interestingly in view of subsequent developments and current controversies, Henry Willink's 1944 White Paper, "A National Health Service", advocated a mixed funding model. It said: " The costs of the new health service will be borne partly from central funds, partly from local rates and partly from the contributions of the public under any scheme of social insurance which may be brought into operation."

2. The philosophy behind the NHS.

At its foundation, there were six key principles behind the NHS. The service was to be:

1. Universal;
2. Equitable;
3. Comprehensive;

2. Isabel Hardman, "Fighting for Life", Penguin, London , 2023, p 7.

4. High quality;
5. Free at the point of delivery;
6. Centrally funded.

These principles are still broadly adhered to. But, in practice, things are a bit more complicated than this list implies. In particular, the division between public and private is not cut and dried.

The provision of healthcare, just like other services, can take place in a number of ways. At one extreme, there can be a thoroughly socialised system where all healthcare is provided by the state and there is no private healthcare. At the other extreme is a completely private system which treats healthcare like any other good or service where the amount provided and its price are determined by the interplay of supply and demand and the access to it is determined by income as well as need. And there are umpteen possibilities between these extremes.

In practice, neither of these extremes has been realised. Of course, the inspiration behind the NHS was that healthcare could and should be socialised. Yet, right from the beginning of the NHS, it was recognised that there would also be private healthcare. Indeed, the service came into being after a massive row with the consultants which resulted in a climbdown by the government that allowed NHS consultants to continue doing a certain amount of private practice. Additionally, under the NHS GPs remained independent contractors rather than direct employees of the state.

Similarly, there has been an increase in the types and amounts of specific medical services provided outside the NHS, including dentistry, the services of opticians and chiropody.

The case of dentistry is interesting. From the beginning there were both NHS dentists and private dentists. NHS dentists also charged the patient for their services but much less than the equivalent charged by private dentists. The dentists then received a top-up fee from the NHS. But the extent of this top-up has failed to keep pace with the increase in private dental charges and the profits to be made in private practice.

The result is that many dentists have withdrawn from the NHS. It is now extremely difficult to find an NHS dentist to take you on. The consequence is that this particular medical service is gradually being "privatised".

Remarkably from a modern perspective, at the time of the foundation of the NHS, it was widely believed, including by the government of the day, that the establishment of a high quality universal service would so improve the health of the British people that before very long, the demand for healthcare would fall and the cost of the NHS would drop over time.

But, as we all now regard as inevitable, as the decades rolled on, the NHS became more and more expensive, both absolutely and as a share of government spending and GDP. The OBR has estimated that in the absence of fundamental change to the system, public spending on health will rise to 14.5% of GDP by 2073/74. [3] The BMJ Commission on the Future of the NHS concluded that by 2070 more than a fifth of the UK's

3. https://obr.uk/docs/dlm_uploads/Fiscal-risks-and-sustainability-report-September-2024-1.pdf (p. 10)

GDP would be spent on the NHS. [4]

Although there is still widespread public support for the NHS, it is the view of the authors that the system cannot continue to adhere to the founding six principles. Something must give.

3. The changing scope of NHS services and expenditure

While the operating principles of the National Health Service have been unchanged since 1948, there have been changes to the scope of services, and what treatments can be obtained by patients for free through the NHS. Much of this has been driven by advances in technology and demographic changes, as the British population has aged.

Charges

In the first instance, charging has expanded greatly since the NHS's inception. In 1948, patients could expect to receive prescriptions, sight tests, spectacles and dental care all via the NHS, and all for free. But in its first year, the Health Secretary Aneurin Bevan had to seek an additional £53 million from the Treasury due to higher than forecast spending – almost an additional third on the NHS's original estimates.

In the context of these fiscal difficulties (and other spending pressures, particularly from the Ministry of Defence), legislation was passed in 1949 giving power for prescription charges. Similar powers for dentistry and spectacles were introduced two years later, and fees were eventually introduced in 1952.

The 1960s saw further considerable controversy over these charges. (In 1951, the architect of the NHS, Nye Bevan, had resigned over the introduction of charges.) Having been doubled in 1956, fees were abolished in 1965, only to be reintroduced in 1968 with a wider range of exemptions. This system, with changes and modifications to the exemption categories, is broadly the arrangement today.[5]

Expansion of services

When it comes to the scope of NHS services, much of the growth has been supply driven. First of all, preventative health interventions have expanded as the NHS has sought to influence public health up-stream. This includes health screening for breast or cervical cancer, vaccination programmes, as well as public information campaigns like that concerning smoking. Nevertheless, preventative health only constitutes around 2% of total NHS expenditure.[6]

Technological advancements have brought with them innovative new drugs and treatments for malignant diseases like cancer. But these have come with an increasing price tag too. A study by the London School of Economics in 2023 found that the total cost of prescription medicines to the NHS in England was £17.2 billion in 2021-22, and that NHS spending on branded medicines increased by over five per cent annually between 2018 and 2022. Cancer related treatments in particular have got more expensive: medicines for malignant disease and immunosuppression -

4. https://www.bmj.com/nhs-commission
5. House of Commons - Health - Third Report
6. NHS funding has to translate into improvements the public can see - The Health Foundation

including cancer drugs - accounted for around £900 million of the total medicines bill growth since 2018, a 43% rise in spending on this particular category of drugs.[7]

Maternity related services have also expanded greatly. Around 60% of births took place in NHS hospitals in the 1950s[8]; that figure today is close to 98%.[9] Alongside this has come wider availability of services like pre- and post-natal care, as well fertility treatment like IVF, which is available for women under the age of 42 if they meet certain criteria. (This a treatment, however, for which there is significant variation in availability across the country.)

Other services have been introduced to address the challenges and health risks associated with old age. These include everything from physiotherapy to palliative and end of life care. It is worth noting, however, that both physiotherapy and palliative care are examples of a mix of public and private provision.

Finally, in recent years, the NHS has greatly expanded its services related to mental health, including anxiety and depression, but also learning difficulties, autism and dementia. New treatments including prescription drugs, as well as counselling, psychological and behavioural therapy are available. These services have expanded rapidly in a short period of time; spending across mental health services amounted to about £15 billion in 2024/25, or 9% of all recurrent NHS spending. [10]

4. The central principles of a reformed healthcare system in the UK

Some advocates of radical NHS reform on the Right, as well as some detractors on the Left, speak of such a programme as the "privatisation of healthcare". As far as the programme of reform advocated in this paper is concerned, that massively misconstrues both the nature of the problem and the nature of our proposed solution. We do believe that a successful reform of the NHS will involve more use of the private sector and greater use of charging. But this will stop well short of wholesale privatisation. In particular, there will remain a large role for the state and the poor and vulnerable will be protected and generously treated.

In many ways, what we envisage is a real "mixed economy" solution for this vitally important part of the economy and society. This isn't because we wish to have some nice, cozy but wishy washy answer to the problems of healthcare. Rather, it is rooted in the very nature of healthcare and the functioning of markets and takes full cognisance of international experience with different healthcare systems.

The limits to the market

Let us begin at the beginning. Why can healthcare not be fully provided by the private sector without any involvement by government?

There are five main reasons:

7. Costs of expensive new drugs threaten financial sustainability of NHS while pharma industry lobbies for increase on medicines spending
8. BIRTHS AND MATERNITY BEDS IN ENGLAND AND WALES IN 1970 on JSTOR
9. Birth characteristics in England and Wales 2019.pdf
10. https://questions-statements.parliament.uk/written-statements/detail/2025-03-27/hcws562

- **Concern for the less well-off.** In a civilised society we cannot leave people to suffer and die because they cannot afford treatment that would ease their suffering and keep them alive.
- **The pooling of risk.** Serious illness or injury will happen to a proportion of society but in advance, generally we cannot be sure who the victims will be. Yet it is one of those events which, if it affects us, can consume most or even all of our financial resources. Rather like insuring your house against fire, it makes sense for societies to pool this risk, either through public provision or insurance. Without some involvement by government, insurance systems can malfunction, and without compulsion by the state, many individuals will fail to take out sufficient insurance.
- **Externalities.** Public health is a public good. Or at least some of it is. With regard to communicable diseases, we all have an interest in our fellow citizens being healthy because this enhances our own prospects of remaining healthy. (This does not apply to things such as heart disease, cancer or injuries.)
- **Myopia and misplaced optimism.** If all healthcare provision were left entirely to the market and paid for by individuals, many people would tend to under-spend on their own healthcare, both preventative and palliative.
- **Power imbalance.** When someone is seriously ill or injured they cannot be expected to shop around for better or cheaper offers in the way that market efficiency requires. There is a huge imbalance of knowledge and power between them and the medical professionals they come face to face with. Accordingly, without some form of surveillance there would be a tendency for medical professionals to earn huge sums, at the cost of the rest of the population.

Accordingly, even when the state was not directly involved in healthcare, there was a plethora of charities which provided health services either free or at subsidised rates. And doctors often treated the poor and indigent for little or no financial gain. But this did not satisfactorily cover everyone who needed care. As we noted above, the NHS was created to fill in the gaps left by this patchwork system.

Moreover, systems that rely for their funding of healthcare on an insurance model, do not normally operate a system of private insurance in the way that is true for car or house insurance. Rather, the system that they operate is often described as "social insurance". There is no hard and fast definition of such an arrangement, but we can usefully think of social insurance systems having five key characteristics, although any particular social insurance system would not necessarily have all five:

- Mandatory participation;
- Shared risks (as opposed to individual risk profiles which dominate private insurance);

- Not for profit (such as "sickness funds" that were first established in Germany);
- Employer and employee contributions;
- State support and regulation.

The problems of socialised healthcare

Yet a fully socialised healthcare system also has its problems and in almost all the world such a thing has never been attempted. There are good reasons for this. Although the founders of the NHS envisaged that, under their system, the best healthcare would be available to everybody regardless of cost, in practice this has not been true.

Indeed, it cannot be true. Resources are finite. It is possible to imagine a state of the world where a preventative treatment administered to every citizen would bankrupt the country. And short of that, there has always been the possibility that public money spent on health could have been better spent on education, housing or some other good cause.

Accordingly, there have always been some procedures, treatments and medicines that have not been available on the NHS. And even when such things are available, their quantity has been limited so that provision is effectively limited by queuing.

This opens up gaps for private provision to fill. People who are able to afford more expensive treatment, with or without insurance, have the option of going outside the NHS to private providers either in this country or abroad, usually the United States or Switzerland.

In practice, though, the bulk of the demand for private medical services does not come from this source. Indeed, it is common for identical operations and other procedures to be available on the NHS and privately, often delivered by the self-same health professionals. This outcome is reinforced by the fact that in the UK, a top private consultant will derive their prestige and experience mainly from their appointment as a consultant in the NHS.

The choice to go private is driven either by the expectation that a private hospital stay will be more comfortable and congenial than one in an NHS hospital, but usually it is about the availability of appointments when and where the patient wants, without being subject to long delays and/or cancellation.

A recent survey has laid bare the reasons for going private.[11] 41% of respondents cited NHS waiting times, 20% said that care was not available on the NHS, 19% said they wanted a higher quality of care, 17% wanted more flexibility and choice, while 11% cited a previous unsatisfactory experience with the NHS.

The result is that, against the wishes of the founders of the NHS, we have a two-tier system in this country. For the majority of people, the NHS provides all healthcare. A minority of people, however, who are generally more prosperous than the average, either have private insurance or can choose to buy private provision when the NHS equivalent is deemed to be not quite up to the mark in either quality or availability.

11. Barber, S., *Finder*, December 2024.

Different data sources give slightly different percentages of the population with private insurance cover but it is noteworthy that, as Table 1 shows, the percentage of the adult population with private insurance has increased markedly over the last few decades from only 1% in 1950 to an estimated 14% in 2025.

Table 1: The Proportion of UK adult population with private health insurance

Year	Proportion of Population (%)
1950	1
1970	2
1980	3
1990	6.5
2000	11.5
2008	12.4
2010	c. 11
2021	11.1
2025	14

For sources see footnote [12].

In 2024, a total of 4.68 million people were subscribed to private medical cover (health insurance) schemes in the UK. Once dependents are included, it means that 8.06 million people were able to make use of private medical cover.[13] This equates to coverage of 11.8% of the UK population – the highest since 2008 (12.3%).[14] The vast majority of coverage (approximately 80%) is from insurance schemes provided by employers.[15] The rest (approximately 20%) is paid for by individual households.[16]

The age cohort using private healthcare the most are those aged 18 to 24 (approximately 40%) with the second highest being those aged over the age of 65 (approximately 36%). The cohort with the lowest use was those aged 45 to 54 (approximately 25%).[17]

People in higher socio-economic grades are more likely to have made use of private healthcare with grade AB being the highest (approximately 50%) while grade DE being the lowest (approximately 19%).[18]

This may make it seem as though a fully socialised system could deliver the best service if only sufficient financial resources were devoted to it to make all treatments available and to eradicate delays. And this is indeed the implied conclusion of the frequent occurrence of funding crises in the NHS. Yet the system is riddled with inefficiencies. Most importantly,

12. Data for 1950, 1970, 1980, and 1990 is from Emmerson, C., Frayne, C., & Goodman, A., 'Should Private Medical Insurance be Subsidised?', *IFS*, 2001. Data for 2000 is from King, D., & Mossialos, E., 'The Determinants of Private Medical Insurance Prevalence in England, 1997-2000', *Health Services Research*, February 2005. Data for 2008 and 2010 is from Collinson, P., 'Private Health Insurance Sales Surge Amid NHS Crisis', *The Guardian*, January 2017. Data for 2021 is from LaingBuisson, 'Health Cover UK Market Report', June 2023. Data for 2025 is from FCA, 'Financial Lives Survey', May 2025
13. LaingBuisson, 'Health Cover UK Data Insights Report', January 2025
14. *Ibid*
15. *Ibid*
16. *Ibid*
17. Independent Healthcare Providers Network, 'Going Private', 2023
18. *Ibid*

financial crisis is the inevitable result of the collision between unconstrained demand and limited, tax-funded supply, free at the point of consumption.

So exclusively market provided healthcare does not work and there are major problems with socialised healthcare. The upshot is that pretty much everywhere in the world, healthcare systems are a mixture of public and private. The key lies with getting the mixture right. The proposals in this paper aim to alter the current mixture in the UK, giving more scope for market forces and reducing the burden on the taxpayer, while retaining a considerable role for the state.

An outline of our proposed solution

In the rest of this document, we discuss various proposals for the redesign of the NHS. The key characteristics of what we propose are outlined below.

The essential problem of the NHS lies with the funding model under which patients pay nothing towards their care and the costs are fully borne by taxpayers. This dichotomy is a driver of considerable inefficiency in the system. But a much more important consequence is the contribution of NHS funding to the overall level of taxation and hence to the disincentive effects of taxation for economic growth.

Many non-economists misunderstand this point. They say that in countries that use an insurance-based system rather than relying on finance from tax payments, the total costs to consumers are pretty much the same. (In fact, the international evidence on this, which we will review shortly, is mixed.)

Yet, even if this were true, the point is that insurance premiums do not create disincentives but higher tax rates do. Under an insurance system you cannot avoid paying the insurance premiums by working less and you do not pay more insurance if you work more and earn more money. But these effects are brought on by high marginal tax rates.

So the main part of a solution to our healthcare crisis lies with a replacement of a tax-funded system with one that relies on compulsory insurance, backed up with a publicly funded safety net to catch those who, for one reason or another, the insurance system does not cover, or at least does not cover adequately, decently and fairly.

But the evidence is that, on its own, such a system does not achieve the best results in regard to efficiency. To incentivise people to look after themselves more and not to overuse health services, some element of co-payment needs to be involved.

Which of the six founding principles behind the NHS would survive?

1. Universal
   The reformed system would continue to give universal coverage as now. No one would lose access to treatment because they could not afford it.

2. Equitable
   People would continue to be treated the same regardless of which income group they came from. But, as happens now, people who were prepared and able to pay for such things could get access to more comfortable hospital environments.

3. Comprehensive
   The system would provide for coverage across all sorts of needs for healthcare, as well as social care. (See the separate section below on reform of the Social Care system.) But even the current NHS diverges in this regard from the original vision behind the System when it was first established. Under our proposals, the NHS would be partly subdivided and some services provided mainly or wholly in the private sector, rather as happens now with chiropody and, increasingly, with dentistry.

4. High Quality
   The aim would be for the reformed system to provide a better quality of care on average than what is available on the NHS now. And the objective would be that waiting times would be radically reduced as market forces came more into play.

5. Free at the point of delivery
   This is where our proposed system would differ critically from the current set-up. Not that the current system is completely free in that charges are made for prescriptions and a significant part of the population opts to take some or all of their medical services from the private sector. But our system would see more charging for appointments, the payment of excesses on insurance policies and the end of exemption from prescription charges just because of old age.

6. Centrally funded
   This is the area of greatest difference between the current system and our proposals. There would be some central funding, notably to provide for the coverage of the poor and those whose health conditions meant that they would not ordinarily be covered by insurance companies. But the explicit objective would be to substantially reduce the amount of central funding of healthcare in order to be able to reduce taxation.

The details of our proposed reforms to the current system of healthcare are laid out in Section E.

5. The links with the system of social care

This paper is primarily about the system of healthcare in this country. But even though they have grown up separately, there are clear links between the system of healthcare and the system of social care and, accordingly, we must give the latter some consideration.

Social care and the problems associated with it were not seriously considered when the NHS was established for the simple reason that life expectancy was so much lower then. As it has increased in recent decades, the demand for social care has increased enormously.

The two systems do not interact at all well. For a start, the funding regimes for the two systems are radically different; universal tax-funded care for one and means-tested partial care for the other. And there is some logic behind the idea that the two systems should be put on a similar, if not identical, funding basis.

There are also important clinical links between the two systems. Often beds are taken up in hospitals because insufficient facilities are available in either residential care or in patients' homes to be able to discharge them. In the covid pandemic, the need for hospital beds saw large numbers of elderly people kept in care homes where the virus spread easily, with terrible results.

Accordingly, although it occupies only a minor part of our coverage in this study, in Section D we give separate attention to the problems – and their possible solutions – of the Social Care system.

B) The money spent versus healthcare delivered

6. The facts concerning how much is spent on the NHS as a % of GDP and of total government spending, and how this spending has changed over time

As Chart 1 shows, since 1955/56, government expenditure on healthcare has increased markedly in real terms, as a proportion of GDP, and as a proportion of total government spending. (Whenever possible, we use data for the UK as a whole. But healthcare is a devolved competence. There are instances when we do not have data for the whole of the UK and we rely on data for England, or we scale up figures for England into estimates for the UK as a whole.) Tables 2 and 3 show the relative magnitudes of different definitions of health spending across the UK's four nations and the UK as a whole.

Table 2: Government expenditure on health across UK regions (£ billions), 2023-24

Region	Current spend	Capital spend	Total spend
UK	210.9	12.1	223.1
England	176.7	10.4	187.1
Scotland	17.3	0.9	18.2
Wales	10.5	0.4	11.0
Northern Ireland	6.4	0.4	6.8

Source: IFS, Where and how does the government spend its money? This data shows identifiable expenditure, that is spending that can be linked to a specific region. These figures may not perfectly match figures given throughout the rest of the paper since some expenditure does not directly apply to a specific region and is thought to benefit the entire UK.

Table 3: Government expenditure on health across UK regions (% of UK GDP), 2023-24

Region	Current spend	Capital spend	Total spend
UK	7.69%	0.44%	8.13%
England	6.44%	0.38%	6.82%
Scotland	0.63%	0.03%	0.66%
Wales	0.38%	0.02%	0.40%
Northern Ireland	0.23%	0.02%	0.25%

Source: IFS. Where and how does the government spend its money? This data shows identifiable expenditure, that is spending that can be linked to a specific region. These figures may not perfectly match figures given throughout the rest of the paper since some expenditure does not directly apply to a specific region and is thought to benefit the entire UK.

Chart 1: Government expenditure on healthcare services in the UK (% of GDP and government spending), 1955/56 - 2022/23

Source: Institute for Fiscal Studies - IFS spending composition sheet.

From 1955/56 to 2022/23, government healthcare expenditure rose from £17 billion to £212 billion in constant 2022/23 prices, or from 3% to 8% of GDP. (The OECD and the ONS both report government health spending in 2023 and 2024 to be 9% of GDP.) [19]This is equivalent to a real terms increase of 1167%, averaging real growth of 4% each year. And on a per capita basis, annual government health spending has risen from £328 to £3118 in 2022/23 prices, an 851% real rise.

As Charts 3 and 4 show, the growth in spending on healthcare, both in aggregate and in per capita terms, has almost always exceeded the rate of inflation as measured by the CPI.

But there have been some major fluctuations in government spending on the NHS. Gordon Brown's 2002 Budget included a five-year investment programme for the NHS, funded by an increase in national insurance contributions. Representing the highest sustained funding increase in

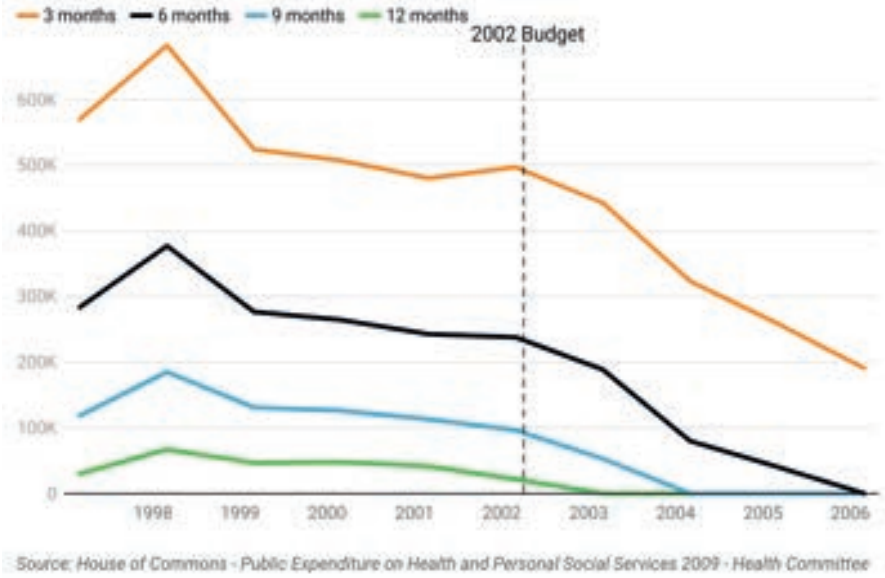
19. This discrepancy is likely to be the result of calendar/fiscal year differences and slightly different definitions.

NHS history, real UK government spending on health grew at an average annual rate of 8.7% from 2000/01 to 2004/05.[20]

Admittedly, some of this injection of cash financed a major increase in pay. In 2002/03, around 31% of the previous year's £5.2bn increase in health budget went towards pay increases intended to attract and retain staff.[21] (It is also worth noting that the Agenda for Change, the current NHS grading and pay system, was introduced in 2004 following the earlier increases to the NHS budget.)

But there is also a good deal of evidence that more spending led to improved NHS performance. Waiting lists fell profoundly, as is shown in Chart 2. Indeed, the number of in-patients waiting over 3 months fell by 62% from 2000 to 2006 while the number waiting over 6 months was reduced from 264,000 to just over 200 people over the same period.[22] There were also improvements in A&E waiting times, with the percentage of patients spending under 4 hours in A&E steadily increasing from 87% to 95% from 2003/04 to 2004/05.[23]

Chart 2: Number of in-patients waiting over 3, 6, 9 or 12 months in NHS England, 1997 - 2006



Source: House of Commons - Public Expenditure on Health and Personal Social Services 2009 - Health Committee

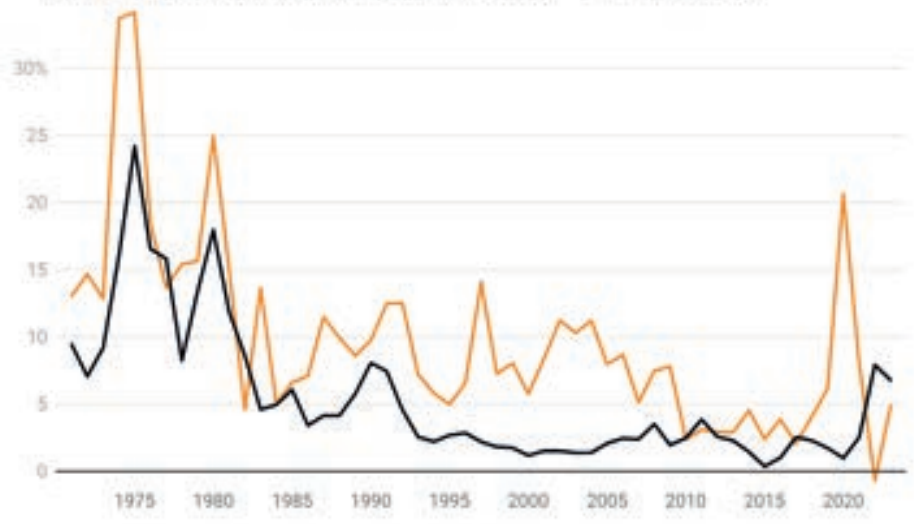
While additional spending enabled success in reducing waiting times, there were also productivity improvements which played their part. Broadly speaking, greater emphasis was placed on accountability and performance within the NHS, with the introduction of reforms such as 'Payment by Results' which paid health providers per patient treated, four-hour A&E targets, as well as performance-based measures and interventions for NHS trusts. The King's Fund also notes that a greater proportion of surgeries were undertaken as day cases after 2004 which saves money relative to keeping patients overnight.[24]

But this burst of much increased funding and improved performance did not last. By 2010 the effects of the Global Financial Crisis dominated

20. Stiebahl, S. (2024), NHS Expenditure, UK Parliament House of Commons Library, link
21. Arthur, C. (2003), One-third of NHS's extra Â£5.2bn spent on pay rises, link
22. House of Commons Health Committee (2010), Public Expenditure on Health and Personal Social Services 2009, link
23. UK Parliament (2005), Select Committee on Public Accounts Sixteenth Report, link
24. Murray, R. (2021), Lessons from the 2000s: the ambition to reduce waits must be matched with patience and realism, link

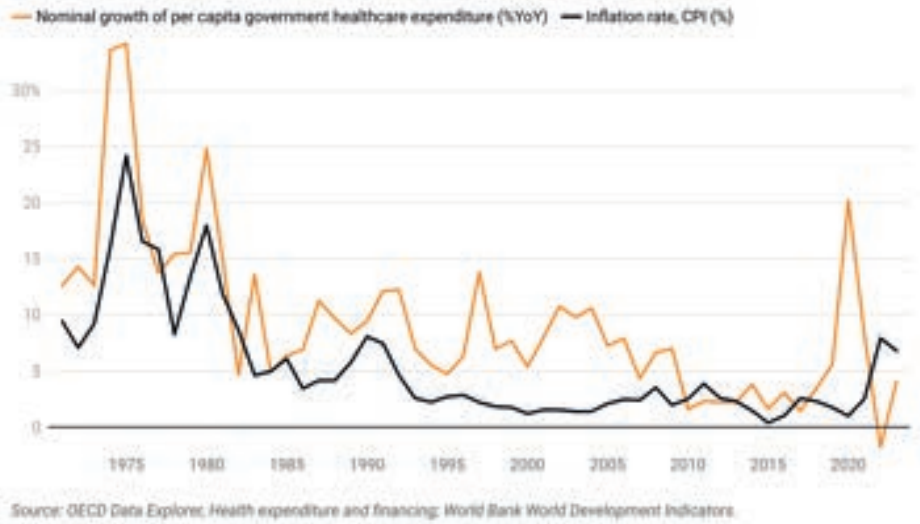
the public agenda and government spending had to be squeezed.

Chart 3: Growth in UK government healthcare expenditure and the rate of inflation, 1971 - 2023



Source: OECD Data Explorer, Health expenditure and financing; World Bank World Development Indicators.

Chart 4: Growth in UK per capita government healthcare expenditure and the rate of inflation, 1971 - 2023



Source: OECD Data Explorer, Health expenditure and financing; World Bank World Development Indicators.

Unsurprisingly, in recent years the biggest shock to government health spending has been the pandemic. In 2020/21, real health expenditure grew by over 25% from the previous year as the government injected huge sums of money into Test and Trace, additional health services, PPE and vaccines to fight Covid.[25]

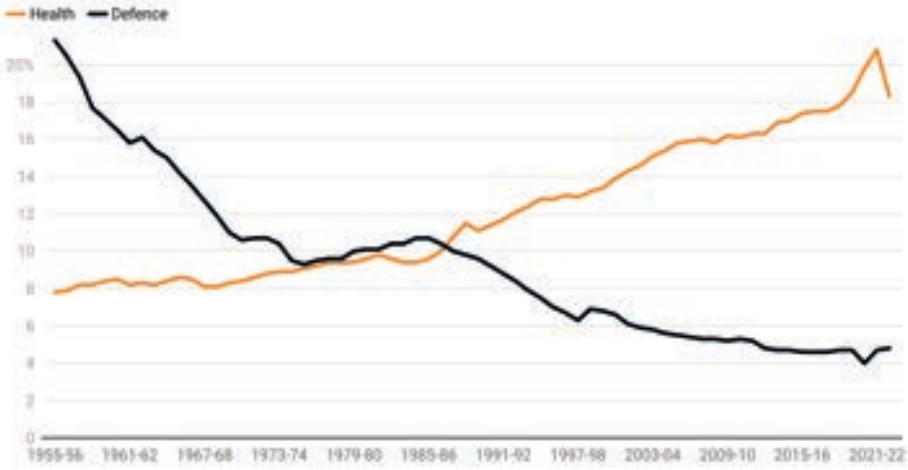
Health also now accounts for a much greater proportion of government expenditure. (See Chart 1.) For every £1 spent by the government, around 18p goes towards health; in 1955/56 this figure was 8p.

25. Stiebahl, S. (2024), NHS funding and expenditure, House of Commons Library, link

During the "austerity" years between 2010/11 and 2018/19, while overall government spending was under the cosh and taxes were increased, health spending grew in real terms by an average of 1.4% per annum. (This compares to an average of 6.5% in the previous 10 years.) This meant that, adjusting for the increase in population and the ageing of the population there was probably no real increase at all. Nevertheless, during this period, the share of health spending in total government spending increased from 16% to 18%.[26]

The largest relative reduction in public funding has come in the defence sector which, since 1955/56, has shrunk from 21% to 5% of total managed expenditure. (See Chart 5.) The drop off in public sector housebuilding and the privatisation of nationalised industries, among other things, have also paved the way for health spending to increase proportionately.[27]

Chart 5: Government expenditure on healthcare and defence in the UK (% of government spending), 1955/56 - 2022/23

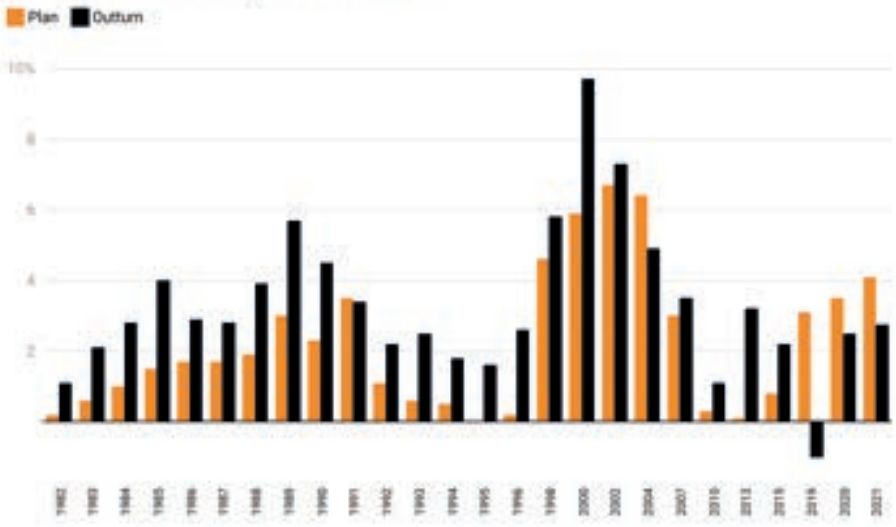


Source: IFS spending composition sheet

It is also worth noting that annual healthcare expenditure generally grows faster than planned spending, and often by a significant margin.[28] In the four decades before the pandemic, in real terms health spending in England grew on average by 1.4 percentage points more than had been planned. But in recent years this pattern has been reversed. The reason is that the budgets are fixed in nominal terms. Therefore, when inflation turns out to be higher than originally expected then spending growth is weaker, and can even turn negative, despite occasional top-ups. This is shown in Chart 6.

26. Johnson, P. (2023), Follow The Money
27. Ibid
28. Stoye, G. Warner, S. and Zaranko, B. (2024), The past and future of UK health spending, IFS, link

Chart 6: Average annual real-terms growth in health spending (%), planned and outturn, 1982 - 2021

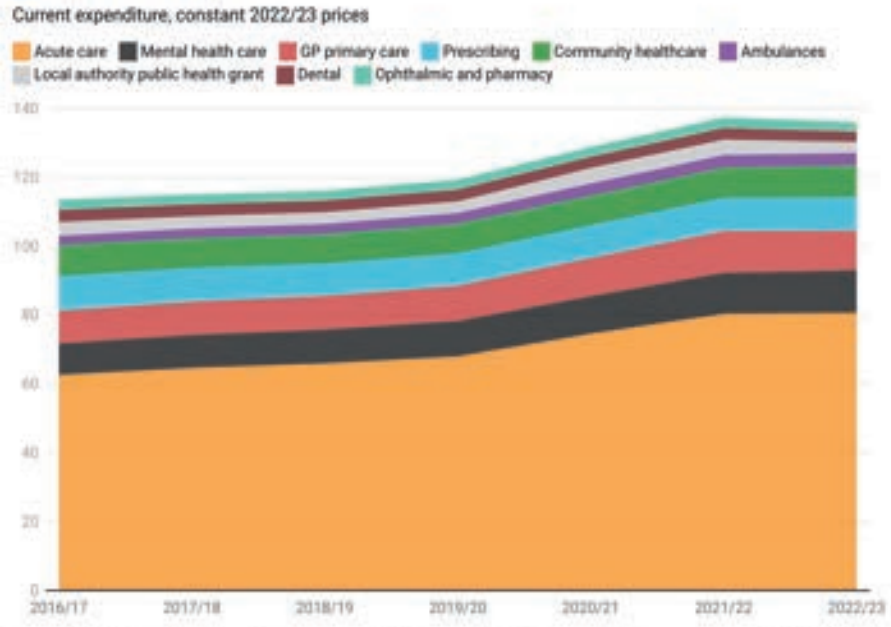


Source: Stoye, G. Warner, S. and Zaranko, B. (2024), The past and future of UK health spending, IFS. Since 1999, this only covers health spending in England. Excludes ringfenced COVID-19 funding in 2020-21 and 2021-22.

While we will later turn to the structural pressures which have caused, and are causing, these increases in health spending, for now we briefly turn to where this vast sum of money goes, before looking at some international comparisons on health expenditure.

A large proportion of UK health expenditure comes from the Department of Health and Social Care (DHSC), which spent £189 billion in 2023/24.[29] Chart 7 shows where much of this funding goes within the NHS system. From 2016/17 to 2022/23, real patient care funding increased by 20%.

Chart 7: Total funding by health care type within NHS England in £bn, 2016/17 - 2022/23

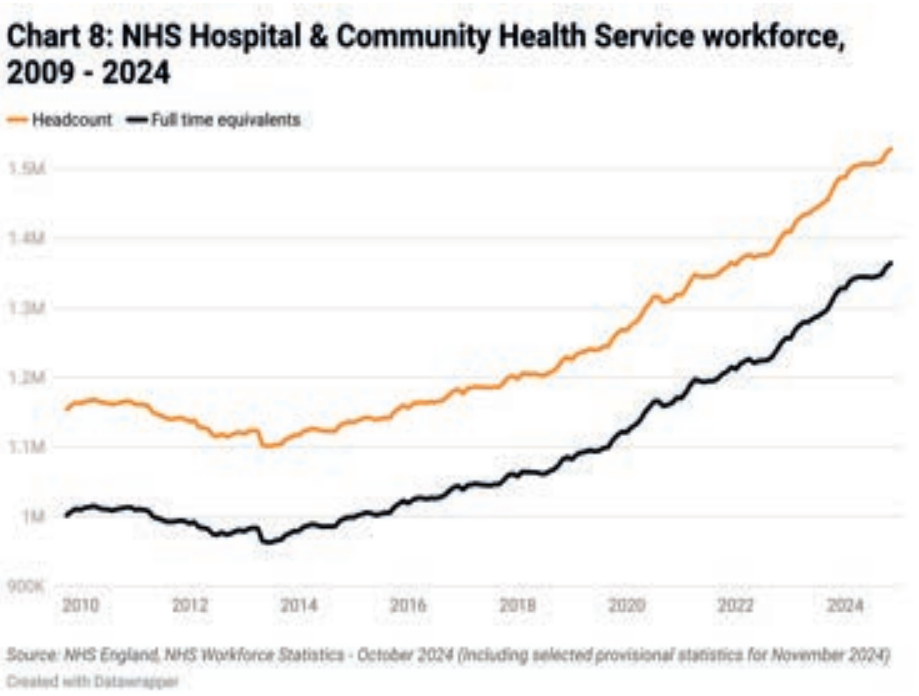


Source: Nuffield Trust, Where does the NHS money go?; HM Treasury, GDP deflators at market prices, and money GDP March 2024 (Quarterly National Accounts). This analysis covers about 90% of health care current funding.

29. The King's Fund (2024), Key facts and figures about the NHS, link

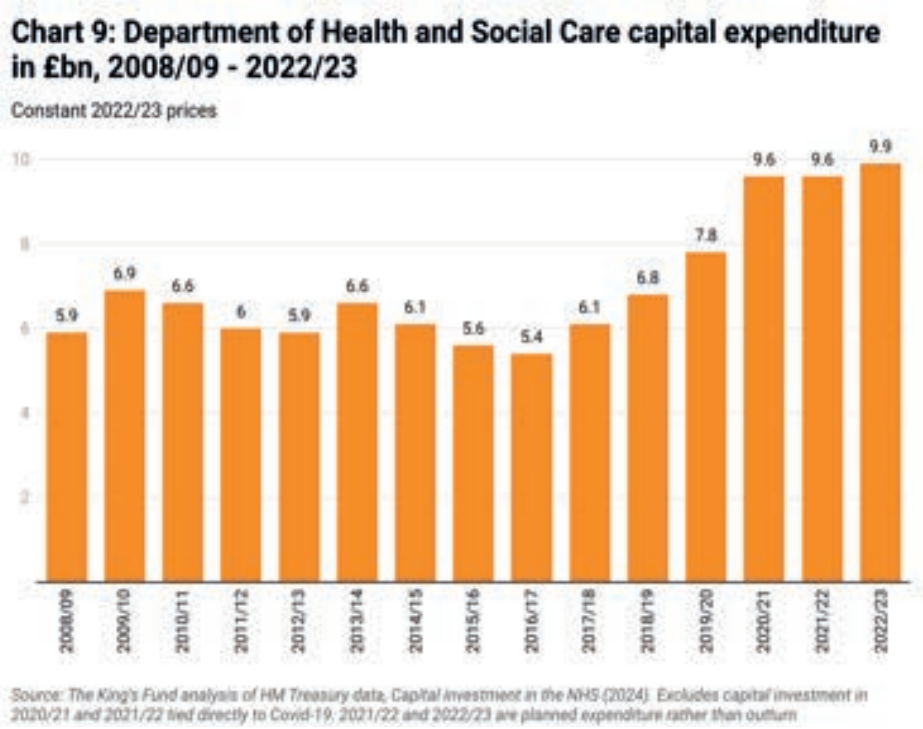
As shown in the chart, the majority of NHS current expenditure goes towards acute care. This is short-term emergency treatment which generally occurs within a hospital, plus elective or planned care. According to NHS data processed by Nuffield Trust,[30] in 2022/23, the NHS spent around £81bn, or almost 60% of its funding, on acute care. The next four largest spending categories were prescription costs, GP primary care, mental health services and community healthcare, which includes services such as end of life/palliative care as well as child health services. Each of these four categories cost the NHS an annual £9-10 billion.

A discussion of NHS costs would be incomplete without mentioning staff. Within each of the categories displayed in Chart 7 are vast numbers of practitioners, nurses, pharmacists and managers, to name but a few professions. Healthcare provision is extremely labour intensive. The NHS is one of the largest employers in the world, employing 1.38 million full-time equivalent members of staff as of February 2025. (See Chart 8.)[31] Despite these huge figures, it is widely reported that the NHS faces staff shortages.[32] Employees cost the NHS £71 billion in 2022/23, or 46% of its budget for current spending.[33]



Finally, one important element of DHSC expenditure to consider is capital spending. This is the money that goes towards new investments in equipment, buildings and development within the NHS which produce long-term benefits and cost savings. Chart 9 shows that this spending has been growing since 2016/17, and this was uplifted following the 2024 Autumn Budget.

30. Gainsbury, S. and Julian, S. (2024), Where does the NHS money go?, Nuffield Trust, link
31. NHS England (2025), NHS Workforce Statistics - October 2024 (Including selected provisional statistics for November 2024), link
32. Mallorie, S. (2024), Staff shortages: what's behind the headlines?, The King's Fund, link
33. The King's Fund (2024), Key facts and figures about the NHS, link. These figures exclude salaries for GPs since they are not employed directly by the NHS.



Capital investments will surely play an important role in helping to reduce the NHS maintenance backlog, the cost and severity of which has been growing since 2004/05.[34] Other notable areas of spend within the NHS include non-NHS provided health care, and expenditure on drugs.

7. A Comparison with spending in a range of countries, both now and historically: The US, Canada, Australia, France, Germany, Switzerland, the Netherlands, Singapore.

Naturally we look to other countries to determine whether we are unusual in our propensity towards immense, ever-increasing healthcare expenditure. In this study we have chosen a group of comparator countries across a wide range of sizes and global location: Australia, Canada, France, Germany, the Netherlands, Switzerland, the US and, whenever data availability permits, Singapore.

We also make some reference to a group of European countries which, like the UK, predominantly use taxes to finance their healthcare systems. These are : Denmark, Finland, Italy, Norway, Spain and Sweden.

As is often the case, international comparisons are made difficult by differences between national health systems in regard to how they operate and how they are financed. In the UK the NHS provides healthcare to all UK residents, free at the point of use and funded through general taxation.

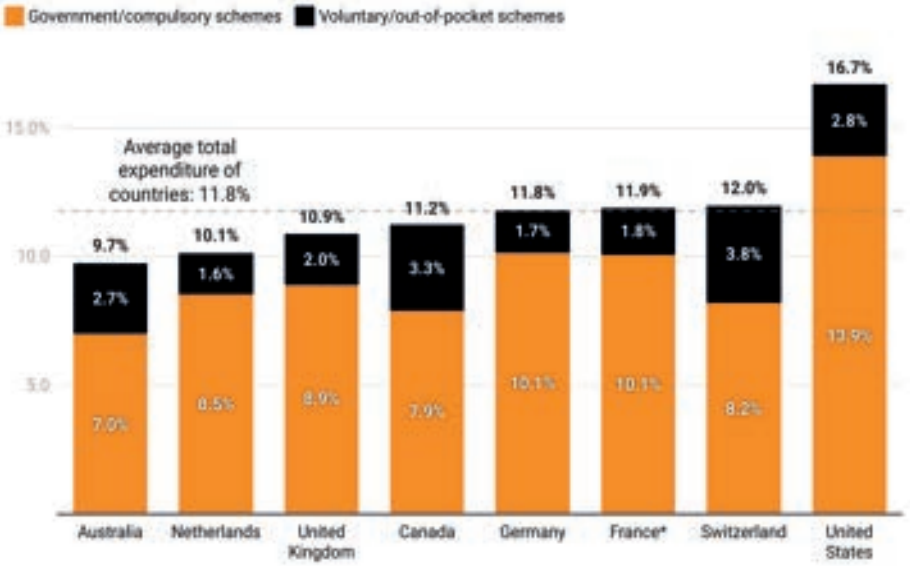
In the Netherlands and France, however, healthcare is partially funded through compulsory insurance schemes which are regulated by government. In the United States, provision comes from a mix of private and public services, private insurance, as well as voluntary, out-of-pocket

34. The King's Fund (2024), Capital investment in the NHS, link

payments.[35]

To account for this, the OECD collates data on government spending and compulsory insurance schemes within each country to give an idea of the extent to which public healthcare is a priority.[36] This data also uncovers the ratio of mandatorily funded healthcare to that which is voluntarily funded and often privately secured. Chart 10 shows a selection of countries and their healthcare expenditures as a proportion of national income in 2023, by financing scheme.[37] (The healthcare systems of most of the countries shown in Chart 10, plus Japan, are analysed and discussed in the Appendices.)

Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.

Of our selected countries, the United States spends the greatest proportion of its national income (13.9%) on government/compulsory insurance schemes. Research suggests that the US pays more for administrative activities and the costs of insurance, prescription drugs and the pay of health professionals.[38]

Germany and France represent the next two largest government/compulsory health spenders as a proportion of GDP, both spending just over 10% of GDP. Germany employs a decentralised system and mandates health insurance, via either public or private means, whereas France funds its system through employee and employer contributions and earmarked taxes.[39]

Out of our selected countries, Australia spent the lowest proportion (7%) of its GDP on government/compulsorily provided health. Since 1984, Australia has adopted a universal healthcare scheme called Medicare which provides free/low cost access to most health services to Australian and New Zealand citizens.[40] Medicare is funded through income taxes: a

35. Out-of-pocket expenditures are direct payments for health care goods and services from the household primary income or savings, including cost-sharing with government and compulsory insurance schemes. Voluntary scheme expenditure corresponds to voluntary private health insurance contributions, paid by both individuals and employers and Non-profit institutions serving households (NPISHs). In the analysis below we have combined these two categories to reflect total voluntary expenditure on healthcare across different countries.

36. OECD (2017), A System of Health Accounts 2011, link

37. The OECD provided figures do not line up perfectly with Chart 10 figures provided by IFS. This is probably the result of minor differences in definitions/methodologies and the usage of calendar/financial years. For the purposes of international comparisons, OECD data is preferred given consistent methodologies across countries.

38. Turner, A., Miller, G. and Lowry, E. (2023), High U.S. Health Care Spending: Where Is It All Going?, The Commonwealth Fund, link

39. European Health Observatory (2022), Germany: health system summary 2022, link; European Health Observatory (2022), France: Health system summary 2024, link

40. Australian Government Department of Health and Aged Care (2019), The Australian health system, link

levy which is 2% of taxable income and an additional surcharge applicable to those earning over a certain income threshold or those without "appropriate private hospital insurance" cover.[41]

Noticeably, Australian government/compulsory expenditure accounts for a comparatively low proportion of total economy-wide spend on health, at about 72% in 2023. This is also the case in Canada (70%) and Switzerland (69%), which are the countries with the second and third lowest government/compulsory spend as a % of GDP. This might suggest that, at least in our selected countries, lower government/compulsory expenditure does not necessarily mean lower *total* spend, just that it is more likely to come from out-of-pocket funding.

Chart 10 shows that the United Kingdom is just below the average of these countries in regard to government/compulsory expenditure on health, at about 9% of GDP. This has not always been the case.

Unsurprisingly, the UK's relative positioning on healthcare spending compared to our selected group of countries, as described above, also applies when compared to the OECD as a whole. The UK's public spending on healthcare of is about the OECD average for public/compulsory spending.[42] The UK's figure of around 11% of GDP when private insurance is also included is slightly higher than the OECD average.[43]

The importance of tax

The aggregation of government funded healthcare spending with compulsory contributory insurance schemes used in the above Chart 10 is thoroughly appropriate and useful for some purposes. But not all. For there is a big difference in the economic effects of a sum raised through compulsory insurance and the same sum raised through taxation. The former is about the closest economic systems come to a non-distorting tax in that, usually and in broad terms, you cannot easily avoid paying the charge and, as you get better off, you do not end up having to pay more.

One important qualification is that most systems subsidise the insurance premiums for the less well-off. So as a person moves up the income scale from the bottom rungs they end up paying more of their own insurance. This operates somewhat as tax systems do. But this is a relatively minor qualification, not least because the proportion of the insured who enjoy this subsidy is normally relatively small and it is a discrete transition, from not paying, or not paying fully, to full payment, across a relatively narrow range of income, rather than a situation where you pay a certain percentage of your income in insurance charges, with the absolute amount of the payment rising without limit, which is what happens with tax.

Exactly the same logic applies to charges and co-payments for medical services. The big distinction to draw is between insurance payments, charges and co-payments on the one hand and tax financed healthcare on the other. Quite apart from the efficiency of different sorts of health system, the differences in financing systems have profound economic consequences. The more a system relies on tax finance the greater the potential damage that it will create, imposing distortions and weakening

41. Australian Government (2025), Medicare and tax, link
42. Maddocks, J., 'Are other health systems more cost-effective than the NHS?', *NHS Confederation*, July 2024
43. ONS, 'Healthcare expenditure, UK health accounts: 2023 and 2024', April 2025

incentives throughout the economic system, thereby reducing GDP.

Interestingly, when the NHS was first established in 1948, this was hardly a consideration because the cost of the Service, and the accompanying burden on taxpayers, was so low. But now taxpayer funded healthcare in the UK consumes about 9% of GDP.

In this regard, Table 4 is extremely interesting.[44] It breaks down the spending totals shown in Chart 10 into different sorts of funding and adds in the group of European countries, which we identified earlier, that largely rely on government funding for healthcare care. It is striking that, apart from Sweden, the UK is far and away the most reliant on government funding at 9.1% of GDP. The other members of our European largely tax-financed group shown in the table spend a much lower percentage of their GDP on government-financed healthcare. France, the Netherlands and Germany are at 0.5%, 1% and 1.5% respectively.

Now it can be argued that there is not a direct carryover from spending a large proportion of GDP on tax funded healthcare and having a high taxi-take. But most of the countries in this table do have a lower tax take than the UK. And that is without making reference to Singapore where publicly funded healthcare is minimal and the tax-take is low.

Cleary, if a UK government wanted to move to a low tax system, the fact that the NHS is a tax funded system is going to make the achievement of a low tax environment extremely difficult. What's more, the problem is set to intensify due to demographic and technological pressures.

To put the matter the other way round, if a British government was determined to move to a system with a lower tax-take it would do well to start with moving away from the current, predominantly tax-funded healthcare system towards the blended model common elsewhere, which typically places much lower demands on the public purse.

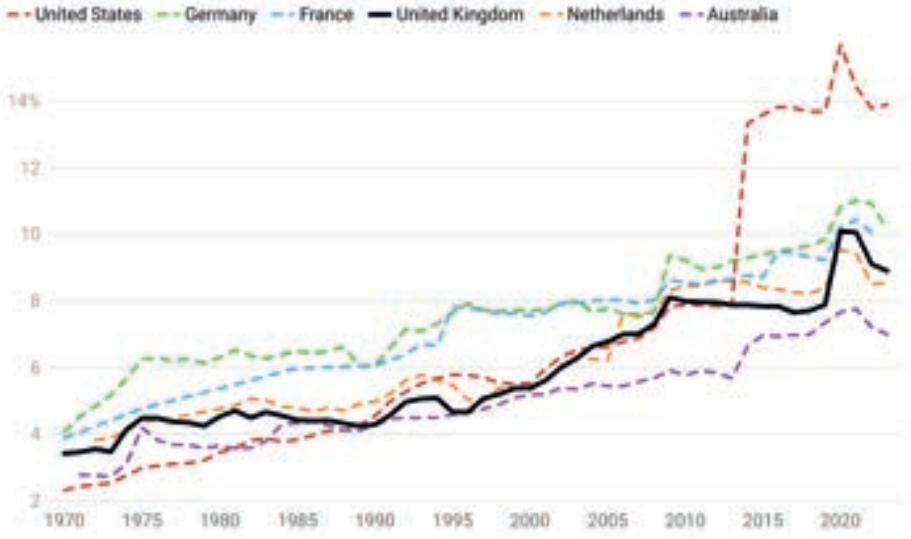
44. The following figures, as well as the figures in Table 4, refer to 2022 since this is the latest year that data is available for all the countries shown in Table 4. Accordingly, there may be some discrepancies between the figures shown here and those used throughout the rest of this paper.

Table 4: Health expenditure by financing scheme in a selection of countries (% of GDP), 2022

Country	Government schemes	Compulsory contributory health insurance schemes	Voluntary health care payment schemes	Household out-of-pocket payments	Unknown	Total
Australia	7.1%	0.1%	1.2%	1.5%		9.9%
Canada	7.7%	0.1%	1.6%	1.7%		11.1%
Denmark	8.0%	-	0.2%	1.2%		9.5%
Finland	6.5%	1.3%	0.4%	1.6%		9.7%
France	0.5%	9.5%	0.7%	1.1%		11.8%
Germany	1.5%	9.3%	0.4%	1.3%		12.4%
Italy	6.5%	0.0%	0.3%	2.1%		8.9%
Japan	1.8%	8.8%	0.3%	1.4%		12.3%
Netherlands	1.0%	7.3%	0.5%	1.2%		10.0%
Norway	6.8%	-	0.0%	1.1%		7.9%
Spain	6.7%	0.4%	0.6%	2.0%		9.7%
Sweden	9.4%	-	0.1%	1.4%		10.9%
Switzerland	2.9%	5.0%	1.0%	2.5%	0.2%	11.6%
United Kingdom	9.0%	-	0.5%	1.6%		11.1%
United States	5.0%	8.9%	0.9%	1.8%		16.5%

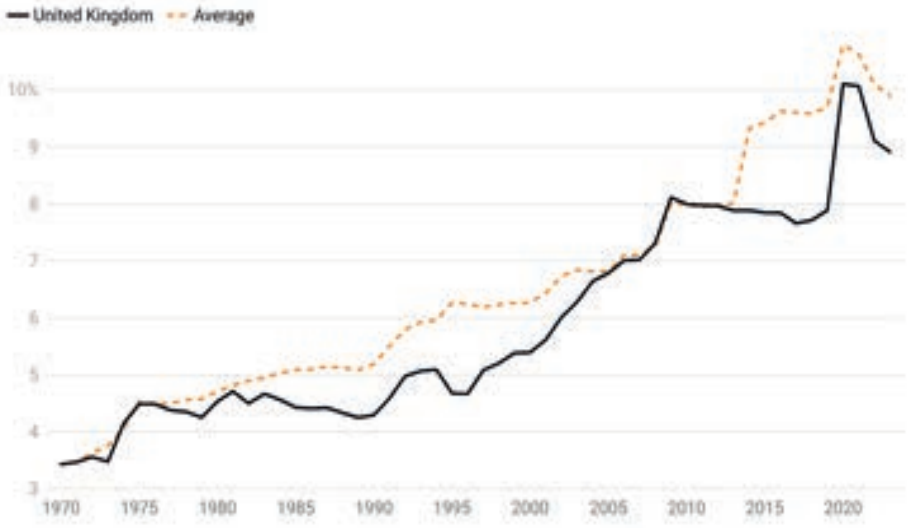
Source: OECD Data Explorer, Health expenditure and financing

Chart 11: Government/compulsory health scheme expenditure in selected countries (% of GDP), 1970 - 2023



Source: OECD Data Explorer, Health expenditure and financing. Data has been imputed over periods of missing data for France and Germany.

Chart 12: Government/compulsory health scheme expenditure in the United Kingdom compared to the average of our selected countries (% of GDP), 1970 - 2023



Source: OECD Data Explorer, Health expenditure and financing. Our selected countries are United States, Germany, France, Netherlands and Australia

Charts 11 and 12 show the change in government/compulsory health spend as a proportion of GDP over time in our selected countries. Since 1970, health expenditure has increased as a proportion of GDP in all countries. (See Chart 11.) Chart 12 shows that since 1970, the United Kingdom has often spent a lower proportion of national income on healthcare relative to the average of our selected countries. While there have been brief periods when we have caught up to the average (1975 and 2008), generally we have fallen short by 0.5 to 1.5% of GDP.

A very different picture for per capita spending

The percentage of GDP spent on healthcare gives a telling picture but this is not the be-all and end-all for comparing different countries. Table 5, by contrast, shows the spending on healthcare *per capita* by various countries. The UK comes out with the lowest spending per capita. The reason is simply that in this group of countries the UK has the lowest productivity per capita across the economy. Per unit of output, the UK has more people and less productivity per person.

This comparison seems to make the UK system appear to be good value and suggests, perhaps, that the UK's poor health outcomes (to be discussed later) are due to inadequate spending. Yet this would be a dangerous conclusion to reach. A similar comparison of expenditure on defence would show UK spending per capita much lower than other comparable countries relative to a comparison based solely on overall GDP. This would not be a good basis for assessing the adequacy of UK defence spending.

There are plenty of countries in the world with much lower per capita GDPs than the UK. If they also spend much less per capita on healthcare than we do (as would be true for most of them) it would be unwise to

conclude they should radically increase the amount of healthcare spending simply on the basis of these metrics. Spending on healthcare must be considered with regard to the overall economic health and performance of a country. We cannot magic better economic performance out of thin air. The share of GDP taken up by healthcare spending, rather than the amount of healthcare spending per capita, is a reasonable measure of the strain put on the economy by the financing of the health system.

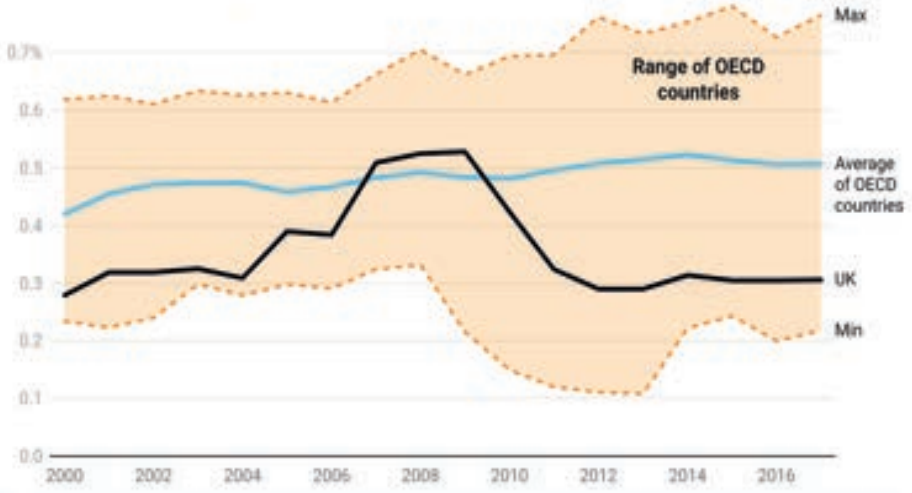
Table 5: Per Capita Health Spending in various countries in 2022, US $ in constant 2015 prices, converted at Purchasing Power Parity (PPP) exchange rates.

	Government schemes	Compulsory contributory health insurance schemes	Voluntary schemes	Household out-of-pocket payments	Unknown	Total spend per person	Health spend (% of GDP)
Australia	4,021	59	678	858		5,616	9.9
Canada	3,795	73	757	807		5,432	11.2
France	221	4,129	326	458		5,133	11.9
Germany	749	4,791	166	686		6,392	12.6
Netherlands	509	3,995	307	536		5,348	10.1
Switzerland	1,811	3,129	610	1,557	106	7,214	11.7
United Kingdom	**3,729**	-	**194**	**601**		**4,524**	**11.1**
United States	3,178	5,709	567	1,180		10,635	16.5

Capital spending

One final comparison of interest is the relative expenditure on capital spending items. This should give an indication of the extent to which countries are making long-term investments in their health systems. As shown in Chart 13, the UK performs poorly on this front.

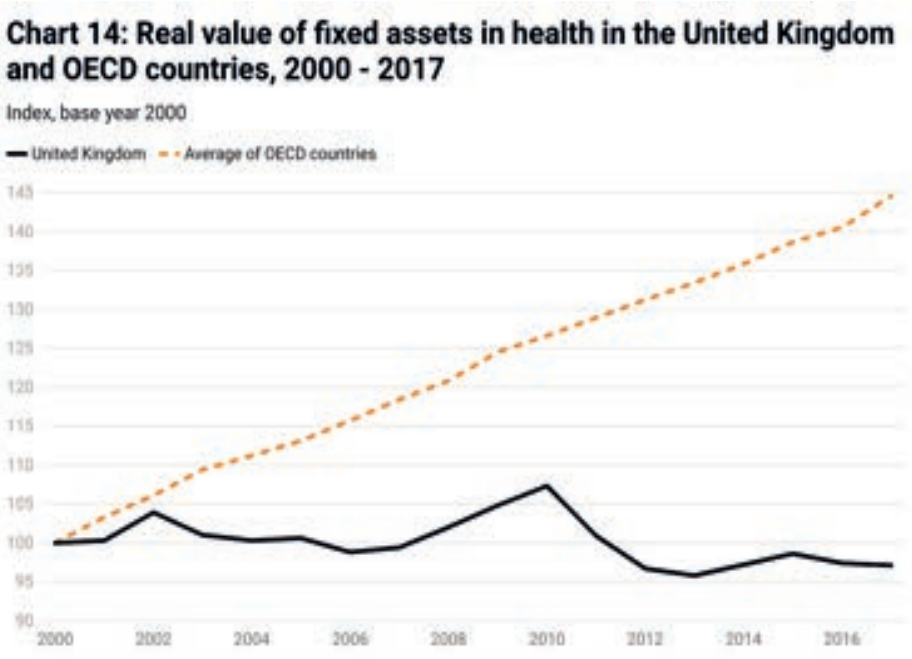
Chart 13: Gross fixed capital formation in the health care system in the United Kingdom (% of GDP), 2000 - 2017



Source: OECD data processed by: The Health Foundation, International comparisons of capital in health care: why is the UK falling behind? The OECD countries include: Austria, Canada, Denmark, Finland, France, Greece, Ireland, Norway, Sweden and United States.

As a proportion of GDP, the UK spends around 0.3% on capital expenditure for healthcare, whereas the figure for the average of a range of OECD countries stands at around 0.5%. Although these figures may seem relatively small, it has been shown that while the value of healthcare capital has risen in most European countries, in the UK is has decreased over the period 2000 to 2017. (See Chart 14.)

Chart 14: Real value of fixed assets in health in the United Kingdom and OECD countries, 2000 - 2017



Source: Eurostat data processed by: The Health Foundation, International comparisons of capital in health care: why is the UK falling behind? The average line is the mean of results from the following countries: Belgium, Czech Republic, Denmark, Greece, France, Italy, Netherlands, Austria, Slovak Republic, Finland, Sweden, Norway.

8. Health outcomes in the UK and their trends over time

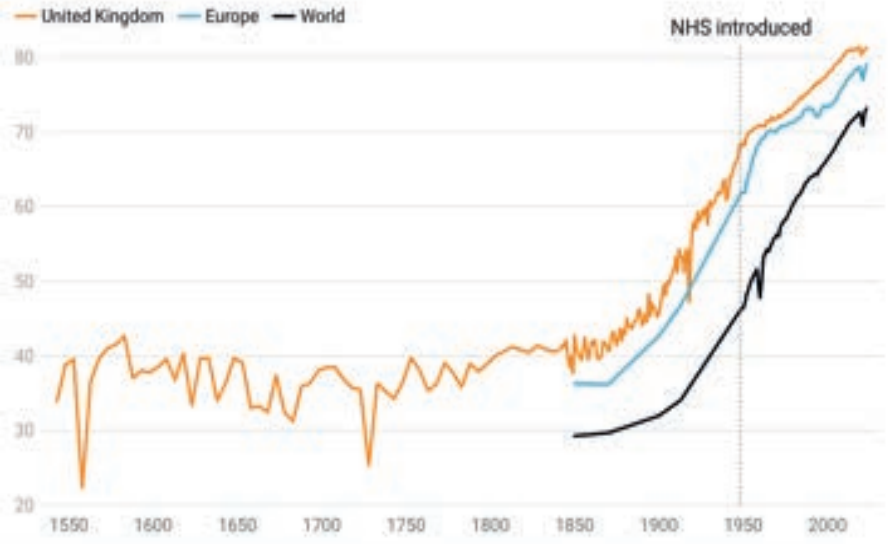
Are we getting value for the enormous amount of money that goes into our healthcare system? When analysing our performance on health outcomes, there are countless measures that we could choose from. In this section we will consider some of the broader metrics of health before looking more specifically at problems faced by our healthcare system.[45]

There is no doubt that during the NHS era – from 1948 to the present – the health of the UK population has improved dramatically. On this metric, the NHS ranks as a stonking success. Nevertheless, since the advances of medical science are largely responsible for these improvements, we should expect them to have been experienced pretty much across the world, or at least the developed world. Accordingly, the performance of our healthcare system should be assessed by comparison to the performance of the healthcare systems of other countries. We will turn to this shortly. But first we should review what has happened in the UK.

There are, of course, plenty of determinants of the following health measures which are not directly linked to the performance of a country's healthcare system (e.g. education levels, income, pollution/environmental factors). But we should start our analysis by reviewing the most important health outcomes.

Life expectancy seems a natural place to begin. Chart 15 shows that, commencing in about 1900, across the world there has been a profound increase in the expected lifetime of a newborn. In 2023, life expectancy in the UK stood at 81.3, compared to 45.6 in 1900. Major improvements in maternal care quality which have reduced the number of infant deaths are a big factor in explaining this development.[46]

Chart 15: Life expectancy at birth in the United Kingdom, Europe and the world, 1543 - 2023



Source: UN WPP (2024), HMD (2024), Zijdeman et al. (2015), Riley (2005) – with minor processing by Our World in Data. Data has been imputed for Europe and the World for the periods 1851-1869, 1871-1899, 1901-1912 and 1913-1949.

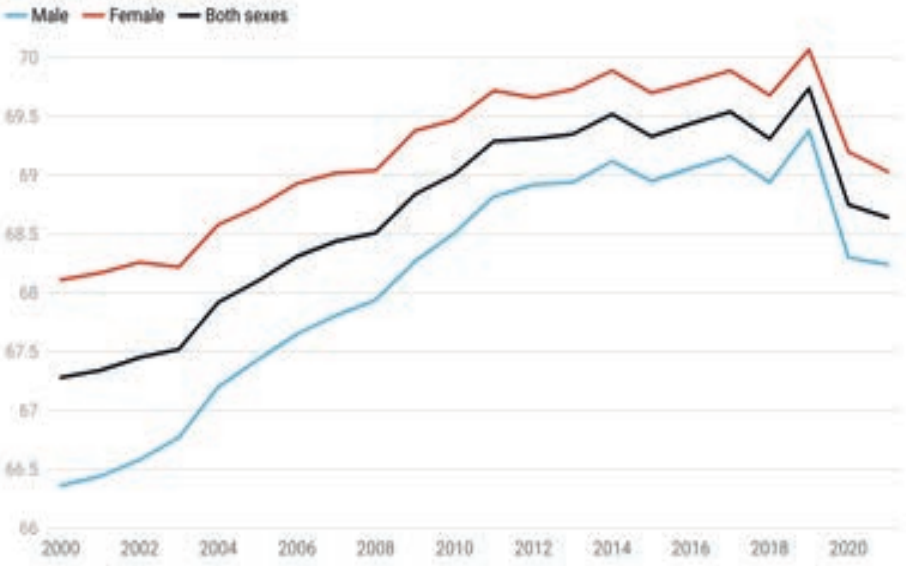
45. While we focus on the UK in its entirety where possible, health is a devolved competence. Accordingly, much of the data here pertains specifically to England given its relative population size and the percentage of healthcare spending.

46. Office for National Statistics (2015), How has life expectancy changed over time?, link

Perhaps a more useful metric to consider, however, is *healthy life expectancy* (HLE). This is defined as the number of years one can expect to live in 'full health'.[47] From a policy perspective, the aim should not necessarily be to prolong life for those in poor health, but rather to maximise the time in our lives spent in good health.

Chart 16 shows that since 2000, healthy life expectancy in the UK increased from 67.3 to a peak of 69.7 in 2019. As a result of the pandemic, this dropped to 68.6 in 2021 which is the latest year available from the World Health Organization. The latest data from the ONS would suggest that we are still suffering from the effects of the pandemic, as we are yet to return to pre-pandemic levels of HLE.[48] HLE also varies across regions, with England higher than Wales and Northern Ireland. HLE at age 65 is also higher in the South and East of England than in the North.[49]

Chart 16: Healthy life expectancy at birth in the United Kingdom (years), 2000 - 2021



Source: World Health Organisation, Healthy life expectancy (HALE) at birth (years). Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

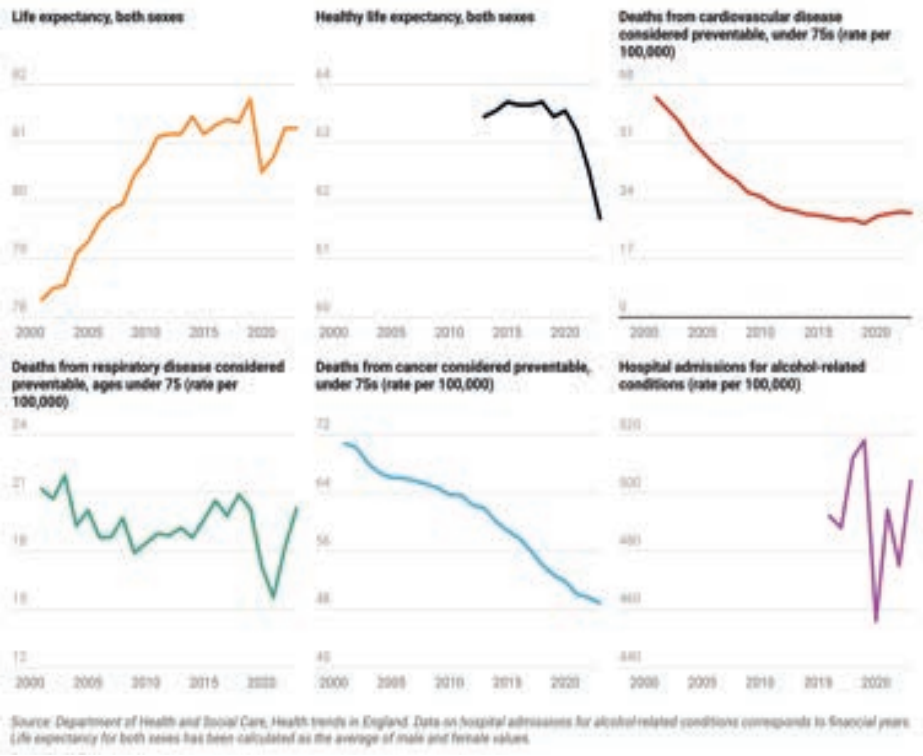
The Department of Health and Social Care publishes data on a variety of health indicators covering England, which are displayed in Charts 17 and 18.

Since 2000 there have been improvements in preventable death rates from cardiovascular disease (CVD), cancer and, to a lesser extent, respiratory disease. Life expectancy has risen by about 3 years over this period, although this improvement seems to be slowing, a trend which is consistent across Western democracies.[50] Healthy life expectancy has decreased by almost 2 years since 2015 according to this data, which can probably be largely attributed to the pandemic.

47. World Health Organization (2025), Healthy life expectancy (HLE) at birth (years), link
48. ONS data gives somewhat lower figures for HLE, likely due to methodological differences. In this analysis, we use data from the WHO for consistency for our next section on international comparisons.

    Office for National Statistics (2024), Healthy state life expectancy, all ages, UK, link
49. Government Actuary's Department (2024), Healthy life expectancy - Mortality Insights, link
50. Youtube (2024), Summit 2024 session: Future patterns of disease and health care, Nuffield Trust, link

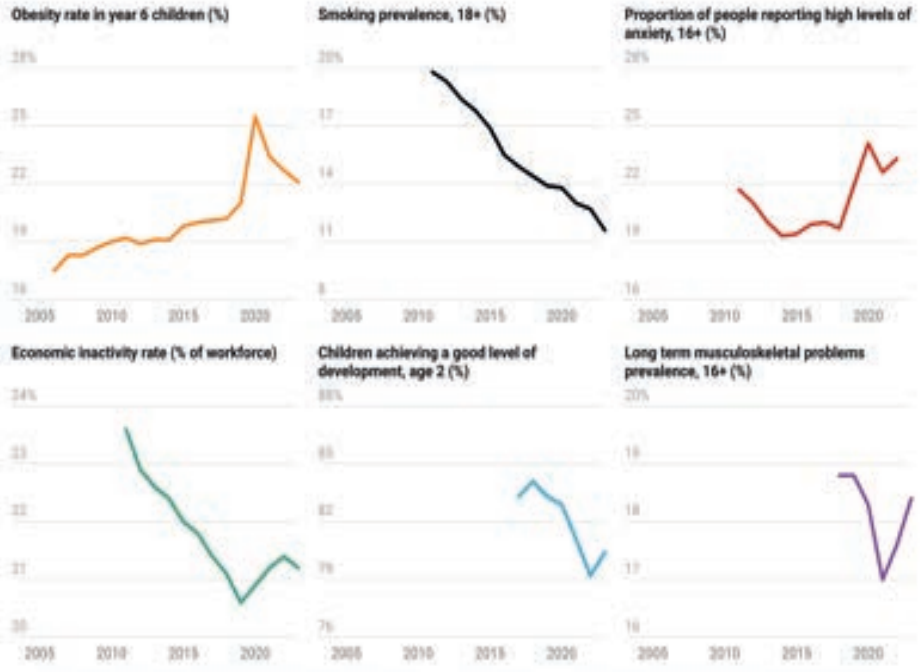
Chart 17: Health trends in England across a range of metrics, 2001 - 2023



Source: Department of Health and Social Care, Health trends in England. Data on hospital admissions for alcohol-related conditions corresponds to financial years. Life expectancy for both sexes has been calculated as the average of male and female values.

Chart 18 shows decreases in the prevalence of smoking as well as the economic inactivity rate since 2010, although it should be noted that the number of *sickness-induced* economically inactive people has dramatically increased in recent years, as we will show later. Obesity rates of children in year 6 have increased from just under 18% in 2006 to 22% in 2023, while the proportion of those aged over 16 reporting high levels of anxiety has increased from 19% in 2014 to 23% in 2023. What these indicators present is a mix of positive and negative developments across various health outcomes in England.

Chart 18: Further health trends in England across a range of metrics, 2006 - 2023



Source: Department of Health and Social Care, Health trends in England. For charts on obesity, anxiety, economic inactivity, and child development, data corresponds to financial years.

Avoidable mortality rates present a fundamental measure of outcomes because if healthcare systems are timely and effective, premature deaths should be a rarity.[51] Avoidable mortality is made up of deaths from *preventable* causes (deaths which are possible to avoid through effective public health/primary prevention interventions, *before* the onset of disease) and *treatable* causes (deaths which are avoidable with timely and effective healthcare interventions, *after* the onset of disease) applicable to those under the age of 75. The leading cause of avoidable mortality in England and Wales is neoplasms (cancers), despite reductions in the rate since 2001.[52]

In England and Wales in 2023, 22% of all deaths were considered avoidable.[53] Chart 19 shows a roughly 30% decrease in avoidable mortality and a 20% decrease in preventable mortality since 2001. As is a common trend throughout many health outcomes, there is a worsening in avoidable mortality from 2020.

51. Office for National Statistics (2022), Avoidable mortality in the UK QMI, link
52. Office for National Statistics (2024), Avoidable mortality in England and Wales: 2021 and 2022, link
53. Ibid

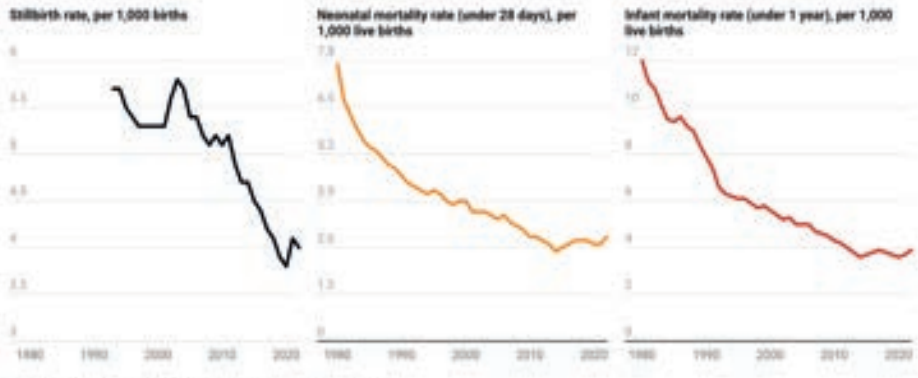
Chart 19: Avoidable and preventable mortality in England and Wales, 2001 - 2023

Source: ONS, Avoidable mortality in England and Wales.

In 2024, the King's Fund raised serious concerns about the fact that avoidable mortality has not yet returned to pre-pandemic levels.[54] It pointed out that preventable mortality is highest in more deprived areas like Blackpool, Liverpool and Manchester, and that avoidable mortality has recently been increasing in young cohorts, while alcohol/drug related deaths have also been on the rise.

Stillbirth, neonatal and infant mortality rates are often used to measure the quality and safety of healthcare and maternal services, though it should be noted that they can also be affected by social, economic and environmental factors.[55] Since 1980, there has been a marked reduction in each of these metrics in England and Wales. Neonatal and infant mortality rates have decreased by 62% and 68% respectively since 1980, while the stillbirth rate is down 30% since 1993. (See Chart 20.)[56]

Chart 20: Stillbirth, neonatal and infant mortality rates in England and Wales, 1980 - 2022



Source: ONS, Child mortality (death cohort) statistics in England and Wales.

However, rates of improvement have recently slowed and there have even been increases in mortality rates since 2014 for neonatal and infant

54. The King's Fund (2024), The King's Fund responds to the latest ONS statistics on avoidable mortality in England and Wales, link
55. Nuffield Trust (2024), Stillbirths and neonatal and infant mortality, link
56. Stillbirth figures start in 1993 due to a change in definition in 1992.

mortality rates, with stillbirth rates also up from both 2019 and 2020. The Nuffield Trust notes that given most stillbirths are unexplained, it is difficult to identify the precise reason behind these increases, although the pandemic did cause some disruption to maternal services which could be a factor.[57]

Improvements surrounding drugs, treatments and lifestyles have led to developments regarding which diseases are the deadliest to us. The leading causes of death in England and Wales are shown in Table 6.

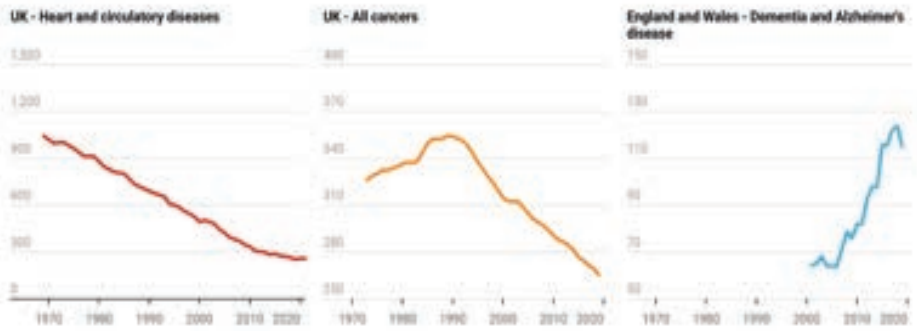
Table 6: Leading causes of death in England and Wales, 2023

Cause of death	Number of deaths	Percentage of all deaths
Dementia and Alzheimers disease	66,876	11.6%
Ischaemic heart diseases	57,895	10.0%
Chronic lower respiratory diseases	32,106	5.5%
Cerebrovascular diseases	29,474	5.1%
Malignant neoplasm (tumor) of trachea, bronchus and lung	27,923	4.8%
Influenza and pneumonia	24,240	4.2%

Source: ONS, Deaths registered in England and Wales: 2023. Cerebrovascular disease is a term for conditions that affect blood flow to the brain.

Broadly speaking, mortality rates in the UK for the three main disease groups (circulatory diseases, respiratory diseases and cancer) have been decreasing since before 2000, as shown in Chart 21, which has contributed towards our increasing life expectancy. As a result of people living longer and avoiding other illnesses, the number of deaths caused by dementia has been increasing dramatically, with mortality rates up almost 80% from 2001 to 2019. It is now the leading cause of death in England and Wales (11.6% of all deaths).

Chart 21: Mortality rates of different diseases in the United Kingdom per 100,000 persons, 1969 - 2021



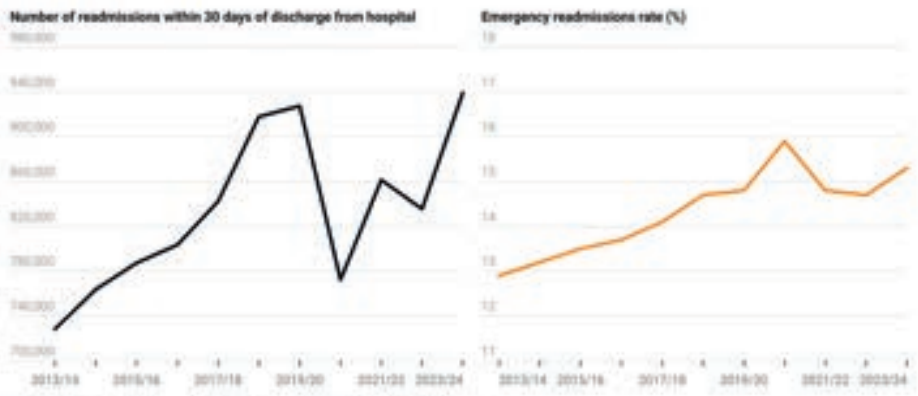
57. Ibid

The rate of patients being readmitted following discharge from hospital presents a potential marker for the quality of patient outcomes. The responsibility for discharged patients can fall on a range of agents from those in primary care (GPs and pharmacies) to providers of community and social care, which can often be a source of confusion for patients, to whom it is unclear who they need to contact.

In 2023, Policy Exchange investigated the relationship between primary and secondary care, estimating that at least 15 million GP appointments each year are dedicated exclusively to managing issues resulting from a breakdown of this relationship.[58] The actions taken by those responsible for discharged patients can have a direct influence on the likelihood of readmission. Poor medicine management often stems from a breakdown of communication between agents and can lead to patients being given incorrect prescriptions causing them greater harm.

Chart 22 shows that both the number and rate of re-admissions in NHS England has generally been increasing since 2013/14. However, there are complications when trying to interpret these results. While some re-admissions may be caused by avoidable actions, others may be unrelated. It could also be that the increasing rate shown below is simply a result of our ageing population rather than failures within the NHS.[59]

Chart 22: Number and rate of readmissions following discharge across NHS providers, 2013/14 - 2023/24

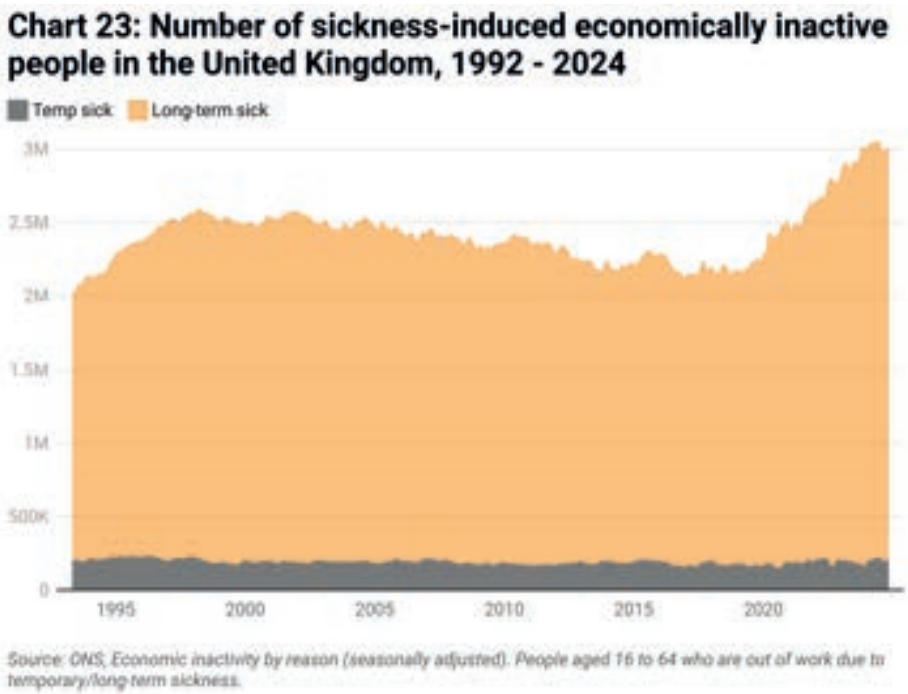


Perhaps the most obvious economic impact of nationwide health deficiencies is seen in the number of economically inactive members of the workforce. While poor health leads to more days taken off work due to common illnesses, one area of particular concern for the UK surrounds the number of *long-term* economically inactive working-age citizens. Recent rises in this figure have been attributed to increases in the number of people with long-term illnesses.[60]

In the three months to November 2024, 9.3 million people aged 16-64 were economically inactive.[61] Of this figure, some 2.8 million (30%) were considered to have a long-term sickness. This figure peaked at around 2.9 million in the three months to November 2023, having increased 35%

58. Landau, D. and Phillips, S. (2023), Medical Evolution, link
59. Nuffield Trust (2022), Emergency readmissions, link
60. It is worth noting that there are reliability issues surrounding this data following low response rates in recent years.
61. Office for National Statistics (2025), INAC01 SA: Economic inactivity by reason (seasonally adjusted), link

from the end of 2019. (See Chart 23.)



There have been a variety of suggestions as to what has caused this worsening of health within the working-age population. Long COVID and long waiting lists for treatments are probably contributing factors, while there is also a notably high proportion of sickness-induced economically inactive people aged between 50 and 64 which might suggest that our ageing population is a potential factor.

Critically, secure employment in itself is a determinant of health outcomes, which can mean that once out of work, people can find it harder to return to the workforce.[62]

Another area of concern is the acute rise in the prevalence of common mental disorders (CMDs) across the UK, pertaining particularly to the younger generation. In 2023, roughly one in five young people aged 8 to 25 had a probable mental disorder.[63] There has been an upward trend across various CMDs, particularly anxiety and depression, as is shown in Charts 24 and 25. This is reflected in the demand for mental health services; the number of young people accessing mental health services has increased by 42% from March 2021 to the end of 2024, while the number of adults accessing community mental health services has increased by 29% from December 2021 to December 2024.[64]

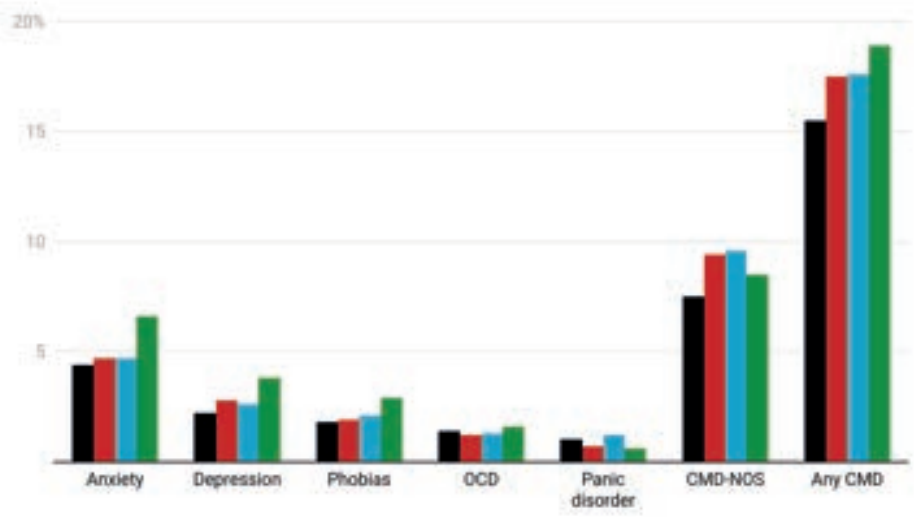
62. Public Health England (2019), Health matters: health and work, link

63. NHS England (2023), Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey, link

64. These figures are likely influenced by the pandemic. NHS England (2025), Mental Health Services Monthly Statistics Dashboard, link

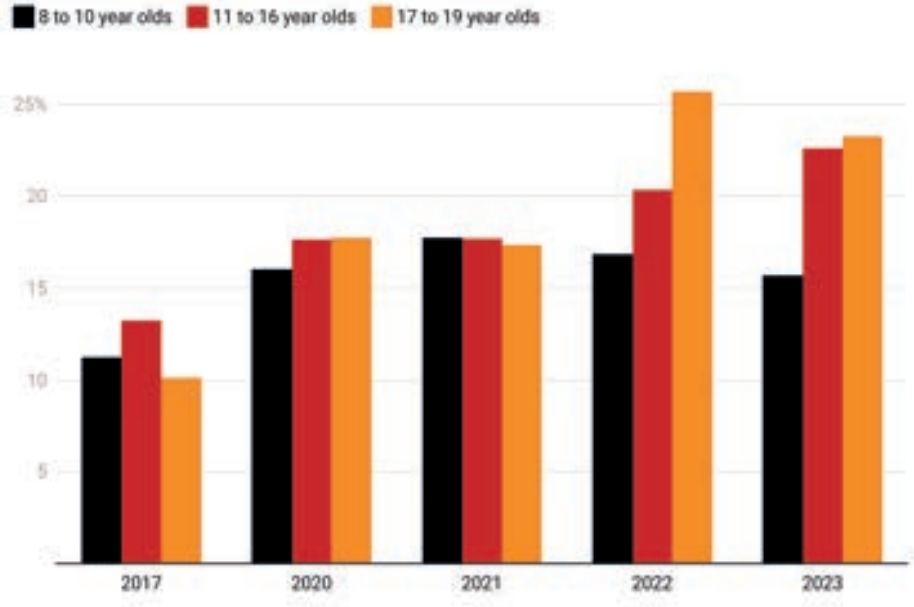
Chart 24: Prevalence of common mental disorders (CMDs) amongst adults in England (%), 1993 - 2014

Percentage of surveyed adults who had experienced CMD in the past week



Source: NHS England, Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

Chart 25: Proportion of young people in England with a probable mental disorder, 2017 - 2023



Source: NHS England, Mental Health of Children and Young People in England 2023 - wave 4 follow up to the 2017 survey: Data tables.

The prevalence of mental illness can be influenced by a multitude of factors. Some of the most commonly cited include: the reduction in its stigma, challenging economic conditions leading to limited opportunities, heightened awareness and anxiety about international conflicts/challenges, academic pressures, social isolation (particularly as a result of lockdowns) and increased social media usage. [65]

65. Mansfield, I. Phillips, S. and Webb, N. (2024), Disconnect, Policy Exchange, link

The last factor is explored further in a 2024 Policy Exchange paper, 'Disconnect'.[66] The trends in worsening mental health follow a wider global trend of reduced life satisfaction, increased feelings of depression and anxiety, as well as suicidal thoughts and behaviours.[67]

The NHS Planning Guidance for 2025/26 sets a number of priorities including: reducing elective care waiting times, improving ambulance and A&E waiting times, improving accessibility to GPs and dental care and increasing mental health patient flows.[68] We investigate some of these metrics below.

The number of GP appointments through the NHS, while volatile month-on-month, has been steadily increasing over time. (See Chart 26.) The average monthly total of GP appointments in 2018 was 24 million, which has since climbed to 31 million in 2024. (Roughly a half of these appointments are with a GP. The rest are with practice nurses, pharmacist, physios' etc.)

Chart 26: Monthly count of GP appointments in England, 2017 - 2024

Source: NHS England, Appointments in General Practice. Data taken from various releases.

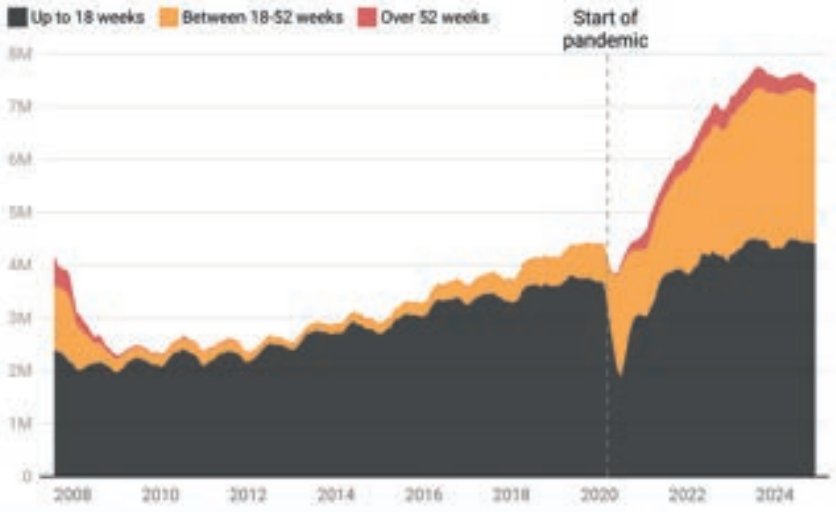
Regarding the accessibility of GPs, the latest data shows that across adults of all ages, about 50% described the ease or difficulty of contacting the GP practice as "easy" or "very easy" while 31% said it was "difficult" or "very difficult".[69] 73% were able to contact the GP practice on the same day, and 64% of adults described their experience as "very good" or "fairly good", while 20% described their experience as "fairly poor" or "very poor". Clearly, patient experiences can vary considerably across practices of different qualities.

While there has been a substantial increase in GP appointments since 2018, one of the main causes of NHS dissatisfaction from the public is the long waiting times for both GP and hospital appointments.[70] The waiting list for consultant-led care within the NHS grew at an average annual rate

66. Ibid
67. Ibid
68. NHS England (2025), 2025/26 priorities and operational planning guidance, link
69. Office for National Statistics (2024), Experiences of GP practice access, 16 January to 15 February 2024, link
70. National Centre for Social Research (2024), Public attitudes to the NHS and social care, link

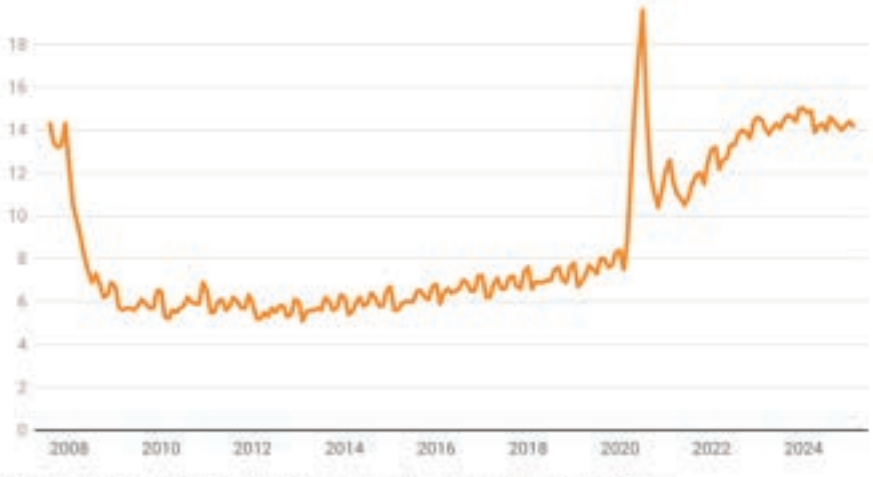
of about 6% from 2009 to 2019. (See Chart 27.) Following the pandemic, waiting times have increased dramatically, with the waiting list growing at an annual average rate of 21% from 2020 to 2023.[71] Since the pandemic, there has also been a striking increase in the number of people waiting between 18 and 52 weeks. These developments have led to an increase in the median wait time from referral to treatment from 6.5 weeks at the end of 2009 to 14.2 weeks as of December 2024. (See Chart 28.)

Chart 27: The waiting list for consultant-led care in the NHS, 2007 - 2024



Source: NHS England, Consultant-led Referral to Treatment Waiting Times Data 2024-25

Chart 28: The median wait from referral to treatment in NHS England (weeks), 2007 - 2025



Source: NHS England, Consultant-led Referral to Treatment Waiting Times Data 2024-25

The NHS Staff Survey captures the experience of over 700,000 employees, and presents a wide range of results about the NHS staff experience.[72] On the positive side, in 2023 88% of respondents said that they felt their role makes a difference to patients, 75% claimed that care of

71. Calculated using monthly estimates of year-on-year average growth.

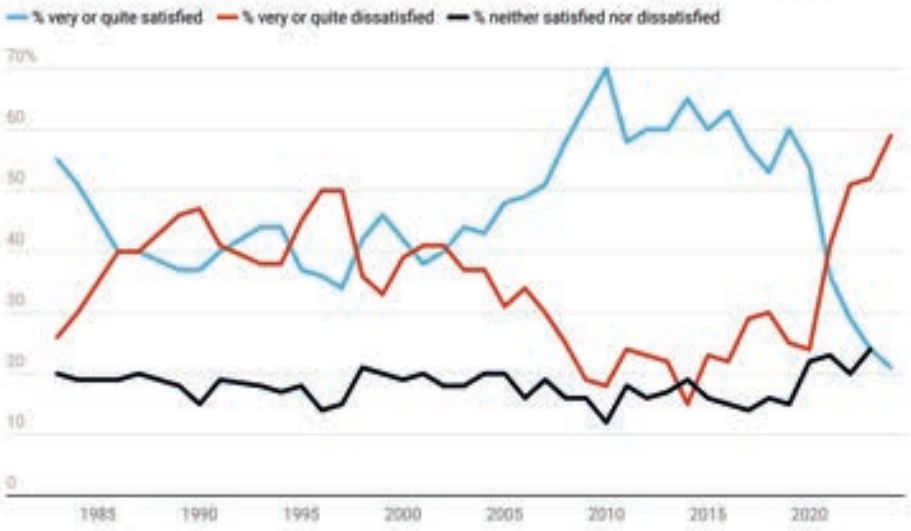
72. NHS (2024), NHS Staff Survey 2023, link

patients/service users was their organisation's top priority and 82% enjoy working with the colleagues in their team.

However, there is plenty of room for improvement. Only 55% of staff were satisfied with the recognition they get for good work, 31% were satisfied with their pay, and 55% of respondents went into work in the previous three months despite not feeling well enough to perform their required duties. 30% of staff feel burnt out because of work, and 30% do not have enough energy for family and friends during leisure time. 29% of staff often think about leaving the organisation, while 21% said they will probably look for a new job at a new organisation in the next year.

Finally, we turn our attention to the public's perception of the NHS. The British Social Attitudes Survey is a robust source of data which has been running annually since 1983, and recent releases reveal some striking statistics.[73] Satisfaction with the NHS is at its lowest level since the survey began for every service, across every demographic and socio-economic group; only 21% of people were satisfied with the NHS in 2023, down from 60% in 2019. (See Chart 29.) Causes of dissatisfaction came from long waiting times for GP (61%) and hospital appointments (63%), and being seen in A & E (68%). Meanwhile, satisfaction with social care is as low as 13%.

Chart 29: The public's satisfaction with the NHS, 1983 - 2024



Source: The King's Fund and Nuffield Trust analysis of NatCen's BSA survey data, National Centre for Social Research, BSA 42 Repairing Britain: Attitudes towards the economy, taxation and public services. There is a change in methodology from 2019.

While there have certainly been positive developments across several useful health metrics (e.g. healthy life expectancy and avoidable mortality), the pandemic has slowed, and in some cases reversed, progress. There are also a number of areas of acute concern, including the rise in the number of sickness-induced economically inactive members of our workforce and the rise in common mental disorders among young people. Given the context of colossal waiting lists and record low levels of satisfaction with

73. Curtice, J., Sivathasan, C. and Morton, G. (2025), BSA 42 | Repairing Britain Attitudes towards the economy, taxation and public services, National Centre for Social Research, link

the NHS, this presents a huge challenge for the government to overcome.

Next, we ask whether these are issues faced by other countries and investigate how our outcomes compare internationally.

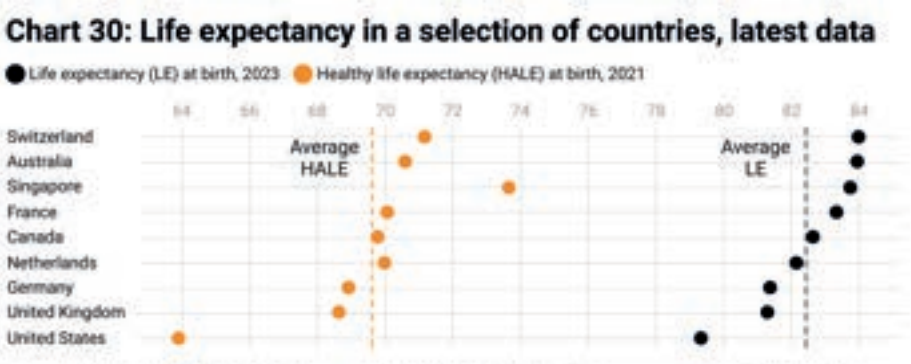
9. A comparison between healthcare outcomes in different countries

Given the scale of the government's funding of healthcare, it is reasonable for citizens to know how the UK's performance on health outcomes compares to other developed nations. That said, we acknowledge that there is more to health outcomes than the quality of the healthcare system. The lifestyles of the public, awareness of health risks and the ways of minimising them, as well as a host of environmental factors, all play a part.

Throughout the following section we compare the UK to our comparator group of countries (Australia, Canada, France, Germany, the Netherlands, Singapore, Switzerland and the US) across a series of broad metrics of health in order to examine both the general health of each country's population and the efficacy of each healthcare system.[74] We will also refer to the group of European countries whose healthcare systems, identified earlier in this study: Denmark, Finland, Italy, Norway, Spain and Sweden.

Chart 30 shows life expectancy and healthy life expectancy across our comparator countries. On both measures, the UK is a relatively poor performer and ranks second to last. The only country with a shorter life (and healthy life) expectancy is the United States, which is particularly striking given that, within our group of countries, it spends the highest proportion of GDP on health. The three notably strong performers on these two metrics are Switzerland, Australia and Singapore. In Switzerland, one can expect to live for almost 3 years longer than somebody living in the UK. Singapore is particularly impressive with regard to healthy life expectancy, which is 5 years greater in than the UK.

Chart 30: Life expectancy in a selection of countries, latest data



Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The Health Foundation found that there is greater variation in lifespan

74. For some metrics, data for Singapore is unavailable since it is not an OECD country.

across the population of the UK when compared to other wealthy countries.[75] While life expectancy inequality with respect to education was moderately low in the UK, there was a high variation in lifespan across geographical areas relative to the other analysed countries.

The performance of our European largely tax-financed group of countries, not shown in the table, is interesting. They all do better than the UK on both life expectancy and healthy life expectancy. Apart from Denmark and Finland, their performance is in line with, or just below, the best performers in our comparator group – except for Singapore's performance on healthy life expectancy, which is outstanding.

Data on the burden of disease presents similar findings. 'Burden of disease' is defined as the sum of mortality and morbidity and can be measured by 'Disability Adjusted Life Years' (DALYs).[76] One DALY represents one year of healthy life lost, either as a result of premature death, disease or disability. Similarly to healthy life expectancy, this data accounts not only for morbidity but also the suffering caused by diseases. This measure should therefore reflect a mixture of the general health of the population as well as the performance of its healthcare system, among other explanatory variables.

Why the US healthcare system is not to be copied

- The US spends far and away the highest proportion of its GDP on healthcare among our comparator countries – 16.7% , compared to 10.9% for the UK.
- For those wealthy enough to afford it, patients in the US have access to some of the best doctors, hospitals, and treatments in the world.
- However, average patient outcomes are worse than in many other highly developed nations, including the UK, and in the case of maternal and infant mortality the rates are significantly higher than other OECD nations and, in many cases, higher than in less economically developed countries.
- The US system does not guarantee coverage for everyone, with a significant proportion of the population having either no insurance at all or insurance which will cover only very basic care.
- Even those with more comprehensive coverage, this is often tied to their employment status and they still face out of pocket costs.
- Many US patients find themselves plunged into debt due to medical costs.
- The system is also incredibly expensive due to high costs for staff, administration, and medication.
- When looking at reforming the NHS, the US serves as an example of a model to be avoided.

75. Cavallaro, F. et al. (2024), Inequalities in life expectancy: how the UK compares, The Health Foundation, link

76. Roser, M. Ritchie, H. and Spooner, F. (2024), Burden of Disease, Our World in Data, link

Chart 31 shows the burden of disease across our selection of countries as of 2019 and 2021. As was the case with life expectancy, the US lags behind others. The UK is the next worst performing country. Once more, Australia, Switzerland and Singapore are the three best performers by this measure.

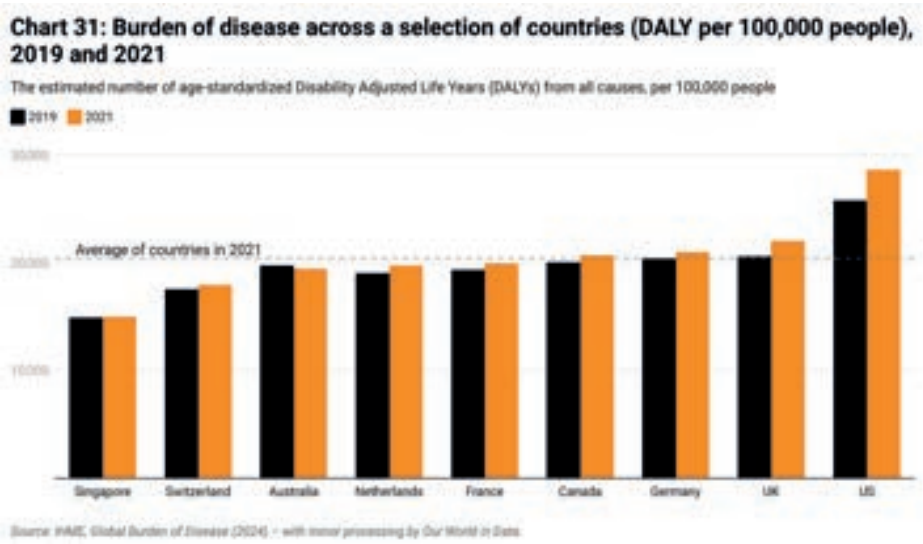


Chart 32 shows avoidable mortality rates across our selection of countries. Its preventable component (mortality avoidable before the onset of disease/injury) should reflect the quality of the population's health while the treatable component (avoidable after the onset of disease/injury) should relate more to the efficacy of each country's healthcare system.

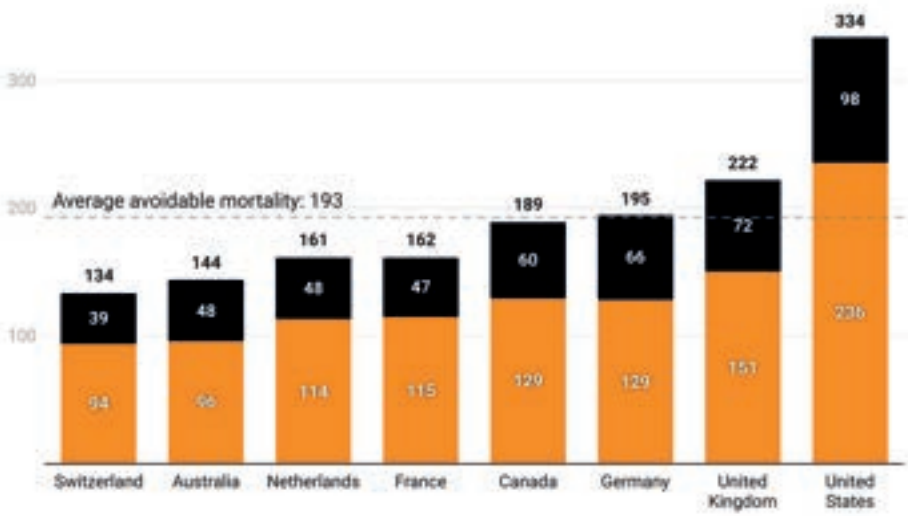
Both overall and with respect to preventable and treatable mortality, the UK is ranked second to last, its avoidable mortality rate being over 15% worse than the average of our countries. The US performs significantly worse than all other countries and over 73% worse than average. The four standout performers by this metric are Switzerland, Australia, the Netherlands and France.

According to the King's Fund, the UK's relatively poor performance is the result of below-average survival rates for some major cancers and worse outcomes following heart attacks and strokes. [77]

77. Mallorie, S. (2023), Comparing the NHS to the health care systems of other countries: five charts, link

Chart 32: Avoidable mortality across a selection of countries (deaths per 100,000 inhabitants), 2020

Avoidable mortality is the sum of preventable mortality (avoidable before the onset of diseases/injuries) interventions) and treatable mortality (avoidable after the onset of diseases/injuries)



Source: OECD Data Explorer, Avoidable mortality. Totals may not sum due to rounding.

The UK also performs moderately worse than other countries with regard to maternal mortality rates, with 9.2 deaths per 100,000 live births compared to an average of 8.3 for our selected countries. (See Chart 33.)

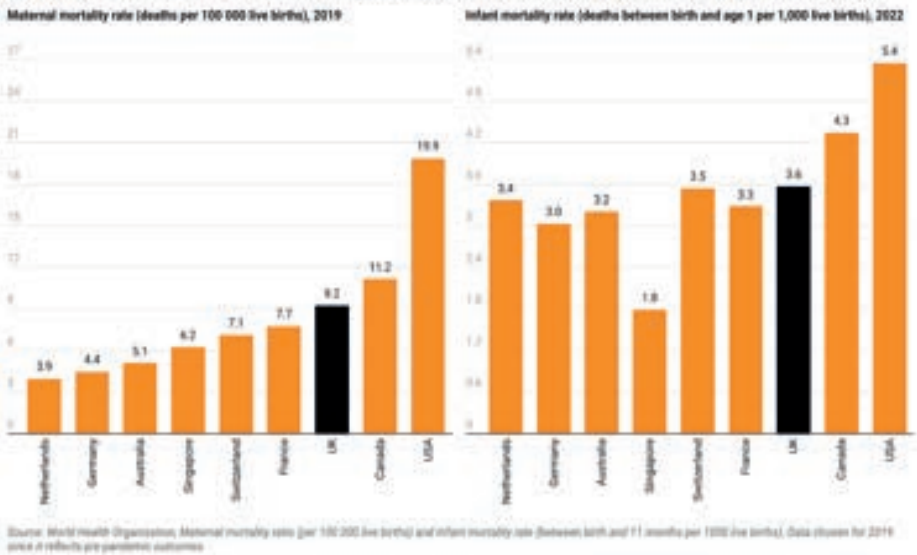
This is similarly the case for the infant mortality rate (also shown in Chart 33); the UK's rate (3.6 deaths per 1,000 live births) is slightly worse than the average (3.5). However, the next five countries cluster between 3.0 and 3.5 which would suggest that we are not lagging far behind. Nonetheless, Singapore's rate of 1.8 shows that there is still substantial progress that can be made.

Singapore's Healthcare Model: Lessons for the UK

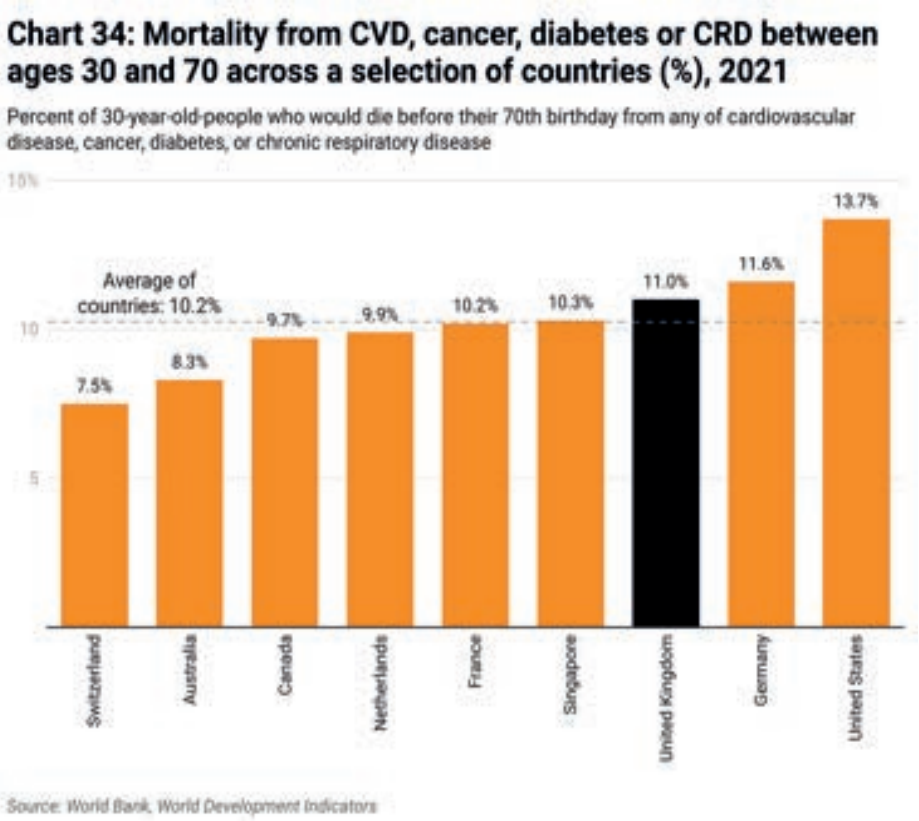
- Despite spending only about 5% of GDP on healthcare, Singapore achieves world-leading outcomes (e.g. high life expectancy, low infant mortality), suggesting incentives and efficiency matters over and above the mere expenditure of money.
- Singapore embeds personal responsibility through mandatory savings (Medisave), insurance (Medishield Life) and cost-sharing (co-payments, annual excess payment), limiting overuse and incentivising healthy behaviour. Savings allocated for healthcare provision can be shared with family members.
- The Medifund endowment ensures low-income Singaporeans remain covered, but on a discretionary basis, making for both a compassionate and fiscally responsible system.

- Healthcare delivery blends public and private providers. Public hospitals are corporatised and incentivised to be efficient while still publicly owned, introducing market forces without losing state control.
- The state intervenes when necessary (e.g. market failure, low-income support, setting mandatory contribution rates and what they can be used for), but otherwise allows autonomy and competition, avoiding both over-centralisation and unmanaged privatisation.
- Hospitals publish treatment costs and performance data, promoting informed choice and provider accountability, areas where the NHS remains opaque.
- The capitation funding model for Singaporean hospitals creates incentives to intervene early to prevent more costly procedures or hospital services, and most new doctors are qualified in family medicine.
- An ageing population may be a key driver of rising healthcare costs, but supply-side factors can also induce their own demand. Singapore aims to temper demand through its blended funding model but also constrains the supply of doctors and hospital beds, the opposite of the NHS model, which often equates more provision with better care.

Chart 33: Maternal and infant mortality rates across a selection of countries in 2019 and 2022



We next turn our attention to mortality and survival rates of some of the deadliest diseases. Chart 34 shows the probability of dying between the ages of 30 and 70 from cardiovascular disease, cancer, diabetes or chronic respiratory disease in each of our countries. By this metric, the UK performs slightly worse than the average of our group of countries. Again, the US has the highest rate of mortality, this time followed by Germany. Meanwhile, Switzerland and Australia perform relatively well.



Cancer survival rates reflect the quality of treatment as well as the timeliness of detection, since earlier diagnoses are associated with improved survival rates. Chart 35 shows the proportion of people alive five years after a diagnosis of various forms of cancer.

Out of the four analysed types of cancer survival rates, the UK is ranked last in three (colon, stomach and lung) and below average for rectal cancer. Australia, Switzerland and Canada are the strongest countries on cancer survival rates and perform above average for each form of cancer. This is also an area where the US performs comparably well, with above-average survival rates for three of four cancers.

The latest comparable data here from the OECD is unfortunately somewhat outdated, although more recent research by the International Cancer Benchmarking Partnership has suggested that the UK still remains around 10 to 15 years behind the leading countries, citing lower use of chemotherapy and radiotherapy as well as longer waits for treatment as potential causes.[78] The Darzi review also noted that cancer mortality rates were appreciably higher in the UK compared to other countries.[79]

78. Smith, J. (2024), How does cancer treatment in the UK measure up to other countries?, link
79. Department of Health & Social Care (2024), Summary letter from Lord Darzi to the Secretary of State for Health and Social Care, link

The Netherlands' Healthcare Model: Lessons for the UK

- The Netherlands spends only slightly less than the UK on its healthcare system (10.1% versus 10.9% in 2023) but its health outcomes are much better.
- All residents must purchase basic insurance, but premiums are community-rated (not based on health risk). Government compensates insurers for enrolling high-risk individuals, making for an equitable system without distorting competition. Even those with long term conditions are covered.
- Dutch healthcare is financed through a mix of insurance premiums, income-related contributions, out of pocket payments and tax subsidies, which together deliver universal coverage, demand-side restraints, affordability, and greater fiscal sustainability than fully socialised funding models.
- Government mandates insurance, sets the minimum level of coverage in the basic plan and the annual excess, regulates hospitals and intervenes to subsidies high-risk individuals.
- The government defines the basic plan and the minimum level of coverage, but insurers can compete on premium prices, quality of care, efficiency and so on, promoting better outcomes for policyholders. Likewise, within the reformed healthcare system, there is now a greater diversity of healthcare providers, with new specialist surgeries delivering high quality services.

On the Politics of Reform

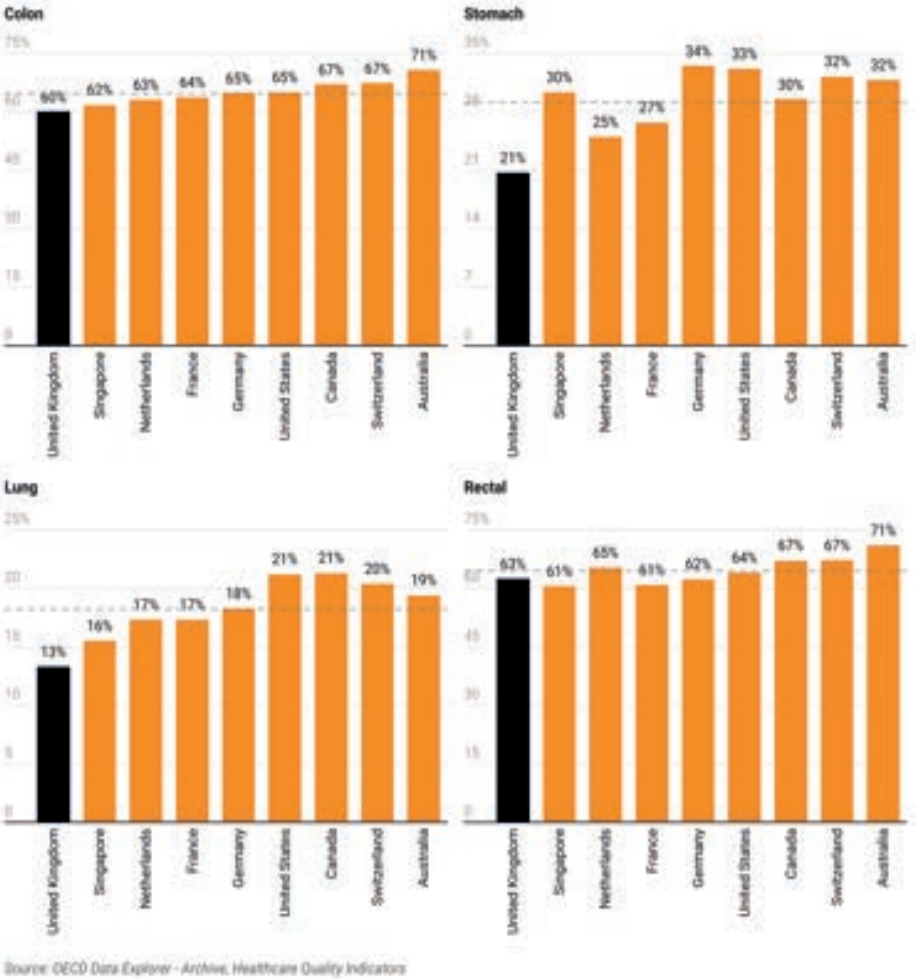
- The pre-2006 Dutch healthcare system was insurance-based but with a statist structure. All those employed were compulsorily insured while those not compulsorily covered could join voluntarily. Patients had very little choice over healthcare providers. Since insurers were not obliged to cover everyone, those with serious diseases or in high-risk groups struggled to get coverage.
- Although the 2006 Dutch reforms were sweeping, they were framed as an evolution of existing structures, and the case for them was made over a sustained period.
- The 2006 reforms enabled the controlled introduction of competition into the insurer and provider markets, and secured swift improvement in waiting list times.
- Universal access was guaranteed, while insurers and providers were diversified.
- Dutch GPs were given higher capitation fees and greater professional autonomy during reforms.
- To defuse potential opposition and preserve a sense of social solidarity in the system, the Netherlands provided for significant

subsidies to be available for lower earners. It also committed to paying for the insurance of under eighteens.

- Risk adjustment in the Dutch system means that insurers compete on efficiency, not on selecting healthy patients.
- The Dutch model involved a reimagined role for the state, not its absence. Instead of healthcare *planning*, the Government serves as a market-maker, a regulator of providers and insurers, and a safety-net operator for those who cannot afford to be self-sufficient.
- Individuals can choose their insurers, take out additional coverage, and reduce their insurance premiums through agreeing a higher annual excess.

Chart 35: Five-year survival rates for various forms of cancer across a selection of countries, 2010 - 2014

Percentage of people who are alive five years after being diagnosed with a disease or cancer, of those 15 years and older. Dotted lines show the average across countries.



Source: OECD Data Explorer - Archive, Healthcare Quality Indicators

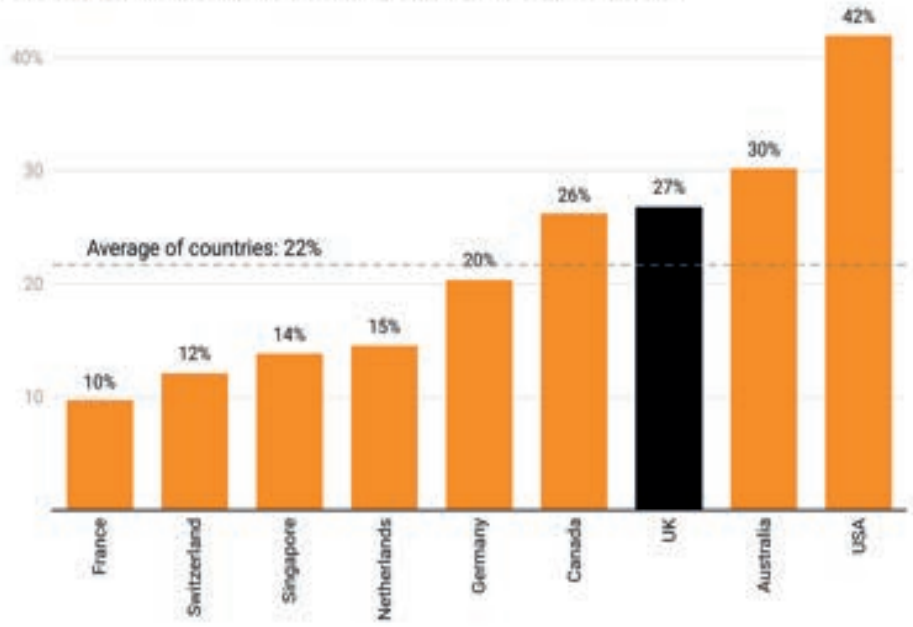
Obesity increases the risk of contracting many of the deadliest diseases discussed above, including cardiovascular diseases, diabetes, cancers, neurological disorders and chronic respiratory diseases, and so it is worth examining its relative prevalence. Chart 36 shows the prevalence of obesity

among adults in our basket of countries.

27% of UK adults are considered obese, 5 percentage points higher than the average of our countries. The US performs particularly poorly at 42%, while adult obesity rates in France stand as low as 10%. Obesity is an increasingly global issue; as of 2022, 43% of adults were considered overweight while 16% were obese.[80]

Chart 36: Prevalence of obesity amongst adults in a selection of countries, 2022

Percentage of adults with a body mass index (BMI) greater or equal to 30



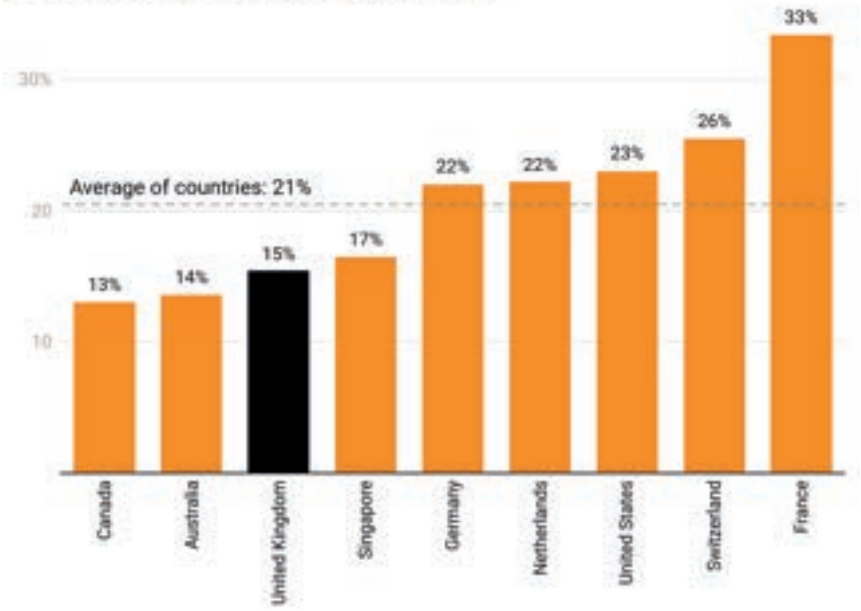
Source: World Health Organization, Prevalence of obesity among adults, BMI >= 30 (age-standardized estimate) (%)

Given its associated health risks, one area of relative success for the UK is the proportion of adults who smoke. (See Chart 37.) In 2020, the average across our countries was 21% while the rate in the UK was 15%. This has not always been the case; according to this source, in 2000 38% of adults smoked, which was the highest of our selected countries.[81] This development can probably be attributed to greater public awareness about the risks of smoking, increased taxes, stricter regulations and anti-smoking campaigns.

80. World Health Organization (2024), Obesity and overweight, link

81. Our World in Data (2025), Prevalence of current tobacco use (% of adults), link

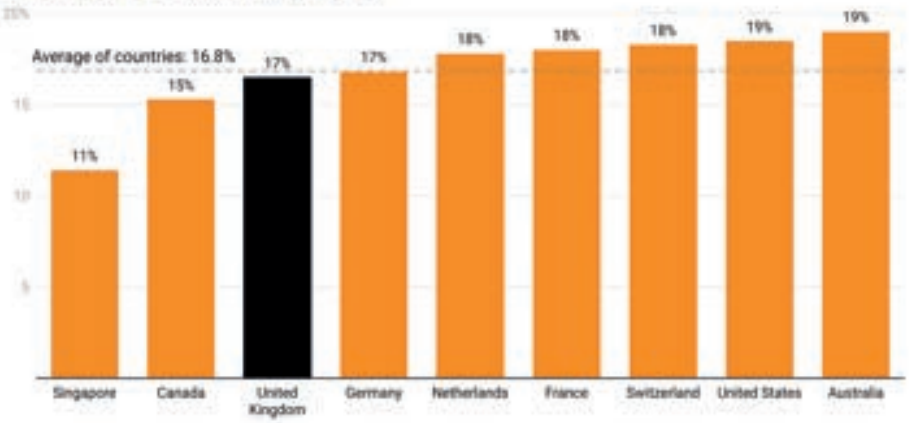
Chart 37: Proportion of adults who smoke across a selection of countries (%), 2020



Source: World Health Organization (via World Bank) (2025) – processed by Our World in Data

As mentioned in the previous section, the increasing prevalence of mental health disorders over recent years is a trend that has not been limited to the UK. The results of this development are borne out in Chart 38 which shows that the proportion of the population with a mental health disorder in the UK (16.5%) is marginally lower than the average of our countries (16.8%). Once again, Singapore performs particularly well with only 11.4% of its population having a mental health disorder. Interestingly, while Switzerland and Australia have generally performed well with regard to other measures, they are both worse than average when it comes to mental health prevalence. This highlights the different challenges between fighting physical health ailments and mental health issues.

Chart 38: Percentage of population with mental health disorders across a selection of countries (%), 2021



Source: IHME, Global Burden of Disease (2024) – with major processing by Our World in Data. Mental health disorders include depression, anxiety, bipolar, eating disorders and schizophrenia

The results so far show that for the majority of these broad measures of health, the UK performs poorly. In fact, for many of these indicators, the UK would be the worst ranked country of our basket if not for the US.

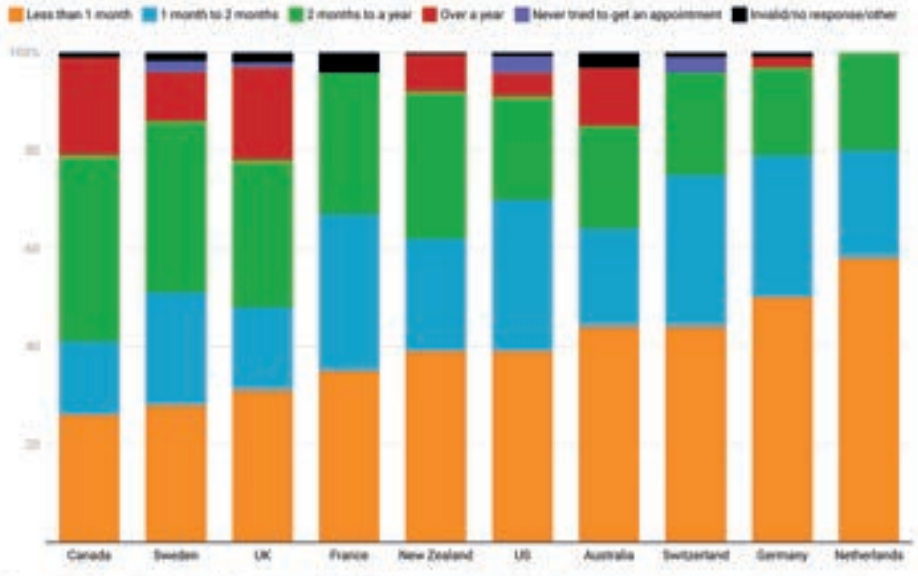
Some of the results above will somewhat reflect the efficacy of health systems in reducing and treating various diseases, although it is difficult to separate this component from the influence that the general health of the population can have on outcomes such as mortality rates.

We now turn our attention to patients' experiences of using healthcare systems. According to the Commonwealth Fund's 2023 International Health Policy Survey of 10 developed countries, the UK ranks poorly when it comes to waiting times, with respect to both non-emergency surgeries and specialist appointments.[82] This is shown in Charts 39 and 40.

Firstly, on non-emergency and elective surgeries, the UK has the second highest proportion of patients waiting for over a year (19%) of the selected countries, ranked ahead of only Canada (20%). Meanwhile in the Netherlands, Switzerland and France, nobody waits over a year. The proportion of patients who faced a waiting period of under a month was highest in the Netherlands (58%) and Germany (50%), while the UK (31%), Sweden (28%) and Canada (26%) were the bottom ranked nations. (See Chart 39.)

Regarding specialist appointments, the UK had the highest proportion of patients waiting for over a year, at 11%. This was followed by Canada (10%) and Sweden (5%), while in Switzerland and the Netherlands less than one percent of patients waited for over a year. The proportion waiting less than a month was greatest in Switzerland (64%) and the Netherlands (62%) and lowest in the UK (37%), France (35%) and Canada (31%). (See Chart 40.)

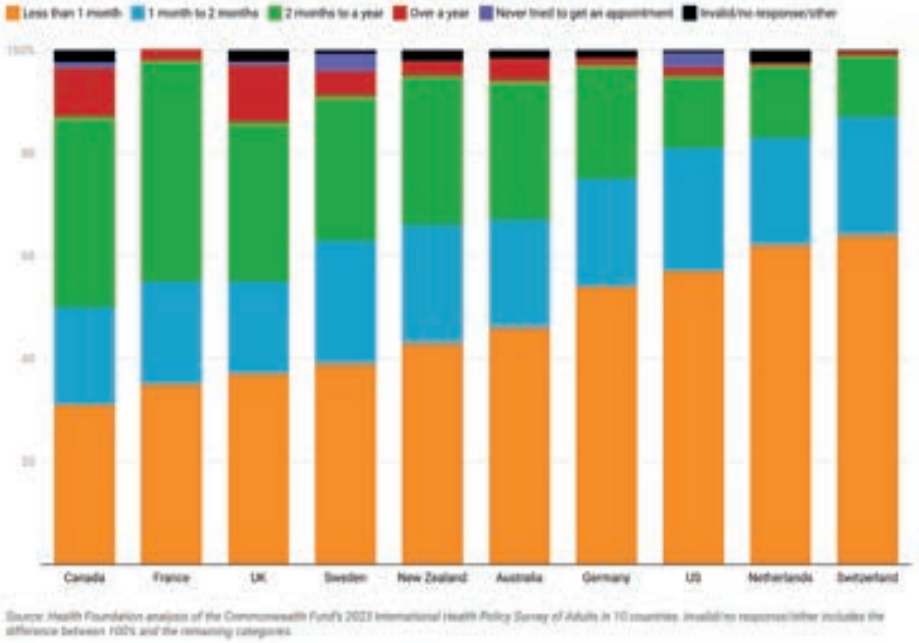
Chart 39: Responses to the question 'How long did you wait for non-emergency or elective surgery?' across a selection of countries (% of respondents), 2023



Source: Health Foundation analysis of the Commonwealth Fund's 2023 International Health Policy Survey of Adults in 10 countries. Invalid/no response/other includes the difference between 100% and the remaining categories.

82. Mendelsohn, E. et al. (2024), Feeling the pressure: what the 2023 Commonwealth Fund survey reveals about the state of the UK health system, link

Chart 40: Responses to the question 'How long did you wait for a specialist appointment?' across a selection of countries (% of respondents), 2023



On the equity of healthcare systems, according to the Commonwealth Fund, the UK performs relatively favourably, ranking fourth out of 11 countries.[83] That is to say that it has relatively small income-based disparities in outcomes. Australia was the highest ranked country, followed by Germany and Switzerland, while the US lagged significantly behind the rest of the group.

Regarding general practice, analysis of Commonwealth Fund survey results gives a mixed bag of results. On a positive note, the UK performs well on the proportion of patients reporting being able to get same or next day appointments (42%); only the Netherlands (50%) and Germany (49%) ranked significantly higher. It also performs well on the percentage of people with access to a regular GP/practice at 97%, with the results ranging from 86% in Canada to 99% in the Netherlands.[84]

However, only 16% of people in the UK said that it was 'very easy' or 'somewhat easy' to receive care in the evenings and on weekends without having to go to A&E. None of the countries in our basket ranked lower than this, while countries such as the US and Australia boasted rates of 36% and 30% respectively.[85]

Similarly concerning are results on the experience of GP appointments. Only 80% of adults said that their regular GP 'often' or 'always' explains things in a way that is easy to understand, 71% said that they were involved as much as they wanted to be in decisions about their care and treatment and only 58% felt that their GP spent enough time with them. On each count, this was significantly lower than the average percentage of the analysed countries. (See Chart 41.) On coordination between health care professionals, the UK also performs poorly.[86]

83. Schneider, E.C. et al (2021), Mirror, Mirror 2021: Reflecting Poorly; Health Care in the U.S. Compared to Other High-Income Countries, The Commonwealth Fund, link
84. Mendelsohn, E. et al. (2024), Feeling the pressure: what the 2023 Commonwealth Fund survey reveals about the state of the UK health system, link
85. Ibid
86. The Health Foundation (2024), UK among worst performing high income countries on waits for hospital care, link

Chart 41: Responses to GP-related questions across a selection of countries (% of respondents), 2023

Source: Health Foundation analysis of the Commonwealth Fund's 2023 International Health Policy Survey of Adults in 10 countries

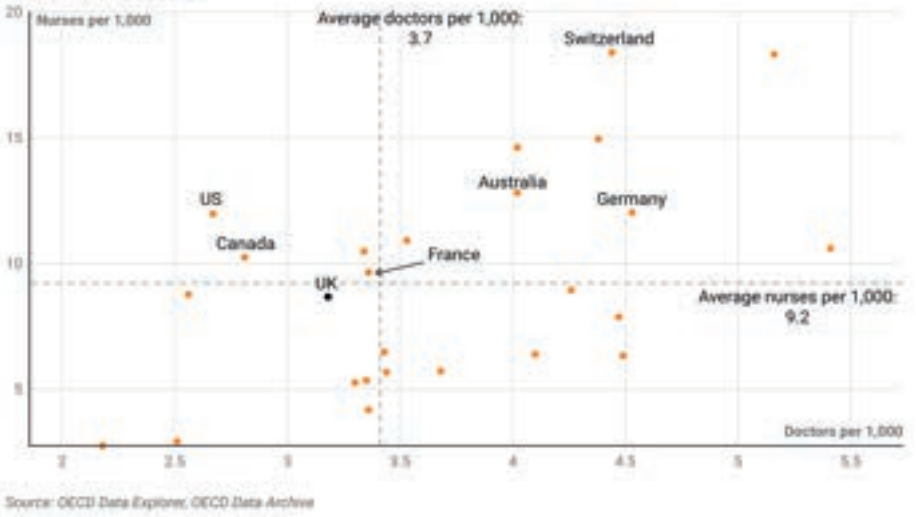
Chart 42 shows the number of doctors and nurses per 1,000 across 26 OECD countries. Compared to the average of these countries (3.7 doctors and 9.2 nurses per 1,000), the UK has a lower number on both counts (3.2 doctors and 8.7 nurses per 1,000). This is not the case for any of the other countries in our basket. While the US, Canada and France have a lower number of doctors per 1,000 than the average, they each have a higher number of nurses. Meanwhile, Australia, Germany and Switzerland have more nurses *and* doctors per capita than the average OECD country.

The German healthcare system

- Germany spends a high proportion of its GDP on healthcare (11.8% versus 10.9% for the UK in 2023), second in our group only to the US.
- It does reasonably well on life expectancy compared to other highly developed nations, although its figure is only slightly higher than the UK's.
- The German healthcare system has relatively good patient outcomes for diseases such as cancer, cardiovascular disease, and diabetes. This is because these conditions are diagnosed early and comprehensive care pathways for treating and managing these diseases have been established.
- The UK could learn from these care pathways and implement something similar.
- Germany has a large number of hospitals, hospital beds, and doctors and nurses relative to its population compared to other highly developed countries. This allows patients to be seen relatively quickly and get the treatment they need in hospitals which is something the UK could emulate.
- The insurance based system in Germany provides both universality and some degree of patient choice as insurance providers compete with each other to attract patients.
- This is relevant to the UK as it shows that it is possible to have an insurance style system which provides universal healthcare to the population.

- Its experience of utilising technology in the healthcare system has improved patient outcomes.
- However, the German healthcare system is very expensive because of a high administrative burden.
- The German system also shows that implementing reforms to a healthcare system can be slow and not achieve their desired aims.

Chart 42: Number of doctors and nurses per 1,000 inhabitants in OECD countries, 2021



Source: OECD Data Explorer, OECD Data Archive

The King's Fund argues that this data, alongside high vacancy rates and staff dissatisfaction levels show that our current level of physicians per capita is insufficient, although inspection of Chart 42 reveals that we have only slightly fewer nurses and doctors per 1,000 people than France.[87] The number of NHS England vacancies in December 2024 was 106,432 which gives a vacancy rate of 7.2%.[88] On top of this, a Commonwealth Fund survey showed that out of 10 developed nations the UK had the highest proportion of primary care physicians who intended to stop seeing patients within three years (20% for those aged under 55 and 67% for those aged over 55).[89]

Data suggests that the UK has significantly less medical equipment per capita than many developed countries, which could be a contributing factor to long waiting times.[90] This is shown in Charts 43 and 44.

Out of 19 countries, the UK is ranked last with regard to both CT and MRI scanners per capita. (See Chart 43.) Of those countries in our basket, the US and Australia are relatively well equipped while Canada and Netherlands fall substantially below the average.

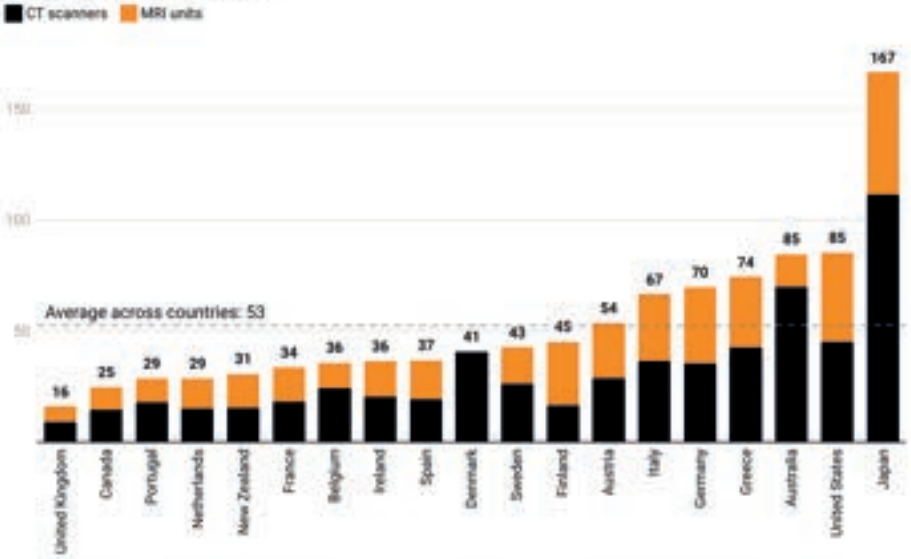
Finally, Chart 44 shows that the UK has the lowest number of hospital beds per capita across our basket of countries. Compared to the average, the UK has 16 fewer beds per 10,000. Canada, Singapore, the US and the Netherlands also fall significantly below the average, while France and Germany lead the group.

87. Mallorie, S. (2023), Comparing the NHS to the health care systems of other countries: five charts, link
88. Stiebahl, S., Danechi, S., Harker, R. (2025), NHS key statistics: England, House of Commons Library, link
89. Gunja, M Z. et al., (2022), Stressed Out and Burned Out: The Global Primary Care Crisis, link
90. Mallorie, S. (2023), Comparing the NHS to the health care systems of other countries: five charts, link

The French healthcare system

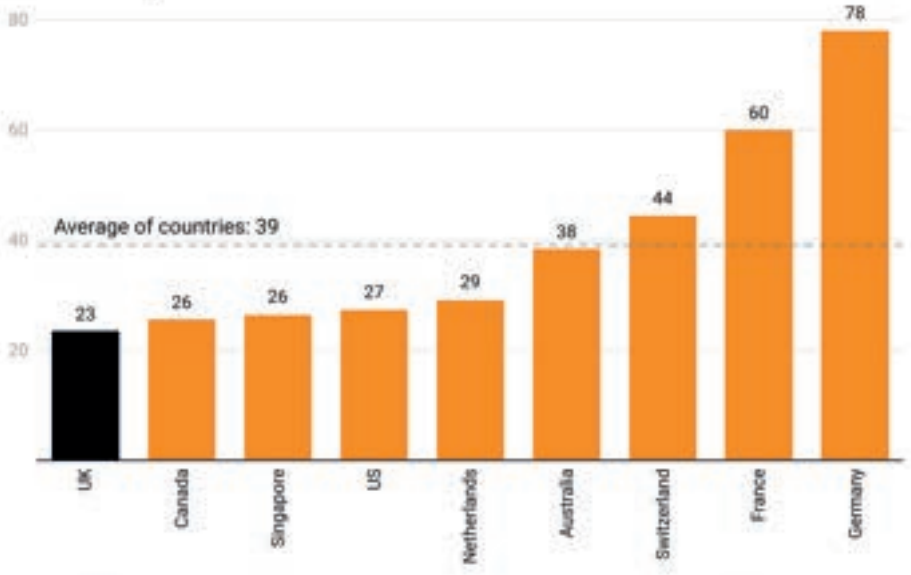
- France spends slightly less of its GDP on healthcare than Germany, but slightly more than the UK (11.6% versus 10.9% in 2023).
- The French healthcare system ranks highly for quality compared to other wealthy countries, with relatively low levels of avoidable mortality and high life expectancy.
- Patient satisfaction is relatively high in France and this is partly a result of patient choice. This serves as an example to the UK and shows that enabling greater choice for patients leads to them feeling empowered and more satisfied with their care.
- GPs in France take a more active role in coordinating patient care, including for specialist treatment. As GPs know their patients well, this tends to lead to a more efficient use of resources and so lowers costs and achieves better patient outcomes.
- The French system also places an emphasis on preventative care, with patients entitled to an annual checkup which means that some conditions are detected and treated early.
- However, the French healthcare system is incredibly expensive due to high spending on administration and medications.
- What is more, the high level of bureaucracy increases the burden on medical staff and patients and can lead to patients facing delays for reimbursements.
- There are also long waiting times in France for elective surgery and specialist care.
- The French healthcare system shows the danger of too much reform. There have been frequent reforms over the past 30 years which have led to uncertainty for medical professionals and patients and has resulted in worse patient outcomes, as well as burnout and fatigue among doctors which has led many to leave the profession.

Chart 43: CT and MRI scanners per million across a selection of countries, 2019 or nearest year



Source: The King's Fund, Comparing the NHS to the health care systems of other countries: five charts; OECD Health Statistics 2021. Denmark does not have data for MRI units. Equipment outside hospitals are excluded for Portugal, Sweden and the United Kingdom.

Chart 44: Hospital beds per 10,000 across a selection of countries, latest data



Source: World Health Organization, Hospital beds (per 10,000 population). Data for the UK, Switzerland and Singapore is from 2021. Data for the US, Canada, the Netherlands, France and Germany comes from 2020. Data for Australia comes from 2016.

The above analysis would suggest that with regard to both the health of the country and the performance of the UK healthcare system, the UK is in pretty poor shape. Across many of our chosen indicators, a similar pattern emerges: the US is often the worst of the pack, despite spending the highest proportion of its GDP on health, while the UK regularly ranks just behind. Countries such as Australia, Switzerland and Singapore perform

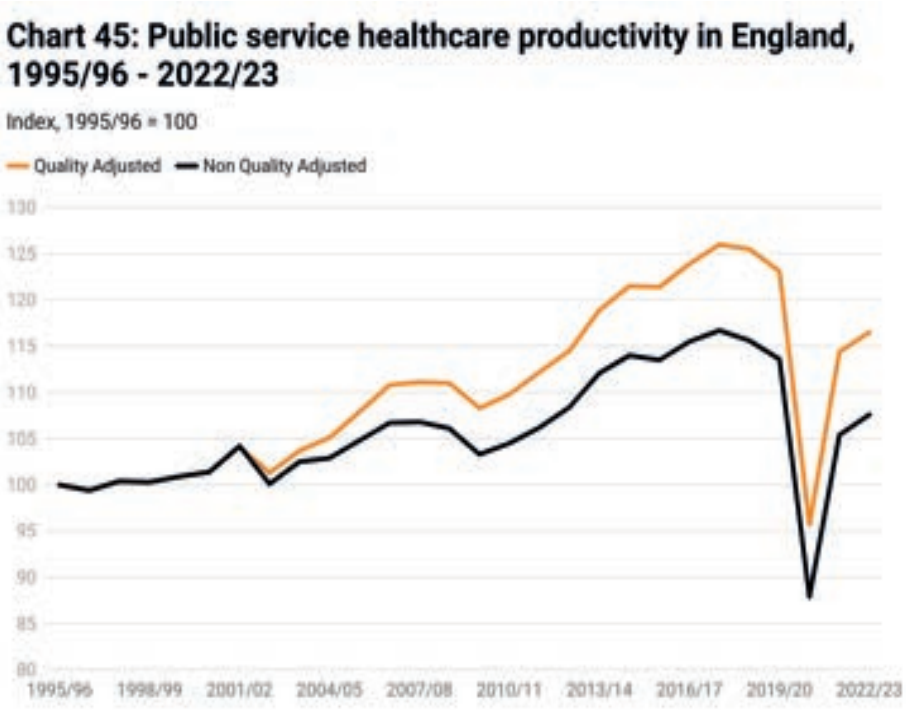
well across a wide range of metrics.

This suggests that we are currently not getting good value for the money going into the system. On indicators like life expectancy and avoidable mortality, we should do better. Other areas of particular concern surround cancer survival rates and waiting times for healthcare appointments, which are of course linked. Compared to similarly developed countries, our performance across a wide range of health metrics is concerning. Health policy must aim to improve our position within the current international standings.

An overall assessment

There is some compelling data to suggest that UK citizens are not getting good value for their tax funding of the NHS. Firstly, as Chart 45 shows, however you measure it, the recent productivity performance of the healthcare sector in the UK has been dire.

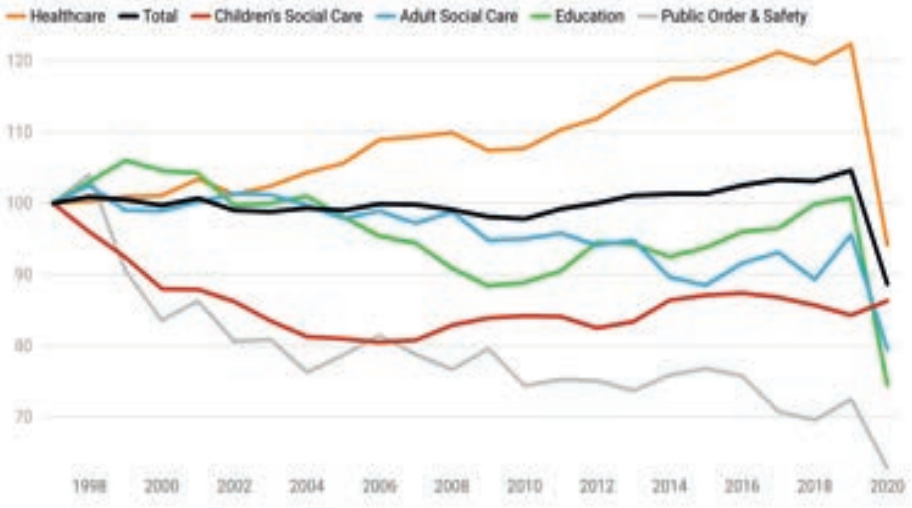
Chart 45: Public service healthcare productivity in England, 1995/96 - 2022/23



Source: ONS, Public service productivity estimates: healthcare, England. The quality adjustment has three components: one for health gain in most hospital procedures, one for the degree to which GPs follow best practice and one for the quality of the patient experience.

Admittedly, Chart 46 makes clear that productivity in the whole public sector has recently been poor, but Chart 47 shows that productivity changes in the healthcare sector have made a huge contribution to movements in overall productivity in the public sector.

Chart 46: Total public service productivity in the UK, by service area, 1997 - 2020



Source: ONS - Public service productivity, UK 1997 to 2022.

Chart 47: Contributions to public service productivity growth by sector in the UK (%), 1998 - 2022

It is true, though, that on some measures our NHS does not do too badly. This is the message of Table 7. In regard to the spending on healthcare, the UK comes out 3rd lowest in a selection of 10 developed countries. Remarkably, it comes out first on administrative efficiency. But

if you look at health outcomes, we come in at number 8.

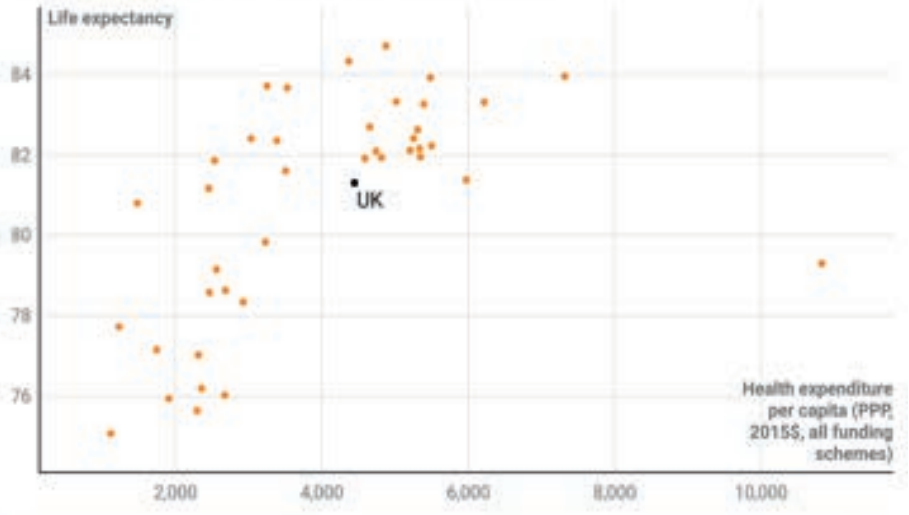
Table 7: Key Health Statistics across Various Countries

	AUS	CAN	FRA	GER	NED	NZ	SWE	SUI	UK	US
Total health spend, public and private (% of GDP), 2023	9.7	11.2	11.9	11.8	10.1	11.0	10.9	12.0	10.9	16.7
Government/ compulsory health spend (% of GDP), 2023	7.0	7.9	10.1	10.1	8.5	8.8	9.4	8.2	8.9	13.9
OVERALL RANKING	**1**	**7**	**5**	**9**	**2**	**4**	**6**	**8**	**3**	**10**
Access to Care	9	7	6	3	1	5	4	8	2	10
Care Process	5	4	7	9	3	1	10	6	8	2
Administrative Efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

Source: OECD Data Explorer, Health expenditure and financing; The Commonwealth Fund, Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System. Expenditure data for France is from 2022.

Chart 48 is especially striking in this regard as it compares health spending per capita with life expectancy across a number of countries. As you would expect, there is a clear connection. Countries that spend more generally have a higher average life expectancy. But at the UK's level of healthcare spending our life expectancy is the lowest.

Chart 48: Health expenditure per capita and life expectancy across a selection of countries, 2023

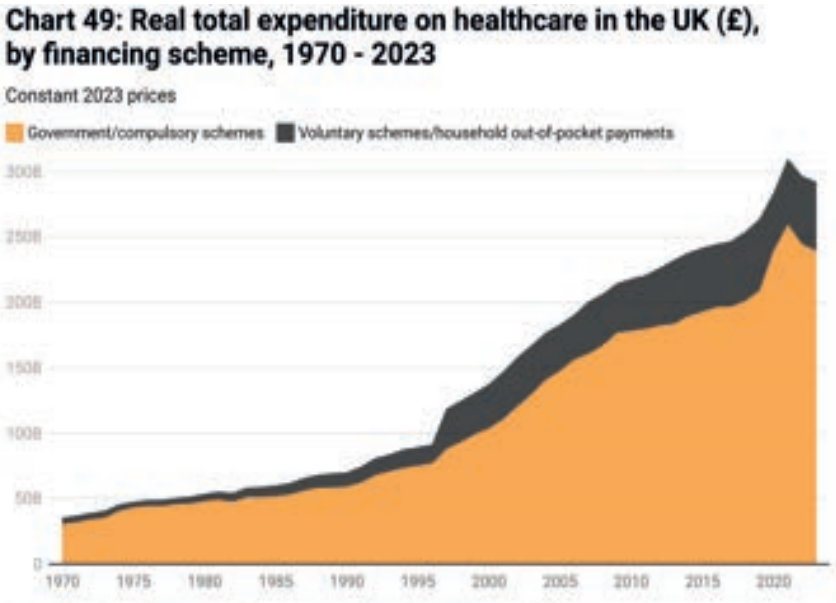


Sources: UN, World Population Prospects (2024)OECD Health Expenditure and Financing Database (2024) HYDE (2023) Gapminder - Population v7 (2022) Gapminder - Systema Globalis (2022)Our World in Data – with major processing by Our World in Data

10. The long-term structural pressures for higher health spending and comparisons with other countries.

Since 1975, total healthcare spending has increased from £48bn to £292bn in 2023 prices (see Chart 49). In real terms, that represents a growth of 515% - averaging around 50% every decade.[91] The UK economy, by contrast, has grown 167% in the same period, or around 24% each decade.[92] Thus, as a proportion of the economy, healthcare expenditure has grown from just under 5% to 11% between 1975 and 2023.

Chart 49: Real total expenditure on healthcare in the UK (£), by financing scheme, 1970 - 2023



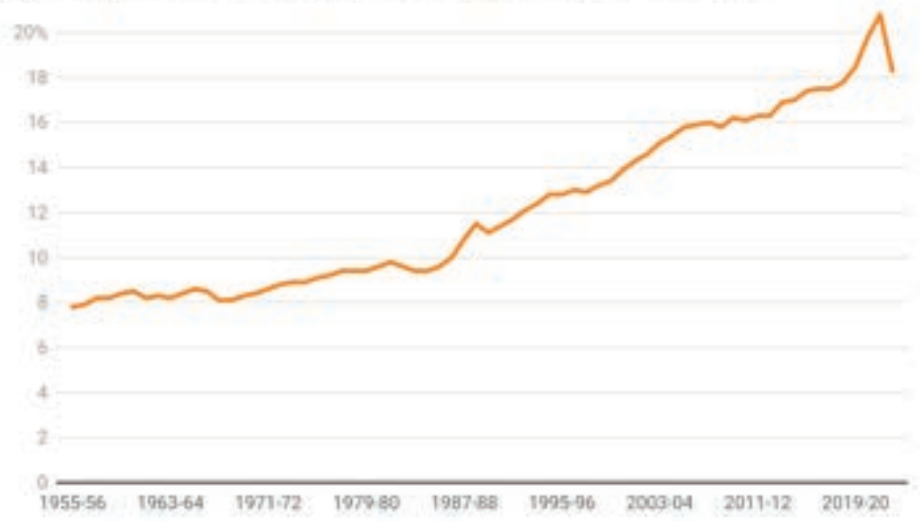
Source: OECD Data Explorer, Health Expenditure and financing; HM Treasury, GDP deflators at market prices, and money GDP December 2024 (Quarterly National Accounts). Whilst the OECD categorises government and compulsory schemes together, in the UK there are no compulsory schemes.

91. OECD Data Explorer, *Health Expenditure and financing*; HM Treasury, GDP deflators at market prices, and money GDP December 2024 (Quarterly National Accounts). Decade growth statistic taken as the mean 10-year growth rate each period.

92. ONS, *Gross Domestic Product: chained volume measures: Seasonally adjusted £m*. Decade growth statistic calculated similarly to above.

As a proportion of that total healthcare expenditure, *government* healthcare spending has been relatively stable at about 75-80% for the last quarter of a century. But government spending on healthcare is consuming an ever-growing proportion of total public expenditure. Put differently, a growing slice of the public spending pie is going towards the NHS. Chart 50 shows that healthcare constituted about 9% of total expenditure in 1975, but today, this figure stands at 18%.

Chart 50: UK government spending on health (% of government expenditure), 1955/56 - 2022/23



Source: IFS - IFS spending composition sheet. Total managed expenditure is used for government expenditure.

What is driving this remarkable surge in healthcare spending?

Some of the resource challenges the NHS presently faces are contingent. Most important of all in recent times has been dealing with the cumulative costs presented by Covid and its subsequent effects on waiting lists. Between 2020 and 2022 alone, the NHS budget was increased by £80 billion to fight the virus and to fund amongst, other things, Test and Trace, PPE, and treatment of increased acute care needs.[93]

But the more problematic pressures driving higher health spending are structural, and relate to the very logic of our healthcare model in the UK of fully socialised funding and universal coverage.

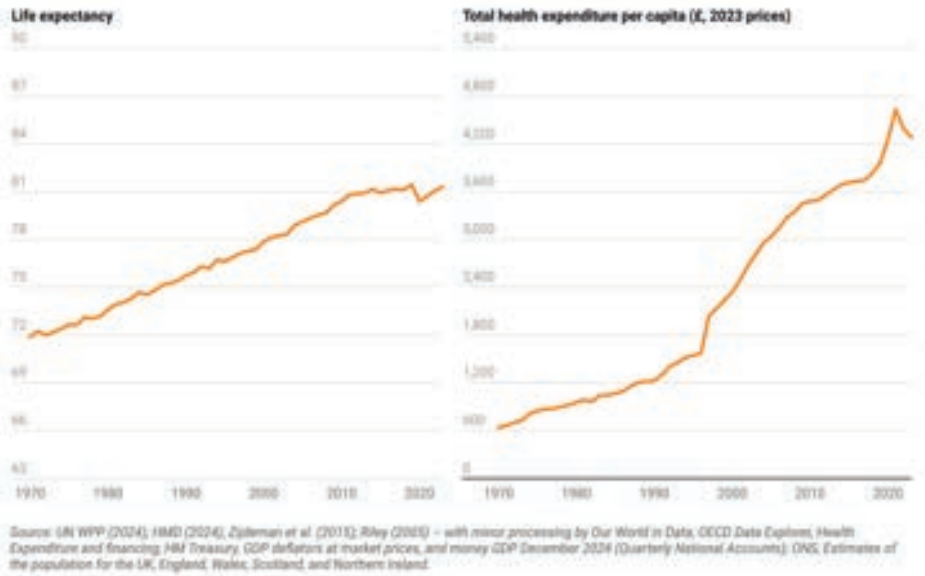
When the modern welfare state and national health service were established in the immediate postwar period, one of the critical assumptions made was that, as society got healthier, demand for healthcare expenditure would decrease. A healthier society in the long run would be a fiscally cheaper one. Universal coverage "from the cradle to the grave" paid for through general taxation was economically sensible in the long term, thought the welfare state architects.

These assumptions have over time been proved to be false. In fact, even as people have generally got healthier, the demand for healthcare spending

93. House of Commons Library, *NHS Funding and Expenditure*, 2024.

has increased. Chart 51 shows that whilst the average life expectancy has improved since 1970, real per capita health spending across the entire economy has increased over sixfold.

Chart 51: Life expectancy and health expenditure per capita in the UK, 1970 - 2023



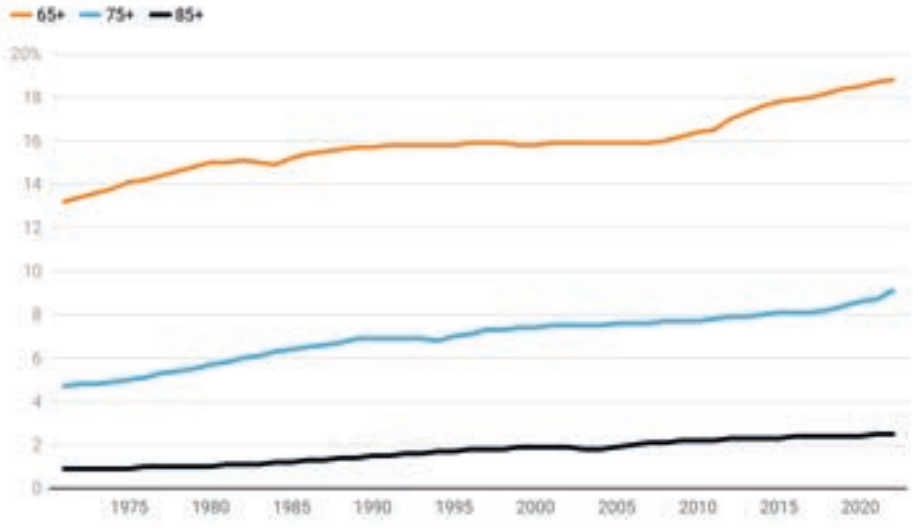
Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data. OECD Data Explorer, Health Expenditure and financing; HM Treasury, GDP deflators at market prices, and money GDP December 2024 (Quarterly National Accounts); ONS, Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland.

There are a number of drivers behind these trends. The first and most important is demographic. As people get healthier, they live longer, and both health and social care spending increases dramatically after people pass a certain age.

The majority of an individual's healthcare spending is concentrated towards the end of life. Degenerative diseases like dementia arise specifically in older people, cancer is far more common in elderly people, and reduced physical capacity in old age makes the likelihood of injury or ailment from falls or slips far higher too. Even the healthiest of people will see their healthcare spending increase over time with bodily wear and tear. These trends are apparent in social care spending too, which will be examined in another section.

Since 1971, the proportion of people in Britain over the age of 65 has increased from 13% to 19% ; in the same period, the percentage of people over 75 years old has grown from 5% to 9%, and those over the age of 85 from 1% to 2%. (See Chart 52.)

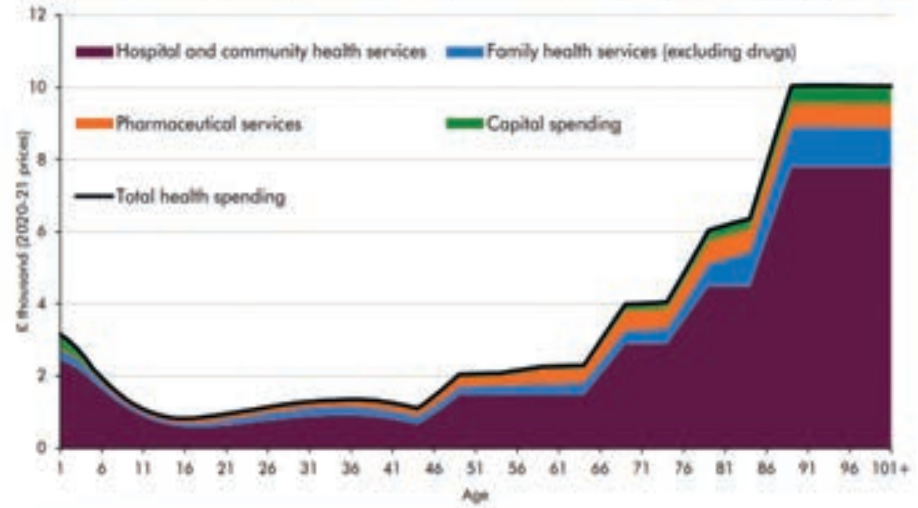
Chart 52: Percentage of UK population aged over 65, 75 and 85, 1971 - 2022



Source: ONS - Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland

Our ageing population comes with acute cost implications. The average healthcare spend on someone aged 30 is just over £1,000. For someone at 70, it is around £4,000. Health expenditure on an average 90 year old is about £10,000. Chart 53 sets out health spending on individuals by their age group, based on NHS England spend data.

Chart 53: Government expenditure on health per capita, by age



Source: OBR - Fiscal sustainability and public spending on health

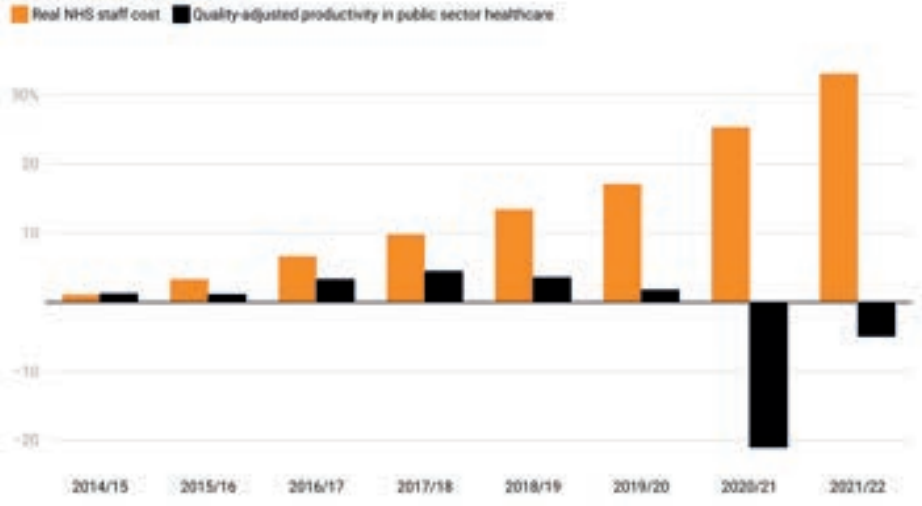
While this is potentially the most significant long-term pressure on healthcare spending, there are a number of other pressures which are not confined to older demographics. On the demand side, while the biggest spending pressure remains in acute care, there has also been a precipitous

rise in mental-health related NHS spending. In 2023-24, NHS Trusts spent £13.7 billion on mental healthcare - more than primary care, community services and continuing care. Between 2015-16 and 2023-24, spending on mental health grew by around 45% in real terms, compared to only 29% for acute care.[94]

Healthcare is also simply becoming more *costly*, as a consequence of a process theorised by William Baumol. As he wrote in his book *Performing Arts: The Economic Dilemma*, when productivity gains drive wage growth in certain sectors, wages will grow in others without corresponding productivity improvements. In these latter sectors, the cost of delivering the same service or product will increase.

This is in part what has happened in healthcare; the sector is labour intensive and so is particularly exposed to these trends. Indeed, staff costs have risen considerably without real gains in productivity. (See Chart 54.) The last two years shown in Chart 54 will be somewhat influenced by the effects of the pandemic. However, even before this, the disparity between staff costs and productivity in the sector is clear.

Chart 54: Real NHS staff costs and public health productivity growth, relative to 2013/14



Source: Department of Health and Social Care - NHS PRB evidence 2023/24; HM Treasury - GDP deflators at market prices, and money GDP December 2024 (Quarterly National Accounts); ONS - Public service productivity, healthcare, England: financial year ending 2022. NHS data corresponds to the calendar year whilst productivity data corresponds to the financial year.

In addition to these labour cost related pressures, new technologies also play a key role in driving up healthcare costs. New treatments for diseases and ailments can have a transformative impact of the quality of life of patients. But they can be immensely expensive. In the 2021-2022 fiscal year, prescription medicines cost the NHS £17.2 billion; within that, the cost of hospital-prescribed drugs and medicines increased by 35% 2018-2022.[95]

Currently, the challenge mechanism in the UK against unmitigated cost growth from new treatments is the National Institute for Health and Care Excellence (NICE), which makes assessments on the effective use of public

94. House of Commons Library, *NHS Funding and Expenditure*, 2024.

95. Aris Angelis et al, Promoting population health through pharmaceutical policy The role of the UK Voluntary Scheme, LSE (2023)

monies by evaluating how much a new drug or health intervention will cost, how many people it will help, and how certain the health outcomes deriving from the new drug or intervention will be. NICE estimates the additional cost required to gain an additional quality adjusted life year from the use of a new medicine compared to a comparator, known as the incremental cost-effectiveness ratio (ICER). If this cost is below NICE's approval threshold, it will be given approval; if it is above, it will be adjudged to be cost-ineffective.

However, a recent LSE study found that due to a range of NICE exemptions lacking a rigorous empirical basis, the effective threshold for new drugs has been increasing, with the result that many recently approved treatments are actually not offering good value for taxpayer money.[96] (This study has come in for substantial challenge from the pharmaceutical sector, including the industry body the ABPI.)

In the future, many of these cost pressures cited above are likely to intensify. The cost of treatments and drugs is trending consistently upwards, and for degenerative diseases like Alzheimer's, we are on the cusp of potentially transformative breakthroughs in science. Our population is still growing older. And the Institute for Fiscal Studies recently estimated that the 2023 NHS Workforce Plan implied a funding increase for NHS England of 3.6% per annum by 2036/37 to pay for the vast proposed increase in staffing.[97]

96. Ibid.

97. IFS, The Past and Future of UK Health Spending

D) The problems of the Social Care System and how it should be reformed

11. How Adult Social Care has evolved

This pamphlet is primarily about the NHS and its financing. But it would be remiss if we did not also consider our system of social care. After all, the two are closely linked. As noted above, inadequate provision of social care is often responsible for extending the hospital stays of the old and infirm. Equally, poor social care can end up causing some people to have to spend time in hospital when such stays could have been avoided. And both the NHS and social care are subject to the same pressures from an ageing population.

In addition, the two face similar issues with regard to funding, although they begin from very different starting points. Whereas use of the NHS is free at the point of use, the cost of social care is subject to means testing. But over recent years there have been suggestions that the funding of social care should be put on a basis much closer to the NHS model.

Accordingly, it is essential that we consider social care alongside the NHS.

The history

Adult social care refers to the care and support provided to people who require assistance to live independently outside of a medical setting. These include the elderly and infirm as well as those with disabilities or learning difficulties. It can involve a mixture of short- and long-term care, and can take place in either a residential setting – care homes - or via means-tested domiciliary care in one's home.

Prior to the advent of the modern welfare state, social care provision – as with welfare in general – was pluralistic. In addition to families themselves, a range of religious and voluntary organisations provided care on an informal basis.

Over and above this, some public support was provided through the poor law system. Under this system, parishes, the basic administrative unit for much local government, were responsible for providing care for the needy in their area, distinguishing between the "deserving" poor – the infirm and those incapable of work – who were to receive support, and the "undeserving" poor – the idle or vagrant - who were to be placed

in workhouses.[98]

In the 1940s, and following worsening poverty in the depressed economic environment of the interwar years, momentum built for a more generous, centralised system of support. In 1946, the Labour Government abolished the poor law system via the National Assistance Act. Of a piece with the "paternalistic rationalism" that underlay the thinking of the modern welfare state's architects, the Act nationalised social care provision and created statutory duties for local authorities – subject to national oversight - to deliver social care services.

Gone was the distinction between the deserving and undeserving poor. The National Assistance Act divided those needing support on a means-tested basis into the sick, who were to be supported in hospitals, and those "needing care and attention", who were placed in residential care homes (often former workhouses). Unlike with healthcare, local authorities were permitted to introduce levies upon their residents on a means-tested basis to fund social care. For those unable to afford charges for residential care, the The National Assistance Board (NAB) provided funding.

Even in the early post-war period, the relationship between health and social care was ill-defined. Responsibility for local government moved from the Department of Health to a dedicated ministry in the early 1950s. The NAB, the original executive body for social care, was responsible to the Health Secretary, but it also had a statutory duty to work with the Department for National Insurance. The NAB was eventually abolished and subsumed into the Department of Health and Social Security, and later, the Department of Health.[99]

A series of Acts of Parliament increased both the powers and the responsibilities of local authorities in the provision of social services. The 1970 Local Authority Social Services Act required authorities to establish social services departments that would be responsible for the planning and delivery of local social services.

From the 1970s onwards, efforts were made to publicise provision for the elderly, and requirements were introduced for local authorities to register those requiring disability support. Over time, there was a move towards supporting more elderly or disabled people within the community, accelerated in the Thatcher period, when the government sought to reduce government spending and enlist non-state providers of care.[100]

The present system

This is, to a large extent, the system we have inherited today: 153 local authorities are responsible for adult social care across England on a means-tested basis, and they are funded through a blend of central government grants and council tax receipts. Councils have a statutory duty to provide certain minimum standards of care and to deliver need assessments. Local authorities spend more than £20 billion a year on social care to support some 750,000 people; millions more people pay privately or rely on unpaid family support.[101] The Institute for Government estimates that two

98. See Karl Polanyi, The Great Transformation,
99. Pat Thane, *Evidence to House of Commons' Health Committee Inquiry: Social Care* (October 2009)
100. *Ibid.*
101. IFS, Adult Social Care in England: What Next?

thirds of local government expenditure now goes on adult and children's social care.[102]

The present means-testing regime works as follows: those with assets over the upper limit of £23,250 are ineligible for support; those with assets between £14,250 and £23,250 can access partial support; and those with assets below £14,240 are not charged for the cost of their care.

The value of one's home is included in that asset calculation, except if another family member is continuing to reside in that home. However, given that most people will remain at home if they have a partner, the majority of those being assessed for funded residential care will have their home included in their asset calculation. Even those who are eligible may need to make contributions from their pension income, subject to a minimum income floor.

This low threshold (which has actually been frozen since 2010-11) means that only around one in ten people are eligible for state support. The vast majority will pay towards their care, and these costs are becoming increasingly expensive. The Department of Health and Social Care estimates that 1 in 7 over 65s will face costs of over £100,000. [103]

Social care in England currently involves a patchwork of public and private providers. Some 95% of social care beds are provided by the independent sector. And the private social care sector itself is highly fragmented: there are nearly 18,000 social care providers ranging from care home operators to organisations that offer home care.[104]

12. The money spent on social care in the UK and the outcomes delivered

Four broad trends are evident in social care expenditure and outcomes: the amount of money being spent by local authorities is increasing; the number of elderly people actually eligible for and receiving support is falling; unmet demand for social care services is rising; and satisfaction with provision is decreasing. Together, this offers a rather bleak prognosis for social care in England.

In the first case, local authority spending was cut in real terms between 2010-11 and 2014-15 but has been on a decided upward trajectory since then. Last year, it stood at over £27 billion, or about 1% of GDP. (See Charts 55 and 56.) This level of expenditure, as the following section will highlight, is only likely to grow.

102. Hoddinot, S., Kim, D., & Davies, N., "Fixing public services: Local government", *Institute for Government*, July 2024.

103. The King's Fund, "Key facts and figures about adult social care", July 2024.

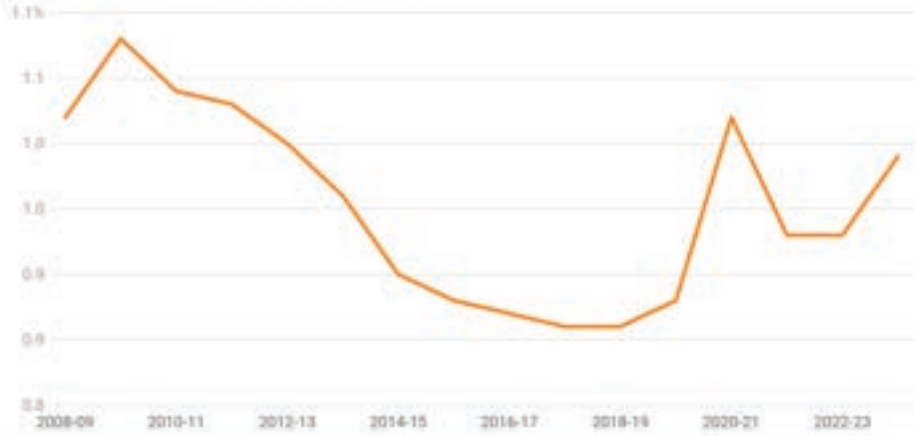
104. NAO reforming adult social care

Chart 55: Real local authority expenditure on adult social care in England (£), 2008/09 - 2023/24

Constant 2023/24 prices

Source: NHS England, Adult Social Care Activity and Finance Report, England, 2023-24. Expenditure is 'gross current expenditure'.

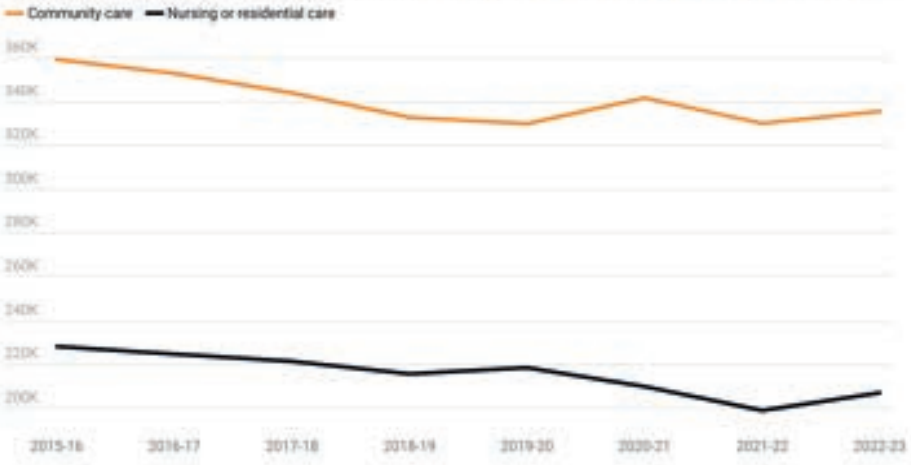
Chart 56: Local authority expenditure on adult social care in England (% of GDP), 2008/09 - 2023/24



Source: NHS England, Adult Social Care Activity and Finance Report, England, 2023-24; ONS, Gross Domestic Product at market prices: Current price, Seasonally adjusted £m. Expenditure is 'gross current expenditure'.

Yet, at the same time, because of the aforementioned stringent eligibility criteria for state-funded care, between 2015/16 and 2022/23, the number of older people actually receiving community care has fallen by 7%, while the number receiving nursing or residential care has decreased by 9%. (See Chart 57.)

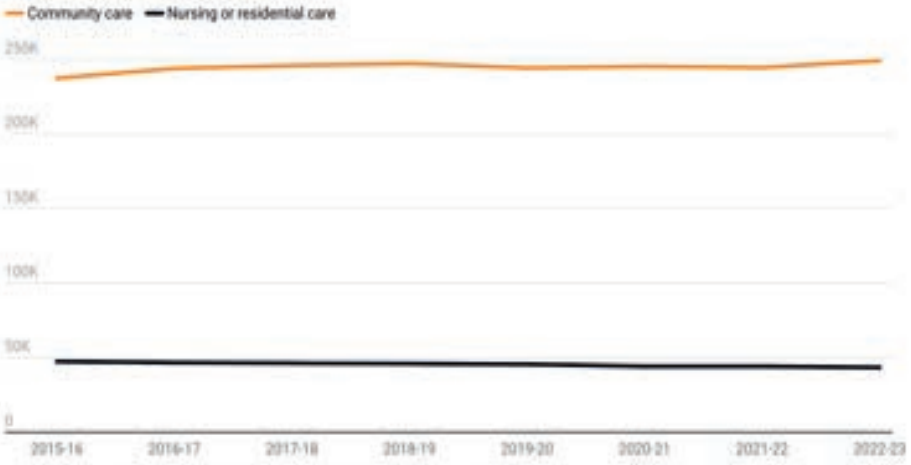
Chart 57: Number of people aged 65 and above receiving nursing/residential care or community care in England, 2015/16 - 2022/23



Source: NHS England, Adult Social Care Activity and Finance Report, England, various years

A caveat to these trends is that, as you can see from Chart 58, the number of people between the ages of 18 and 64 receiving support is relatively stable.

Chart 58: Number of people aged 18-64 receiving nursing/residential care or community care in England, 2015/16 - 2022/23

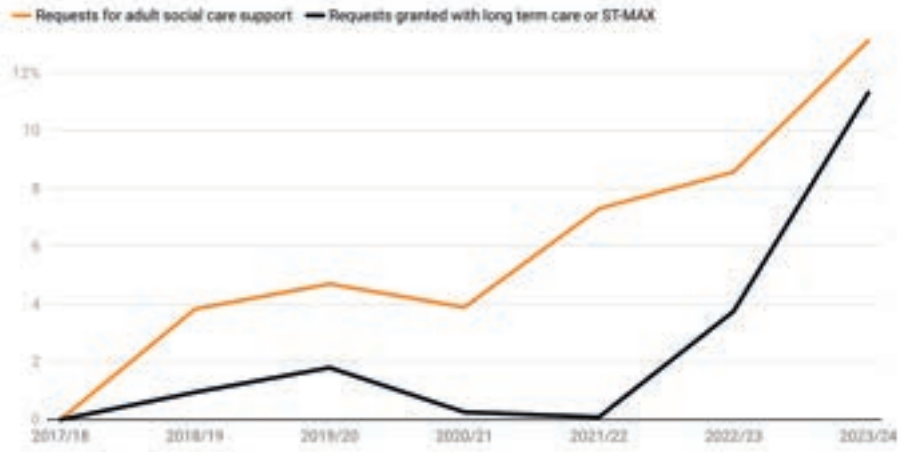


Source: NHS England, Adult Social Care Activity and Finance Report, England, various years

And while expenditure is increasing and fewer people are receiving support, outcomes are deteriorating. The Care Quality Commission (CQC) watchdog's 2023-24 report on the state of health and social care provision suggests that from 2017-18 to 2022-23, the number of new people requesting support with care had grown by 9%, but the number of requests granted had grown by less than half of that (4%), indicating rising unmet demand.[105] While in 2023-24 this gap narrowed somewhat, there is still considerable unmet demand. (See Chart 59.)

105. Care Quality Commission, "The State of health care and adult social care in England 2023/24", May 2025.

Chart 59: New requests for local authority social care support in England, and number of requests granted with long-term care or short-term care to maximise independence, % change relative to 2017/18, 2017/18 - 2023/24

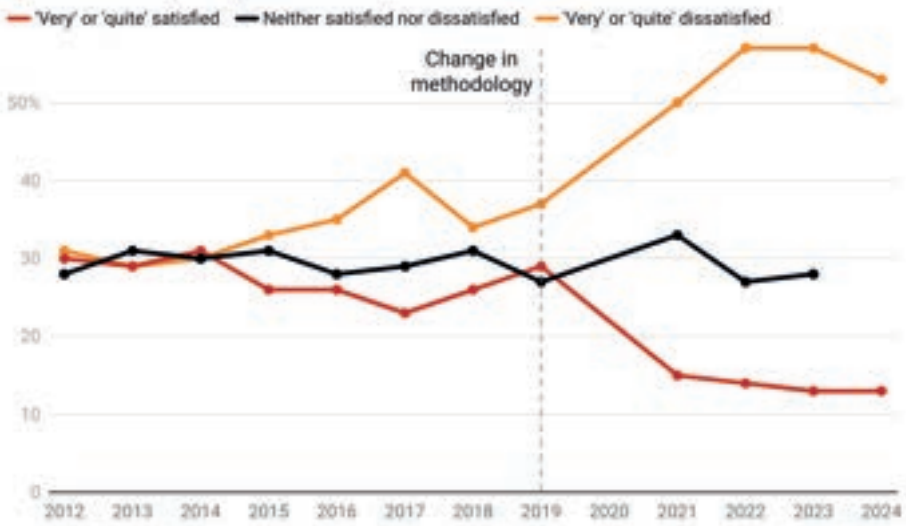


Source: Adult Social Care Activity and Finance Report, England (various years)

The CQC also found that a lack of available residential or home-based social care provision was probably responsible for an average of 45% of delayed hospital discharges for those who had been in hospital settings for 14 days or longer, or around 4000 people per day. Limited social care supply is thus hampering the effectiveness of healthcare services too.

Public satisfaction with the quality of care is also falling. The British Social Attitudes survey found that satisfaction with social care services was as low as 13% in 2024. 53% of people have reported being dissatisfied with social care, a 77% increase on a decade ago.[106] The number of residential social care homes rated as inadequate or requiring improvement by the CQC has grown from 3658 in 2019 to 4211 in 2024.[107] (See Chart 60.)

Chart 60: The public's satisfaction with social care services (% of survey respondents), 2012 - 2024



Source: The King's Fund and Nuffield Trust analysis of NatCen's BSA survey data. Responses do not sum to 100 since 'dont know' and 'refusal' responses are not shown.

106. Adult social care - Care Quality Commission
107. Appendix: CQC ratings charts - Care Quality Commission

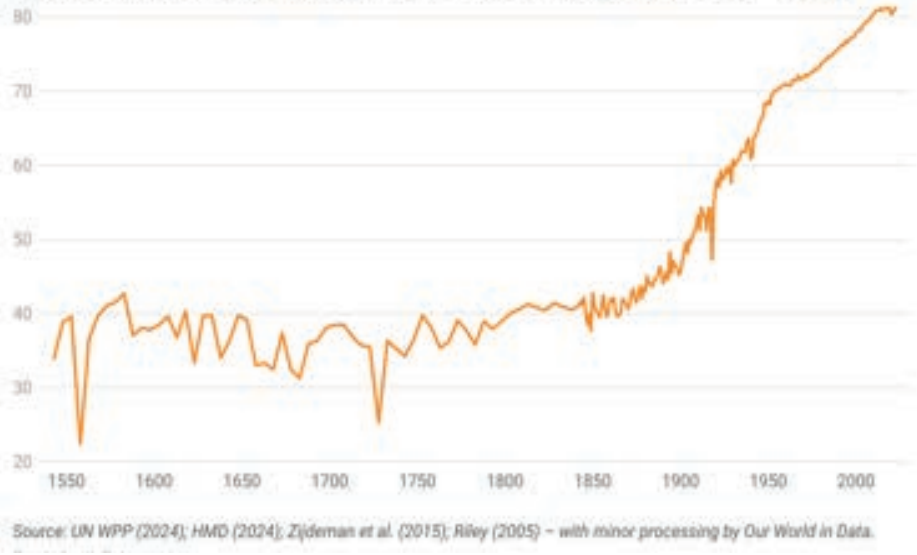
Long term pressures on the demand for social care.

Social care costs are rising rapidly too. In 2019-20, local authority gross current expenditure on social care in England was just below £20 billion. In 2023-24, the figure was over £27 billion, including an 8% real increase on the previous year. The Institute for Fiscal Studies believes that to meet the additional demand for social care over the next decade or so, local council spending will need to grow by 3.4% in real terms each year up to 2032/33, and from around 1.3% of GDP in 2023/24 to about 2% by 2053/54.[108]

At the core of these trends is once again our ageing population. (See Chart 61.) And demographic changes have not just driven increasing costs for councils, but the cost of care for the elderly *in general*. There is no data for private expenditure on care, but in 2017 the Competition and Markets Authority estimated that private residential care costs are some 41% higher than those paid for equivalent residential space on a means-tested basis by the council.[109] In 2020, *LaingBuisson* estimated the annual private spend on social care in England at £8.3 billion, or roughly £10 billion today.[110]

In other words, the local authority spend on social care is just one part of the overall amount of money spent on adult social care in the UK. And assuming that with an ageing population there is a growing number of people over the age of 65, and that the majority of these people will be over the current asset threshold for means-tested support, it is likely that private expenditure on social care will rise considerably in the years to come.

Chart 61: Life expectancy in the United Kingdom, 1543 - 2023



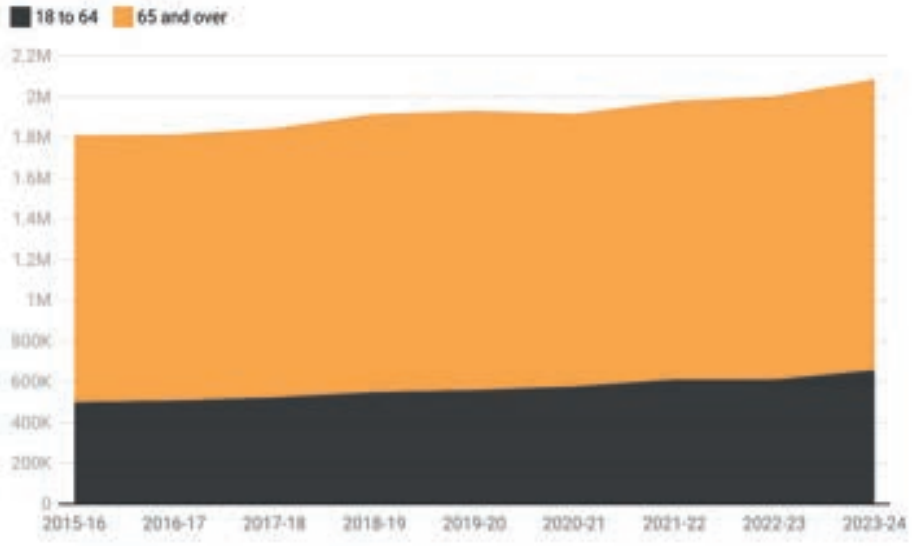
Costs can also vary considerably; the IFS calculates that social care spending is twice as high for a 60-year-old than a 30-year-old, three times as high for a 75 year old, twelve times as a high for an 85 year old, and 24 times as high for a 95 year old.[111]

And while the overall cost of social care has increased, because the

108. IFS, Adult Social Care in England: What Next?
109. Competition and Markets Authority, Care Homes Market Study: Final Report, 2017.
110. National Audit Office, *Reforming Social Care in England*, 2023.
111. IFS, Adult Social Care in England: What Next?

asset thresholds for the means test have been frozen since 2010-11, the number of older people receiving state assistance for social care has actually decreased by 10% since 2014-15. Local authority spending per elderly recipient has increased by almost 25% in that time.

Chart 62: Total number of new requests for social care support in England, 2015/16 - 2023/24



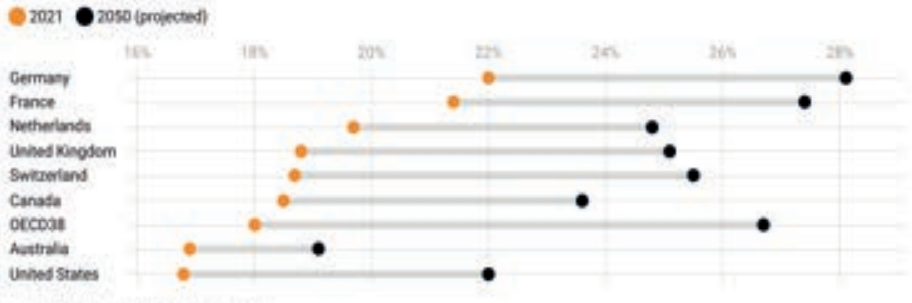
Source: NHS, Adult Social Care Activity and Finance Report, England - Various years

Comparisons with social care in other countries.

Britain's social care expenditure dilemma is driven by demographic trends that are affecting a host of other nations across the world, and not just in Europe either. As such, other nations are also facing acute fiscal pressures from the growing number of elderly people requiring long-term care.

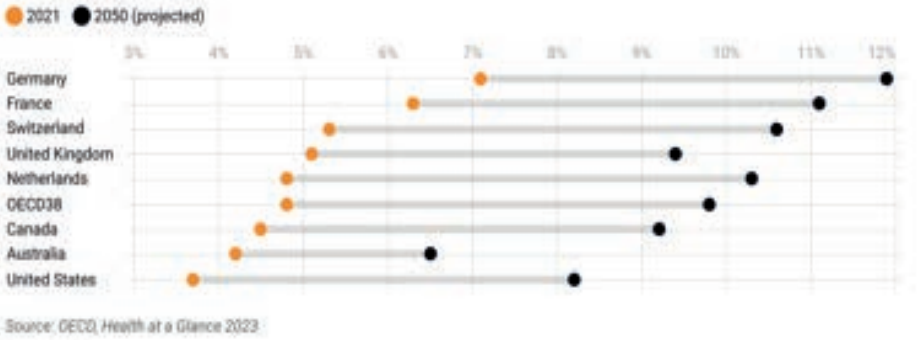
Charts 63 and 64 shows these population trends in perspective. The proportion of people over the age of 65 and 80 is on the rise in every country displayed, which in turn is driving higher demand for social care services.

Chart 63: Proportion of the population aged 65 and over across a selection of countries (%), 2021 and 2050



Source: OECD, Health at a Glance 2023

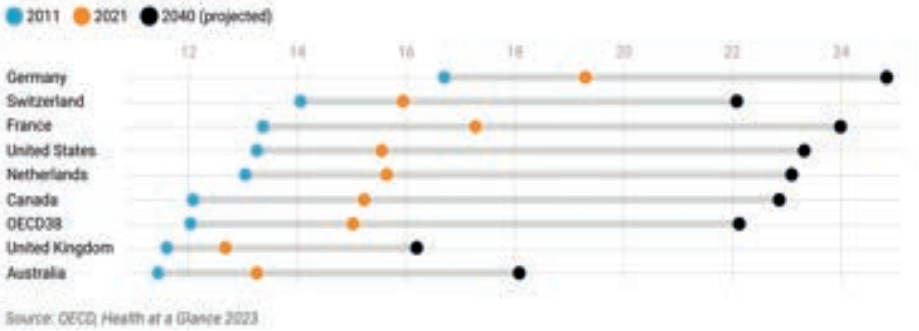
Chart 64: Proportion of the population aged 80 and over across a selection of countries (%), 2021 and 2050



Source: OECD, Health at a Glance 2023

To take one concrete driver of potential higher demand for social care services, as shown in Chart 65, the prevalence of dementia is forecast to increase appreciably in every OECD country. With this will come a requirement for more expensive social care provision.

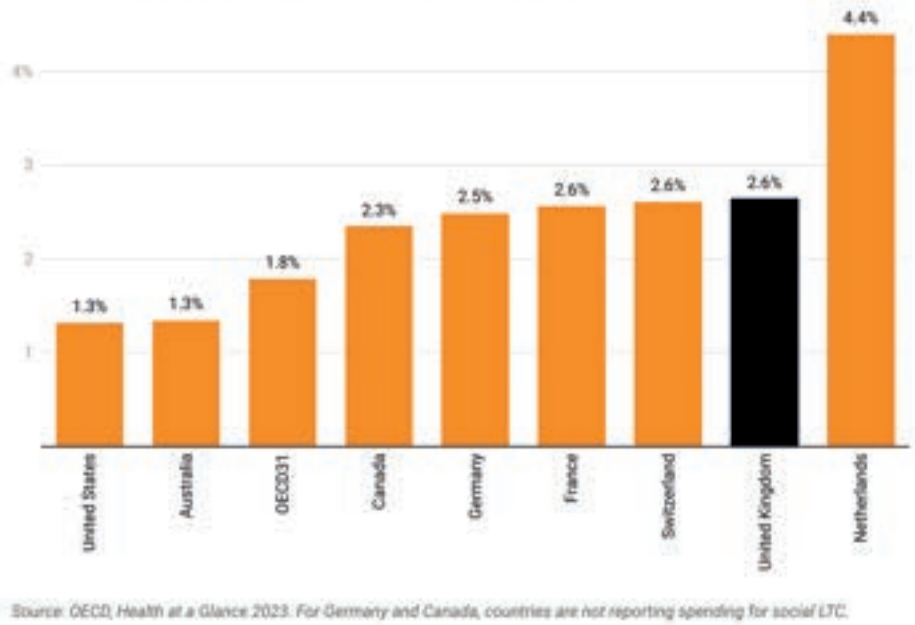
Chart 65: Number of people with dementia per 1,000 population across a selection of countries, 2011 - 2040



Source: OECD, Health at a Glance 2023

The OECD found that on average, countries are spending about 2% of GDP per annum on long term social care services; that figure was around 2.6% in the UK, France and Germany, and as high as 4.4% in the Netherlands. (See Chart 66.)

Chart 66: Total long-term care spending across a selection of countries (% of GDP), 2021 or nearest year



Source: OECD, Health at a Glance 2023. For Germany and Canada, countries are not reporting spending for social LTC.

However, variations are evident in social care spending based upon how mature a given country's social care system is, and what funding model they employ. We consider a few different systems below.

France

Like England, France's state-funded social care is paid for through general taxation as part of its comprehensive social security system.

The main funding source for long term care is the *Allocation personalisee d'autonomie* (APA) – a cash for care scheme managed by local authorities and paid to anyone over the age of 60 with care needs. Benefit payments can be used for both the costs of home care and residential care.

The government covers from 0% up to 90% of the cost of social care depending on a means test based on income and assets. The rest is covered out of pocket.

Netherlands

Similarly, the Netherlands has a higher level of social care spending because its model for the funding of long term care model, unlike its healthcare system, is based on general taxation. The Dutch Long-term Care Act covers people who require daily assistance. It is paid for through a premium applied as a fixed percentage of income, and offers universal coverage.

More minor care services are covered by the basic insurance discussed in greater detail in Appendix F.

Germany

Germany operates a mandatory, national insurance-based scheme for social care based on employee and employer contributions (split equally), where receipts are ring-fenced by government for social care provision.[112] These contributions equate to around 3.5% of the average German worker's income, and childless adults over the age of 23 pay an additional 0.25%.[113]

Compulsory insurance is expected to cover basic needs, rather than the full cost of care. Out of pocket payments are usually required to supplement insurance plans as the costs of care rise.

People requiring support with their care are assessed by the Statutory Health Insurance Medical Review Board. The amount of social care coverage provided by government depends on the severity of an individual's care requirements, and individuals are graded according to five levels of need from 1 (little impairment of independence) through to 5 (hardship).[114]

Those in residential care receive a fixed monthly amount which will partly defray the cost of care, with the rest paid for out of pocket. Those not in residential care settings can receive cash payments in accordance with their need grading.

Japan

Japan also operates an insurance-based long term care model called the "Kaigo Hoken" system, which was established in 2000. It is funded through a blend of general taxation, mandatory insurance premiums for those aged between 40 and 64, set as percentage of income, along with employer contributions, and premiums for those over the age of 65 based on income and assets.[115]

For those under the age of 64, the system only covers serious, chronic illnesses or care requirements; for those over 65, the system helps people meet the cost of a wide array of social care costs from residential care to home support.

Those requiring care provision undertake an assessment of need. This is blind to financial or personal circumstances. Benefits cannot be taken in cash, but they can be used for a whole range of services-in-kind. This has catalysed the development of a competitive market in care providers.

Users contribute a co-payment towards the cost of their care, but for most people, this is capped at 10% of the service's cost, with the co-payment rising for those with much higher incomes.

13. A new approach to financing Social Care in the UK

As outlined in this paper, the current system of social care in this country is haphazard and sits awkwardly with the current universal, free-at-the point-of-use principles which underpin the NHS. Reform is long overdue.

In recent years, various reforms have been considered to put adult social care funding on a more sustainable footing. In 2011, the Dilnot Commission proposed a lifetime cap on care costs of £25,000-50,000, and a more generous means test, above which people would have to

112. What can England learn from the long-term care system in Germany? | Nuffield Trust
113. Funding social care: an international comparison
114. ltci-germany-br1924-6-web.pdf
115. rb_aug18_international_comparison_of_social_care_funding_and_outcomes.pdf

pay the full cost of their care. Although the Coalition Government at the time endorsed the principles, it said its proposals could not then be implemented, citing the adverse economic conditions. Indeed, there was cross-party support for the Dilnot recommendations but a general lack of political will to push them through.

In its 2017 General Election manifesto, the Conservative Party proposed a more generous means test with a single capital threshold of £100,000. For those in domiciliary care, the value of their home would be included in the means test, but arrangements would be introduced so that no-one would be required to sell their home in order to fund their care. Confusion and criticism of the policy – branded by opponents as the "dementia tax". Jeremy Corbyn, then the leader of the Labour Party, said: "The dementia tax is itself unfair but what's made matters even worse is the way Theresa May announced a cap and then failed to say how much it would be". The Prime Minister, Theresa May, dropped the proposals.

The Johnson Government proposals made in the 2019-2024 Parliament were largely based on the Dilnot Commission's findings. A lifetime care cap would be set at £86,000, above which the government would foot the bill, and the means test would be made less stringent, with the lower threshold increasing to £20,000 and the upper threshold rising to £100,000. All of this was calculated to add £6.2 billion to annual social care spending by 2031.[116] These proposed reforms were delayed by successive Conservative Chancellors, and in the summer of 2024, Rachel Reeves confirmed that the Government would not be moving forward with them at all.

So social care funding reform has been kicked down the road by successive governments, in the main because of the thorny politics that would be involved with delivering such reform. Asking people to front up more of the cost for their own care using their existing assets – as the Conservatives found in 2017 – is unlikely to be popular. Equally, introducing a lifetime cap on social care costs would be highly expensive at a time when the UK's fiscal position is already fragile.

All of this largely relates to social care for those over the age of 65. But in fact, roughly half of all social care spending is on working age adults. While the majority of social care expenditure on over 65s relates to those requiring physical assistance, the majority of spending on working age adults concerns those with learning disabilities.[117] Over the last decade, the number of new requests for support from 18-64 year olds grew by around a fifth, whereas the population for that cohort only grew by roughly 5%.[118]

There has been much discussion about transitioning social care provision in the UK to a fully tax-funded model akin to the way the NHS is paid for, with more universal coverage and a cap on lifetime care costs. We strongly oppose this approach, since it will produce the same systemic issues that currently blight healthcare provision: namely, excess demand, and a disconnect between the consumption of services and the payment for them.

It is right to question why healthcare and social care should be organised

116. National Audit Office, *Reforming Social Care in England*, 2023.
117. Adult Social Care: Key facts And figures | The King's Fund
118. IFS, Adult Social Care in England: What Next?

and funded in such different ways. But this does not imply that we should move social care towards the troubled and hugely expensive NHS funding model.

An insurance-based model

Instead, just as with the NHS, new funding arrangements for which we are about to discuss, social care should be moved to an insurance-based system. The social care precept should be reduced and replaced by compulsory employee contributions out of salary for those below retirement age, and premiums for those above retirement age. After retirement age, there would be a needs assessment, which would establish the degree of benefit an individual would be able to receive.

Premium payments for social care should commence, as they do in Japan, when people reach their forties; this is the point in people's lives when they start to think more seriously about their retirement provision, but also when they are likely to have immediate family members who require care services. This should help build support for the proposed system.

Benefits should be available via both services in-kind and cash in-kind; the number of residential care homes should be regulated, and home or community care incentivised. Co-payments would be expected in addition to the insurance programme when accessing social care services, but should be capped at a certain proportion of the total cost of the insured service.

State subsidies would be required, but these should come from central government. These reforms will thus also assist in lifting a suffocating fiscal burden off local authorities, who should then be incentivised to deliver on their core duties. This will require reform of the local government funding formula, but that subject is beyond the scope of this report.

As a guide to the costs of such a funding model, Japan's Long Term Care Insurance (LTCI) system has annual expenditures of around Y12 trillion per annum, or around £60-70 billion – around £500 per person.[119] Funding is evenly split between insurance (46%) and state subsidy (46%), with a smaller proportion contributed via copayments (8%).[120] Very roughly, we might say that individuals over the age of 40 might face premium payments of around £230 per year or £19 per month, but in reality, this would vary considerably depending on the age of the individual and their financial means. In 2022, average monthly premiums ranged from just over £11 to as much as £50.[121]

On a per capita basis, this would leave aggregate social care expenditure in roughly a similar position to what it is presently. However, a few other things should be noted. Although the UK is heading in the same direction in the long term, Japan's population is considerable older at present, and so the demographic pressures on social care provision are higher. In the short term, costs in the UK might thus be proportionally lower.

Secondly, the present system in the UK is essentially unfunded, with current care being paid for through revenues. This is the least responsible

119. WKC Policy Series on Long-Term Care: Japan
120. Reforming Long-Term Care Arrangements in Japan | The Canon Institute for Global Studies
121. Japan | GOLTC

way to fund care provision, and the development of social care funds will greatly improve the sustainability of the system.

Finally, such a reform would potentially provide support for the development of what is a relatively immature market in social care provision. Giving people choice over how to use their service or cash in-kind support will spur the development of greater diversity and competition in provision.

D) How the NHS could and should be reformed

14. The reform options available for the NHS

In the sections above we have reviewed the cost of the NHS relative to other countries and discussed its performance in regard to waiting times for appointments and treatment, as well as comparing health outcomes across countries. And we have made reference to how it is regarded by the public. Overall, it is not a happy picture.

It is now time to turn to policy options. In the following sections we review a number of approaches, moving through the least radical to the most radical, with attempts to gauge possible savings and benefits, as well as the possible problems. But, not least because many of the possible policy options involve changes to how the NHS is funded, it is sensible to begin first with a brief description of the current NHS funding model.

The present NHS Funding Model

The NHS is funded primarily from general taxation. Individuals and businesses pay taxes to HM Treasury, which holds responsibility for setting overall public spending levels across government departments. Within this framework, the Treasury allocates a budget to the Department of Health and Social Care (DHSC) — the government department responsible for health and social care.

From the DHSC, funding is split into two main types**:** revenue spending (day-to-day running costs such as staff salaries, medicines, and GP services) and capital spending (investment in infrastructure like hospitals, technology, and major equipment).

Currently, the largest share of this funding is passed on to NHS England, the body responsible for overseeing the operation of the NHS in England and ensuring money is spent effectively. NHS England manages the bulk of the healthcare budget and plays a key strategic role in funding allocation. However, the Government recently announced that NHS England would be wound up, and the DHSC would in future be responsible for allocating funding directly.

At present, NHS England then distributes the majority of this funding to local commissioning bodies called Integrated Care Boards (ICBs), which are responsible for planning and commissioning health services in their

areas, based on population health needs.

The allocation to each ICB is determined by a weighted capitation formula, which considers factors like the size and age of the population, levels of deprivation, and local health inequalities. This is designed to ensure fair distribution of funds, with areas of higher need receiving more support. ICBs use their budgets to commission a range of services from NHS trusts, foundation trusts, GPs, community services, and mental health providers.

In addition to funds passed to ICBs, NHS England retains a portion of the budget for nationally commissioned services. These include specialised services such as rare disease treatments, national screening programmes, and some high-cost drugs and devices — services that are best planned and procured at the national level due to their complexity or low volume.

Local authorities also receive some health-related funding from the DHSC, specifically for public health services (e.g., smoking cessation, sexual health, and drug misuse services). This is delivered via a ring-fenced public health grant.

Finally, providers — hospitals, GP practices, mental health services, community care organisations and so on— receive payments based on the contracts agreed with ICBs and NHS England. These payments fund the direct delivery of care to patients across the country.

Now the policy options.

The option of doing nothing

The first, and least radical, option is simply to do nothing. Nor would this necessarily be an act of madness. It is possible to imagine a future in which the burgeoning demand for healthcare which has characterised the last 80 years levels out or even goes into reverse. The prime drivers behind such an outcome would be technological: the increased availability of preventative care and the increased availability of relatively cheap treatments for medical conditions already developed.

Mind you, although such an outcome may be just about possible, it hardly seems likely. Such technological improvements might well enhance health outcomes but on all past form they are likely to involve higher and not lower spending.

Even without the benefit of reduced demand because of prevention and/or the advent of cheap and effective treatments, it is open to the UK simply to carry on with the existing healthcare model, limiting demand through queuing and accepting that the most advanced and expensive treatments are not available on the NHS. The result would be that the breadth, if not the quality, of medical care available on the NHS was deliberately accepted as inferior to what can be obtained in the private sector, and in both the public and private sector abroad.

Yet, even if rationing and disappointing outcomes were accepted, this would not stop the cost of the NHS from rising alarmingly, not least because of demographic pressures. Before long, this would be unacceptable. Accordingly, something would have to be done.

Putting in more money

It would surely be possible to improve UK health outcomes and reduce waiting lists by spending more money on healthcare without altering the organisation and funding of the NHS. Indeed, some commentators have argued that the debate about the method of funding has served as a distraction from the really important concerns about the amount of resources. [122] Certainly, our comparisons of health spending across a range of countries showed that, although the UK spends proportionately much more on healthcare than Singapore, it spends a bit less than some comparator countries such as France and Germany.

Surveys of public opinion tend to find support for the idea that the government should spend more on the NHS. The latest BSA Survey states " just 8% say that the government is spending "too much" on the NHS, while over two-thirds (69%) think it is spending "too little" ".

Yet if the government simply pumped in a lot more money into the NHS without fundamental reform, we doubt that the public would be satisfied with the outcome. For a start, it is not at all clear how much of an improvement in health outcomes could be secured for each extra 1% of GDP spent on health and paid for by higher taxes. Bearing in mind the internal challenges of the NHS, the answer might well be not very much.

Admittedly, the large increase in spending on the NHS under Gordon Brown did initially bring a very large reduction in waiting lists Moreover, it is noteworthy that the UK has a relatively low number of CT scanners and MRIs compared to other developed countries. More money spent here could bring earlier and better identification of serious conditions.

Nevertheless, on the whole past large injections of money into the NHS do not appear to have moved the dial and there is a danger that such injections end up financing major increases in pay.

Moreover, the UK faces an acute economic challenge. There is no scope to "let borrowing take the strain". The UK simply isn't in a position to blithely divert more resources into healthcare without fear of the economic consequences. Raising NHS performance by a notable degree just by pumping in more money would require enormous sums, which would have to be found by cutting other sorts of public spending and/or by substantial increases in taxation. So simply pumping in more money into the NHS without other changes is not an attractive option.

Accordingly, we disagree with those who have argued that discussion of funding models is a "distraction". On the contrary, we believe that how we fund the National Health Service is of great import, and not just to the financial sustainability of the service, but also to the quality of healthcare people receive, and the incentives people have to lead healthier lives.

Improving the functioning of the current model

Another approach is to improve the functioning of the NHS to make it work more efficiently and to save money. These savings could then be used to fund improvements in the NHS itself, thereby delivering a better service for no more money than is spent currently, or to reduce the demands of

122. Long-term sustainability of the NHS: Options for systems and funding - House of Lords Library

the NHS on the taxpayer.

It is not difficult to imagine ways in which you could attempt to improve the functioning of the NHS, as currently structured. One attractive possibility is to end national pay bargaining within the NHS, enabling the service to reduce pay in some less over-heated parts of the country. In 2012, Policy Exchange estimated that the cost of national pay bargaining across the entirety of the public sector was at least £6.3 billion.[123] Uplifting this figure according to real increases in the public sector pay bill would suggest that today national pay bargaining might cost around £6.9 billion across the whole public sector.[124]

In 2022-23, the NHS spent some £71 billion on staff salaries while across the public sector this figure totalled £240 billion.[125] By adjusting our previous figure according to the proportion of the public sector wage bill attributed to the NHS, we estimate that the abolition of national pay bargaining could save the NHS in England about £2 bn per year.

Another interesting possibility is to relax the restrictions on advertising in NHS hospitals. But this would potentially raise only nugatory amounts of money.

But what most people think would be a source of major savings is to make the NHS more efficient through some sort of reorganisation and/or a reduction in "bureaucracy". This has some undoubted attractions. There are surely many aspects of the functioning of the Service which are not properly efficient and where there is definite room for improvement, from missed appointments with GPs, to less than full usage of operating theatres to bloated management.

This temptation to go down this route is all the stronger once you contemplate the sheer size of the NHS with its umpteen layers and management groups. It is Europe's largest employer with something like 1.38 million (full time equivalent) staff on its payroll. The recent abolition of NHS England is an encouraging step in the direction of a slimmed down bureaucracy and greater efficiency. Doubtless there are many more such steps that can be taken.

Nevertheless, there are four reasons for believing that culling the NHS bureaucracy, improving management and boosting efficiency is not going to solve the funding crisis for the NHS or bring a substantial improvement in the quality of the service.

First, there is some evidence to suggest that the efficiency performance of the NHS is not that bad. In 2021 the Commonwealth Fund put the NHS fourth in its ranking of healthcare systems behind Norway, the Netherlands, and Australia. It also put the NHS top for the affordability of care. But the NHS was near the bottom for healthcare outcomes at ninth, above only Canada and the US. [126] In 2024 the Commonwealth Fund ranked the UK first among ten developed countries for the administrative efficiency of the healthcare system.[127]

Second, the recent history of the NHS has been riddled with reorganisations which have been traumatic and yet have achieved only mixed positive results. By the time that Labour left office in 2010, there

123. Holmes, E. and Oakley, M. (2012), Local Pay, Local Growth, Policy Exchange, link

124. HM Treasury (2012), Public Expenditure Statistical Analyses 2012, link;

HM Treasury (2023), Public Expenditure Statistical Analyses 2023, link;

HM Treasury (2025), GDP deflators at market prices, and money GDP March 2025 (Spring Statement & Quarterly National Accounts), link

125. The King's Fund (2024), Key facts and figures about the NHS, link

HM Treasury (2023), Public Expenditure Statistical Analyses 2023, link;

126. Schnelder, E., et al., 'Mirror, Mirror 2021: Reflecting Poorly', *The Commonwealth Fund*, August 2021

127. Commonwealth Fund, "Mirror, Mirror 2024: A Portrait of the Failing US Health system: Health Care System Performance Rankings".

had been 9 big changes to the structure of the health service. The health economist Alan Maynard described these as "re-disorganisations". [128]

Third, if a radical improvement in efficiency were to be made, with the best will in the world, this is unlikely to be able to save more than a small percentage from total NHS spending. After all, the abolition of NHS England, which seemed a pretty bold move, is forecast to save approximately **£500 million** each year.[129] This is due to a reduction in staff costs and a drive towards eliminating the duplication of tasks, reducing the time spent by staff on paperwork and other superfluous activities. This is not a trivial amount but neither is it a game changer.

Fourth, this would be a one-off saving. There might be some measures which could improve productivity growth in the NHS which could provide some continuing improvement over the status quo, e.g. through greater use of AI. (But the record of the NHS on major investments in technology is not at all good.) And unless the productivity gains were very large, whatever improvement was generated by the efficiency drive would soon be swallowed up by the inexorable pressures for increased spending outlined in this paper. These pressures threaten to overwhelm the public finances.

Nevertheless, there are potential savings to be found through freeing up frontline staff from a variety of administrative and manual tasks and allowing them to be more efficient and focus on patient care by better utilising technology and automation. Although this would involve upfront costs this would have the potential to bring significant savings to the NHS.

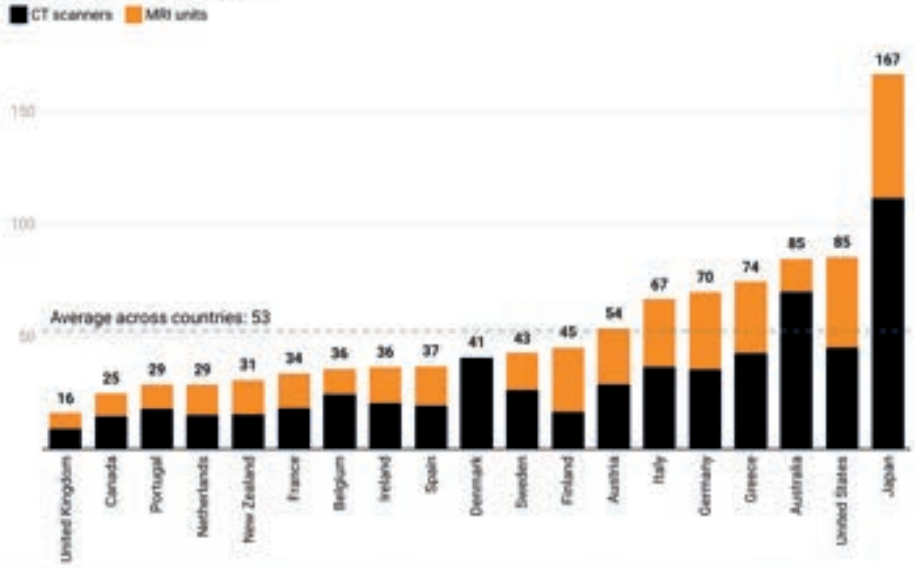
There is significant potential for the NHS to reduce costs and deliver patient care when providing a range of services including screenings for serious diseases such as cancer, diabetes, and cardiovascular disease. It could also be used to improve other diagnostic procedures while also helping patients to effectively manage their conditions.[130]

Moreover, the utilisation of new technology has the potential to reduce the burden on healthcare professionals by undertaking more unpleasant and repetitive tasks which would allow doctors and nurses to instead focus on providing the highest possible quality of care to patients and increasing overall productivity.[131] [132]

The UK has a smaller proportion of MRI and CT scanners than other comparable countries. (See Chart 43.) Yet an early diagnosis is often essential for effective treatment. So increasing the MRI and CT capacity of hospitals in the UK has the potential to improve patient outcomes and lower costs.[133]

128. Quoted by Hardman, op. cit., p225.
129. Moon, J., Crew, J., & Cursino, M., 'Keir Starmer abolishes NHS England to cut bureaucracy', *BBC*, March 2025
130. Sinha, R., 'The role and impact of new technologies on healthcare systems', *Discover Health Systems*, November 2024
131. EBME, 'The impact of technology on NHS efficiencies', July 2023
132. Ramanauskas, B., 'Embracing technology in health and social care', *TPA*, April 2019
133. NHS England, 'Early diagnosis', June 2025

Chart 43: CT and MRI scanners per million across a selection of countries, 2019 or nearest year



Source: The King's Fund, Comparing the NHS to the health care systems of other countries: five charts; OECD Health Statistics 2021. Denmark does not have data for MRI units. Equipment outside hospitals are excluded for Portugal, Sweden and the United Kingdom.

However, it is not just equipment which is traditionally used in hospitals which could potentially be used to improve patient outcomes while also reducing costs. There are also many other products such as apps and wearable devices which could be utilised.[134]

A 2019 study found that greater use of automation could result in a saving of **£12.5 billion** each year.[135] The Department for Health and Social Care currently spends approximately **£2.8 billion** of its budget on administration in the department and the healthcare system.[136] Reducing costs by a half through automation could therefore bring in potential annual savings of **£1.4 billion**.

Moreover, the NHS spends about £3bn agency staffing each year. If it introduced more efficient staffing procedures and/or increased regular staff numbers somewhat then this could potentially reduce the use of much more expensive agency staff. It doesn't seem unreasonable to aim for a reduction of a half in the use of agency staff. This could perhaps save the NHS approximately **£1billion** net annually.[137]

So there are credible ways in which money could be saved and the existing system could be made more efficient. But the simple truth is that managing any healthcare system is always going to be extremely difficult and the system is bound to be riddled with inefficiencies. Most fundamentally, in most parts of virtually all healthcare systems, the profit motive does not drive and guide decisions as it does in private business. And despite repeated efforts to replace this with targets and quasi-markets, there is no effective substitute.

As we shall discuss shortly, there is much to recommend the use of insurance as a major source of funding for healthcare, yet this brings its own complexities and administrative costs. In many countries that operate

134. May, E., 'How digital health apps are empowering patients, improving outcomes, and increasing accessibility', Deloitte, October 2021
135. Ramanauskas, B., 'Embracing Technology in Health and Social Care', *TPA*, April 2019
136. The King's Fund, 'NHS Key Facts and Figures', June 2024
137. UK Government, 'Secretary of State pledges to contain NHS agency spend', November 2024

some form of insurance-based funding for healthcare, high administrative costs are a bugbear. This is most obviously true of the United States but it is also a major negative against the systems in Australia, Canada and France. (See the Appendices in Section F.)

Charging patients for certain services

There would undoubtedly be widespread public resentment if people were made to pay for various services which they currently receive for "free" on the NHS. But doubtless they would get used to it as they have had to do with prescription charges and payments for dental services. And some European countries have grasped this nettle, as shown in Table 8, although there is a wide variety of charging practice across different European countries.

Table 8: User charges by country in a selection of countries

	Germany	France	The Netherlands	Italy	Spain	Sweden	UK
GP visit	No	Yes	No	No	No	Yes	No
Inpatient stay	Yes	Yes	Yes	No	No	Yes	No
Outpatient visit	No	Yes	Yes	Yes	No	Yes	No
Prescription drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes (England only)
Dental care	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medical aids	Yes	Yes	Yes	No	Yes	Yes	Yes

Source: Thorlby, R. and Buzelli, L. (2024), 'Is the grass really greener?', The Health Foundation, link

Appointments with a GP

There are several ways in which patients could be made to make payments towards the cost of NHS provided services. The most obvious option would be to charge people for appointments with GPs. There is clearly much room for debate about the amount to charge per appointment. £50 might seem a plausible sum, while still being below the full cost. However, a charge this large would surely cause widespread consternation. Perhaps it would be wiser to start by charging £20 and then to gradually increase the charge over the years to £50. Specsavers charge £20-25 for a simple eye

test.[138] There is a charge of £30 to see a GP in Jersey.

An interesting variation on this idea is to leave GP visits free during core hours but to give GP surgeries the option to charge for evening or weekend appointments. Alternatively, these things could be combined so that all GP visits incurred a charge but for appointments during the evening or at weekends, the charge would be higher.

In the year to March 2025, there were an estimated 370 million GP appointments made, although only 331million were actually attended.[139] If there were a £50 charge for each of these appointments, this would raise approximately £18.5 billion, or £7.4 bn if the charge were £20 per appointment. (This applies to England only.)

Of course, introducing a price for appointments would probably cause demand to fall somewhat. It would surely reduce the number of missed appointments. Suppose that in response to the introduction of the charge, demand for appointments fell by 20%. That would bring the amount raised to £14.8 billion, or just under £6bn for a £20 charge. Some low-income patients would also be able to reclaim their fee. If we assume that 20% of the population reclaimed the charge, that would bring the figure down to about £12 billion, or just under £5 bn for a £20 charge.

In addition, though, there would be some saving of resources from the reduced number of appointments, including missed ones. Because the total cost of providing an appointment with a doctor is well in excess of the sum being charged in this example, this saving of resources may be worth considerably more than the notional value of the reduction in appointments. On the other side of the account, however, there would be some administrative costs involved in charging patients. These would need to be stringently controlled to make sure that there was a significant net saving overall.

A potential downside of this policy is that, because of the charge, some people who *should* have an appointment may decide not to make one. This effect may be particularly significant for those on lower incomes. This could lead to some worse health outcomes at the individual level and could ultimately end up costing the NHS as the chance to take a preventative approach to healthcare was missed and health issues were given longer to develop without necessary interventions.

There is a suggestion also that in Jersey an effect of the introduction of a charge for visiting a GP has been to divert more people into A & E, whose services cost much more.

There would also need to be careful consideration of how much to charge patients for appointments in GP surgeries with a professional other than a GP, such as a nurse, pharmacist or other members of the practice team. Similarly, how much should be charged for telephone appointments with a GP? And there might be room for different treatment of people who had long term medical conditions that required frequent visits to a GP. The fact that there are these important details to be ironed out does nothing to undermine the basic principle.

138.https://www.specsavers.co.uk/eye-test?

139.NHS England (2025), Appointments in General Practice, March 2025, link

Prescription charges

Another possible measure would be to end the automatic entitlement of the over 60s to free prescriptions. This could potentially save £0.5-1 bn per annum for England alone. A bolder policy would be to follow the recommendation of the 2014 Barker Commission and remove all exemptions from prescription charges and replace them with a cap to protect those on low incomes and with long-term conditions. A simplification of the charging regime would raise in the region of £1 bn for the Exchequer.

Hospital accommodation

It has been suggested by some that patients should be charged for hospital accommodation. If implemented, this could certainly raise some large amounts of money. In 2023/24 Q4, there was a daily average of roughly 96,000 NHS hospital beds occupied each night out of a total of some 104,000.[140] If a £30 charge per night were introduced, this might raise something in the region of £1bn each year. Assuming that the 20% of the population with the lowest incomes were made exempt would mean that such a charge might raise some £840m each year. Of course, the total revenue would vary based on the level that the charge was set at; a £50 charge could raise £1.4bn per year and a £100 charge could raise £2.8 bn. (These estimates are for England only.)

But most of the public would surely greatly resent such charges and their opposition could present formidable challenges to implementing any sort of charging. A more plausible suggestion is to keep most hospital accommodation free but to offer a more luxurious experience for, say, £100 per night. If 20% of hospital patients took up this offer, then it would raise about £700m per annum, gross of any extra costs incurred in providing upgraded accommodation.

Cosmetic surgery

Cosmetic surgery is not routinely performed on the NHS. However, some procedures such as breast enlargement operations and ear 'pinning' are sometimes performed if they are needed in order to alleviate psychological distress for patients or physical health problems.[141]

A more significant issue is the high prevalence of patients receiving surgery and other forms of treatment on the NHS in order to correct the mistakes of medical staff in other countries who performed botched cosmetic procedures or provided inadequate after care for patients.[142] For the use of laser surgery to remove tattoos, NHS providers already charge. Perhaps the NHS should also charge for remedial work after problems caused by botox performed by someone unregulated.

This is a growing problem and also includes non-medical cosmetic procedures performed in the UK.[143] It is estimated that this is costing the NHS approximately £1.7 million every year. As such, the NHS could save £1.7 million each year by charging patients for the cost of any corrective surgery which they received on the NHS.[144] But as this is a relatively small

140. Nuffield Trust (2024), Hospital bed occupancy, link
141. NHS, 'Is Cosmetic Surgery Available on the NHS?', April 2023
142. Roberts, J., Eckersley, M., & Davies, K., & Gilmour, A., 'The cost of cosmetic surgery tourism complications to the NHS: A retrospective analysis', *The Surgeon*, October 2024
143. Whiteman, E., *et al*., 'The rising NHS burden from cosmetic surgery procedures performed abroad and non-surgical procedures performed in the UK', *Journal of Plastic, Reconstructive, and Aesthetic Surgery*, March 2025
144. Aesthetic Medicine, 'Should the NHS fix botched cosmetic treatments', July 2023

sum, we do not include it in our estimate of the possible total savings which can be made.

It would be possible for the NHS to offer cosmetic surgery but priced competitively in order to make a profit for the Service, which could then be used to fund other, free, treatments, or to reduce the overall cost of the Service. The provision of cosmetic surgery might help the NHS to retain some good medical staff. We have not, however, included this idea in our proposals.

Hiving off

It was noted above that one of the NHS's major problems is its sheer size which makes it extremely difficult to manage. Hiving units off would help to make it smaller. In addtion, such specialist medical units could generate efficiency savings through economies of scale and the benefits of specialisation.

In due course these separate clinics, could be privately owned and run and charges for their services could be levied directly on patients. (This idea is definitely not a new one. Optometry and dentistry both used to be routinely provided by the NHS but are now mainly provided by private businesses.)

Given the scale of likely charges, however, these could not be levied on patients directly until a full system of comprehensive insurance was in place. (See below.) But a transition could be initiated relatively quickly with specialist centres being hived off, although still paid for by the NHS.

We give examples below of possible medical procedures which could be hived off. Because we are not proposing that patients be charged for these procedures before a comprehensive system of medical insurance was in place, however, we have not included them in our list of possible savings which can be made under the existing system.

Orthopaedic

Hip replacement and knee replacement operations cost the NHS approximately **£2 billion** each year. Given that the UK is facing demographic challenges in the form of an ageing population, this cost is set to increase significantly in the coming years and decades.[145]

Ophthalmology

Cataract surgery funded by the NHS but often provided by private clinics costs approximately **£430 million** annually.[146] As with orthopaedic procedures, cataract surgery is predominantly required by older people and so demand is set to increase.[147]

Gynaecology

The NHS performs approximately 30,000 hysterectomies each year.[148] As these cost approximately £8,000 in a private hospital this means that a conservative amount costs the NHS **£240 million** each year.

145. Mathrau, G., Culliford, D., Blom, A., & Judge A., 'Projections for primary hip and knee surgery up to the year 2060: an analysis based on data from the National Joint Registry for England, Wales, Northern Ireland, and the Isle of Man', *Annals of the Royal College of Surgeons of England*, June 2022
146. Kollewe, J., 'Boom in cataract surgery in England as private clinics eye huge profits', *The Guardian*, June 2024
147. The Royal College of Ophthalmologists, 'Cataract Sector Data Report', August 2022
148. The Hysterectomy Association, 'Hysterectomy Information', 2025

Dermatology

There is not much in the way of recent data for the cost of dermatology treatments to the NHS but estimates have placed it in advance of **£700 million** per year.[149]

Encouraging more individual responsibility for health

Another approach would be to give people an incentive to take more responsibility for their own health and deny NHS treatment to people who blatantly ignore medical advice and take great risks with their health, e.g. by smoking. It is unclear how much of a benefit could be derived from this but, as things stand, it is difficult to imagine the NHS denying necessary treatment to people because of their previous lifestyle or behaviour.

It would also be possible to encourage people to opt out of the NHS by making private medical insurance tax deductible. Of course, far from saving money, at least directly, this measure would cost it in the form of reduced tax payments by those who took out private insurance. Given that health insurance is already tax deductible for companies, this measure effectively means introducing tax deductibility for *individuals* with private health insurance.

According to private healthcare analysts LaingBuisson, latest data shows that 3.8 million people from a total of 4.9 million private health insurance policyholders were covered by a policy from their employer. Therefore 1.1 million had taken out policies as individuals.[150] We estimate that making such insurance premiums tax deductible would cost the UK Treasury only about £0.25bn.

However, making private health premiums tax deductible would probably lead to greater demand. If we assume that the number of people taking out private insurance doubled, this would take the total cost of this measure to £0.5bn.

The potential offset to these costs to the Treasury, of course, is a saving in the amount of NHS resources required to provide healthcare for the population.

One major objection to such a scheme might be that it would make the adoption of a system of general, compulsory health insurance all the more difficult. Presumably, if such a system were adopted then medical insurance premiums would cease to be tax deductible, making such a move unpopular with those people who had already taken out private medical insurance. But if some sort of tax voucher were dispensed to all taxpayers at the time of the introduction of compulsory health insurance then those people who had previously been medically insured would still be better off. (See the discussion below about compulsory medical insurance.)

Accordingly, we have not included making private medical insurance tax deductible in our estimate below of the total possible savings from the various measures discussed above.

149. McKee, S., 'Skin conditions cost NHS £723 million a year', *Pharma Times*, March 2018

150. Campbell, D. (2025), Almost one in eight Britons now has private medical insurance, say healthcare analysts, The Guardian, link

The overall savings

So, the total potential saving from all the measures discussed above, excluding the privatisation of certain medical procedures, could be just over £11bn per annum. Far and away the greatest saving comes from charging to see a GP, and this calculation assumes that the GP charge is set at £20. It that were raised to £50 then the total amount raised would increase by £7bn to £18bn.

£11bn is substantial but not transformatory in the context of total NHS spending in England in 2023/24 of £188.5 bn. It amounts to a reduction in health spending of just under 6%. If we gross up these savings for England into savings for the UK as a whole, the figure comes to just under £13bn, or slightly less than ½% of GDP.

Most importantly, such a saving would not deal with the inexorable rise in costs and consequent ever-increasing burden on taxpayers that happens under the current system. So we are still lacking a really radical option.

Table 9: The potential amounts raised/saved in England from various measures taken within the existing NHS model, £bn	
Ending national pay bargaining in the NHS	£2bn
Halving the administrative cost of the DHSC through better use of technology	£1.4bn
More efficient staffing procedures reducing the use of agency staff	£1bn
Charging £20 to see a GP	£5bn
Rationalisation of prescription charges, including the end of exemption for over 60s.	£1bn
Charging for more luxurious hospital accommodation	£0.7bn
Total	**£11.1 bn**

A completely different model: compulsory insurance

All of the interventions above could have some role in improving the amount of cash available for NHS services, or reducing waiting lists, or both. But they would leave the fundamentals of our healthcare funding system untouched - a system which by its very design will continue to precipitate crises in resourcing, and to disincentivise improvements in the quality of care that British people receive from the NHS. The opportunity to rewire the incentives in healthcare provision and transform the services and treatments available to the benefit of all is offered by moving to a different funding model – one with a significant role played by a system

of compulsory insurance.

This idea is bound to alarm some people who would believe that they would end up paying more. After all, they believe, they currently receive their healthcare "free". Yet the NHS is definitely *not* free. In fact, it is expensive, and increasingly so. The question, rather, is *who* pays, *how* do they pay, and how does the burden of payment fall *distributionally* across society. At the moment, healthcare in the UK is funded predominantly through taxes, and the tax system is progressive. The payment for services is largely unconnected to their consumption.

The introduction of a compulsory insurance element into the model would reduce the distance between the payment for services and their consumption, and if well designed, would offer better incentives for improved services, reduced waste and long-term funding sustainability.

The insurance principle

Of course, insurance is something that most people are familiar with. We insure our cars, our homes, our lives and so on. Nor is the concept of compulsory insurance unfamiliar. Car insurance is compulsory for drivers. Although home insurance is not compulsory, it is for anyone wanting to secure a mortgage.

By setting aside a small amount of capital to purchase insurance, we protect ourselves against the potential costs associated with catastrophic events – a crash, a fire, an injury, and so on. Companies providing insurance policies agree to indemnify people against the financial liabilities of such events and do so by pooling risk across a wide number of policyholders. They then invest the "premiums" – the fee that policyholders pay – in assets to generate revenue.

Premiums and returns on investment help to build the funds out of which insurance claims are paid to policyholders. But insurance policies often have an annual "excess" or "deductible" too – that is, a minimum amount that must be paid out of pocket before an insurance policy kicks in. In many cases, lower insurance premiums – the cost of the policy – can be secured in return for a higher excess.

Some will argue that we already operate a "national" insurance model in the UK. Individuals supposedly insure themselves against illness through their national insurance contributions, and the state acts as both insurer and provider. Yet, even if something like this was envisaged when the system was established, it is certainly not the case today. National Insurance does not provide medical *insurance* in any meaningful sense. Entitlement to healthcare is not linked to national insurance contributions. (This contrasts with the state pension, where the amount of the entitlement is determined by an individual's N.I contribution record.)

Nor is there a fund somewhere in the government's coffers used to pay for the NHS out of built-up contributions. Rather, the costs of healthcare are funded out of current government revenues, and those revenues are generated through taxes and N.I. contributions, which are a form of quasi-tax.

Types of private insurance

As it pertains to healthcare, there are good ways and bad ways of implementing an insurance component in the funding model. The worst are to be found in the US. As this study has highlighted, however, many other countries have much better systems, including Australia, the Netherlands and Singapore, to name only three.

The most significant systemic issues for insurance-based healthcare relate to adverse selection and coverage. In the first place, those who might expect higher healthcare costs – perhaps those with chronic conditions – are more likely to take out comprehensive insurance, while healthier individuals with lower anticipated costs may opt not to purchase insurance, or to take on more restricted plans. At an aggregate level, this increases the average risk of those insured, and will encourage insurers to increase their premiums. And this in turn may further push healthy individuals out of the risk pool, aggravating the problem further. The result is higher bills and lower coverage – precisely the problems that have plagued the American system assessed in Appendix A.

But most health care insurance systems do not operate on a pure, private insurance basis. In most cases the government intervenes proactively to counter these potential downsides. Often, governments mandate insurance coverage while operating some scheme of risk equalisation, whereby insurers are compensated for their high-risk policyholders in order to keep costs down through tax funded subsidies. Often too, they will pay the premiums of those least able to pay, like those below a certain earnings threshold, or children.

An additional problem with a fully insurance-based model is that it may lead to excessive demand for services, since the marginal cost of consuming more healthcare for the policyholder can effectively be reduced to zero, as it is in the current tax-funded model This can be mitigated through the use of co-payments for services and/or the inclusion of excess payments in insurance contracts.

The Dutch model set out in detail in Appendix F employs all of these devices to mitigate the systemic risks of insurance-based models. In addition, it also regulates the providers – hospitals – to scrutinise care standards and ensure an adequate supply of more expensive healthcare services. It also sets a minimum level of provision for insurance policies – the Basic Plan – which works both to guarantee coverage but also to prevent the problem of excess consumption; services beyond the Basic Plan come with additional costs.

The latest figure for the average annual cost of medical insurance in the Netherlands is 1900 euros, or about £1600. Given that we favour using the Dutch model as a template for the sort of system that the UK might adopt, this is probably a reasonable starting point for what to assume about the average cost of medical insurance in the UK. It has to be acknowledged that for most people this is a very considerable sum. It compares with an average annual cost of car insurance in the UK of £589. [151]

Moreover, in the Netherlands there is also an income related health

151.Hooson, M., & Pratt, K., "UK Car insurance Statistics 2025", *Forbes*, May 2025.

contribution paid by employers to the tax authorities. On the median Dutch salary this amounts to an annual employer contribution of 2,500 euros. If the UK were to follow something like the Dutch system, we would have to decide whether to include this employer contribution, perhaps balanced by a reduction in employer National Insurance contributions, or simply to finance the shortfall out of general tax revenue.

Ultimately, a healthcare system with some insurance-based funding component can be highly flexible, and this would be the case for a reformed NHS. The Government can determine the threshold at which it intervenes to subsidise insurance premiums and can set it both higher and lower to achieve the right balance between affordability and generosity. It can set the annual excess higher or lower to flex the amount paid by individuals out of pocket, and it can determine how many services are subject to co-payments, what the rate is, or indeed it can leave that to insurers.

What would health insurance look like in the UK?

As noted above, there is a range of ways in which insurance can be employed to fund healthcare provision. Unfortunately, the political debate in the UK tends to associate insurance-based healthcare with the model operated in the US and ignores that some of the most highly regarded healthcare systems in the world – like that in the Netherlands – with the very best outcomes for patients, are largely based upon some scheme of insurance payments.

So let us be clear about what we are advocating here: we believe that better quality healthcare with universal coverage and improved long term funding sustainability could be secured by moving from our present, entirely socialised model to a hybrid model with a significant social insurance component. This reformed healthcare system would ensure universal, affordable coverage, subsidise the cost of the care for those under the age of eighteen, those on low incomes and those with long term conditions, employ a blend of insurance premiums, annual excesses, tax contributions and copayments, and would ensure a high minimum standard of provision as well as greater choice for individuals over their healthcare.

Health insurance would be compulsory, and individuals would be required to take out a policy with an insurer, to which they would pay premiums directly. There would be a standard minimum annual excess regulated by government; this intervention would be designed to curb demand, and help generate the funds required for insurers to contribute towards subsidy programmes.

Insurers would be required to charge all their enrolees the same annual premiums, and they would not be able to refuse individuals coverage. This would be achieved by introducing a system of risk equalisation, whereby the government would compensate insurers for the cost of covering individuals with higher health risks. A central fund would be established through insurer contributions and funded by the tax system, which would then be distributed to insurers enrolling individuals with

serious or chronic health needs.

The government would regulate the level of provision offered by insurers by setting out a 'basic plan' in statute. This would establish the minimum set of services and treatments to be covered by an insurance policy. At the start, it should be set to cover core services from current NHS provision, but with a number of important exclusions.

Firstly, GP appointments and prescriptions would be covered by insurance, although both would be subject to co-payments. The Government could introduce a savings vehicle whereby people could set aside money tax free to use for co-payments, with transferrable allowances for families.

Secondly, a range of elective treatments – potentially including dental care, ophthalmology, and some orthopaedic treatments - would not be included in the basic plan and would require supplementary coverage.

Together, insurance premiums, the annual excess, co-payments, and a small tax-funded state contribution would replace the proportion of people's tax liability which currently goes towards government spending on healthcare. These savings would be passed on to taxpayers via a reduction in the rate of income tax. (See below.)

Insurers would be largely comprised of regionally-based not-for-profit organisations. However, over time, the system would allow for regulated competition from private insurance providers, trade unions, employers, and so on.

Insurers would be given freedom to establish contracts with providers of healthcare services, so long as they guaranteed the minimum level of provision to their policyholders as set out by statute. Hospitals would be allowed to convert to not-for-profit foundations, and new providers like specialist clinics or centres would be allowed to enter the market. All providers would be regulated by the government, but they would have greater freedom to set budgets and prices. They would also be able to set their own remuneration policies for both administrative and medical staff.

The whole system would be underpinned by a commitment to an affordable, minimum level of provision with universal coverage. But it would also be one based on a greater degree of freedom and choice than the entirely socialised system we presently operate. This includes choice for individuals, who would not only be able to choose their insurance provider, but should also be able to opt for a higher annual excess in return for lower monthly premiums.

Additionally, hospitals ought to be able to charge differential rates for wards offering different non-medical related amenities like greater space, privacy, or wifi. (Doctors would not be able to be remunerated differently for work in different wards.) And while insurers would be required to charge enrolees the same monthly premiums for core coverage, they should be allowed to offer higher rates for those who wished to access a wider range of elective treatments or the non-medical amenities set out above, as well as discounts for those who participate in health schemes, purchase gym membership, or who take preventative health measures

like screenings or smoking cessation programmes. But the government would regulate what risk factors insurers would be able to adjust premium payments on.

The government would still be actively involved in this reformed healthcare system, but its role would be significantly changed – from a centralised planner of healthcare to a market-maker, regulator, and a safety-net provider for those unable to fund their own provision.

What we are **not** proposing

It is important to be clear on what is not being recommended. The very worst of healthcare systems is to be found in the US. In the US, healthcare insurance is not compulsory, coverage in not universal, and insurance packages – often secured by Americans through their employer – often leave a lot to be paid out of pocket.

Around 25 million adults are uninsured, and over 60 per cent of adults of working age cite the prohibitive costs of insurance as the reason why they do not take out coverage. Even with higher government and out-of-pocket expenditure, healthcare coverage is narrower in the States than in the UK.

An insurance-based system designed in such a way would be entirely unacceptable for the UK and would fail to improve either the quality of care or long-term funding sustainability.

Learning from the Dutch

In many ways, the most impressive healthcare system in the world is to be found in Singapore. Its health outcomes are excellent yet it is one of the cheapest systems in the world. If a British government were to set out to emulate the Singaporean system, we would not demur. But the cultural differences between Singapore and the UK are huge. It would be very difficult to persuade the UK electorate to reform healthcare so radically as to turn the UK's system into something like the one that exists in Singapore.

Instead, we believe that it is sensible to set our sights closer to home. We suggest that the UK adopts something akin to the Dutch healthcare model – one of the very best in the world in regard to outcomes. It employs a hybrid funding model comprised of compulsory private insurance, significant state subsidies, co-payments, and proactive state regulation. It has shorter waiting times than in the UK, lower infant mortality, higher healthy life expectancy, and all at a lower level of expenditure both as a proportion of the economy and of total government spending.

The centrepiece of the Dutch system is the Healthcare Insurance Act of 2006. In contrast to the US system, this is a compulsory healthcare insurance model, in which everyone is required to be insured. Insurers are private and can compete on price. However, the government legislates for a minimum level of provision set out in statute that every insurer must deliver. It also sets an annual excess that must be charged by insurers before policies kick in; policyholders can exchange a higher excess for

lower monthly premiums. Average annual premiums in 2023 were about £1600, and the annual excess was set at roughly £325.

Insurers are required to charge all policyholders the same premium to avoid the issue of adverse selection. It does this by operating a system of risk equalisation, where it uses a mixture of insurer contributions and government funding to subsidise insurers for enrolling individuals with higher health risks, including those with long term conditions.

This risk equalisation system goes a long way to promoting universal coverage. But the Dutch government also covers the healthcare costs of under eighteens, the premiums of those on low incomes, and runs a separate programme for those with daily care requirements.

Insurers are free to contract with providers, and there is considerable competition amongst the latter. Indeed, since its main healthcare reforms in 2006, a number of specialist surgeries and clinics have entered the market and perform a significant share of the total number of procedures in areas like dermatology and cataract surgery. It is also the case that, after the present Dutch healthcare model was introduced in 2006, waiting lists fell appreciably.

It is the Dutch model that this paper primarily draws inspiration from, not simply because it delivers very high quality care and is more fiscally sustainable, but because the Dutch themselves transitioned from one form of healthcare provision to another, and so their experiences hold potential lessons for how reform here might be carried out. In particular, their healthcare transformation was phased, involved the gradual introduction of competition in a context of careful regulation, and carefully balanced both a commitment to universal affordable coverage and the institutionalisation of greater choice and personal responsibility. These are all facets that a reformed British healthcare model ought to incorporate.

The links to tax

If a government proposed setting up a largely insurance-based system for financing healthcare, the first reaction of most people would surely be to see the cost of their insurance premiums and excess payments when they make a claim as being just another burden to be added to the taxes that they already pay to the government. The perception that this would be the case would pose an enormous political barrier against any government – or even an opposition party – proposing such a reform.

Yet a major objective of the move to an insurance-based system is to reduce the tax burden and thereby reduce the blunting of incentives that inevitably occurs through taxation.

Accordingly, there should be a rebate of tax for each citizen in the same year that insurance premiums begin. The details of such a system are up for debate. For instance, would the rebate be a certain fixed sum to be received by each citizen or would it vary with the amount of tax paid? What would happen with people who do not pay income tax? After all, every citizen pays some tax through VAT and excise duties. Perhaps, each person should receive some sort of cheque or digital payment, reminiscent

of what happened during Covid.

But the principle is clear: a switch from paying for the NHS largely through taxes to paying for it largely through insurance premiums.

International evidence on insurance premiums

As is often the case with international comparisons, comparing insurance premiums across various countries' health systems presents serious complications. Coverage differs across insurance packages, as do funding methods. In Singapore, premiums are determined by age, whereas in the Netherlands prices are the same for holders of the same policies. In countries like France and Germany, contributions are taken as a percentage of the workers' salaries and in many of these countries, employers play an important role in funding the system.

Despite these difficulties, we have attempted to compare what the average person might expect to pay through premiums in each of our different countries. These are shown in Table 10.[152] Premiums vary enormously from less than £200 per annum for young people in Singapore to over £4,000 in Switzerland and over £6,000 in the United States.

152. The exchange rates used are as follows: € to £ = 1.19, Singapore $ to £ = 1.75, Swiss Franc to £ = 1.12, US $ to £ = 1.35, CAN$ to £ = 1.85, AUS$ to £ = 2.08.

Table 10: Health systems and average premiums/excesses in our selected countries

Health system	How is the system financed?	Average annual premium	Coverage	Excess
Australia				
Universal health care (Medicare) Private insurance optional	Medicare is primarily financed through tax revenues, with elements of cost sharing in outpatient care	**Private (optional) insurance averages:** Aged under 36: £1,536 Aged 36 - 59: £1,785 Aged 60 and above: £2,004	Premiums correspond to a lower level of hospitals and 'extras' (e.g. dental, physio, optical) coverage Free hospital care and substantial coverage for physician, pharmaceutical and other services are available for all citizens through Medicare	£360
Canada				
Universal health care (Medicare) Private insurance optional	Medicare is funded through tax revenues	**Private (optional) insurance averages:** £480 - £720, age-dependent	Private healthcare often covers prescriptions, dental, physiotherapy, ambulance services and prescription eyeglasses Medically necessary hospital and physician services are free through Medicare	£14
France				
Statutory health insurance	Payroll taxes paid by the employee and employer	**Private (optional) supplementary insurance average:** £822	National system covers most costs for hospital, physician, long term care and prescription drugs. Supplementary insurance covers remaining costs	N/A
Germany				
Statutory health insurance	Wage contributions are shared by employers and employees. Copayments apply to inpatient services and drugs	**Wage contributions (14.6% of gross salary plus additional 0.9%-1.6%, both split with employer):** Average salary: £3,589 Maximum contribution: £3,877	Inpatient, outpatient, mental health, and prescription drug coverage	N/A

Netherlands				
Statutory private health insurance	Premiums, tax revenues and grants and employer contributions	£1,596	Generally covers prescriptions, hospital, physician, home nursing and mental health care	£323
Singapore				
Statutory insurance (MediShield Life)	Premiums, deductibles and co-insurance. Patients pay costs above the claim limits.	**Age determined premiums:** 1-40: £114-£287 41-65: £363-645 66-78: £756-£1155 79-90+: £1247-£1611	MediShield Life covers large bills arising from hospital care and certain outpatient treatments. It does not cover primary or outpatient specialist care nor prescription drugs	£855 to £2,565
Switzerland				
Statutory private health insurance	Premiums, regional taxes, social insurance contributions and out-of-pocket payments	£4,044	Most physician visits, hospital and home care, pharmaceuticals, devices, medical services in long-term care and physiotherapy	£267
United States				
Mixed insurance system	Public programmes are funded through federal taxes Private insurance is primarily provided by employers	**Average private premiums:** £6,624	There exists no nationally defined benefit plan for private healthcare; coverage depends on insurance	£1,428

Source: The Commonwealth Fund, International Health Care System Profiles, various; assorted other sources used for average premiums and excess payments.

The "Many Helping Hands" approach

There is also room for a contribution over and above the combination of state finance and insurance cover. Behind all these reforms should be one further guiding principle: that even though a robust and dependable safety net is a prerequisite of any civilised country, the state is not the sole – nor necessarily the best – provider of services related to people's health and welfare. Indeed, and especially when it comes to social care, the best providers are probably those who are closer to the individual, either in their immediate family or in the local community.

To this end, Government should take steps to remove any obstacles or barriers to organisations from civil society or businesses in the private sector that wish to deliver high quality services for those with health and social care needs.

In social care, the shift to a compulsory insurance model with benefits

that can be taken either as services in-kind or cash in-kind should help foster new innovative solutions to the provision of care, both at home or in residential settings.

The Government should also support innovation in the provision of specialist healthcare treatments. Insurers could strike contracts for such providers to deliver elements of the basic package, or they could be accessed via supplementary insurance plans.

Finally, options could be explored to give workplaces a more prominent role in healthcare provision, as recommended in Policy Exchange's paper *None of our Business*, and a regulatory "sandbox" could be introduced to foster innovative healthcare solutions, for example, in primary care.

These are schemes which bring providers, service users and regulators together in order to streamline the regulatory process and bring new products and services to market, faster. The CQC, for example, already operates such devices. Recently, it has run sandboxes for community care and digital triage tools. A new scheme for primary care could look to support telemedicine, novel models for GP provision in rural communities, workplace-based primary care and so on.

15. Making Reform Politically Possible

Fundamental reform of health and social care in this country will be one of the most politically treacherous and technically challenging undertakings in modern British history. Of course, as this paper has shown, more or less minor revisions to the existing model have been implemented on a fairly continual basis (and they have usually involved new layers of bureaucracy, more funding through general taxation, or both). But transformation of the basic operating principles has been considered politically impossible since the system's inception.

Nevertheless, fundamental reform has arguably become more feasible. While the NHS retains a lot of affection, and even admiration, in wide parts of British society, in recent years its standing has fallen precipitately. The British Social Attitudes Survey reports that in 2024, the proportion of respondents satisfied with the NHS was only 21%, the lowest ever. Satisfaction with social care was a mere 13%.

Moreover, as the foregoing has demonstrated, on its current trajectory, British healthcare provision is going to bankrupt the nation without the consolation of improved health outcomes. The financial burden imposed on tax-paying households will grow inexorably, even while the strain on hospitals and care providers intensifies.

And although it does not constitute a systemic transformation of the sort we advocate in this paper, the present Government's decision to fold up NHS England, cut administrative roles by some 9000 employees and gesture to a rethink on our present approach to mental health demonstrate that, with sufficient appetite and conviction, reform is possible.

Below we outline six factors to help overcome the political barriers to radical reform of the NHS funding model:

i. Careful and correct communication of the reasons for the change and its benefits;
ii. A clear presentation of the costs of the current system to ordinary citizens;
iii. Public dissatisfaction with elements of the NHS's performance, e.g. on waiting lists;
iv. Introducing the various charges we have suggested first;
v. The possibility of introducing insurance for social care as a forerunner of introducing insurance for medical care;
vi. The importance of proceeding in stages.

Communicating the case for reform

For some time, a considerable obstacle to reform has been posed by the framing of the political debate. Reformers have struggled to articulate a principled vision for the sort of healthcare service that they would seek to substitute for the existing one. As such, a misleading dichotomy has been allowed to take hold in many minds: between affordable (tax-funded) healthcare with universal coverage and expensive (insurance-based) healthcare that either saddles the most vulnerable with crippling bills or leaves their healthcare needs unmet.

This is a false dichotomy and it needs to be demolished, not least because the model we advocate here will involve a mix of tax-funded "risk equalisation" and subsidies, insurance premiums, co-payments, and a mix of providers.

But more critically we need to refute the view that only healthcare systems fully funded through general taxation are affordable, or that those who seek funding reform are solely interested in fiscal sustainability. And to do this we should commence with a statement of the principles that would underpin our proposed model, and which we believe could command considerable support among the British public:

1. That personal responsibility must underpin the entire structure of social service provision.
2. That the overall cost of the healthcare system to the average household, combining insurance premia, charges, excess payments, co-payments and whatever remains of taxpayer funding should not initially exceed what the average household pays in taxes to finance the NHS.
3. That, through the tax system, the wealthy and more fortunate should support those unable to meet the cost of funding their own healthcare. That the market alone will not be able to deliver an acceptable level of affordable provision.
4. That high quality, affordable healthcare should be available to all in Britain.
5. That greater competition will improve both the affordability of healthcare, and the quality of services.

But as the Dutch case study shows, for something as sensitive as healthcare reform, the ground must be carefully prepared. (See Appendix F.) Below, we consider how to do this.

Understanding the true cost

In addition to an unhelpful framing of the political debate, much of the British public is operating under an illusion. A key tenet of our present healthcare system is that it is "free at the point of use".

But the reality is that the only place that healthcare provision is free is at the point of use. Not only is it expensive, but it is getting more expensive year by year in the context of limited supply and effectively limitless demand.

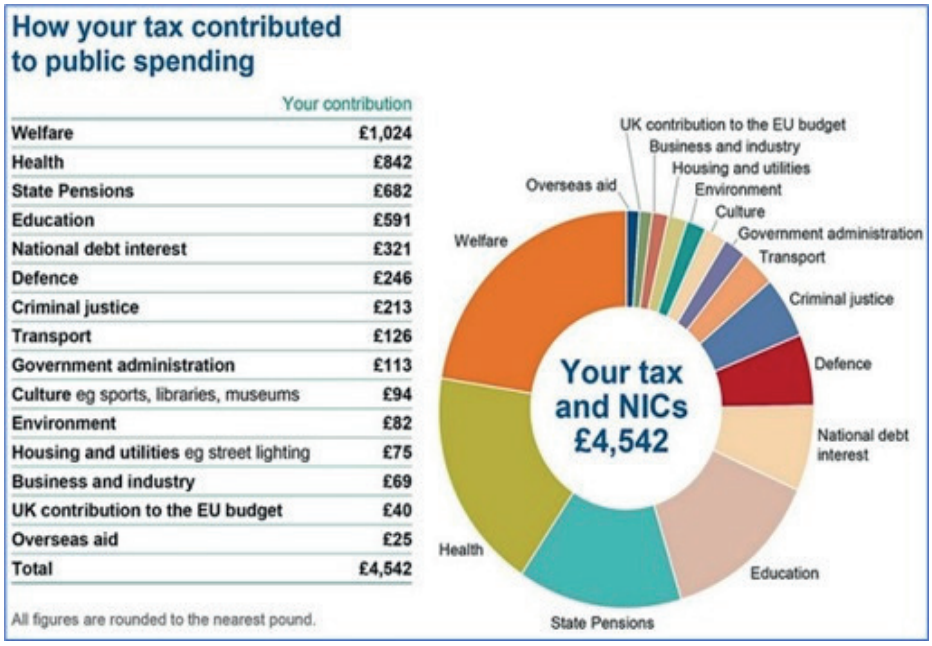
One possibility for encouraging the change in public attitudes towards the financing of healthcare would be for the NHS to provide patients with a receipt for the services they consume. There is already a rough model for how this might be done. In 2023, comparison website GoCompare produced an online calculator which took the costings for a range of common procedures and services, and enabled users to estimate their annual healthcare costs.

This was a very narrow calculator, which considered a limited number of services and costings. But a scheme run by the government could be more expansive and utilise the NHS's annually published cost collection data. Patients would receive a receipt through the NHS App, or via email.

On balance, however, we are not persuaded that issuing receipts would be helpful. It would generate more bureaucracy to assess costs and issue receipts and might even persuade some people that they were getting really good value from the NHS which provides such services "free".

But HMRC could help by sending a breakdown of each individual taxpayer's annual tax bill, offering an approximation of how much they pay for healthcare, as well as other sorts of public spending. (See the example in Chart 67.) HMRC formerly did this via a letter but now does this primarily through its online portal. But given that many people may not use this portal – particularly those who do not have to complete a self-assessment – we think this should be sent to people via email.

Chart 67: An example of a personal tax statement issued by the UK Government



How your tax contributed to public spending

	Your contribution
Welfare	£1,024
Health	£842
State Pensions	£682
Education	£591
National debt interest	£321
Defence	£246
Criminal justice	£213
Transport	£126
Government administration	£113
Culture eg sports, libraries, museums	£94
Environment	£82
Housing and utilities eg street lighting	£75
Business and industry	£69
UK contribution to the EU budget	£40
Overseas aid	£25
Total	£4,542

All figures are rounded to the nearest pound.

Connecting the reform agenda to a clear failing of the NHS

The success of the Dutch healthcare reforms was largely due to fact that the Overton Window of political possibility had been decidedly shifted by the crisis in healthcare waiting lists and increasing budgetary constraints. Indeed, in the elections prior to the 2006 reforms, *all* the major parties had felt compelled to make the case for systemic change because of deteriorating waiting lists.[153]

A reforming government should link any transformation programme to a specific issue of major public concern. The public needs to be persuaded that healthcare reform is not being pursued to bend the system into conformity with some abstract ideal, but as a pragmatic response to dealing with an acute problem that affects everyone.

Waiting lists could be that hook in the British context. Choice and competitive contracting, transparency on price, the introduction of new private or non-profit providers (particularly specialist surgeries) might all help to tackle the backlogs.

Piecemeal reform and charges first

We have suggested a number of changes to the organisation and charging system for NHS services which could provide an alternative to the introduction of a fully insurance-based system. In practice, however, we argued above that the savings to be gained from such an agenda were not large enough to obviate the need for further radical change.

Yet that does not mean that we should not introduce them. On the contrary, bringing some charges into the NHS would be a helpful first step in helping the British public to change their attitudes to the provision of medical services, before the move to an insurance-based system.

153. Roland Marnix Bertens, "Care, Cost and Questions of Control: Dutch Health Care Reform 1987-2006", MA Thesis, Utrecht University, 2016.

A phased transition

However much compensatory payments take the edge off opposition to the switch to an insurance based-system for healthcare, there is still likely to be opposition to the move. In particular, considerable disruption in the *provision* of healthcare services would not be acceptable to the British public. And to that end, any transition to a new model – in terms of funding, providers and so on – will need to be phased.

Step One

Any transformation of UK healthcare provision will take place within the context of a well-established regime which has generated expectations among both its users and those that work within the system. As such, and as the Dutch case study recommends, there ought not to be a single "big bang" moment in which we move from the existing system to one designed from first principles.

Instead, at the outset, we need to get the NHS into the position where it is capable of being further improved. For as we have seen with various policy initiatives over the NHS's history, the existing arrangements are effectively inimical to reform. It will be easier to deliver reform in three smaller jumps, than one uncertain leap into the unknown.

Following the concerted information and communication campaign recommended above, including the provision of receipts for healthcare services, a first staging post for reform would be to establish a system of compulsory insurance providers. As Kristian Niemietz of the Institute of Economic Affairs has suggested, the best way to do this while minimising disruption would be to convert the Integrated Care Boards (ICBs) into such insurers on a non-profit basis, rather like the Dutch Sick Funds that existed prior to 2006.[154] Initially, individuals would be obliged to take up insurance with their local ICB.

At the start, the Government would convert the proportion of tax receipts currently used to fund the NHS into an insurance premium, with a commensurate reduction in people's income tax and national insurance contributions. This would be collected by government, clearly marked on people's payslips, and paid to the ICBs.

Those below a certain earnings threshold would receive an annual allowance to pay for their premiums, and a risk equalisation system would need to be introduced to support ICBs with the costs of those with high health risks.

Ideally, some proportion of the money that is currently raised though general taxation to fund the NHS would be raised through co-payments on a defined set of services, rather than via the insurance premium. This will imbed the expectation of out-of-pocket payments and maximise the effect of funding reform upon demand for healthcare services. If a reforming government wanted at this stage to stick resolutely to a free at the point of use ideal, this could be put off, but we believe taking such a difficult step early would be important.

154. NHS-Paper-Print_V3-1-1.pdf

At the same time, and like the Dutch model again, the Government would need to define a minimum or "basic" plan that all insurers – in our proposals the reformed ICBs – would be required to offer. To minimise disruption, this could largely mirror the current level of service provided to NHS users. Over time, however, a government would be able to potentially reduce or expand the basic package.

The current arrangements between ICBs and service providers (hospitals) could at this stage continue as normal.

Step Two

The second stage of reform would be to give contracting freedom to the new insurance bodies. The ICBs would be able to come to arrangements with whatever hospitals or service providers they wanted, so long as they could guarantee the basic level of provision to their policyholders.

Hospitals currently managed by the government (at the moment through NHS England but after its abolition, directly), to gain more autonomy and new privately owned or foundation hospitals or specialist centres would be able to enter the market. These would be closely regulated and would require a license to operate. But they would have the freedom to set budgets and prices and provide services more flexibly. They would also be able to determine remuneration.

The risk equalisation system would need to be employed and adapted in order to avoid the issues that plagued the internal market reforms of the 1990s – namely, by ensuring that hospitals are not incentivised to specialise in low-cost treatments, thus reducing the supply of services for more acute conditions.

Step Three

The next step in the reform process would be to introduce contestability in the insurance market and freedom for policyholders. Individuals would still be able to insure themselves via tax contributions and the existing ICBs. But the Government would now enable people to take out policies with a provider of their choice to replace their previous compulsory plan with an ICB, so long as the new policy offered the statutorily defined basic level of coverage.

To do this, the income-linked insurance premium would have to be converted into a flat rate fee which would be collected by insurers themselves, rather than being collected through general taxation and redistributed. A mandatory deductible would also be introduced, set nationally by government.

At first, people would remain insured by their ICBs. But large insurance companies, trade unions, employers would all now be able to enter a regulated insurance market and compete for business.

Legislation would need to be introduced to require that insurers charged policyholders the same rate for the basic insurance package in order to avoid adverse selection. However, the risk equalisation system would compensate insurers for higher cost enrolees, much as it would

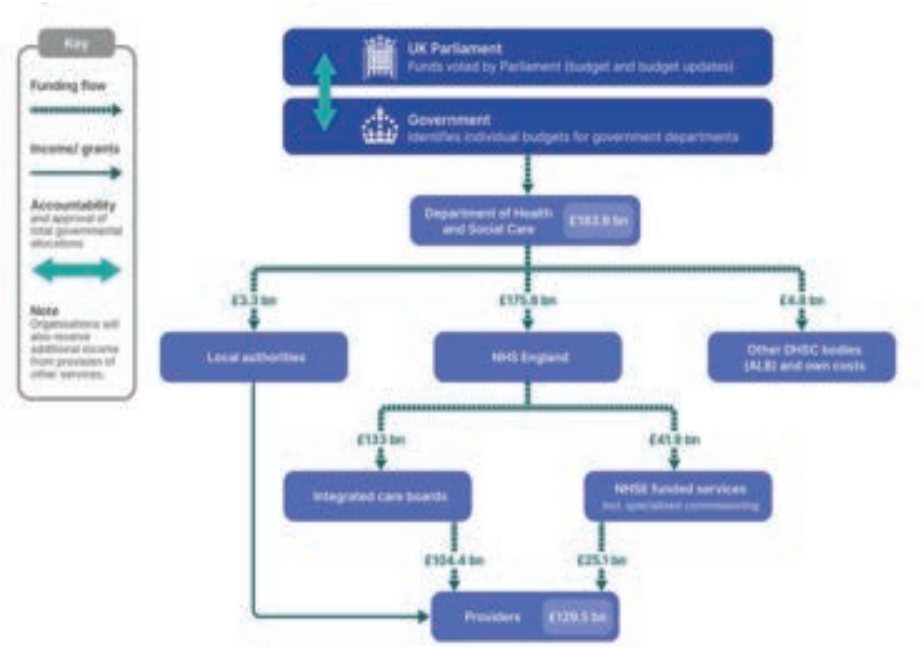
with the ICBs after step one of the proposed reform programme. Subsidies would remain for those who could not afford the basic coverage.

The Government would need to regulate the coverage requirement for the basic plan, both to guarantee that no one lacked basic coverage, but also to ensure that the level of provision for the basic plan did not expand in such a way as to reduce flexibility. Policyholders would be permitted to take out supplementary insurance for additional coverage.

With the shift from redistribution through the tax system to collection by the insurers, the Government would need to introduce penalties to deter people from not taking out coverage.

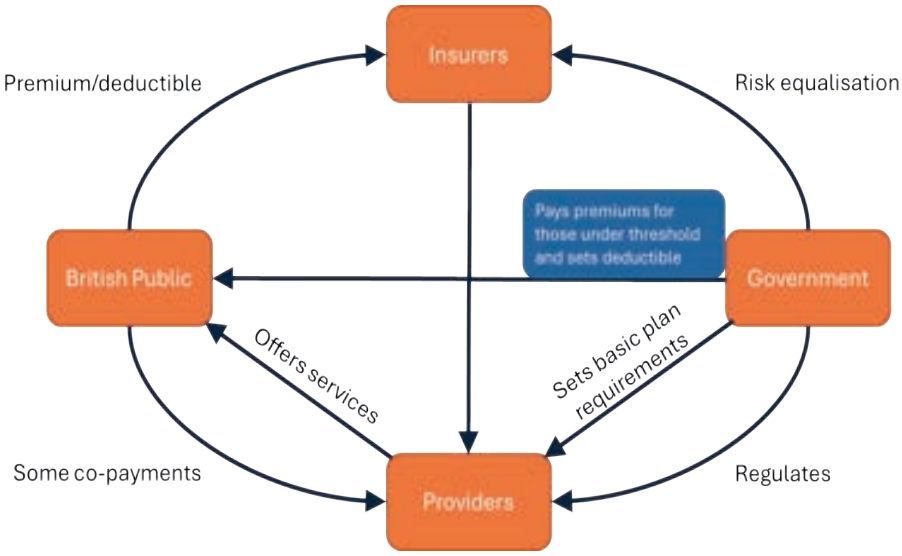
One option for delivering this could be to introduce individual health savings accounts. Some proportion of the funding raised for the new health insurance premium could be rebated to taxpayers and placed in a tax-free savings account. The funds in this account could be used for a select set of services like GP appointments, prescription drugs, or minor treatments, and the funds could be transferable amongst family members. Insurance would be left to cover more serious healthcare costs, while these individual savings accounts would cover smaller out of pocket expenses.

Figure 1: The current funding system



Source: *HFMA introductory guide to NHS finance, 2024*

Figure 2: Our proposed funding system



16. Conclusions

Britain's National Health Service is neither the paragon of virtue that its supporters claim nor the basket case that its detractors allege. Hundreds of thousands of professionals and support staff are dedicated to achieving the Service's objectives. And, at its best, it often achieves results of the highest order.

But at the other extreme, its service can be poor, with serious adverse consequences for patients. Moreover, by international standards it achieves only moderate average health outcomes; and it is increasingly regarded by the public with frustration and sometimes rage.

Perhaps a few decades ago its failings, although regrettable, could be regarded as isolated from the big questions about economic policy. But the NHS has grown so much in size and cost that this is no longer the case. Indeed, sorting out the NHS is one of the prime requirements of any programme to restore the British economy to prosperity.

One aspect of its centrality is the importance of a good health service in ensuring the health of the country's workforce. There is much evidence to the effect that disappointing standards of healthcare and long waiting lists have been an important factor (although by no means the only one) behind increasing rates of worklessness among groups who would normally have high rates of labour force participation.

Another is the effect of health service efficiency, or otherwise, on national rates of productivity and thereby on overall economic performance.

But the aspect of healthcare most relevant to the economy and economic policy is its cost. Government spending on health has risen from about 3% of GDP in 1955/56 to about 9% today. Government financed expenditure on healthcare in the UK consumes only slightly less than the total revenue raised from income tax. What's more, according to the BMJ Commission

on the Future of the NHS, by 2070 more than a fifth (21%) of our GDP will be spent on the NHS.[155]

This cannot be allowed to happen. The consequences for other sorts of government spending and/or tax rates are simply unthinkable. We have to be hard-nosed about the sources of the problem and about the possible solutions.

The ultimate source of the NHS's problems is the collision between unconstrained demand and limited, tax-funded supply, free at the point of consumption. Even though the state will retain a major role, the solution must involve compulsory insurance as the primary source of funding, accompanied by greater use of charging.

Moreover, in contrast to the lobbying in favour of an extension of the NHS model of tax-funded provision to social care, a similar, predominantly insurance-based, financing system should be adopted for social care.

Any attempt to move towards an insurance-based system for the NHS will be met with howls of protest from health practitioners and doubtless also many members of the public. They will no doubt refer to the founding principles of the NHS and regard such reforms as a betrayal of the original vision. Yet even the most egalitarian societies operate hybrid approaches to funding, involving much more charging at the point of service than we do. Sweden is a striking example.

And the world has changed fundamentally. Today's NHS, and its cost, are a far cry from what was envisaged at its foundation. The structure and funding of our provision of healthcare cannot be treated as a sort of museum exhibit. They must evolve to suit the changed circumstances of the times. Radical reform is long overdue.

155. https://www.bmj.com/nhs-commission

E) Appendices

Appendix A. A model to be avoided. How things are done in the US.

The majority of American citizens receive health insurance through their employer. This often covers a significant proportion of their healthcare costs. However, it does not always cover the entirety of costs and the specific treatments and conditions which are covered tend to be determined by the employer.[156] This can lead to out-of-pocket expenses where the patient has to pay the shortfall themselves in addition to any premiums which they may need to pay.[157]

There is also insurance available for people over the age of 65, people with disabilities, and those on very low incomes. Medicare provides insurance for the elderly as well as people with certain disabilities and for some patients who are terminally ill and so are unable to obtain insurance through employment.[158]

It has four parts. Part A covers hospital care and procedures. The majority of people do not pay a premium for Part A. However, a deductible is charged for hospital stays longer than 60 days. If you are not eligible to receive Part A for free then a monthly premium must be paid.[159]

Part B covers medical appointments and outpatient care. There are monthly premiums of at least $185 and an annual deductible of $257 which the patients have to pay. Patients also pay 20 per cent coinsurance for Medicare approved services.[160]

Part C covers the same benefits as Parts A and B as well as some additional benefits such as dental and vision services but is provided by private insurers. Premiums vary and the cap on out pocket spending is $9,350.[161]Part D covers medications. They are offered by private insurers and require monthly premiums.[162]

People who are already receiving social security payments are automatically enrolled into the Medicare system. If you are not already in receipt of benefits then a person must enroll within a certain time frame in order to avoid penalty charges.[163]

Medicare does not provide coverage for all types of care or for the full cost of the treatment. In these cases the patients can purchase a Medigap plan or receive support from a former employer or trade union. Alternatively they can apply to Medicaid to help to cover the shortfall. However, not all patients are eligible for these forms of support and some cannot afford to purchase a Medigap plan. These patients either have to

156. U.S. Department of Labour, 'Health Plans and Benefits', 2024
157. Cox, C., Ortaliza, J., Wagner, E., & Amin, K., 'Health Care Costs and Affordability', KFF, 2024
158. Center for Medicare Advocacy, 'Basic Introduction to Medicare', 2024
159. U.S. Government, 'Medicare', 2025
160. Ibid
161. Ibid
162. ibid
163. U.S. Social Security Administration, 'When to sign up for Medicare', 2025

cover the shortfall themselves or go without the care.[164]

Medicaid provides insurance for low-income households including those on low salaries and the unemployed, children, and pregnant women. What it provides funding for varies by State but covers basic care such as hospital stays, medical appointments, and medications.[165]

However, it does not cover all forms of treatment and so patients may not be able to access certain types of treatment or may have to pay the shortfall themselves.[166] What is more, patients often struggle to access the Medicaid system or to remain enrolled due to the complex eligibility procedure and application process. They can also struggle to find providers who accept Medicaid, especially specialty care providers.[167]

Other households purchase medical insurance directly from insurance companies while others purchase it through a marketplace which was established by the Affordable Care Act (ACA) in 2010.[168] These marketplaces are regulated by State governments and allow households to choose from a number of different providers.[169]

Approximately eight per cent of the population remains uninsured. This means that around 25 million adults have no form of medical insurance. Over 60 per cent of adults aged 16-64 cite the high cost of insurance as the reason why they have not purchased it. A significant number of Americans have also stated that they were unaware of options available to them which would suggest that there is a lack of accessible information available.[170]

Patients without insurance therefore have to pay for their treatment themselves using their salary, savings, and credit. They either pay the entire sum up front or in installments to the care provider.

People without insurance tend to live in more rural and economically deprived areas. Moreover, they are more likely to have a lower level of education while also suffering from multiple medical conditions.[171] This is significant as it not only has a detrimental impact on their quality of life but also means that they will face additional costs if they do seek medical treatment or eventually purchase insurance due to their condition getting worse.

A lack of medical insurance can have a very negative impact on patients. For example, people are far less likely to access medical care and are more likely to delay or even forgo care if they have no insurance.[172] A lack of insurance can also place a significant financial burden on patients. Approximately 50 per cent of uninsured adults have struggled to pay for their treatment and around 60 per cent of them have skipped or postponed getting necessary health care due to costs.[173]

Although there are State laws designed to limit what creditors can do, patients who have medical debt can face having their credit history negatively affected, and have to cope with the stress of dealing with debt collectors, wage garnishment, and even liens on their property and foreclosures.[174] [175]

In emergency cases hospitals must provide medical treatment to uninsured patients as a result of the Emergency Medical Treatment

164. Freed, M., Ochieng, N., Cubanski,J., & Neuman, T., 'Medigap May Be Elusive for Medicare Beneficiaries with Pre-Existing Conditions', KFF, October 2024
165. Center on Budget and Policy Priorities, 'Introduction to Medicaid', 2020
166. Burns, A., Hinton, E., Rudowitz, R., & Mohamed, M., '10 Things to Know About Medicaid', KFF, 2025
167. Coleman, A., 'Medicaid', The Commonwealth Fund, 2024
168. U.S. Department of the Treasury, 'Number of People Who Have Enrolled in ACA Market Coverage', https://home.treasury.gov/system/files/131/People-Enrolled-ACA-Mkt-Coverage-2014-24-09032024.pdf
169. KFF, 'State Health Insurance Marketplace Types: 2014-2025', 2025
170. Tolbert, J., Cervantes, S., Bell, C., & Damico, A., 'Key Facts about the Uninsured Population', KFF, December 2024
171. Tolbert, J., Cervantes, S., Bell, C., & Damico, A., 'Key Facts about the Uninsured Population', KFF, December 2024
172. Smith, K., Monti, K., et al., 'Access in necessary but not sufficient: factors influencing delay and avoidance of health care services', Medical Decision Making Policy & Practice, 2018
173. Lopes, L., Montero, A., Presiado, M., & Hamel, L., 'Americans' Challenges with Health Care Costs', KFF, March 2024
174. Kona, M., & Ralmugla, V., 'State Protections Against Medical Debt: A Look at Policies Across the U.S.', The Commonwealth Fund, 2023
175. Hashim, F., et al., 'Characteristics of US Hospitals Using Extraordinary Collections Actions Against Patients for Unpaid Medical Bills: a Cross-Sectional Study', BMJ Open, July 2022

and Labor Act (EMTALA) which came into force in 1986. Emergency departments must: give patients an appropriate medical screening exam; treat patients until their condition is stable and; arrange transfer to a more appropriate venue.[176] The impact of the legislation on patient outcomes and the burden on healthcare providers is disputed.[177] For example, there are a number of EMTALA violations every year which have contributed to the deaths of patients.[178]

Positive aspects of the US healthcare system

While discussion of healthcare in the US tends to focus on the negative aspects of the system (which we will discuss below), the US system does have some positive features. It performs well compared to other highly developed countries in screening for certain conditions such as various cancers and cardiovascular disease.[179] Moreover, the number of MRIs performed in the US is also proportionately much higher than in other wealthy nations.[180]

What is more, the time to wait between diagnosis and treatment is lower than in many comparable countries, including the UK.[181] Again, this improves the likelihood of some patients surviving and recovering from their conditions.

A further positive aspect of the US healthcare system is the access it gives some patients to many of the best hospitals, clinics, and medical staff in the world.[182] Similarly, the US system allows wealthy patients and those with comprehensive medical insurance to access the very best treatments, including medications and procedures which are often unavailable to patients in other countries. This improves the chances of those patients making a swift and complete recovery after their treatment.[183]

Finally, the US system offers a high degree of patient choice to those who can afford it. The insurance model gives patients who are able to pay higher premiums greater freedom to choose their healthcare team, the location where they will be treated, and the type of treatment they will receive. This differs from the system in many highly developed countries where there is very little choice for patients over any of this. Greater patient choice leads to many beneficial outcomes for patients, while having the potential to increase competition and drive up standards.[184]

Negative aspects of the US healthcare system

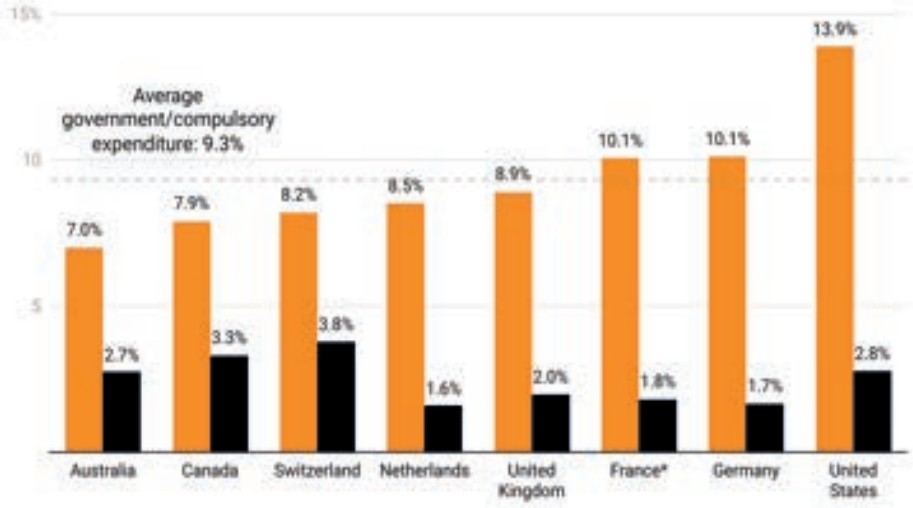
Despite the positive aspects of the US healthcare system, it is deeply flawed and, on average, leads to negative outcomes for patients, their families, taxpayers, and the American economy.

Strikingly, the US spends far more on healthcare than other developed countries. Its spending is considerably higher than the second and third highest spending countries in our comparator group and its spending is significantly higher than the OECD average. (See Chart 68.) Government and compulsory expenditure on healthcare in the US amounts to 13.9 per cent of GDP, while out of pocket payments and insurance premium payments by US households amount to a further 2.8 per cent. By comparison, the

176. American College of Emergency Physicians, 'Understanding EMTALA', https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet
177. Wells, M., Conrad, C., & Taylor, K., 'The Past, Present, and Future of EMTALA', The Regulation Review (University of Pennsylvania), September 2024.
178. Cheng, T., 'Vascular Surgery-Related Violations of the Emergency Medical Treatment and Labor Act'., Journal of Vascular Surgery, August 2021
179. Gunja, M., Gumas, E., & Williams, R., 'Global Perspectives on U.S. Health Care, The Commonwealth Fund, 2022
180. The Royal College of Radiologists, 'NHS must do more to future-proof its MRI capacity, say imaging experts', **https://www.rcr.ac.uk/news-policy/latest-updates/nhs-must-do-more-to-future-proof-its-mri-capacity-sa y-imaging-experts/**
181. OECD, 'Waiting Times for Health Services', https://www.oecd.org/content/dam/oecd/en/publications/reports/2020/05/waiting-times-for-health-services_9d746179/242e3c8c-en.pdf
182. 'World's Best Hospitals', Newsweek and Statistata, 2024
183. Blankart, K., Naci, H., & Chandra, A., 'Availability of New Medicines in the US and Germany from 2004 to 2018', JAMA, 2022
184. Wohlin, J., et al., 'As predicted by theory: choice and competition in a publicly funded and regulated regional health system yield improved access and cost control', BMC Health Services Research, 2021

next highest spending government of our selected countries, Germany, spends 10.1 per cent of GDP whereas the UK government spends 8.9 per cent of GDP.[185]

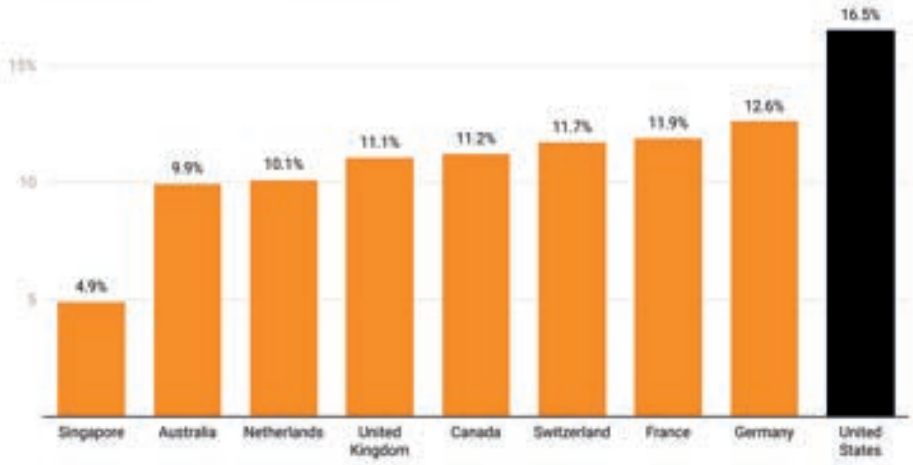
Chart 68: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



*Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.*

Chart 69: Health expenditure in a selection of countries (% of GDP), 2022

Current expenditure (excluding capital expenditure)



Source: World Health Organization, Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%). Current health expenditure as a share of GDP provides an indication on the level of resources channelled to health relative to other uses. It shows the importance of the health sector in the whole economy and indicates the societal priority which health is given measured in monetary terms.

At this point it is appropriate to ask why healthcare is so much more expensive in the US than the rest of the world. There are many reasons for this. For example, healthcare provider consolidation means that large hospitals and clinics have significant bargaining power and face less competition, which means that they can charge higher prices.[186]

185. OECD Data Explorer, 'Health expenditure and financing, 2023.

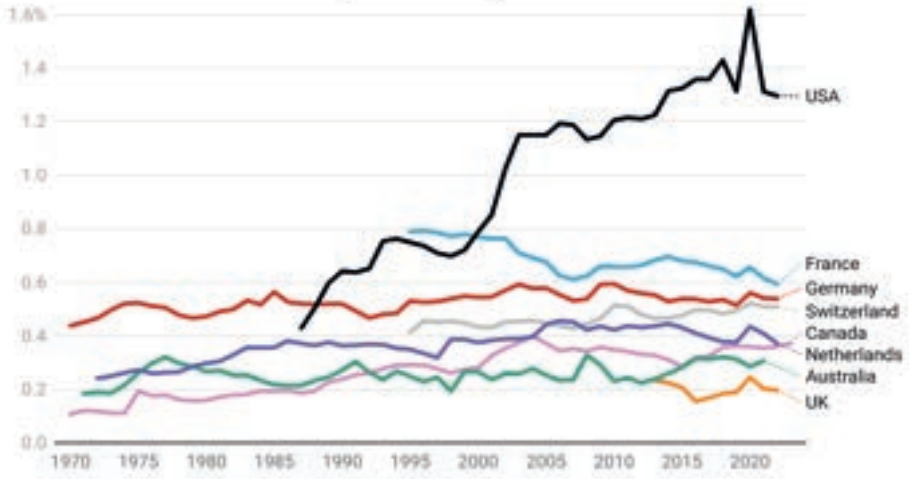
186. Levinson, Z., Godwin, J., Hulver, S., & Neuman, T., 'Ten things to know about consolidation in health care provider markets', KFF, April 2024

Moreover, there is a very strong patent system in the US. This allows pharmaceutical firms to block the creation of generic versions of their products and delay the arrival of generic alternatives. This means that pharmaceutical firms are able to charge more for medications.[187]

A related issue is the marketing of medications. Pharmaceutical firms spend a significant amount of money on marketing - over $18 billion a year. These costs are then passed onto the consumer while also raising demand for the medications which also has an impact on the price.

Another key factor is the cost of administration. One third of US healthcare funding is spent on administration which is significantly higher than in comparable countries. It increased significantly even while this cost tended to decrease or remain relatively stable in comparable countries. (See Chart 70.) The reason for this is the plethora of providers and insurance companies involved in healthcare. While a high number of providers is usually a positive thing due to the benefits of increased competition, in this context it means that there is no standardisation in processing insurance claims and sharing medical records.[188] [189]

Chart 70: Health system administration costs across a selection of countries (% of GDP), 1970 - 2023



Source: OECD Data Explorer, Health expenditure and financing; Data shown refers to governance and health system and financing administration costs.

What is more, while we mentioned it as a positive in the section above, the US healthcare system's access to the latest technologies is also a key driver of costs. Moreover, it is potentially leading to a misallocation of resources. For example, huge sums of money being spent on diagnostic equipment may help doctors to detect certain conditions early. However, there is an opportunity cost associated with this as there is finite money and resources and so it means that this money and these resources are no longer available to be utilised for providing more routine care which might actually provide greater benefits to more patients.[190]

Finally, the salaries paid to doctors in the US are among the highest in the world.[191] And nurses earn roughly double what they earn in the UK. A

187. Brough, W., 'Patent Problems Create Higher Drug Prices. Time to Fix the System', R Street Institute, July 2024
188. Turner, A., Miller, G., & Lowry, E., 'High U.S. Health Care Spending: where is it all going?', The Commonwealth Fund, October 2023
189. Cutler, D. 'Reducing administrative costs in US health care', Brookings Institute, 2020
190. Freedman, D., 'Towards Better Test Utilization - Strategies to Improve Physician Ordering and their Impact on Patient Outcomes', The Journal of the International Federation of Clinical Chemistry and Laboratory Medicine, January 2015
191. 'Doctor Pay by Country', World Population Review, 2024, https://worldpopulationreview.com/country-rankings/doctor-pay-by-country

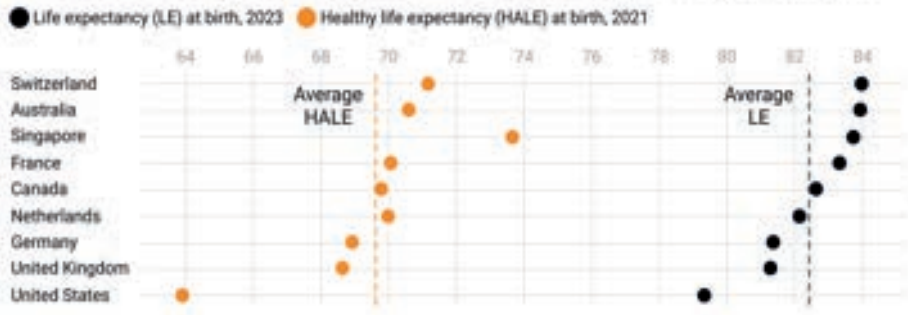
key driver is the shortage of doctors and other medical professionals. This is due to doctors retiring and exiting the profession, combined with the significant barriers to entry facing people – including medical professionals from other countries – who wish to practice medicine in the US.

For example, the funding cap from the Federal Government coupled with lobbying from the American Medical Association means that there is a lack of residency places for doctors who have completed their initial medical training in other countries.[192] Moreover, the American Medical Association requires qualified doctors from other countries to complete lengthy residencies before being granted a licence to practice medicine in the US system.[193] This restricts the supply of doctors, particularly specialists, and so increases costs.

Moreover, despite the vast sums of money spent on healthcare in the US, the system is failing to deliver for patients, especially the most vulnerable. For example, life expectancy is lower in the US than in other highly developed countries and has started to decrease in recent years. (See Chart 30.) This has been due to a number of factors including the Covid pandemic, increases in deaths from cardiovascular disease, the opioid crisis, and overdoses from illegal drugs.[194]

An issue related to deaths from the opioid crisis and overdoses from illegal drugs is what is known as 'Deaths of Despair' which also include suicide and alcohol-related deaths. These have increased over the past 30 years and predominantly affect working-age males. While there is no one factor which has driven this increase, research has shown that job insecurity is a contributing factor.[195] [196] [197]

Chart 30: Life expectancy in a selection of countries, latest data



Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data. World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The US also has a higher proportion of deaths which could have been prevented if the patient had received timely medical care and treatment than in comparable countries. Also, a significant proportion of patients – especially those from lower socio-economic households – experience co-morbidity where they suffer from a number of different chronic conditions simultaneously.[198] This has a detrimental impact on their quality of life, and means that they are more likely to be out of work, and can lead to

192. Pierson, L., 'The AMA Can Help Fix the Health Care Shortages it Helped Create', The Petrie-Flom Centre, Harvard, 2022
193. 'Residency Program Requirements for International Medical Graduates', American Medical Association, December 2024
194. Shmerling, R., 'Why life expectancy in the US is falling', Harvard Medical School, 2022
195. Knapp, E., et al., 'Economic Insecurity and Deaths of Despair in US Counties', American Journal of Epidemiology, April 2019
196. Lowenstein, C., 'Deaths of Despair Over the Business Cycle: New Estimates from a Shift-Share Instrumental Variables Approach', Economics and Human Biology, April 2024
197. Rehder, K., Lusk, J., & Chen, J., 'Deaths of Despair: Conceptual and Clinical Implications', Cognitive and Behavioral Practice, February 2021
198. Dehry, S., & Krueger, P., 'Excess Deaths in the United States Compared to 18 other High-Income Countries', Population Research Policy Review, 2023

them dying earlier than their peers.

The reason for this is that patients may delay or even completely put off seeking medical assistance due to concerns over costs. This means that conditions which could have been treated if there had been an earlier intervention become more difficult or impossible to treat and so the patient is sicker for longer or dies earlier. For example, a study found that approximately 45,000 people die each year in the US due to a lack of health insurance. Uninsured working age Americans are 40 per cent more likely to die than their privately insured peers.[199]

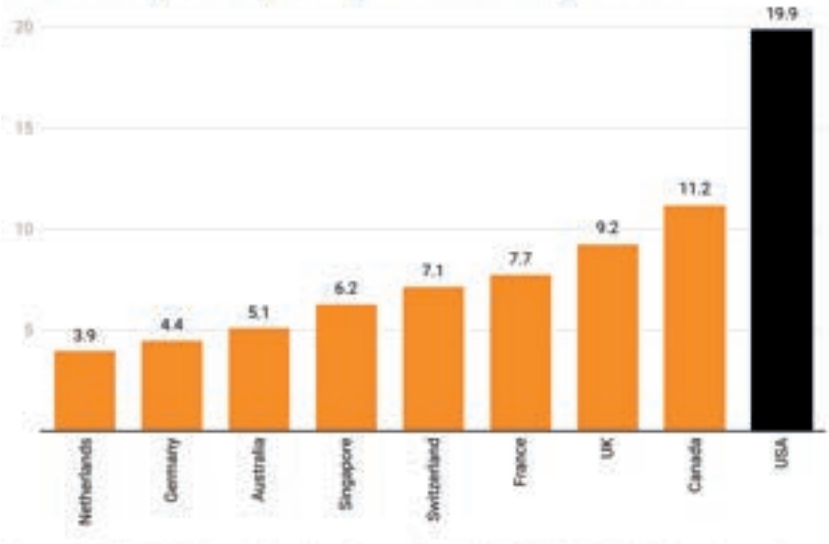
The US also has one of the highest rates of infant and maternal mortality in the world. (See Charts 71 and 72.) They are both considerably higher than comparable countries and significantly higher than the OECD average.

Moreover, the maternal mortality rate is similar to countries which are not often associated with providing high quality healthcare such as Iran, China, and Costa Rica, and is significantly higher than in Kazakhstan. It has actually been decreasing in those countries while increasing in the US. (See Charts 73 and 74.)

Approximately 80 per cent of maternal deaths are preventable. Two thirds of maternal deaths occur in the postpartum period. This is due to a lack of support for new mothers such as home visits and guaranteed paid leave. Approximately 20 per cent of maternal deaths occur in the pregnancy period prior to delivery. This is due to a lack of appropriate care, with around seven million women living in counties with no hospitals or care centres offering obstetric care. The US also has a much lower proportion of midwives than in other comparable countries.[200]

As for infant deaths, there is a clear link between mortality rates and birth weight and gestation age. Low birth weights and premature births disproportionately affect children from lower socio-economic households.[201][202]

Chart 71: Maternal mortality rate across a selection of countries (deaths per 100,000 live births), 2019



Source: World Health Organization Data, Maternal mortality ratio (per 100 000 live births). Number of maternal deaths during a given time period per 100,000 live births during the same time period. Data selected for 2019 to reflect pre-pandemic outcomes

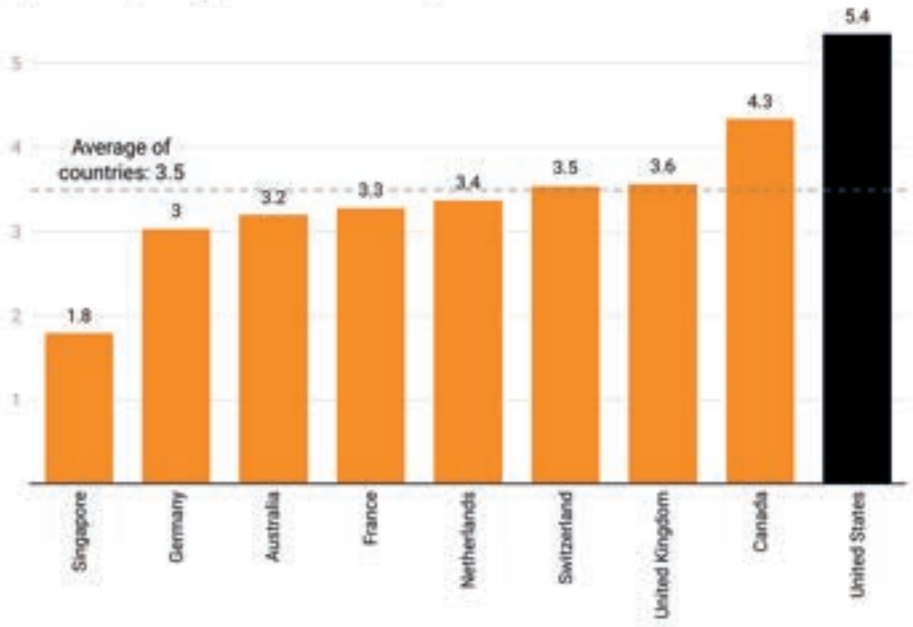
199. Wilper, A., et al., 'Health Insurance and Mortality in US Adults', American Journal of Public Health, December 2009

200. Gunja, M., Gumas, E., Masltha, R., & Zephyrin, L., 'Insights into the U.S. Maternal Mortality Crisis: an International Comparison', The Commonwealth Fund, 2024

201. 'Low Birth Weight', World Health Organization, 2025, https://www.who.int/data/nutrition/nlis/info/low-birth-weight 47 'Preterm Birth', World Health Organization, May 2023,

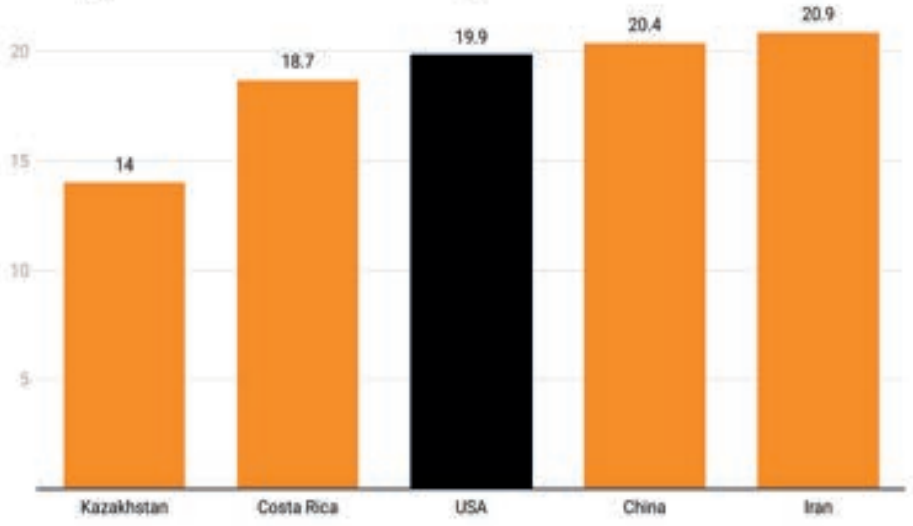
202. https://www.who.int/news-room/fact-sheets/detail/preterm-birth

Chart 72: Infant mortality rate across a range of countries (deaths per 1,000 live births), 2022



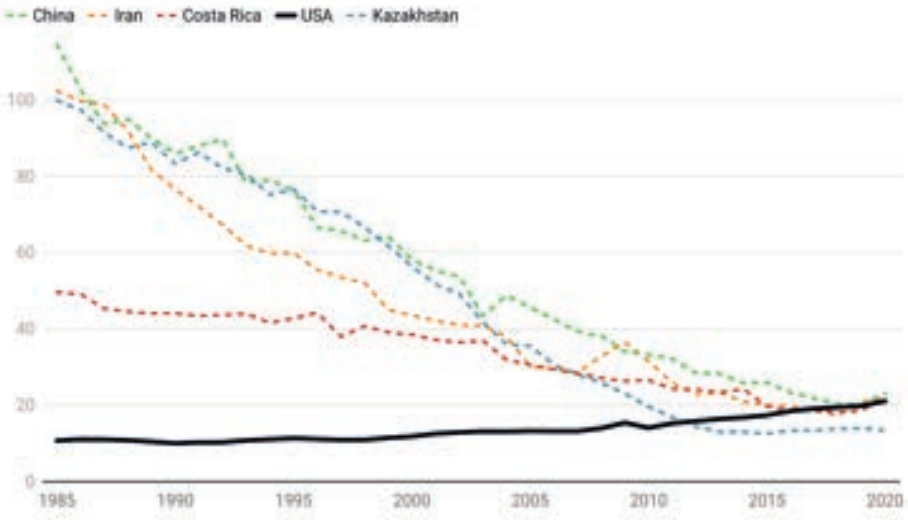
Source: World Health Organization, Infant mortality rate (between birth and 11 months per 1000 live births).

Chart 73: Maternal mortality ratio (deaths per 100,000 live births) in a selection of countries, 2019



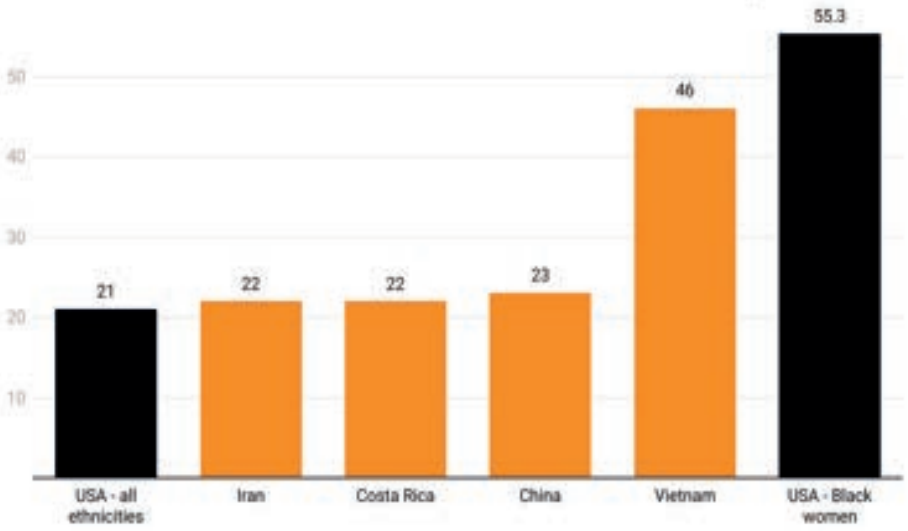
Source: World Health Organization Data, Maternal mortality ratio (per 100 000 live births). Data chosen for 2019 because it should reflects pre-pandemic outcomes.

Chart 74: Maternal mortality ratio (deaths per 100,000 live births) across a selection of countries, 1985 - 2020



Source: World Health Organization, Maternal mortality ratio (per 100 000 live births).

Chart 75: Maternal mortality rate (deaths per 100,000 live births) for Black women in the US and a selection of countries, 2020



Source: World Health Organization Data, Maternal mortality ratio (per 100 000 live births); National Center for Health Statistics, Maternal Mortality Rates in the United States, 2022. Numbers differ to Chart X since this chart shows 2020 data.

As discussed above, the system does not guarantee coverage for everybody. The US is the only highly developed country with a healthcare system which does not provide universal coverage.[203] This is problematic as it means that people without coverage are unable to afford anything other than the most basic healthcare. Such a system means that people from more deprived socio-economic backgrounds do not receive adequate care and so this exacerbates health inequality and means that these people suffer for longer, die earlier, and are less economically productive.[204]

Health inequality is not just something which is associated with

203. Gunja, M., Gumas, E., & Williams, R., 'Global Perspectives on U.S Healthcare', The Commonwealth Fund, 2023

204. Stringer, K., 'Here's how social and economic inequalities are impacting everyone's life expectancy in America', Washington School of Public Health, 2023

differences in socio-economic status or race. There is also a high degree of health inequality between the different regions of the US. There are fewer options and less comprehensive coverage for people living in rural areas of the country than in urban areas.[205]

How the US healthcare system has developed in recent years

The US healthcare system has developed dramatically in recent years because of both planned policy changes and the need to respond to crises.

Perhaps the most fundamental development was the introduction of the Affordable Care Act (ACA) by the Obama administration in 2010. The ACA expanded coverage of Medicaid to a greater number of low-income households. It also required insurance companies to cover pre-existing medical conditions without charging higher premiums and established health insurance marketplaces which allowed households and firms to compare and purchase plans.[206] [207]

Table 11: Breakdown of total healthcare expenditure in the US, 2023

Category of spending	Expenditure (billion $, 2023 prices)	Percentage of total expenditure (%)
Health Insurance	3,559	73%
Private Health Insurance	*1,465*	*30%*
Medicare	*1,030*	*21%*
Medicaid	*872*	*18%*
Other	*193*	*4%*
Out of pocket	506	10%
Other Third Party Payers and Programs	403	8%
Public Health Activity	160	3%
Investment	239	5%
Total National Health Expenditures	**4,866**	**100%**

Source: Centers for Medicare and Medicaid Services, National health expenditure data

The impact of the Act appears to be mixed but there is evidence to suggest that it did increase the number of Americans – especially the most vulnerable – who gained greater access to healthcare.[208]

However, health outcomes for low-income households and some ethnic minorities remain considerably worse than in other highly developed countries. What is more, spending on healthcare in the US continues to increase at a higher rate than in other advanced economies. As such, it would appear that the Affordable Care Act has failed to tackle these two major problems facing US healthcare.

One favourable aspect of the US healthcare system is that it has been quick to adopt new technologies and to utilise data. For example, the Health Information Technology for Economic and Clinical Health Act incentivised the shift to electronic records and improved data sharing among providers of medical services. Moreover, it required providers to focus on interoperability so that new technologies could be adopted

205. Dwyer-Lindgren, L., et al., 'Ten Americas: a systematic analysis of life expectancy disparities in the USA', The Lancet, 2024

206. 'Health Benefits and Coverage', Health Care Governance, May 2023

207. 'Pre-Existing Conditions', Department of Health and Human Services, March 2022

208. Sullivan, J., Orris, A., & Lukens, J., 'Entering their second decade, Affordable Care Act coverage expansions have helped millions, provide the basis for further progress', Center on Budget and Policy Priorities, 2024

quickly and seamlessly. A review of the relevant literature suggests that the impact of these reforms was mixed.[209]

Conclusion

There is far greater patient choice in the US than in many other countries and patients have access to world class facilities and treatments which are not as readily available in most other countries. It also leads the world in adopting new technologies. This benefits patients and ensures that they are diagnosed and receive treatment in a timely manner.

Nevertheless, average US healthcare outcomes are poor. Indeed, life expectancy in the US has recently decreased while the rates of avoidable deaths and chronic conditions have all increased.

Moreover, American healthcare is incredibly expensive which places a burden on households. And given the relatively poor outcomes, it clearly does not deliver good value for money for American citizens. A significant proportion of Americans do not have medical insurance and so they are deprived of all but the most basic healthcare.

While reforms have been made to empower patients by providing greater transparency in regard to costing, and potential plans to increase coverage will go some way towards tackling the failings of the US healthcare system, they are unlikely to be enough. They do not address the key causes of the high costs of healthcare in the US. The US healthcare system is definitely not one which should be emulated by the UK.

Appendix B. A model to be followed? How things are done in Singapore

When Lee Kuan Yew went about designing the public services of a newly independent Singaporean state in the 1960s, he was clear in his mind that Singapore would have to develop its own unique healthcare model.

Lee had been a student at Cambridge in the 1940s, and had initially considered the National Health Service to be a highly "civilised" approach to health provision. Over time, however, his youthful idealism was replaced by a sharp scepticism about the effects of a system which vitiated people's sense of personal responsibility for their own wellbeing. As he put it in his memoirs:

> *The ideal of free medical services collided against the reality of human behaviour, certainly in Singapore. My first lesson came from government clinics and hospitals. When doctors prescribed free antibiotics, patients took their tablets or capsules for two days, did not feel better, and threw away the balance. They then consulted private doctors, paid for their antibiotics, completed the course, and recovered.*[210]

Lee's critique of healthcare in particular was of a piece with his concerns about welfarism in general. He believed that universal, socialised, "cradle to the grave" support would in the medium to long term invite expanding demand and "ballooning" costs, and these could only be

209. Modi, S., & Feldman, S., 'The Value of Electronic Health Records Since the Health Information Technology for Economic and Clinical Health Act: Systematic Review', Journal for Medical Information Research, 2022

210. Lee, From Third World to First, 2000, p.100

funded by progressively increasing the tax burden on the hardworking and enterprising. Singapore, a third world country at the time with a small economy, could not afford such a growth-inhibiting approach to healthcare.

The decision to pursue a different approach to healthcare provision, one based on personal responsibility and insurance, was not an easy one in the context of the 1960s. The shortcomings of the European systems "were not yet self-evident", and opposition parties at the time were calling for a more generous model.[211] But Lee's philosophical view on the pitfalls of socialised healthcare have continue to define the Singaporean approach. His successor, Goh Chok Tong, remarked in the 1980s that:

> *There is no place for a cradle-to-grave welfare health system in Singapore. Such a system is politically motivated and disregards the basic truth that resources are finite in terms of funds, doctors, nurses and other supporting staff. It blunts the population's incentive to work [which is] so necessary to pay for the services they want. It is not even healthy for the medical service itself as the experience of the British National Health Service has shown.*[212]

Personal Responsibility

Over the long-term, the model that Lee conceived of has delivered both good health outcomes and funding sustainability. So, what are the defining features of the modern Singaporean system? A 1993 government White Paper entitled *Affordable Health Care* offers a powerful summary of its core assumptions and institutions.[213]

The document states that the Government's "health care philosophy is based on five fundamental objectives":

a. To nurture a healthy nation by promoting good health;
b. To promote personal responsibility for one's health and avoid overreliance on state welfare or medical insurance;
c. To provide good and affordable medical services to all Singaporeans;
d. To rely on competition and market forces to improve services and raise efficiency; and
e. To intervene directly in the healthcare sector, when necessary, where the market fails to keep health care costs down.

The paper continues:

> *We owe it to ourselves individually to keep fit and healthy. The health care system needs to be structured to strengthen this sense of personal responsibility. It must give the individual the maximum incentive to stay healthy, save for his medical expenses and avoid using more medical services than he absolutely needs.*

Singapore essentially has a blended model of healthcare provision: a basic set of services available to all citizens; strong emphasis on personal responsibility for health through savings and insurance; the use of market

211. *Ibid*, p.104.
212. National Archives of Singapore, "Speech to the Singapore Medical Association Annual Dinner,"
213. Singapore Ministry of Health, *Affordable Health Care: A White Paper*, 1993.

competition; and selective intervention by government when necessary. It is neither a totally regulated national health service nor a pure free market system where providers have full freedom to organise and to price their service. It is a hybrid system, seeking to link the consumption of healthcare services with responsibility for their financing, while ensuring a good basic level of provision for all.

And quite unlike the approach of Britain's welfare state architects in the immediate postwar period, there is an explicit recognition within the Singaporean system that fully socialised cradle to the grave provision is financially unsustainable in the long term. To avoid the pitfall of 'free' medical services stimulating insatiable demand, patients in Singapore are expected to pay directly for part of the cost of the services they consume, and to pay more when they demand a higher level of service.

A blended funding model

The Central Provident Fund

The foundation of the Singaporean system is the Central Provident Fund (CPF), a comprehensive social security system based on compulsory savings. All citizens have a CPF account and high contribution rates which are matched by employers. CPF Accounts are broken down into sub-accounts from which savings can only be drawn for specific purposes, including retirement, certain pre-retirement purposes like home purchase, and healthcare costs.

The CPF operates two main healthcare schemes. The first is called Medishield Life, a mandatory, universal, basic insurance programme which requires premium payments that are subsidised based on age and income. Medishield Life covers catastrophic illnesses and is designed to protect enrolees from heavy bills and costly outpatient treatment.

Table 12: Current Medishield Premiums

Age next birthday	Annual Premiums (inclusive of 9% GST)	Age next birthday	Annual Premiums (inclusive of 9% GST)
1 - 20	$200	74 - 75	$1,816
21 - 30	$295	76 - 78	$2,027
31 - 40	$503	79 - 80	$2,187
41 - 50	$637	81 - 83	$2,303
51 - 60	$903	84 - 85	$2,616
61 - 65	$1,131	86 - 88	$2,785
66 - 70	$1,326	89 - 90	$2,785
71 - 73	$1,643	> 90	$2,826

Source: Ministry of Health Singapore, Premium and Subsidy Tables. Premiums measured in Singaporean dollars.

Table 13: Current Medishield Subsidy Schedule

Subsidy rates for Singapore Citizens based on household monthly income per person

Age Next Birthday	Lower Income, $0 - $1,500	Lower Middle Income, $1,501 - $2,600	Upper Middle Income, $2,601 - $3,600
1 - 40	25%	20%	15%
41 - 50	30%	25%	20%
51 - 60	35%	30%	20%
61 - 70	40%	35%	25%
71 - 80	45%	40%	30%
81 - 85	50%	45%	30%
86 - 90	55%	50%	35%
> 90	60%	55%	40%

Source: Ministry of Health Singapore, Premium and Subsidy Tables

Government subsidies play a key role in keeping premiums relatively low. In addition, patients can obtain further subsidies by choosing wards with fewer amenities. Emergency services at public hospitals are subsidised for all.

The second CPF scheme is Medisave, which is a savings rather than an insurance scheme and is intended for the funding of expected out-of-pocket expenses. Individual contributions are placed in CPF accounts and earn interest; they can be drawn upon for a wide range of health-related purposes, including the care or treatment of other family members. The scheme promotes a high degree of personal responsibility to keep healthy and control demand for healthcare, as consumption of services is funded through drawing down on personal savings.

The CPF contribution rate for employees under 55 is roughly 20%,

while employers contribute at a rate of about 17%. These contributions *decrease* as people get older. Of that contribution, for people under the age of 45, about 20-25% is placed in their Medisave account, and this *increases* as they get older.[214]

There is no inheritance tax in Singapore. After death, any unused savings in a CPF account are distributed to individuals nominated by the account holder.

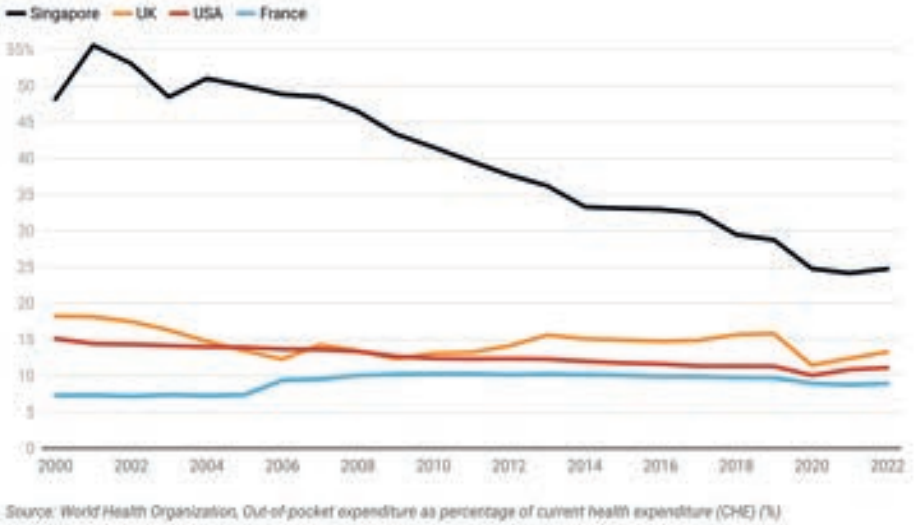
Support for Low-Income Groups

In addition to these two compulsory schemes, Singapore also operates a programme called Medifund, an endowment which is used to pay for the care of the poorest of Singaporeans. The fund is topped up from government funds and acts as a safety net. Access to it is means-tested, based on the financial circumstances of the patient and the size of the medical bill. Those who do not have sufficient savings to pay for medical bills can apply for Medifund assistance, but this is granted on a discretionary basis.

Those with higher incomes and monthly savings can also take out additional private insurance on top of the compulsory schemes for services or treatments not covered, or for private hospital rooms for example.

There is also a strong element of cost sharing within the Singaporean model. Individuals are expected to pay a yearly deductible as part of their Medishield Life plan in addition to their premiums, and co-payments are used in primary care and prescriptions. These are often subsidised depending on income and residency. In combination, insurance schemes with deductibles and co-payments also have a strong incentive effect which works to curb demand.[215] Despite falling over time, out-of-pocket healthcare expenditure is much higher in Singapore than in other countries. (See Chart 76.)

Chart 76: Out-of-pocket expenditure (% of current health expenditure) in Singapore and selected countries, 2000 - 2022



Source: World Health Organization, Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%)

214. CPFB | How much CPF contributions to pay

215. Bryan Cheang et al, *Meritocracy, Personal Responsibility and Encouraging Investment: Lessons From Singapore's Growth Miracle*, 2024.

Hospitals and Doctors

Singaporean hospitals are a combination of state-owned facilities and private institutions operated on a for-profit basis. In fact, in 2020, 39% of Singapore's acute care hospitals were privately owned. Public hospitals are corporatised, that is, they are legally autonomous private firms owned by the government and held by The Ministry of Health Holding Company (MOH Holdings). They have a high degree of flexibility over recruitment, remuneration, pricing and commissioning, but the government also regulates these facilities and can intervene to influence service.

Public hospitals are expected to meet their expenses through government funding and patient fees, but they are able to build reserves from surpluses to meet shortfalls or to invest.[216] Recently Singapore moved to a capitation funding model for hospitals, by which the quantum of money they receive is based on the number of people they serve and what age band they fall into. (In the UK, we operate a capitation system for general practice but not for hospital trusts.) This incentivises preventative interventions upstream, since these are likely to be less expensive than more serious interventions in hospital settings.[217]

The Ministry of Health intervenes to control the supply of both doctors and hospital beds. In diametric opposition to the assumptions that underpinned the founding of the NHS, the 1993 White Paper articulated the belief that rising healthcare costs would be substantially supply-driven. Singapore thus explicitly rations the supply of healthcare services in order to curb demand.[218]

Since 2003, the Government has required hospitals to publish data on the average price for treatments and other common services to promote competition among providers. Data on the occupancy of hospital bed spaces is also published weekly.

Primary care is prioritised in the training of new practitioners, and is seen as the key to mitigating the potential cost pressures deriving from an ageing population. Around 60% of Singapore's doctors have postgraduate qualifications in family medicine and are accredited as family physicians.

Healthcare spending

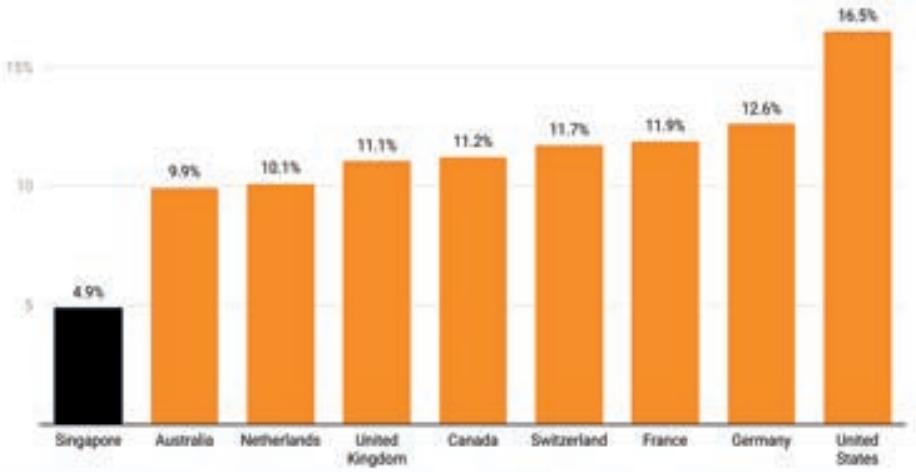
Singapore's healthcare model and the incentives that both the blended funding system and the mixture of private and public provision have ensured that, as a proportion of the economy and government spending, healthcare expenditure has remained remarkably low.

Chart 77 shows the total current healthcare spending in Singapore as a percentage of GDP, in comparison with a range of other countries. (Please note that the figures shown in this chart may not align perfectly with data referred to elsewhere in this report owing to the use of different sources.)

216. *Ibid.*
217. Capitation | Ministry of Health
218. Singapore Ministry of Health, *Affordable Health Care: A White Paper*, 1993.

Chart 77: Health expenditure in a selection of countries (% of GDP), 2022

Current expenditure (excluding capital expenditure)

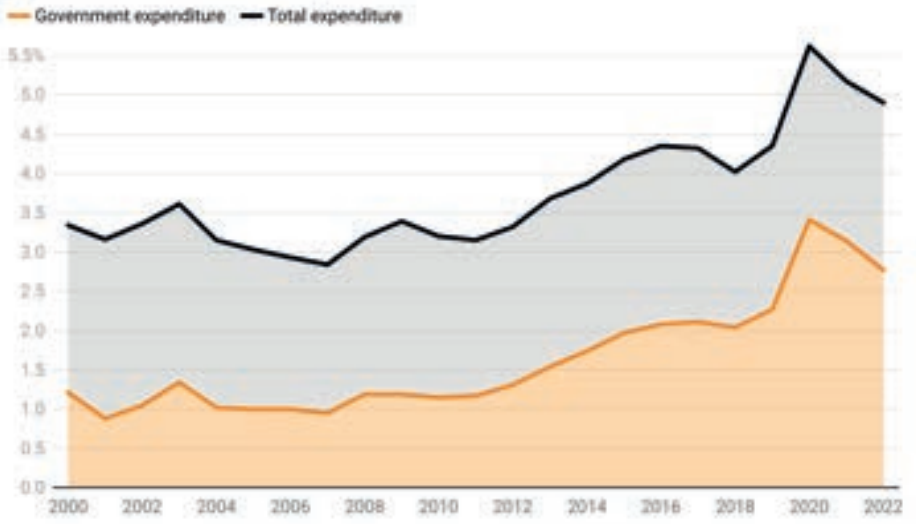


Source: World Health Organization, Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%). Current health expenditure as a share of GDP provides an indication on the level of resources channelled to health relative to other uses. It shows the importance of the health sector in the whole economy and indicates the societal priority which health is given measured in monetary terms.

The chart shows current health expenditure across the whole economy (not just government spend). So 4.9% is the percentage of GDP spent on *current* health expenditure across the economy, while government health expenditure is only about 2.8%. (See Chart 78 using World Health Organisation data.)

The Singaporean Government has in recent years increased public expenditure on healthcare to meet the demands of an ageing population, investing in primary care, new hospitals, and an increase in staffing.

Chart 78: Current health expenditure in Singapore (% of GDP), government and total, 2000 - 2022



Source: WHO, Current health expenditure (CHE) as a percentage of gross domestic product (GDP) (%); WHO, Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)

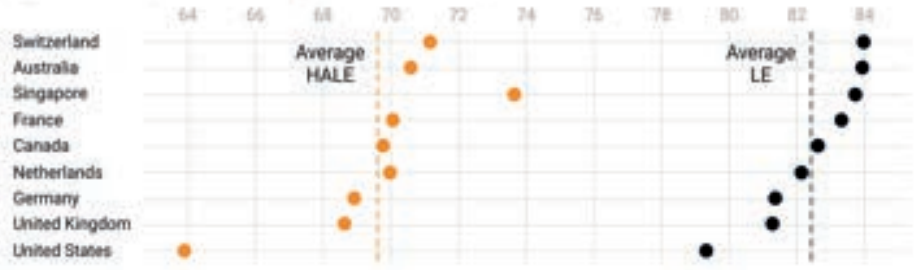
This system does not leave the average Singaporean with overwhelming out of pocket costs. Indeed, well over half of health expenditure in Singapore is still government subsidy. The sums of money raised through the Medisave and Medishield Life schemes is thus potentially less important than the overall effect they have in controlling demand, and so constraining costs - both for individuals and for the government.

Healthcare outcomes

Despite spending considerably less than most other developed countries, Singapore achieves some of the best healthcare outcomes in the world.

Chart 30 shows Singaporean life (and healthy life) expectancy in comparison to a number of other countries. Chart 79 shows the prevalence of obesity across those same countries, while Table 14 and Chart 80 show data on waiting times at various Singaporean clinics and hospitals.

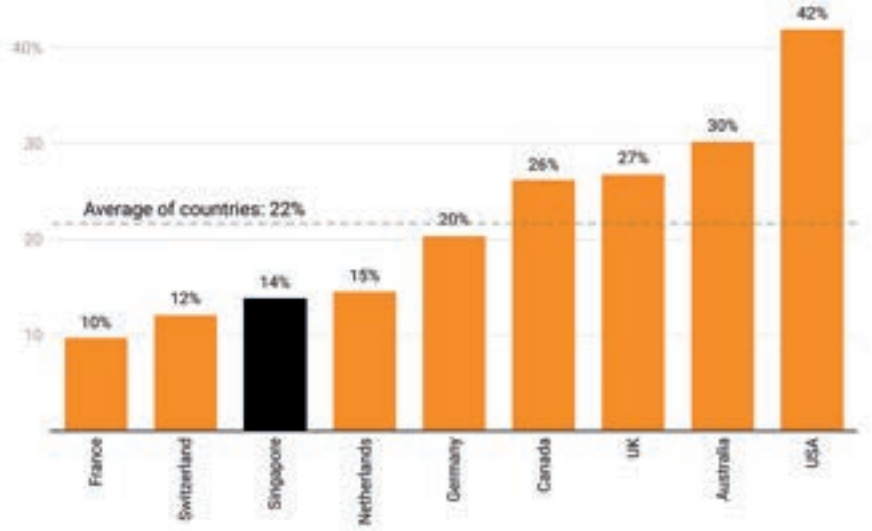
Chart 30: Life expectancy in a selection of countries, latest data



Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

Chart 79: Prevalence of obesity amongst adults in a selection of countries, 2022

Percentage of adults with a body mass index (BMI) greater or equal to 30

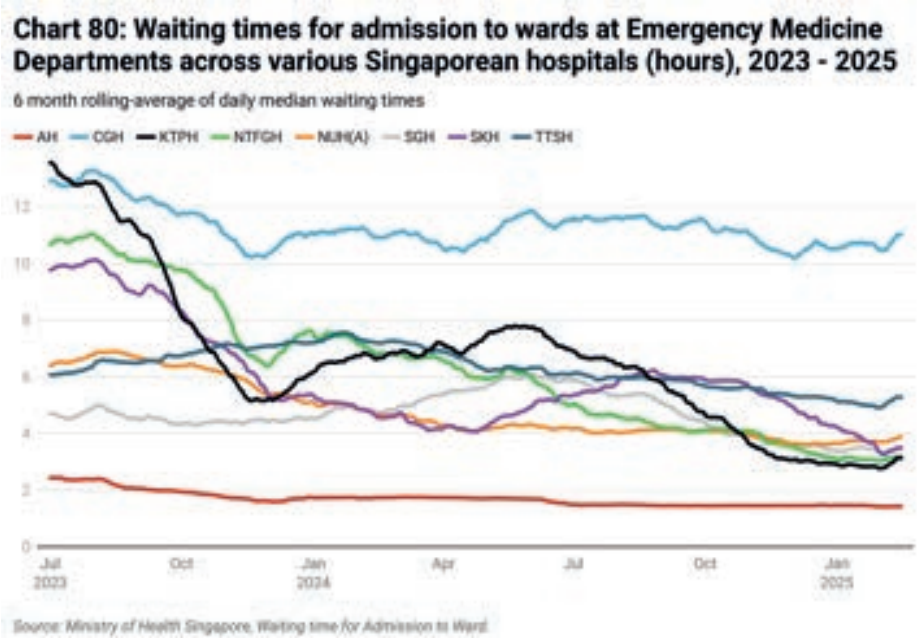


Source: World Health Organization, Prevalence of obesity among adults, BMI >= 30 (age-standardized estimate) (%)

Table 14: Polyclinic Median Waiting Times For Registration and Consultation in Singapore (minutes), December 2024

Institution	Registration	Consultation
Ang Mo Kio Polyclinic	3	18
Bedok Polyclinic	0	7
Bukit Batok Polyclinic	4	15
Bukit Merah Polyclinic	1	9
Bukit Panjang Polyclinic	1	6
Choa Chu Kang Polyclinic	4	10
Clementi Polyclinic	7	13
Eunos Polyclinic	1	13
Geylang Polyclinic	2	3
Hougang Polyclinic	3	7
Jurong Polyclinic	6	8
Kallang Polyclinic	2	19
Khatib Polyclinic	4	14
Marine Parade Polyclinic	0	12
Outram Polyclinic	1	13
Pasir Ris Polyclinic	1	10
Pioneer Polyclinic	3	7
Punggol Polyclinic	2	15
Queenstown Polyclinic	2	6
Sembawang Polyclinic	2	14
Sengkang Polyclinic	2	9
Tampines North Polyclinic	1	12
Tampines Polyclinic	1	13
Toa Payoh Polyclinic	3	13
Woodlands Polyclinic	4	17
Yishun Polyclinic	2	18
Average	**2**	**12**

Source: Ministry of Health Singapore, Waiting Times for Registration and for Consultation at Polyclinics.



Its results are not perfect, however. And because of the lower proportional spend on healthcare in Singapore, its performances on measures of resource availability – nurse availability, number of hospital beds, number of MRI or CT scanners – is correspondingly poorer than other countries who spend considerably more.[219]

What can the UK learn from Singapore?

If the Singapore model is so good, why hasn't the UK already copied it? The most obvious reason is that Singapore's model works on the principle of compulsion. Contributions to the CPF are obligatory, and no citizen can decide that he or she knows better what to do with their savings than the government. In its purest form, this may well be intolerable for a liberal, free society such as the UK.

But Singapore actually demonstrates how much flexibility and pragmatism can be injected into the provision of healthcare. Its system is blended and hybrid, involving private provision and insurance, state regulation, and large subsidies on the part of the state. The government provides a safety net to catch those not able to put away sufficient savings for their care costs. But that safety net is not so expansive that it saps the incentives to be personally responsible, or promotes excessive demand for healthcare treatments and services.

It also shows that, past a certain point, there is not a straightforward correlation between higher levels of government spending and better health outcomes. Singaporean life expectancy is better than that of many European countries despite the fact that its government spends less on health as a proportion of its GDP.

This points up another lesson which Singapore might provide for potential healthcare reformers: at some stage, improving the overall health of a nation requires investments in things other than healthcare

219. Meritocracy, Personal Responsibility, and Encouraging Investment: Lessons from Singapore's Economic Growth Miracle

narrowly defined. The Singaporean Government invests heavily in the "helping hands" of its civil society, for it believes robust and vibrant communities, pleasant green spaces and lifestyle are just as important for overall wellbeing as the availability of medical resources.

Appendix C. How the French healthcare system operates

The core of the French healthcare system is *L'Assurance Maladie*, which provides basic coverage to all residents. It is funded through taxation and compulsory social security contributions from employers and employees. It covers the cost of emergency care, diagnostic tests, treatment, prescriptions, and surgery. It covers workers (including freelancers and sole traders) and their families and is funded through deductions taken directly from salaries.[220]

However, this system does not cover 100 per cent of healthcare costs. For example, dental care, vision, physiotherapy, and some forms of mental health treatment are not covered. What is more, patients covered by *L'Assurance Maladie* do face upfront costs for medical appointments and medications which are then reimbursed.[221]

As a result, the majority of French citizens belong to a health insurance programme known as *Mutuelles* to cover the remaining costs. These memberships are often provided through employers, but they can be purchased individually. The system works through households or the employer paying a monthly fee to the insurance company. The patient then presents their *Mutuelles* card each time they visit their local doctor or a hospital. This should be considered as a type of 'top up' insurance in that it provides coverage for procedures which are not covered through *L'Assurance Maladie*. It also means that patients who have this form of insurance do not have to pay upfront costs for medical appointments or medications.[222]

Positive aspects of the French healthcare system

The French system aims to guarantee access to healthcare for every legal resident and so is similar to most other highly developed nations in this regard. This coverage includes a broad range of services, including hospital care, outpatient treatment, preventative care, maternity services, and long-term care.[223]

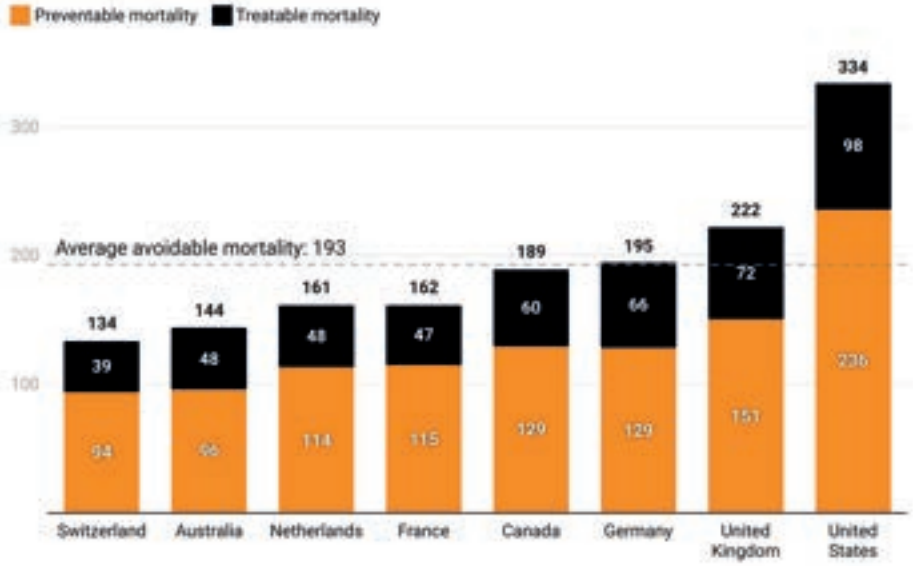
As discussed above, although patients do face upfront costs for certain medications and treatments in France, a significant proportion of these are reimbursed for most patients. The proportion varies but it is approximately 70 per cent on average. For low-income households, the elderly, and people living with disabilities, the reimbursement covers the full cost of the medications.[224] For patients with some forms of cancer, the reimbursement is 100 per cent and they are given greater access to financial support schemes.[225]

220. *Centre des Liaisons Européennes et Internationales de Sécurité Sociale*., 'The French Healthcare System', 2024
221. *Republique Francaise*, 'Reimbursement of Medical Consultations', 2024
222. 'Living in France'., Foreign, Commonwealth, and Development Office, 2024
223. Tikkanen, R., *et al*., 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020
224. *Ibid*
225. 'Cancer Survivorship Country Profile: France', *The Economist Intelligence Unit*, 2023

The quality of French healthcare is ranked highly when compared to similar nations. For example, it scores highly in regard to patient outcomes. This includes having low rates of avoidable mortality and a favourable life expectancy when compared to other wealthy countries. (See Charts 32 and 30.)[226] Moreover, survival rates for certain types of disease such as prostate cancer have increased significantly over the past 30 years while the survival rate for breast cancer is the highest in Europe.[227]

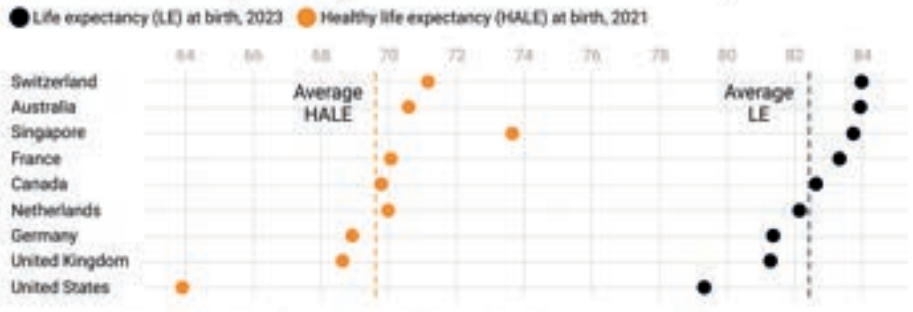
Chart 32: Avoidable mortality across a selection of countries (deaths per 100,000 inhabitants), 2020

Avoidable mortality is the sum of preventable mortality (avoidable before the onset of diseases/injuries) interventions) and treatable mortality (avoidable after the onset of diseases/injuries)



Source: OECD Data Explorer, Avoidable mortality. Totals may not sum due to rounding.

Chart 30: Life expectancy in a selection of countries, latest data



Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The French system also ranks relatively highly in patient satisfaction rates. For example, 92 per cent of patients with chronic conditions report good patient-centred care, which is significantly above the OECD average.[228]

226. Tikkanen, R., *et al.*, 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020
227. 'Cancer Survivorship Country Profile: France', *The Economist Intelligence Unit*, 2023
228. *OECD*, 'Does Healthcare Deliver? France', 2025

The healthcare system in France also places a strong emphasis on patient rights. It has a system which empowers patients by making it very easy for French citizens to access their medical records, and is transparent about information regarding costs and alternative treatments and providers. This allows patients to 'shop around' for more affordable options while allowing them to find the type of treatment which is most suitable to them.

Patient choice is also emphasised in the French healthcare system. For example, patients have the right to choose their GP, their specialists, their hospital, and the form of treatment they receive. This again grants greater freedom to patients to find the most cost effective and appropriate form of care while also meaning that they feel respected.[229]

A positive aspect of the French healthcare system which is not replicated in many other countries is the *Médecin Traitant* which was introduced in 2005. This works by having a GP who coordinates care – including specialist treatment – for their patient. As GPs tend to know their patients well this tends to lead to a more efficient use of resources by reducing the pressure on specialists and so has reduced costs and led to better outcomes for patients.[230]

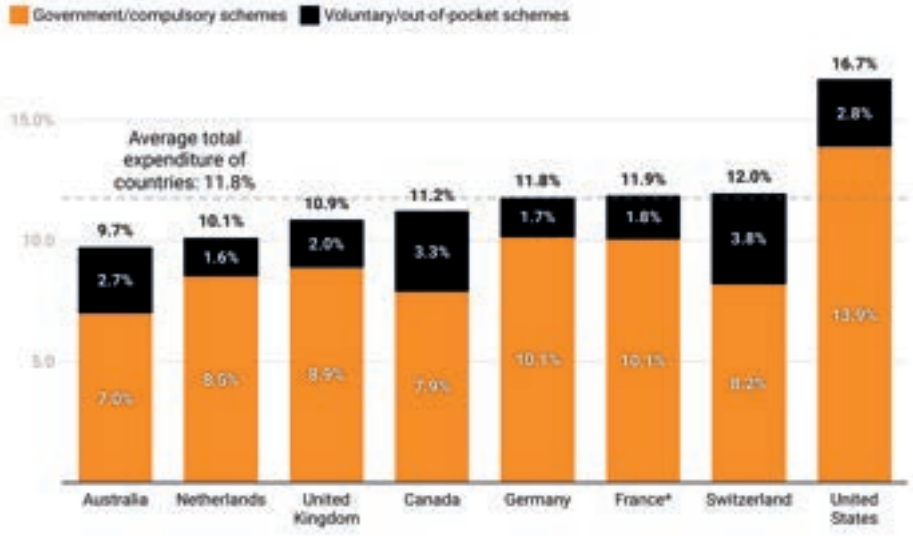
The French healthcare system ranks highly compared to similar countries on preventative care. For example, French citizens are entitled to free vaccinations and also free health check-ups, which helps the detection of diseases in their early stages.[231] Everyone registered for health insurance is entitled to a free health checkup every five years.[232] There is now also a comprehensive and preventative free check up available to people in four key age groups (18-25), (45-50), (60-65), and (70-75).[233]

Negative aspects of the French healthcare system

As with many wealthy nations, France spends a significant proportion of its GDP on healthcare. It is among the highest in the OECD and one of the highest in the EU with the total expenditure including government funding and out of pocket expenditure amounting to about 12 per cent of GDP. (See Chart 10.)[234]

229. *Centre des Liaisons Européennes et Internationales de Sécurité Sociale*., 'The French Healthcare System', 2024
230. Dumontet, M., *et al*., 'Gatekeeping and the Utilization of Physician Services in France: Evidence on the Medecin Traitant Reform' *Health Policy*, 2017
231. Tikkanen, R., *et al*., 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020
232. Thompson, H., 'How do I get a free healthcare check-up in France?', *The Connexion*, March 2023
233. Republique Francaise, 'Taking stock of your health with My prevention check up', September 2024
234. *OECD*, 'Health Expenditure and Financing', 2022

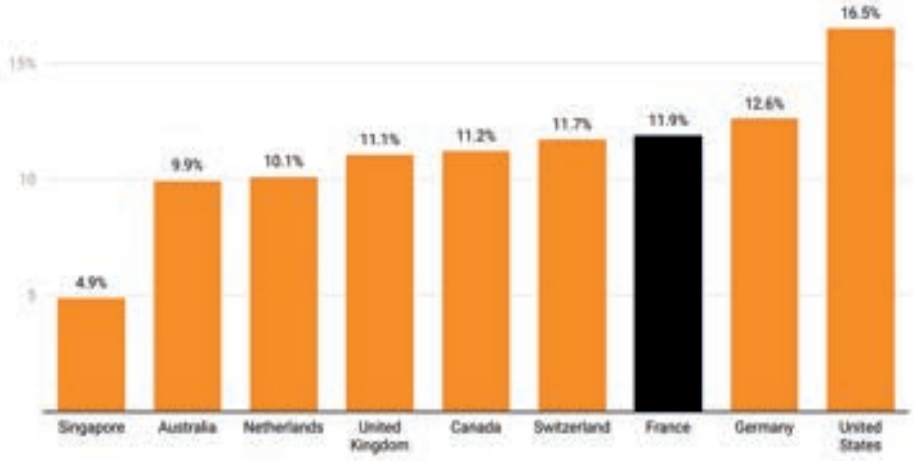
Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.

Chart 81: Health expenditure in a selection of countries (% of GDP), 2022

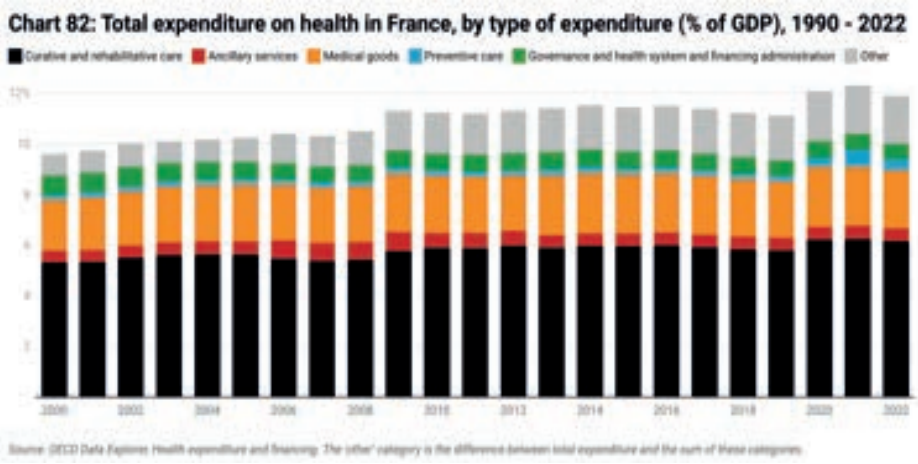
Current expenditure (excluding capital expenditure)



Source: World Health Organization, Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%). Current health expenditure as a share of GDP provides an indication on the level of resources channelled to health relative to other uses. It shows the importance of the health sector in the whole economy and indicates the societal priority which health is given measured in monetary terms.

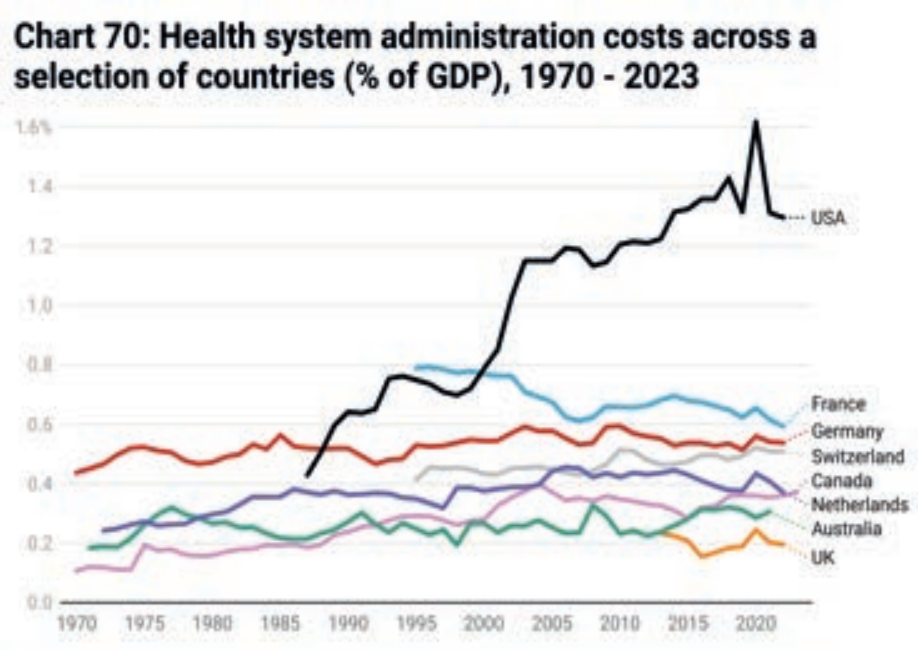
The shifting political landscape in France means that there are often extreme changes in the priorities of the government. For healthcare this means that reforms are introduced which either increase healthcare expenditure or attempt to lower it, which does not provide certainty or stability for patients or healthcare professionals. This can have a detrimental impact on outcomes for patients. (See Chart 82.) For example, it has led to an increase in fatigue and 'burnout' among doctors and other staff and has resulted in many of them taking early retirement or exiting the profession. This has led to a shortage of doctors relative to demand for healthcare in France.[235]

235. Boyer, L., *et al.*, 'The Hidden Crisis: moral injury among French healthcare workers', *Journal of Epidemiological Population Health*, 2024



Although the French system does strive to provide universal healthcare, this only provides basic coverage for the majority of citizens. What is more, although medications and treatments are often reimbursed, this is often only partial and so increases costs for households and firms.[236]

A related point is the high level of bureaucracy within the French healthcare system. Although not as high as in the United States, there is a great deal of paperwork involved in healthcare compared to other countries. (See Chart 70.) This increases the burden on patients and healthcare professionals and can have a detrimental impact on outcomes. This high level of bureaucracy and the high administrative burden means that it can take a long time for patients to be reimbursed for the medications and treatment they are entitled to. This can place a financial strain on households and makes it difficult to provide for themselves.[237]



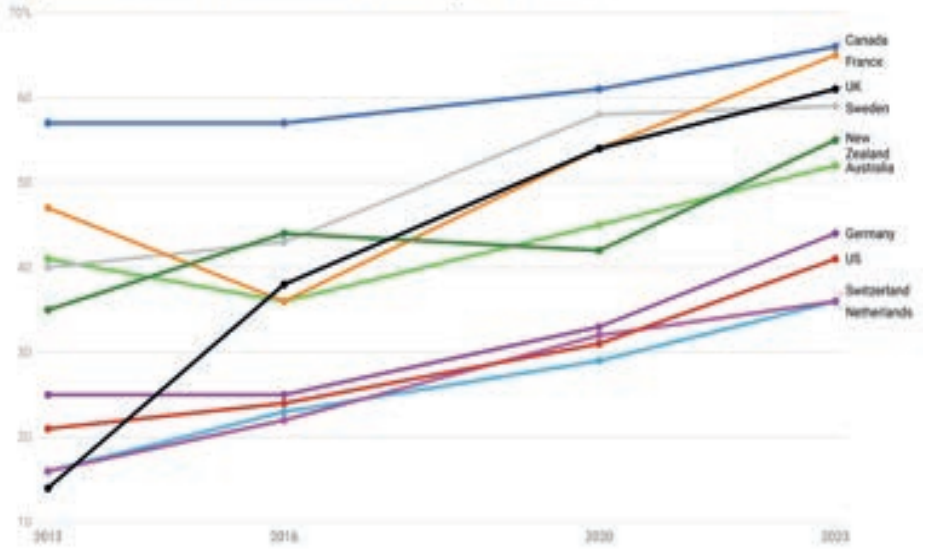
Source: OECD Data Explorer, Health expenditure and financing. Data shown refers to governance and health system and financing administration costs.

236. *Centre des Liaisons Européennes et Internationales de Sécurité Sociale.*, 'The French Healthcare System', 2024

237. Tikkanen, R., *et al.*, 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020

A further issue with the French healthcare system is long waiting times. France compares poorly to other highly developed nations. (See Chart 83.) This sees patients waiting a relatively long time to obtain non-emergency surgery and specialist care. Moreover, since the start of the Covid pandemic wait times have started to surpass those in the UK, New Zealand, Australia, and Sweden.[238]

Chart 83: Percentage of patients who waited 'more than 4 weeks' for a specialist appointment across a selection of countries, 2013 - 2023



Source: Health Foundation analysis of the Commonwealth Fund's 2023 International Health Policy Survey of Adults in 10 countries. Question asked: How long did you wait for your specialist appointment after being advised to see a specialist or consultant (2013–23)?

There are disparities between the level of care received by patients from different social-economic backgrounds.[239] Moreover, there is a noticeable rural and urban divide as doctors are attracted to roles in towns and cities which means that, on average, people in rural areas experience lower quality care than their urban counterparts.[240]

A further issue with the French healthcare system is inadequate mental health care compared to other advanced economies. There are comparatively long waiting times for mental health treatment due to a lack of funding and resources. As discussed above, some forms of mental health treatment such as psychotherapy and counselling are not covered. This means that people requiring this treatment are not receiving the care and support they need.[241]

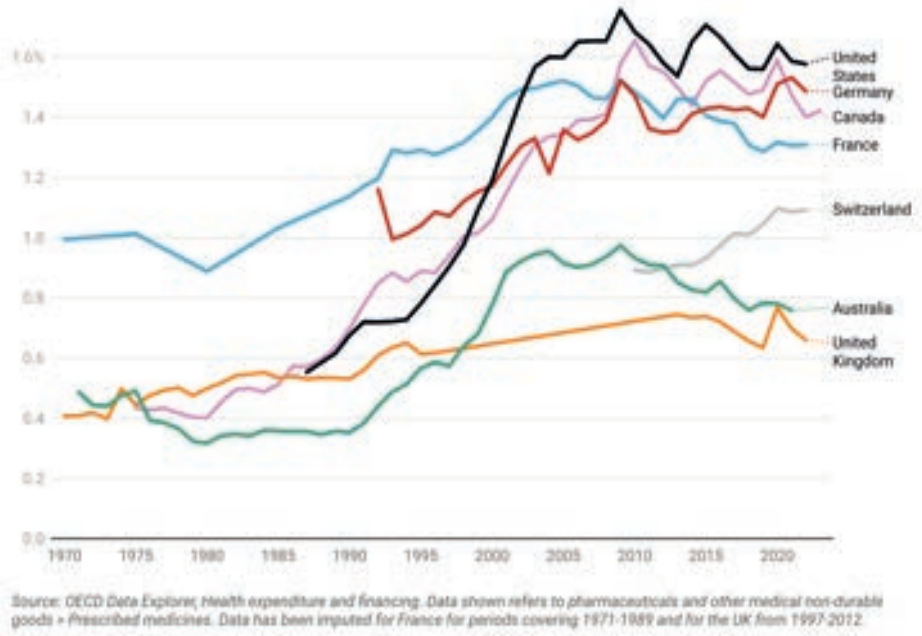
A final issue with the French healthcare system is over-treatment. There is evidence to suggest that certain treatments are incentivised in order to increase revenues for hospitals.[242] This means that resources are being used inefficiently while patients may also be receiving inappropriate care such as unnecessary scans and treatments which might detect certain conditions but which would not have negatively affected the patient. There is an opportunity cost here and a misallocation of resources as it means that medical equipment and treatments are being used on patients who do not

238. 'International Health Policy Survey of Adults in 10 Countries', *The Commonwealth Fund*., (Analysis by *The Health Foundation*)., 2023
239. Jacquet, E., *et al*., 'Social Inequalities in Health and Mental Health in France: the results of a 2010 population-based survey in the Paris Metropolitan Area', *PLOS One*, 2018
240. Blanco-Cazeaux, I.,'Location Dynamics of General Practitioners in France', *SSM: Population Health*, 2022
241. Fond, G., *et al*., 'Mental Health Care Utilization and Prescription Rates Among Children, Adolescents, and Young Adults in France', *JAMA*, 2025
242. Hazard, A., *et al*., 'Implementation of a top five list to identify medical overuse in general practice according to patients' viewpoint in 2019 in France', *BMC Family Practice*, 2021

need it at the expense of other patients, households, firms, and taxpayers.

A particular issue related to this is the overprescription of medications. (See Chart 84.) Not only does this increase the cost of healthcare in France and diverts resources away from other treatments and procedures, it is also potentially dangerous. For example, research has suggested that 50 per cent of medications prescribed in France are of little benefit to patients and are actually harmful. This overprescribing of medications was responsible for approximately 20,000 deaths each year.[243] There have been various explanations for this and they include a greater acceptance of taking medications in France as opposed to other countries, as well as marketing campaigns by pharmaceutical companies which fuel patient demand for medications.[244]

Chart 84: Total expenditure on prescribed medicines across a selection of countries (% of GDP), 1970 - 2023



Source: OECD Data Explorer, Health expenditure and financing. Data shown refers to pharmaceuticals and other medical non-durable goods > Prescribed medicines. Data has been imputed for France for periods covering 1971-1989 and for the UK from 1997-2012.

Previous reforms to the French healthcare system

The healthcare system has undergone a number of reforms over the past 30 years. In this section we will discuss five of the most significant and their impact.

First, there was the expansion of the *Maladie Universelle*. This commenced in 1999 and there have been a number of subsequent adjustments. The reforms aimed to ensure that all legal citizens – as well as undocumented immigrants in certain circumstances – had access to at least basic medical care. This reform has been successful in its stated aim of increasing access to healthcare, especially for vulnerable groups. However, it was expensive and did lead to a subsequent increase in healthcare costs.[245]

Second, in 2009 the government introduced reforms aimed at reorganising healthcare delivery. It established Regional Health Agencies

243. Arie, S., 'Ending the French Love Affair With Drugs', *British Medical Journal*, October 2012

244. *ibid*

245. Tikkanen, R., *et al.*, 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020

to place planning and financial allocation at the regional level. The evidence suggests that this resulted in improved coordination between health providers and subsequently better health outcomes for patients including faster treatment.[246]

Third, the French government implemented the *Tarification a l'Activite* in 2004. This changed the budgeting system from one which was centralised to one where hospitals are paid based on the number and type of procedures performed. This was introduced in order to increase efficiency. However, there is evidence to suggest that it leads to over-treatment and so increases costs while delivering worse patient outcomes.[247]

Fourth, in 2007 and 2012 the government implemented hospital modernisation programmes. These investments focussed on investments in infrastructure and technology as well as reforming management practices in hospitals. There is evidence to suggest that the increased investment in infrastructure and technology did improve patient outcomes but this was at great expense.[248] Moreover, there is scant evidence to suggest that the management reforms have either improved patient outcomes or cut costs.[249]

Fifth, the government introduced *Ma Sante* in 2022. The aim of this provision was to increase the number of trained doctors by 20 per cent by adjusting educational pathways and making it easier for people to enter the medical profession.

Conclusion

The French healthcare system performs well compared to similar countries for average patient outcomes. It provides a high level of care for patients and places an emphasis on patient choice. It also ensures that the vast majority of the population have access to at least some level of medical care.

However, the high level of bureaucracy in the French system places a burden on patients and medical staff. It also means that patients are often not reimbursed in a timely fashion which places a financial strain on them.

Healthcare in France is also expensive relative to comparable countries, requiring funding from taxpayers, firms, and households.

French patients can also experience long waiting times for treatment and non-emergency surgery. This means that many patients are not getting the treatment they need when they need it, risking their health deteriorating further. This is especially the case for mental health treatment.

Successive governments have implemented reforms to the healthcare system designed to address many of these issues. While some of these reforms have achieved their aims,this has often come at great expense. Moreover, some reforms have had little impact and in some cases have exacerbated problems.

246. Field, R., Keller, C., & Louazel, M., 'Can governments push providers to collaborate? A comparison of hospital network reforms in France and the United States', *Health Policy*, 2020
247. Thollet, M., 'Les effets pervers de la tarification à l'activité', *Systemes de Sante*, 2020
248. Tikkanen, R., *et al*., 'International Health Care System Profiles: France', *The Commonwealth Fund*, 2020
249. Field, R., Keller, C., & Louazel, M., 'Can governments push providers to collaborate? A comparison of hospital network reforms in France and the United States', *Health Policy*, 2020

Appendix D. How things are done in Japan

Japan achieved universal health coverage as early as 1961, one of the first countries to do so. Its healthcare system is held in high regard internationally and perceived to be fair, equal and inexpensive. There are also not many services left uncovered by its insurance plans.[250] However, a concerningly low fertility rate, shrinking workforce and ageing population threaten the sustainability of the current system.

Japan employs a statutory health insurance system (SHIS) which is funded through a combination of taxes and individual contributions and covers over 98% of its population.[251] Citizens are required to enrol into one of two types of insurance plans; employment-based plans (of which there are over 1,400) cover about 59% of the population while residence-based plans (of which there is one for each of Japan's 47 prefectures) cover just under 40% of the population. Residence-based plans include those for unemployed (as well as self-employed or studying) individuals aged below 75 and those for adults aged 75 and above. While over 70% of the population also hold voluntary private insurance, these plans are supplementary rather than primary.

The remaining 2% of the population who face difficulties affording employment or residence-based schemes are instead directed to Seikatsu Hogo, Japan's national welfare system, which provides financial and social support across areas such as employment, education and housing as well as medical and long-term care.[252]

For the majority of services, Japanese citizens face a coinsurance rate of 30% (lower for children and low-income adults), insurance premiums and some co-payments.[253] These payments are capped by an annual household out-of-pocket maximum which varies with respect to age and income.

Within employment-based plans, contributions are shared between the employer and employee, representing around 10% of the employee's monthly salaries plus any bonuses. Contributions are tax deductible and capped; for example, in Tokyo the maximum monthly salary contribution was JPY 137,000 or $1,370 in 2018.[254] For residence-based plans, a proportion of the individuals' mandatory contributions is funded by the national government, prefectures and municipalities.

Within each type of insurance plan, citizens do not select a programme. Rather, their enrolment is based on their employment status, age and residence.[255] Despite this, there are no restrictions on access. Enrollees of all plan types are free to receive care from any provider as often as they would like, although hospitals may charge more to patients who do not have a referral. Benefits are consistent across plans and include hospital and outpatient care, prescriptions, dental coverage and mental healthcare.

The right of Japanese citizens to health is expressed within Japan's constitution and it is the state's responsibility to facilitate this. To this point, the national government regulates the SHIS, sets fee schedules, and gives subsidies to local authorities, insurers and providers.[256] Meanwhile, each prefecture is responsible for implementing regulations, managing their residence-based plan and developing delivery networks for health

250. Katori, T. (2024), Japan's healthcare delivery system: From its historical evolution to the challenges of a super-aged society, link
251. Tikkanen, R. et al. (2020), International Health Care System Profiles; Japan, The Commonwealth Fund, link
252. Toyonaka City Welfare Office (2023), Public Assistance Guide, link
253. Tikkanen, R. et al. (2020), International Health Care System Profiles; Japan, The Commonwealth Fund, link
254. Ibid
255. Japan Health Policy NOW (2021), Health Insurance System, link
256. Tikkanen, R. et al. (2020), International Health Care System Profiles; Japan, The Commonwealth Fund, link

care.

Primary care is largely provided at clinics and outpatient specialist care at hospital departments.[257] While some clinics are owned by local governments and not-for-profit organisations, most are privately owned and managed by physicians or medical corporations. At most hospitals and clinics, patients can receive after-hours care through a walk-in. While after-hours care demands additional fees, clinics owned by local governments are somewhat subsidised. Fees for both primary and specialist services are set by the government.

In Japan, physicians have the freedom to open medical practices. In fact, if a physician has a license to practice medicine, they can open a practice in any medical specialty, regardless of whether or not they have a license in that area.[258]

Around 85% of hospitals are privately owned, either for profit or nonprofit, while the remaining 15% are publicly owned.[259] Within the SHIS, both hospitals and clinics send insurance claims to intermediaries which pay a large proportion of the fees to providers. There are various methods of quality control: hospitals face annual inspections by prefectures and face penalties if the staff-to-bed ratio falls under a given threshold. The government facilitates third-party evaluations of institutions such as nursing homes to improve care, and hospitals are also encouraged to report quality indicators on their websites.

The history and development of the system

Employment and residence-based health insurance schemes have developed separately over time to make the Japanese system what it is today.

Before the 1920s, health and life insurance was made available to workers through mutual aid associations which allowed employers and employees to voluntarily contribute towards varying benefit plans.[260] The Japanese government sought to regulate employment-based insurance schemes by introducing the 1922 Health Insurance Law which required most workplaces to offer corporate health insurance, the rates and benefits of which were set by the government. These programmes have since evolved to increase the range of firms which must offer such plans.

Meanwhile, the current form of residence-based National Health Insurance (NHI) was brought to fruition with the promulgation of the National Health Insurance Law in 1938, despite complications arising from World War II. Initially, municipalities were not required to establish local programmes which meant that in 1956 around a third of the population was left uninsured.[261] This was corrected with an adjustment to the National Health Insurance Law in 1958, mandating the establishment and administration of NHI programs by all municipalities and leading to full coverage of the Japanese population by 1961.

The Health Care for the Aged Law represents a critical piece in the history of Japan's health system. In 1972, the government subsidised the 30% coinsurance rate for older citizens which led to a fourfold spiralling of expenditures for this demographic since healthcare had effectively

257. Ibid
258. Japan Health Policy NOW (2021), Health Insurance System, link
259. Tikkanen, R. et al. (2020), International Health Care System Profiles; Japan, The Commonwealth Fund, link
260. Japan Health Policy NOW (2019), Historical Overview, link
261. Ibid

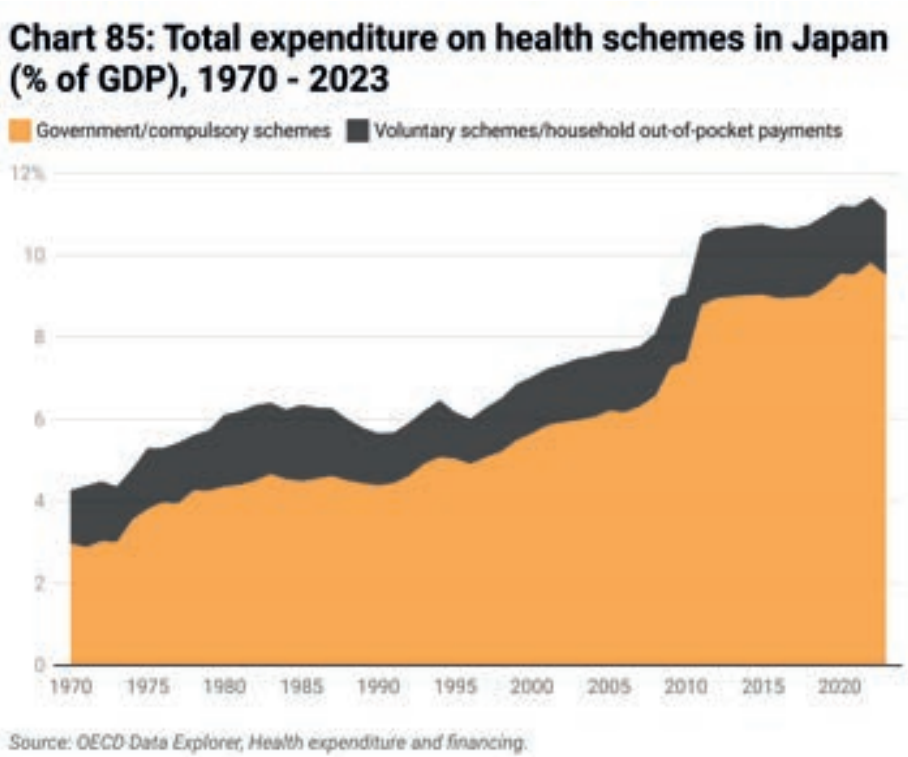
become free. Former officials of the Ministry of Health, Labour and Welfare have described this as the "biggest mistake in Japanese health policy".[262] Although the accessibility of care facilities improved, there was an over-provision of care and hospital waiting rooms became social centres for older communities.

Concerns over financial sustainability led to the 1982 Health Care for the Aged Law which necessitated co-payments from older citizens, as well as cross-subsidising NHI schemes by redirecting revenues from employment-based insurance. Free healthcare for older citizens naturally proved politically difficult to revoke; the elderly have been required to pay 10-20% (depending on income) of medical costs since only 2002, with a relatively low payment limit.[263]

Another important policy development occurred in 1997 when the co-insurance rate for employees' insurance and community health insurance was equalised at 30% of medical costs.

Expenditure and outcomes

In recent history, health expenditure as a proportion of GDP has been on the rise across developed economies and Japan is no exception to this trend. Chart 85 shows total expenditure on government/compulsory schemes and voluntary out-of-pocket schemes in Japan since 1970. Total expenditure in Japan has gradually climbed from 4.3% of GDP in 1970 to 11.1% in 2023. Over this period, voluntary expenditure has remained stable, with compulsory schemes accounting for the majority of this increase.

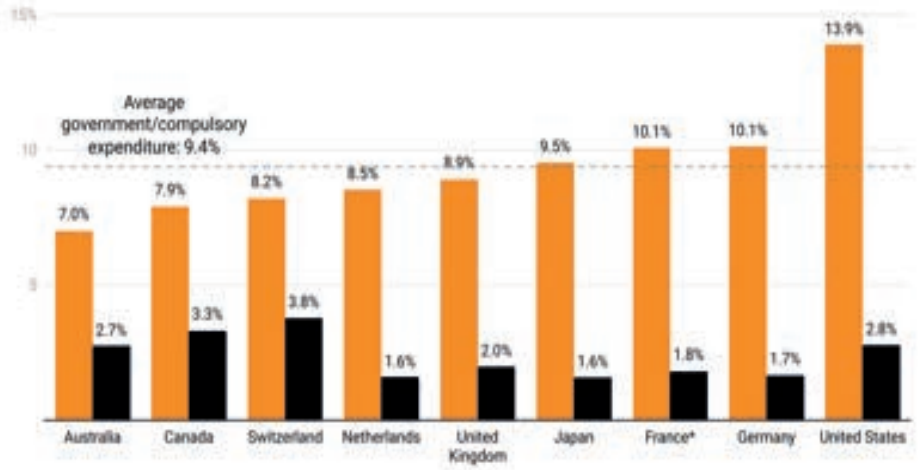


262. Ibid

263. Coady, D. Clements, B.J. and Gupta, S. (2012), CHAPTER 11: Challenges in Reforming the Japanese Health Care System, IMF eLIBRARY, link

As of 2023, Japan's statutory health insurance system, plus additional government expenditures towards health, accounted for 9.5% of GDP while voluntary schemes made up 1.6% of GDP. Chart 86 compares these figures to our selected countries. Japan's government and compulsory scheme spending is marginally higher than the average of these countries (9.4% of GDP) while voluntary scheme spending is somewhat lower than average (2.4%).

Chart 86: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023

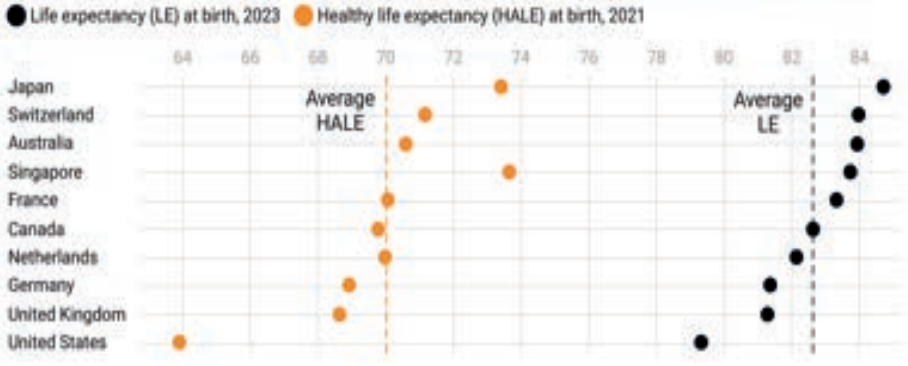


Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.

How then does Japan measure up with regard to various metrics of health outcomes? Chart 87 shows life expectancy and healthy life expectancy in Japan and across our selected countries. With regard to life expectancy, Japan is ranked the best of these countries at 84.7 years, that is 3.4 years longer than the UK (81.3). Japanese citizens can also expect 73.4 years in good health, 5 years longer than those in the UK and almost 10 years longer than US citizens, and second only to Singapore (73.7).

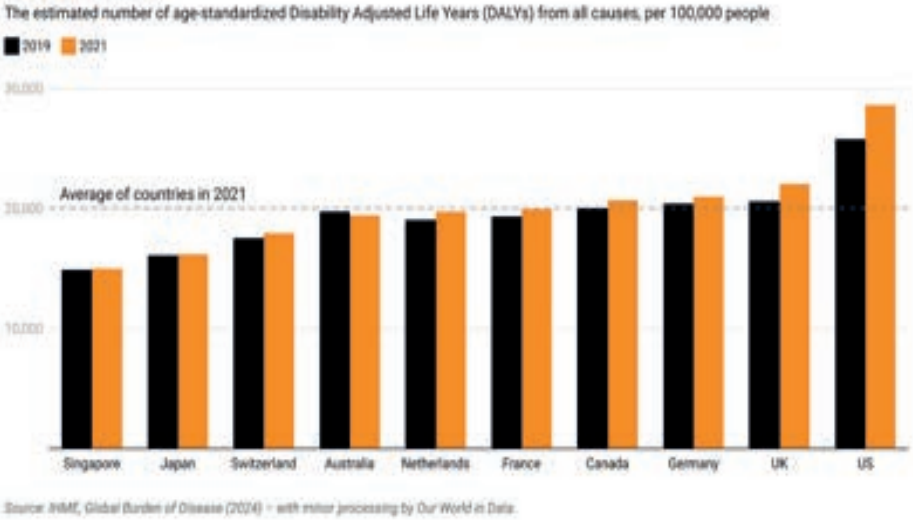
These outcomes are supported by data on the burden of disease. Disability adjusted life years (DALYs) represent lost health via mortality and morbidity and are shown in Chart 88. Once more, Japan performs considerably well, alongside Singapore and Switzerland.

Chart 87: Life expectancy in a selection of countries, latest data



Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

Chart 88: Burden of disease across a selection of countries (DALY per 100,000 people), 2019 and 2021

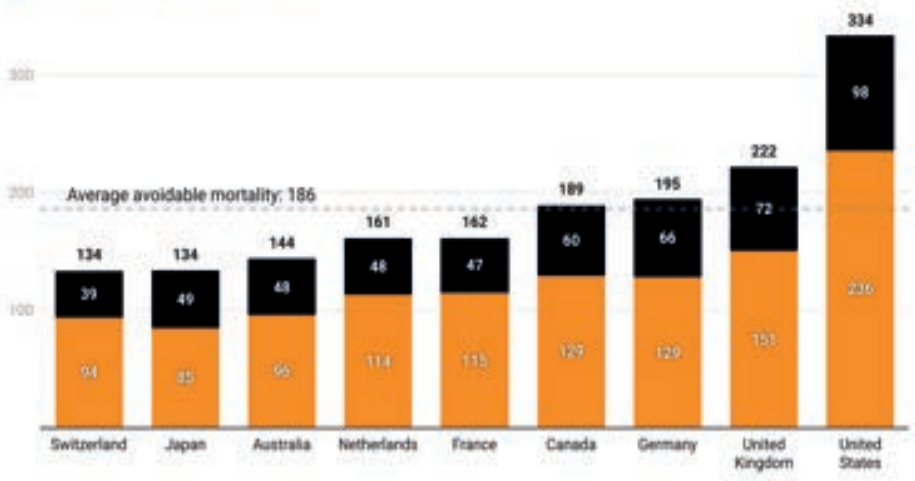


Source: IHME, Global Burden of Disease (2024) – with minor processing by Our World in Data

Avoidable mortality rates reflect both the health of the population by its ability to prevent the onset of disease in the first place, as well as the efficacy of the health system in treating various diseases. This is also an area of success for Japan which boasts the joint-lowest rate with Switzerland, with only 134 avoidable deaths per 100,000. (See Chart 89.) Japan performs well with respect to the preventable mortality component. Indeed, it is the lowest of these countries. This probably reflects healthier lifestyles across the population, which helps citizens to avoid various diseases.

Chart 89: Avoidable mortality across a selection of countries, 2020

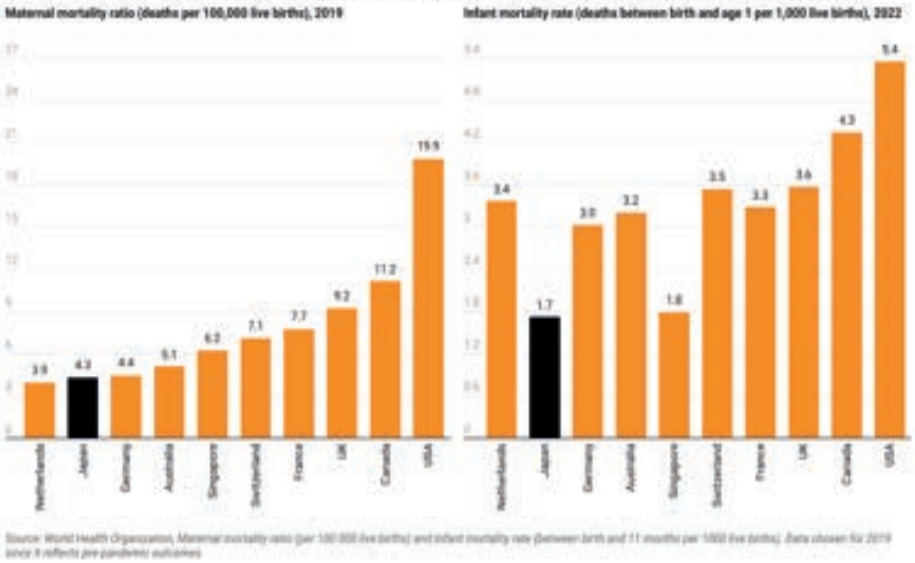
Avoidable mortality is the sum of preventable mortality (avoidable before the onset of diseases/injuries) interventions) and treatable mortality (avoidable after the onset of diseases/injuries). Deaths per 100 000 inhabitants



Source: OECD Data Explorer, Avoidable mortality. Totals may not sum due to rounding

Maternal and infant mortality rates in Japan are among the lowest of our selection of countries. (See Chart 90.) Maternal mortality has remained steady over the last 20 years at around 4 deaths per 100,000 live births, significantly lower than its regional average and second only to the Netherlands out of our selected countries.[264] Japan's infant mortality rate is also one of the lowest in the world, and the lowest of our selected countries with only 1.7 deaths per 1,000 live births.

Chart 90: Maternal and infant mortality rates across a selection of countries in 2019 and 2022



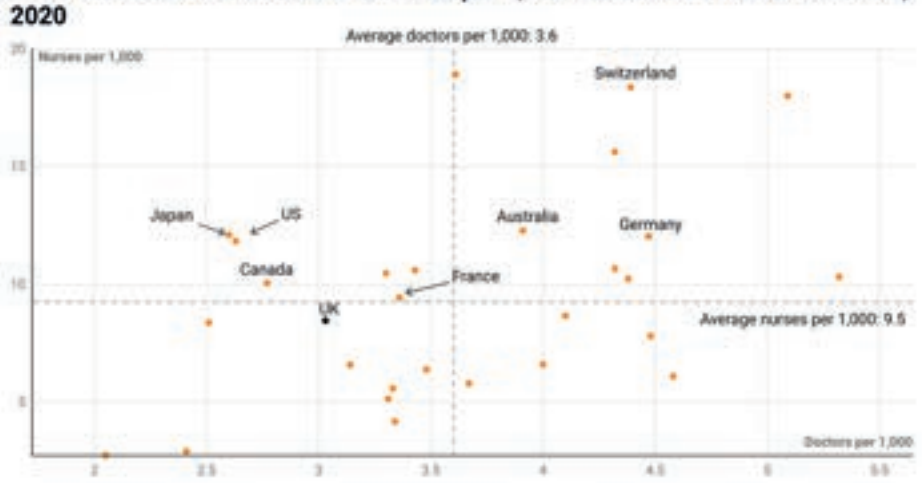
Source: World Health Organization, Maternal mortality ratio (per 100 000 live births) and infant mortality rate (between birth and 11 months per 1000 live births). Data shown for 2019 since it reflects pre-pandemic outcomes

One area of concern for Japan is its number of physicians per 1,000. Chart 91 shows the number of doctors and nurses per 1,000 across various

264.World Bank Group (2022), Japan; Featured Indicators, link

OECD countries. While it has a higher than average number of nurses per capita at 12.1 per 1,000, Japan lags behind the average number of doctors per 1,000 (3.6) with only 2.6, the lowest of our basket of countries.

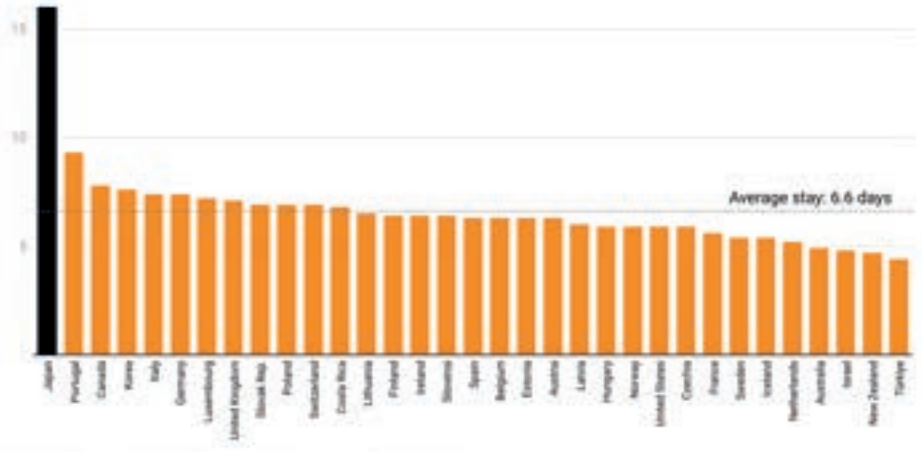
Chart 91: Number of doctors and nurses per 1,000 inhabitants in OECD countries, 2020



Source: OECD Data Explorer, OECD Data Archive. Data is from 2020, unlike the previous chart on the number of doctors and nurses. This is because data for Japan is only available for 2020

Exacerbating this issue is the average length of stays in hospital for acute care cases, the data for which is shown in Chart 92. Japan has by far the longest average stay, at 16 days, well over double the average across OECD countries (6.6 days). Given that health coverage is universal, patients face a much lower cost for hospital stays relative to other countries.[265] Additionally, hospitals receive more money from the government the longer a patient remains in hospital, which incentivises hospitals to keep patients longer. This means that doctors are faced with long working hours and are often expected to work a significant level of overtime. In an attempt to ease this pressure, the government recently set a cap for the working hours of doctors, equivalent to around 80 hours of total work per week.[266]

Chart 92: Average length of hospital stay across OECD countries (days), 2021



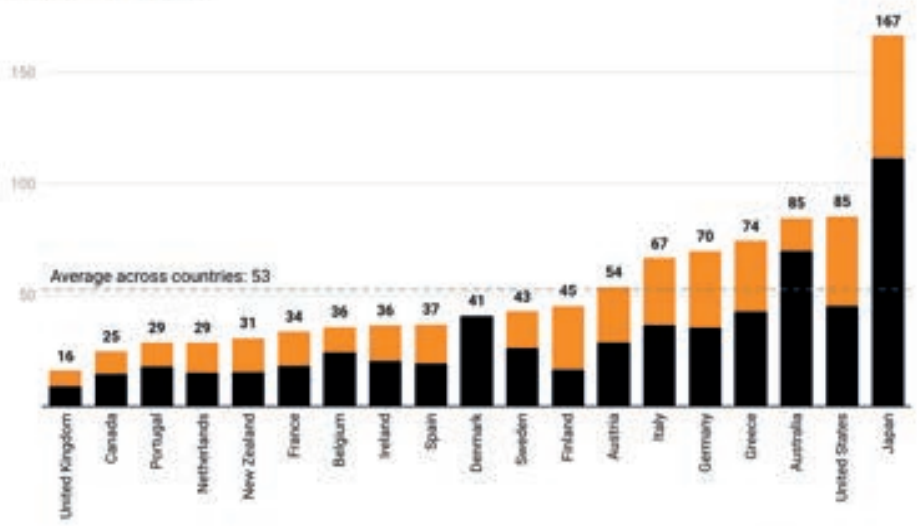
Source: OECD Data, Length of hospital stay. Hospital stay refers to acute care.

265. Magenta Health Japan (2024), Lengthy Hospital Stays: High Quality Care or Over Servicing?, link

266. Doki, S. (2019), Allowing more doctors to work less than full time could reduce burnout, says royal college, link

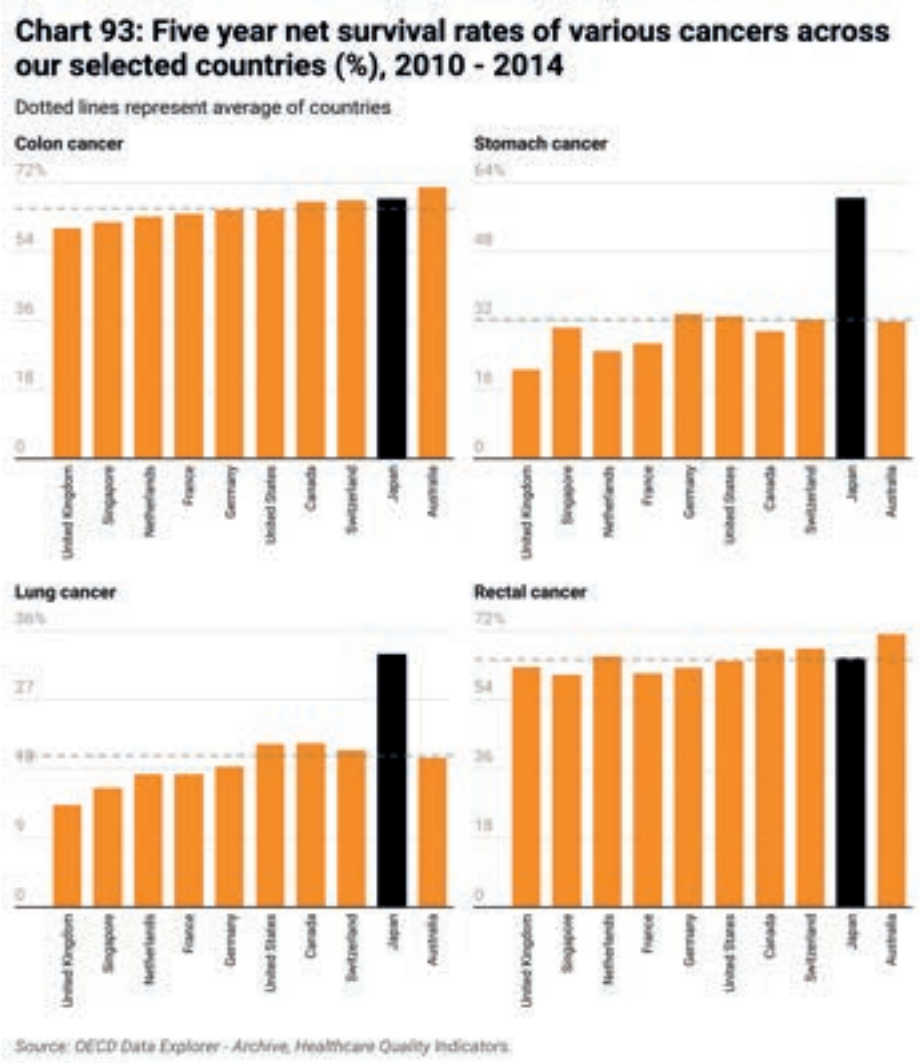
Japan does not suffer from a short supply of CT and MRI scanners, (See Chart 43.) A leader in radiological research, Japan's national insurance system provides CT and MRI scans for all of its citizens, which is not common among countries which have adopted insurance systems.[267] Consequently, OECD data shows that Japan has historically performed relatively well with regard to five-year cancer survival rates.[268] Of our selected countries, Japanese citizens have significantly greater probabilities of survival 5 years after being diagnosed with lung and stomach cancer. Japan also performs well with regard to colon cancers. (See Chart 93.)

Chart 43: CT and MRI scanners per million across a selection of countries, 2019 or nearest year



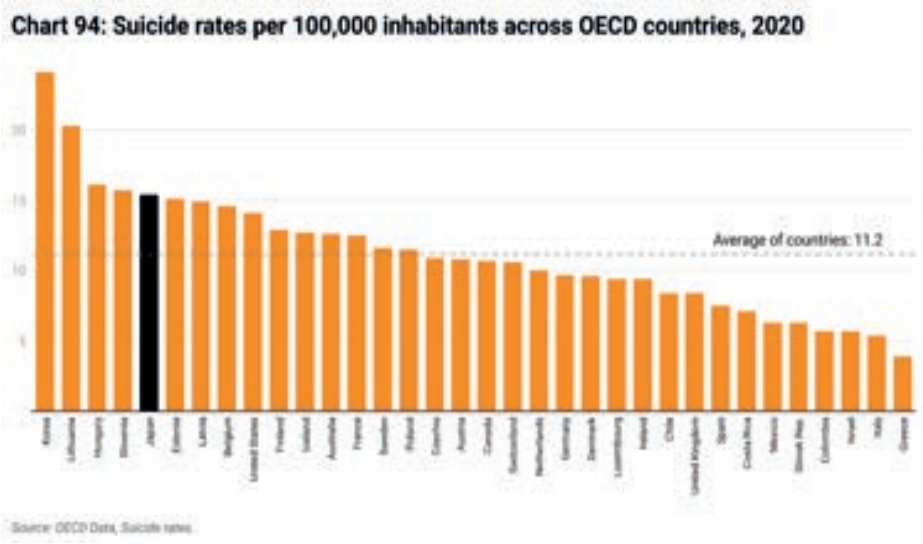
Source: The King's Fund, Comparing the NHS to the health care systems of other countries: five charts; OECD Health Statistics 2021.
Denmark does not have data for MRI units. Equipment outside hospitals are excluded for Portugal, Sweden and the United Kingdom.

267. Nature Portfolio (2024), Why Japan is a leader in radiological research, link
268. OECD Data Explorer – Archive (2024), Healthcare Quality Indicators, link



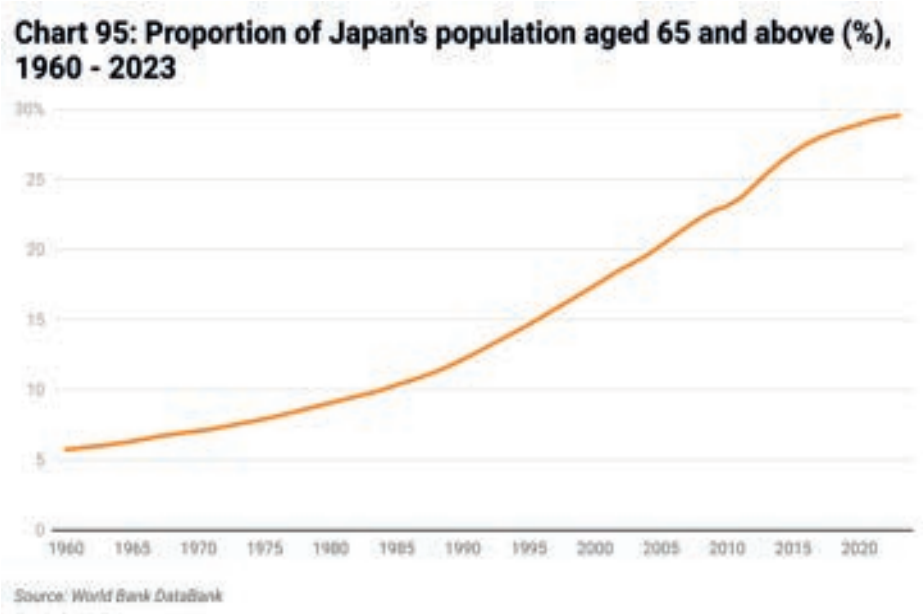
A recent area of prioritisation for the Japanese government has been to reduce the number of suicides. Historically, suicide has been a taboo topic and only since the 2000s has it received increased social attention.[269] From 2006 to 2022, the suicide rate fell by over 35%; despite this, Japan has a notably higher rate than many OECD countries. (See Chart 94.)

269. World Health Organization (2024), Suicide prevention in Japan: a public health priority, link



Social care

Japan's Long-Term Care Insurance (LTCI) system provides long-term care for around 6 million people but faces acute pressure due to Japan's ageing population. Chart 95 shows the proportion of Japan's population aged 65 and over; from 1960 to 2023, there has been a profound increase from 6% to 30%.



Following World War II, Japan experienced two baby booms before a period of low fertility which has since led to Japan becoming a 'super-aged society', (a country where over 20% of the population is aged 65 or older). Towards the end of the 20th century, large numbers of older people had to be admitted to hospital which led to substantial increases in medical expenditure.[270] In response to this, the government implemented

270. Yamada, M. and Arai, H. (2020), Long-Term Care System in Japan, National Library of Medicine, link

the 'Gold Plan'. Historically, the welfare sector had been planned with single-year budgeting and so the government's introduction of a 10-year strategy for health and welfare services represented a deviation from the norm.[271]

The Gold Plan was successful in that it contributed to building basic infrastructure for long-term care. However, the services offered were prioritised for individuals on low incomes, limiting accessibility for the middle class. Additionally, the system was funded by tax revenue which meant that sharp increases in spending led to sustainability issues. This led to Japan developing a Long-Term Care Insurance system in 2000 which is still in place today.

Premiums, set by municipalities, and taxes each fund half of the LTCI system.[272] Every citizen aged 40 and above is required to pay premiums which vary according to income. There is also a 10% co-payment for long term care services for those certified to receive care, while the rest is covered by the system.

Citizens aged 65 and over are eligible to receive benefits, as well as those over 40 with ageing disabilities, regardless of need or income.[273] While those aged between 40 and 64 are required to pay premiums without gaining eligibility, it is thought that they will see the benefit of the system through the support given to their parents.

The benefit package is the same for everyone and includes institutional, home and community-based services which are accessed through a care manager. A questionnaire on daily living is reviewed alongside a report from the enrollee's physician in order to determine the level of need and quantity of services required. These are reassessed every two years or upon request. Each level of need has a payment ceiling after which individuals and families face costs, with benefits available for those on low incomes.

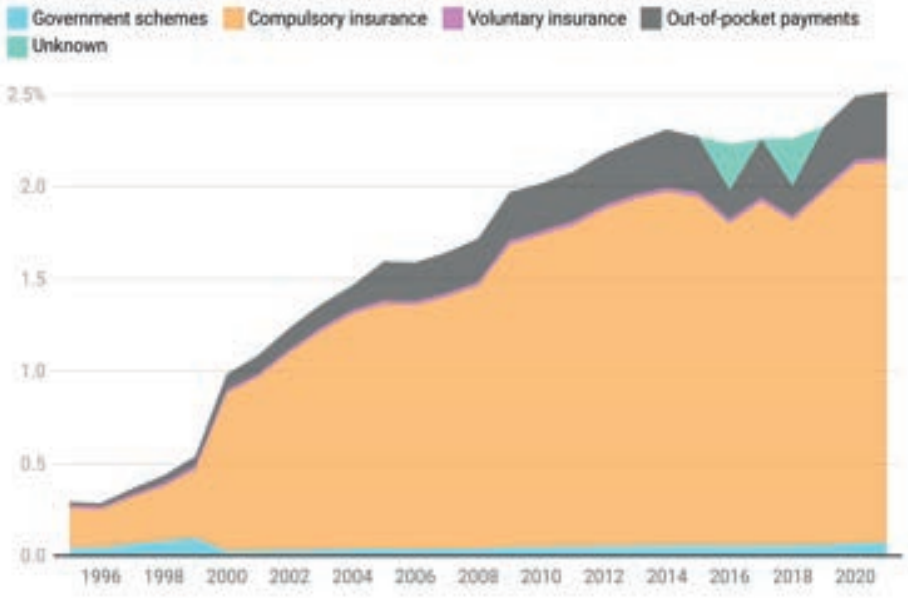
Enrollees are free to choose from various care managers and service providers which acts as a form of quality control, though this is less effective in certain regions which have lower levels of provision.[274] While providers can sometimes be for-profit, fees are established by the government and reviewed every three years.

By making the initial service offer generous and designing the eligibility criteria with fairness and transparency in mind, the government has gained the support of the public.[275] The design of the system has created a competitive market for providers while shifting care responsibilities from families and individuals to wider society.[276] The Japanese government is also able to manage the LTCI system and associated expenditures through its three-year reviews which gives the system a degree of flexibility.

As Chart 96 shows, expenditure on long-term care as a proportion of GDP has been on an upward trajectory since 1995 in Japan and it is probable that the continuing demographic pressures will see a continuation of this trend. These increased pressures have led to an increased burden on individuals with an increase in both premiums and co-payment rates.[277]

271. Nakamura, S. (2018), Japan's Welfare for the Elderly—Past, Present, and Future, Asia Health and Wellbeing Institute, link
272. Yamada, M. and Arai, H. (2020), Long-Term Care System in Japan, National Library of Medicine, link
273. Japan Health Policy NOW (2015), Long-term Care Insurance, link
274. Ibid
275. Curry, N. Castle-Clarke, S. and Hemmings, N. (2018), What can England learn from the long-term care system in Japan?, Nuffield Trust, link
276. Curry, N. Castle-Clarke, S. and Hemmings, N. (2018), What can England learn from the long-term care system in Japan?, Nuffield Trust, link
277. Yamada, M. and Arai, H. (2020), Long-Term Care System in Japan, National Library of Medicine, link

Chart 96: Long term care expenditure in Japan (% of GDP), 1995 - 2021



Source: OECD Data Explorer, Health expenditure and financing. Long term care expenditure includes spending on both health and social care.

Through its LTCI system, Japan has aimed to create a positive vision of ageing and to facilitate the independence of older people with support from the wider community. While benefiting from freedom of choice of providers and locally set premium costs, the long-term care system's resilience will continue to be tested by Japan's ageing population in the coming years.

Challenges

The most obvious challenge faced by Japan's health and social care system is the ageing population and associated implications for expenditure and future capacities of medical institutions. This will only be exacerbated by Japan's currently poor economic growth.

Japan's population is expected to fall by around 15% by 2040 while the number of elderly people is forecast to peak at the same time, which will surely place a significant strain on health and social services.[278] The volume of chronic diseases is also set to grow which will increase treatment rates and lengths. In short, per capita costs are only going up, with more citizens requiring care.

While some propose that the number of doctors per capita is insufficient, what is arguably more problematic is the low number of doctors per hospital bed. In Japan, this figure is one fifth of that in the UK and US and under half that of Germany and France, and this gap seems to be widening. [279]

Some believe that an increased number of general practitioners will be required in order to prevent the onset and worsening of disease, limiting the burden placed on hospitals. More open relationships between

278. Katori, T. (2024), Japan's healthcare delivery system: From its historical evolution to the challenges of a super-aged society, link

279. Ibid

various healthcare institutions could also improve efficiency which will be important given limited medical resources. Many have cited a reform towards a more community-oriented approach to medical care as a necessity in light of future challenges.

Managing the obstacles caused by an ageing population will require a long-term vision which will need to be communicated to the public.[280] In 2015, young Japanese health leaders wrote 'The Japan Vision: Health Care 2035', a 20-year plan for the future of the healthcare system.[281]

It establishes some key actions including: a lean approach to healthcare through the implementation of technology and development of GPs to coordinate a community-based system, supporting personal choice while empowering people to play an active role in maintaining health (through policies such as tobacco tax increases and evidence-based preventive measures), and becoming a global leader in health.

Despite its domestic strains, the report explains that providing international support for various diseases and taking an active role in global policy will create a virtuous cycle in which Japan can improve its own system while boosting economic growth.[282]

While Japan has developed policies to encourage fertility, from new benefits for those with children to government-run dating apps, it is unclear whether these will be sufficient given the scale of the problem. More than 10% of people in Japan are now aged 80 or older.[283] However Japan seeks to navigate this dramatic shift in its demographic structure, it will be difficult to avoid increased expenditures in the face of increased medical needs.

Appendix E. How the German healthcare system operates

German healthcare is based on a system of social health insurance (SHI), which is compulsory for most citizens but certain groups such as civil servants are exempt. Approximately 86 per cent of the population is covered by the statutory health insurance system, which is funded through payroll contributions. The rest are covered by private health insurance (PHI), which is typically available to high earners and self-employed individuals.[284]

The SHI is administered by around 100 health insurance funds called *Krankenkassen*, which negotiate with healthcare providers to set fees for medical services. The system provides comprehensive coverage, including general practitioner visits, hospital treatment, preventative care, and medication.[285]

The German Ministry of Health plays a key role in overseeing the healthcare system. Regional health insurers have some autonomy in regard to coverage options and provider contracts, but the system is heavily regulated.

The SHI system is funded by payroll taxes, with contributions made by both employers and employees. The contribution amounts to

280. Japan Health Policy NOW (2018), Supplement: Interview – Envisioning future healthcare policies, link

281. Health Care 2035 Advisory Panel (2015), The Japan Vision: Health Care 2035 Executive Summary, link

282. Ibid

283. World Economic Forum (2023), More than 1 in 10 people in Japan are aged 80 or over. Here's how its ageing population is reshaping the country, link

284. Tikkanen, R., Osborn, R., Mosslalos, E., Djordjevic, A., & Wharton, G., 'Germany', *The Commonwealth Fund*, June 2020

285. Blumel, M., 'Germany: Health System Summary', *European Observatory*, 2024

approximately 14 per cent of an employee's income with the employee and employer contributing half each. The contributions are collected by public health insurance funds, and these funds are responsible for covering the medical expenses of insured individuals.[286]

PHI is typically available to individuals earning above a certain income threshold (currently €73,800 annually). Private insurance offers more flexibility with regard to the level of coverage and speed of access to care. However, it tends to be more expensive, and is based on the person's lifestyle and age.[287]

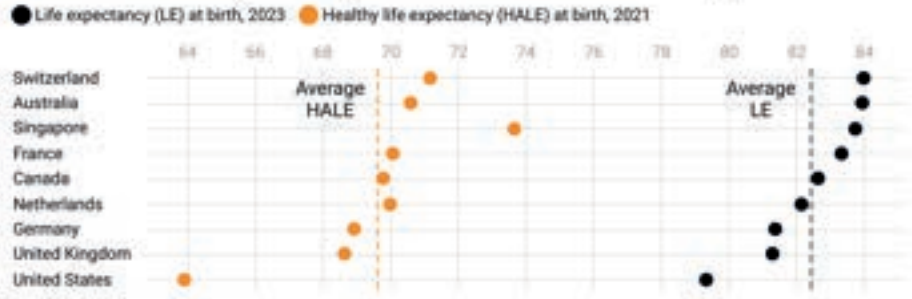
There is also coverage for other groups. The government also provides funding for PHI funds to cover the costs of healthcare for pensioners, children, people with disabilities, and the unemployed.[288]

Patients covered by both SHI and PHI also face out-of-pocket expenses. For example, while there are no deductibles to be paid for GP or specialist appointments, there are for hospital stays, prescriptions, and medical devices. However, these tend to be relatively modest, can be reimbursed in some cases, and the most vulnerable are exempt.[289]

Positive aspects of the German healthcare system

Germany does reasonably well on life expectancy compared to other advanced economies, although the German figure is only slightly higher than the UK's. (See Chart 30.) The average life expectancy is 81 years. For men it is 79 years and for women it is 83 years.

Chart 30: Life expectancy in a selection of countries, latest data



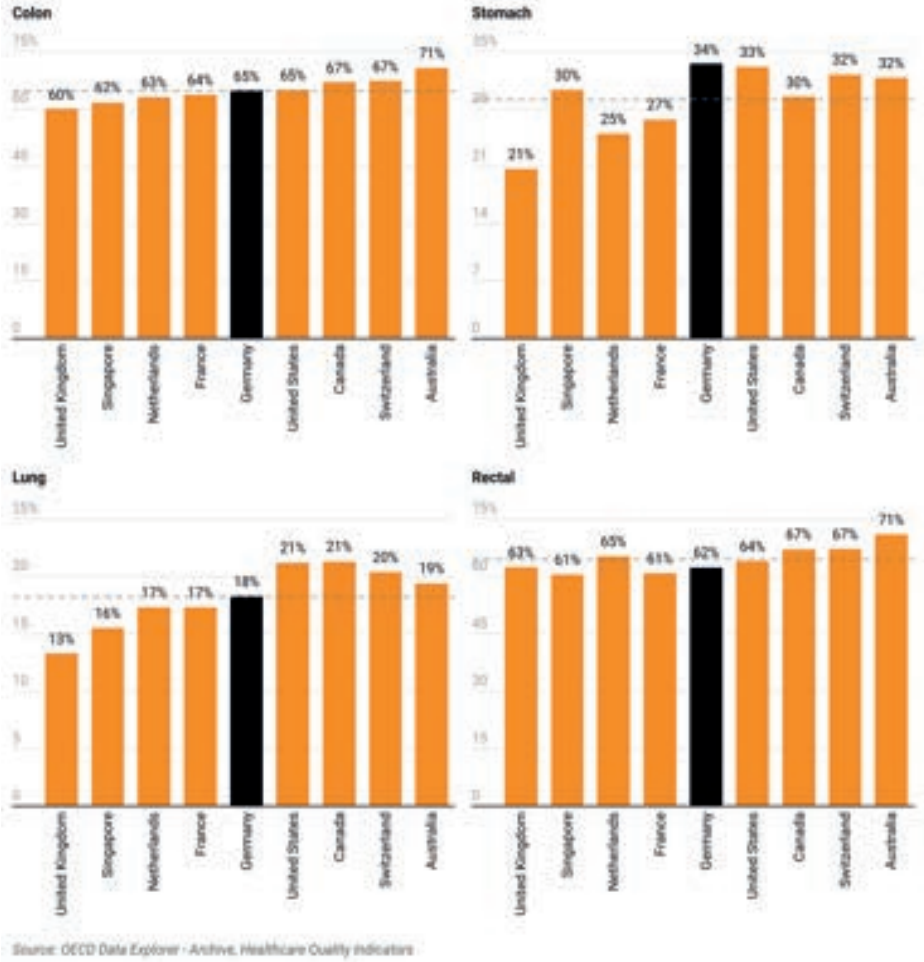
Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The German healthcare system performs relatively well in regard to mortality from a number of serious and chronic conditions such as diabetes, heart disease, and cancer. The survival rate for many of the most common forms of cancer is around the OECD average or higher. (See Chart 97.)

286. Volkwein, T., 'In review: the healthcare framework in Germany', *Lexology*, 2023
287. Tikkanen, R., Osborn, R., Mosslalos, E., Djordjevic, A., & Wharton, G., 'Germany', *The Commonwealth Fund*, June 2020
288. *Ibid*
289. *Ibid*

Chart 97: Five-year survival rates for various forms of cancer across a selection of countries, 2010 - 2014

Percentage of people who are alive five years after being diagnosed with a disease or cancer, of those 15 years and older. Dotted lines show the average across countries.



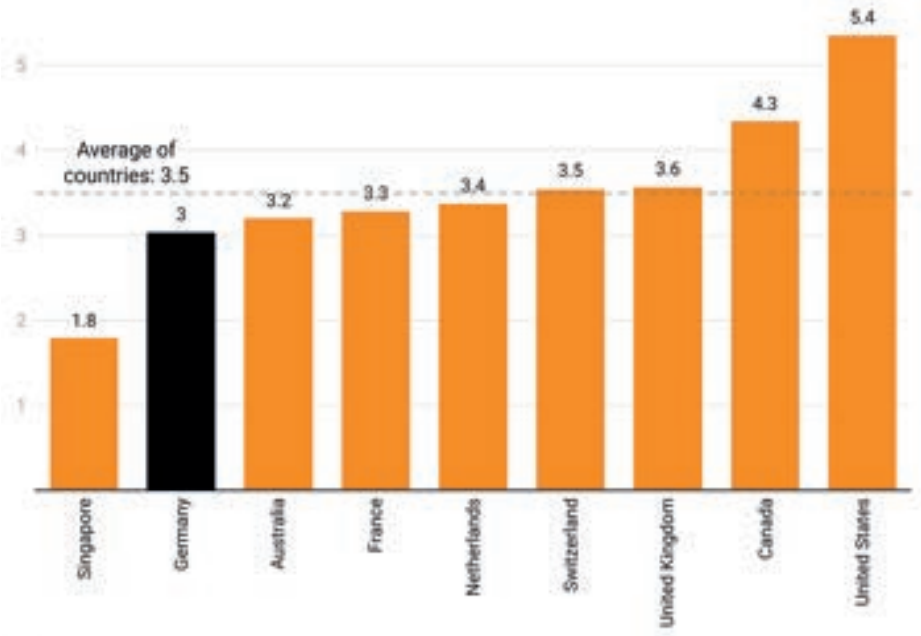
Source: OECD Data Explorer - Archive, Healthcare Quality Indicators

It has achieved this by ensuring that these serious conditions are diagnosed early and receive high quality care. For example, it has established comprehensive care pathways for managing these diseases, with co-ordinated care between GPs and specialists.[290]

Germany has a relatively low infant mortality rate, with approximately 3 deaths per 1,000 live births, one of the lowest in the OECD. (See Chart 98.)

290.Cavlan, O., *et al.*, 'Using Care Pathways to Improve Health Systems', *McKinsey*, 2023

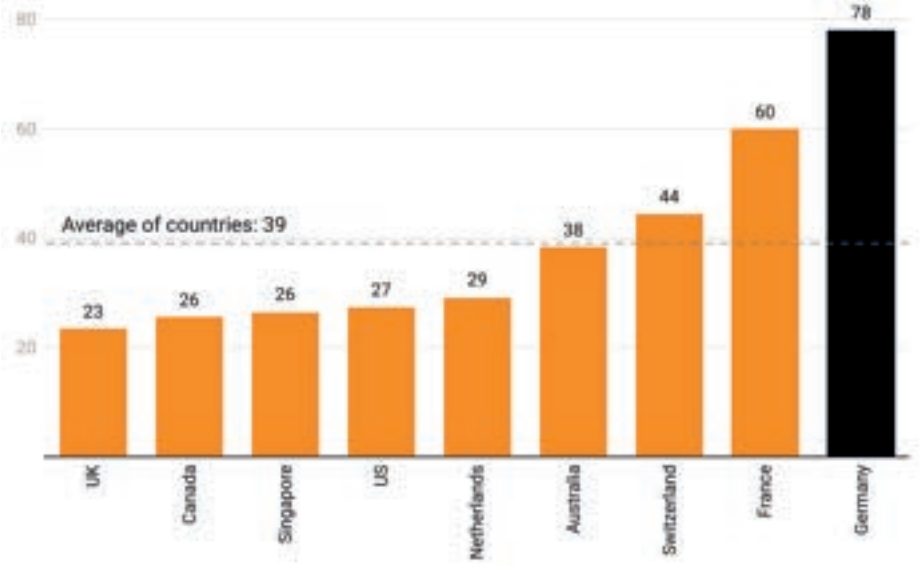
Chart 98: Infant mortality rate across a range of countries (deaths per 1,000 live births), 2022



Source: World Health Organization, Infant mortality rate (between birth and 11 months per 1000 live births).

Germany ranks highly for the number of hospitals available to patients. For example, there is on average one hospital for every 44,000 people which ensures that there is high availability of inpatient care. What is more, Germany also has far more hospital beds compared to comparable countries - approximately 78 per 10,000 people. (See Chart 99.)

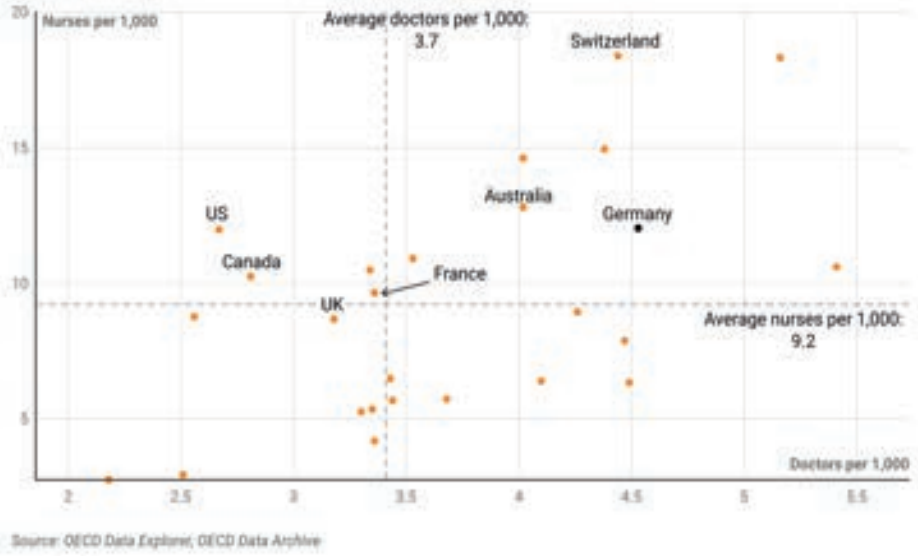
Chart 99: Hospital beds per 10,000 across a selection of countries, latest data



Source: World Health Organization, Hospital beds (per 10,000 population). Data for the UK, Switzerland and Singapore is from 2021. Data for the US, Canada, the Netherlands, France and Germany comes from 2020. Data for Australia comes from 2016.

Furthermore, not only are there lots of hospitals and beds, but they are also well staffed. For example, Germany has significantly more practicing doctors and nurses relative to its population than comparable countries. (See Chart 100.)

Chart 100: Number of doctors and nurses per 1,000 inhabitants in OECD countries, 2021



Source: OECD Data Explorer, OECD Data Archive

The German healthcare system also provides for universality. The vast majority of residents in Germany are insured. This means that whatever their status in life, they are able to access healthcare. What is more, it also ensures that everyone has, in theory at least, access to the same level and quality of care.[291]

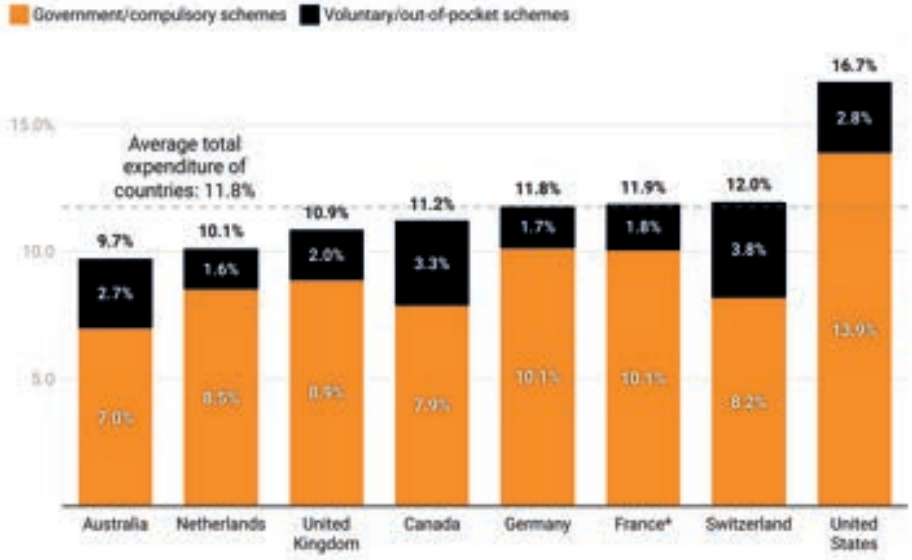
The mixed public-private insurance system provides a degree of flexibility and patient choice. Insurance funds also compete with each other in order to attract patients by offering coverage for more treatments and procedures.[292] Those who can afford private insurance enjoy faster access to care and additional services that are not always available through statutory health insurance.

Negative Aspects of the German Healthcare System

The German healthcare system is expensive. Germany spends about 12 per cent of GDP on healthcare funding, one of the highest shares in the EU and the OECD.[293] (See Chart 10.)

291. Tikkanen, R., Osborn, R., Mosslalos, E., Djordjevic, A., & Wharton, G., 'Germany', *The Commonwealth Fund*, June 2020
292. Kifmann, M., 'Competition policy for health care provision in Germany', *Health Policy*, 2016
293. OECD., 'Health Spending', 2022

Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023

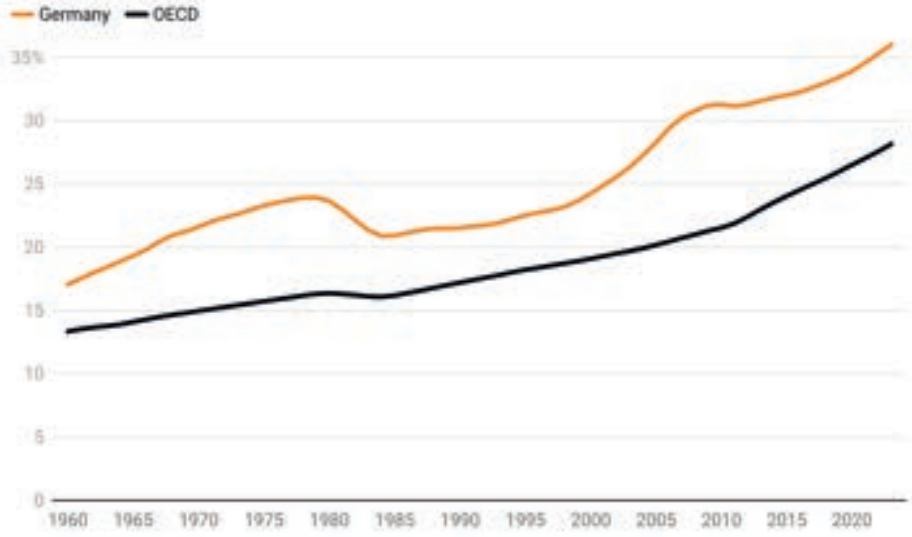


*Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.*

This is projected to increase and indeed to become unsustainable due to the age:dependency ratio shifting as people live longer lives. The ratio of people aged 64 and over to the working population is currently 36 per cent and is set to reach over 50 per cent by 2050, making it one of the highest in the world.[294] (See Chart 101.) Although people living longer is a good thing, it will increase demand for healthcare services at a time when there are proportionately fewer working aged people to fund them.

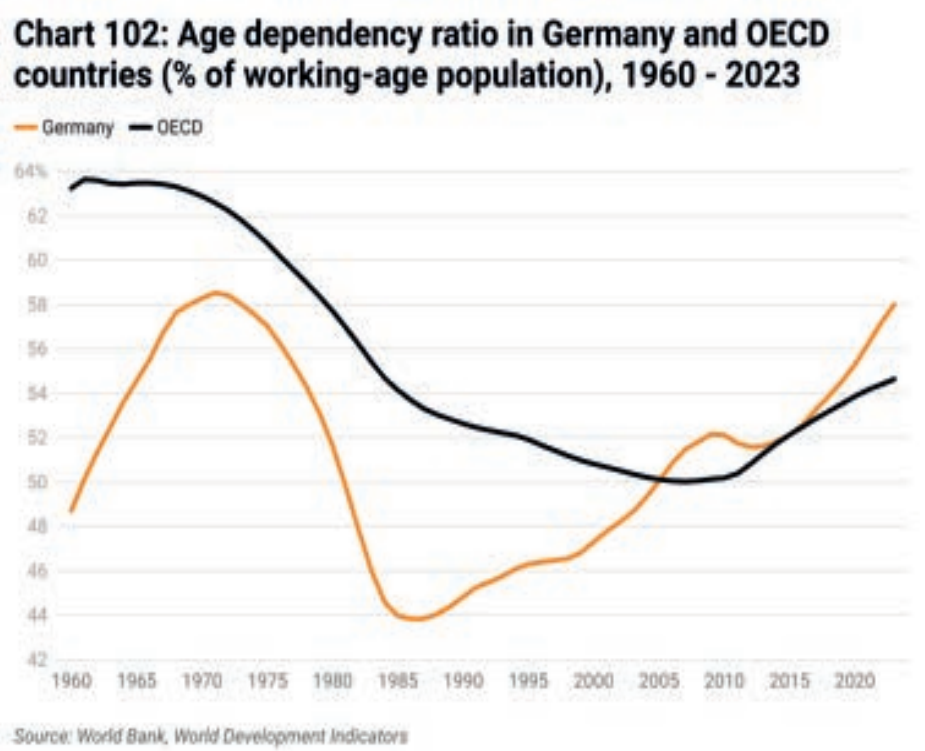
Chart 101: Old age dependency ratio in Germany and OECD countries (% of working-age population), 1960 - 2023

This is the ratio of older dependents (people older than 64) to the working-age population (those ages 15-64).



Source: World Bank, World Development Indicators

294. Perrin, P., 'Germany's old-age dependency ratio set to increase to 51% by 2050', *European Pensions*, 2025



There are also long waiting times for specialised care. While the German system excels in treating serious and chronic conditions, there can be long waiting times to see a specialist, as well as for elective surgery.[295]

While the German healthcare system is efficient, there is a significant administrative burden for both patients and medical staff. Due to the multi-payer nature of the system and the different types of insurance plans, it can be difficult to administer. Medical staff have also expressed their dissatisfaction with the large amounts of paperwork that they have to complete rather than focussing on patient care.[296]

While the German healthcare system does a good job at ensuring universal coverage and strives to ensure that all patients receive high quality of care regardless of wealth, there are inequalities within the system. For example, it could be argued that the SHI and PHI have created a two-tier system, since those with private health insurance are able to access care and treatment more quickly, as well as receiving more personalised care.

What is more, while out-of-pocket costs are often reimbursed for low-income households, the upfront cost can act as a barrier for some patients. This can lead to them delaying or foregoing receiving certain forms of treatment.[297]

One of the significant challenges facing the German healthcare system is regional disparities in access to care. People living in rural areas may experience longer waiting times for medical appointments, reduced access to healthcare professionals, and reduced access to specialized services. In some cases, rural residents may need to travel long distances to receive care.[298]

295. OECD., 'Waiting times for health services', 2020
296. Van den Heuvel, M., 'German Doctors Spend Three Quarters of Each Day on Paperwork', *Medscape*, October 2024
297. Goetjes, E., & Blankart, K., 'Insurance barriers and inequalities in healthcare access: evidence from dual practice', *Health Economics Review*, 2024
298. Potrafke, N., & Roesel, F., 'The urban-rural gap in healthcare infrastructure: does government ideology matter?', *Regional Studies*, 2018

Recent reforms

In 2016 the German government implemented the *Krankenhausstrukturgesetz*, or Hospital Structure Reform Act, with the aim of improving the quality and efficiency of hospital care. It introduced quality-based criteria for hospital funding, moving away from sole reliance on the former system, which incentivised volume over quality. It also established funding for outpatient emergency care units at hospitals to reduce unnecessary inpatient admissions. It also encouraged better co-ordination between inpatient and outpatient care, including discharge management responsibilities for hospitals.[299]

Germany lagged behind similar countries in the use of digital healthcare. In 2018 it ranked 17th out of 18 on the level of digitisation of healthcare delivery. In 2019 the German government adopted the Digital Healthcare Act (DVG). The DVG introduced the Digital Health Applications Ordinance (DiGAV) in order to utilise digital technology such as the use of apps for patients to monitor their conditions and keep track of their medications. It also allowed patients to have appointments with medical professionals online. Additionally, it led to the introduction of digital patient records and prescriptions. This is now seen as a model to be followed as it has been replicated, or wholly or partly, in other healthcare systems in Europe.[300]

In 2018 the German government passed the *Pflegepersonal-Stärkungsgesetz* in order to address staffing shortages and improve conditions in nursing and long-term care. It increased funding for the hiring and training of nursing staff in hospitals and improved staff to patient ratios.[301]

In 2024 the German government passed a law enabling it to make major reforms to hospitals in order to improve the quality of care, increase efficiency, and reduce costs. The Hospital Transformation Fund provides an investment of €50 billion over ten years. Under the former system, hospitals received money based on the number of operations they performed. The new system is designed to eliminate incentives to perform procedures.

Moreover, hospitals must meet strict quality standards to receive money for operations. The aim is that after the reform, only the largest and best resourced hospitals will perform complex operations such as cancer treatment. It will also lead to mergers and closures of approximately 1,700 hospitals.[302]

Appendix F. The Netherlands: How the System Transitioned

The pre-2006 model

The Dutch healthcare system is one of the most highly regarded in the world, achieving better health outcomes than the UK but with less spending as a proportion of the economy. For the purposes of this study, however, one of the main reasons why we should be interested in the Dutch case is that it managed to transition its system towards greater competition and consumer choice.

299. Milstein, R., & Blankart, C., 'The Healthcare Strengthening Act: The next level of integrated care in Germany', *Health Reform Monitor*, 2016
300. Patel, M., Ng, E., & Desai, A., 'Germany: Leading the Way for Digital Health Technology Assessment in Europe', *Value in Health*, December 2023
301. Gerlinger, T., 'Germany: improving staffing and workforce availability in healthcare and long-term care', *European Social Policy Network*, December 2018
302. Klockner, J., 'Germany kicks off biggest hospital reform in history', *Politico*, November 2024

From the Second World War through to the end of the twentieth century, the Netherlands had an insurance-based healthcare model, but one with a largely "statist" structure. Its centrepiece was the Sick Fund Act 1964, which updated a similar provision introduced by the German occupiers in 1941. The Act covered two thirds of the population, and established compulsory coverage for all those in employment on a means-tested basis; healthcare was funded via employer and employee contributions tied to earnings.

As to the third that were not covered compulsorily, retirees and the self-employed could join the scheme on a voluntary basis. The rest of the population – largely higher income workers – relied on private insurance schemes.

This two-tier system was tightly regulated. The arrangements between policyholders, insurers and providers were standardised and largely focused on cost control. Prices for treatments and procedures were set by government, as was remuneration and compensation for doctors and hospitals, much as the NHS does today.

Insurers were obliged to contract with every healthcare provider in a pre-defined geographic area of operation and were reimbursed by the government, which collected and managed all contributions from employers and employees.[303]

Nevertheless, this model was largely ineffective at controlling costs or ensuring quality. Tight regulation discouraged innovation and productivity improvements, while demographic change, particularly the ageing of the Dutch population, increased demand pressures, and the dualistic nature of the system created bureaucratic inefficiencies as people moved above or below the compulsory scheme's means-tested threshold. Customers had very little choice over healthcare providers, while those in the compulsory scheme had no choice at all. At the same time, as insurers were not obliged to accept patients, many individuals with chronic diseases or in high-risk groups struggled to get coverage.

In 1986, spurred by the Dutch economic crisis that took place earlier in the decade, a commission was established to inquire into the structure and financing of healthcare in the country. The Dekker Committee, named after its chairman Wisse Dekker of Philips, published a report in 1987 entitled "Willingness to Change", which advocated a move to a system of managed competition and greater consumer choice in order to promote innovation and greater efficiency, which it contended would help control costs.[304]

It made several key recommendations, including the replacement of the two-tier model with a single health insurance scheme that would cover the whole population. It proposed a mandatory system, but one in which individuals would have choice over their insurer. It was envisaged that the compulsory element would provide for 85% of healthcare demand, with the other 15% being financed by voluntary insurance. It also recommended greater competition between insurers and healthcare providers, especially hospitals.

303. 9789289051828-eng.pdf

304. Roland Marnix Bertens, "Care, Cost and Questions of Control: Dutch Health Care Reform 1987-2006", MA Thesis, Utrecht University, 2016.

Although well received by the liberal Government at the time, the proposals were met with resistance from doctors, unions and regulators, including the Central Healthcare Tariffs Agency which was responsible for setting prices for services and treatments, and some of the Sick Funds (insurers). [305]

Political developments in the late 1980s made reform unviable. The Liberal Party fell out of the governing coalition to be replaced by the Labour Party, and a revised, more state-subsidised version of the Dekker Plan, the "Simons Plan" named after the Labour Deputy Minister of Health, failed to secure majority support. It wasn't until the turn of the century that wholesale reform was put back on the political agenda.

A context of worsening waiting list times and hospital grievances about smaller reforms to control costs brought the subject of systematic reform back onto the agenda. (The Dutch government had managed to introduce hospital budgets in the 1980s, replacing the older model whereby the government compensated providers through a General Fund for whatever costs patients had incurred.) A new conservative coalition introduced legislation for health insurance reform in 2004.

Intense consultation with healthcare providers took place, before the lower and upper houses gave approval for the bill in 2004 and 2005 respectively. The Health Insurance Act came into law in 2006, almost twenty years after the Dekker Committee published its report.[306]

The Health Insurance Act

The Health Insurance Act (HIA) made a number of fundamental changes to the financing and delivery of healthcare in the Netherlands, and its provisions largely define the system in operation today. Among other things, it established: a healthcare funding model based on private insurance, mandatory deductibles, co-payments and state-funded subsidies; a basic healthcare package, to be offered by all insurers, giving fairly comprehensive service coverage; and a competitive market for healthcare providers. These are discussed below in turn.

1. A mixed funding model

First and foremost, all existing Sickness Funds were integrated into a single mandatory basic scheme, which applies to all residents. The state pays the premiums of under 18-year-olds. The scheme is offered by private insurers who compete for clients in the healthcare market. All insurers are required to offer a basic package (determined by the government and discussed below) and set an annual premium to be paid by plan holders, who are able to switch each year. The average premium in 2024 was about €1,800. All citizens are required to purchase an HIA plan from a private insurer, and non-compliance is penalised by heavy fines. [307]

The Netherlands system also operates a mandatory deductible, a minimum payment on healthcare services set by insurers and to be paid by individuals to providers before their insurance plan kicks in. This has proved to be highly politically contentious, and so the rate, €385, has not

305. Patrick Jeurissen and Hans Maarse, "The Market Reform in Dutch Healthcare: Results, Lessons and Prospects", 2021, p18.

306. *Ibid.*

307. Why the Dutch Health Reform Won't Fix the American System

been raised since 2016.

Co-payments – a fixed percentage of the cost of a given treatment - are also applied to certain services like dental care, glasses, medication and some longer-term care costs. However, the category of services to which copayments are applicable has remained relatively narrow.

The Government operates a number of schemes and policies to ensure universal, affordable coverage. Most importantly, HIA explicitly requires insurers to charge the same premium to all for the basic, mandatory coverage. But to offset the cost of those with high healthcare risks (due to old age, or chronic conditions), the Government provides compensation to insurers via its Risk Equalisation Fund for those higher risk individuals they enrol.

This is a highly sophisticated system, which calculates a risk score for insurers based on the age, gender and health status of their policyholders. The Fund is financed through a mixture of general tax revenues and annual income-related contributions charged to policyholders on top of their insurance premiums.

Further support is available to working-age adults and households under an earnings threshold, who receive an annual allowance to help reduce their premiums.

Together, these features of the Dutch system render it considerably different to other insurance-based models, like that in the US. In the American system, insurance is not mandatory, and the government does not intervene in the market to mitigate the risks for insurers of enrolling those with higher potential costs. As such, healthier individuals often opt not to purchase insurance, leaving insurers with more risky policyholders. As a result, premiums are higher in the US, and coverage is less extensive.

2. Healthcare coverage and the basic plan

The basic HIA package which all insurers must provide covers quite a range of essential services. It includes everything from primary care, emergency care, preventative health interventions like vaccinations, many necessary surgical procedures, and necessary rehabilitation care. Not included is dental care over the age of 18, elective or non-urgent treatments, cosmetic surgery, or glasses and eyewear (except for children).

Individuals can also take out "supplementary insurance" for healthcare, over and above that provided by the basic scheme. This might include, for example, dental care, but also private hospital rooms and social care.

3. Purchasing reform and a competitive market for providers

An equally important part of the HIA legislation was purchasing reform, and the altered relationship between insurers and providers. Instead of being obliged to contract with particular hospitals as they were under the previous system, insurers act as "prudent purchasers of health services" on behalf of plan holders and are given freedom to enter into contracts with providers of their choice so long as they provide their clients with the minimum services required by the Health Insurance Act.

State planning of hospitals ceased in 2008, allowing new providers to enter the market and increase choice. Most hospitals are privately-owned, but they operate on a not-for-profit basis and are regulated by government against standards for care quality, financial prudence and service delivery. Every hospital needs a license to operate, but their scope for decision-making under the new system is far higher. At the same time, while the Minister of Health is responsible for ensuring the systemic provision of adequate services, they are not responsible for the survival of particular hospitals.[308]

These reforms transformed the Dutch model from one in which the government controlled the prices, prescribed the contractual arrangements between insurers and providers, and footed whatever bill was forthcoming from the hospitals, to one in which insurers and providers could strike deals relatively freely within a framework regulated by government, prices could be more flexible in response to demand for different services, and hospitals became far more responsible for their own finances.

Similar such reforms were attempted as part of the unsuccessful NHS Internal Market reforms of the 1990s, which sought to separate the purchaser and provider of healthcare services. However, there were some critical differences with the UK reforms.

Firstly, the system remained tax-payer funded, and the purchasers – Primary Care Trusts – remained public bodies rather than private ones. Deductibles, co-payments and premiums were not introduced, which diminished any potential effect on the incentives to manage demand for healthcare. Similarly, prices continued to be set by government rather than healthcare providers themselves, which meant that hospitals could only compete on service delivery.

Equally as important, because the Government did not propose to equalise risk across healthcare provision by subsidising more costly patients, a perverse incentive was created for hospitals to specialise in low cost treatments, and risking longer waiting times for more serious or expensive treatments.

Social Care

Social care in the Netherlands, however, is not covered by the HIA insurance model. Instead, the Long Term Act introduced in 2015 provides that long-term care costs – particularly for those with chronic conditions, the elderly or the infirm – are funded through general taxation. Eligibility is confined to those with the most serious needs, and to qualify, recipients must be assessed. For those in higher income groups, further income-based co-payments may be required. More minor social care services are covered either through the basic insurance package (certain treatments) or supplementary private insurance (non-medical home care).

308. S1744133123000385jra 1..12

Economic Effects

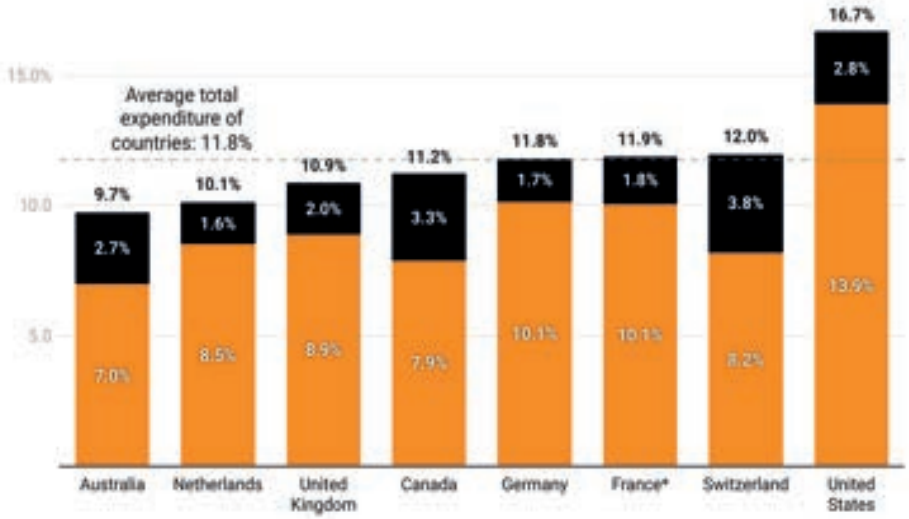
At the micro-level, the Health Insurance Act has had a pronounced effect on the Dutch healthcare market over the last two decades. For a start, it is now more competitive. Prior to 2006, the rate of annual plan switching was between 2% and 4%. This has increased to 8.2% in 2023[309]. The number of hospitals has declined by about 30% since 2000, largely through a process of consolidation and attempts to improve efficiency and reduce costs. There have been some bankruptcies, but these have been rare.[310]

Simultaneously, there has been a remarkable growth of independent treatment centres (ITCs), which specialise in particular routine treatments and cohorts of the population, often high volume routines or inspections.[311] The majority of these ITCs are physician-owned, and although their overall market share of specialist services remains low (less than 5%), they have an outsized market share in particular specialisms. For example, ITCs provide about a fifth of both cataract surgeries and dermatological treatments[312].

More broadly, hospital budgeting (with providers now having to take greater responsibility for their costs), administrative efficiencies via the replacement of the various Sick Funds by a single basic scheme, and improved incentives for insurers to be price competitive have had a pronounced effect on healthcare expenditure in the Netherlands.

For one, total Dutch healthcare expenditure as a proportion of GDP is lower than in many other similarly advanced economies with comparable demographics. (See Chart 10.)

Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.

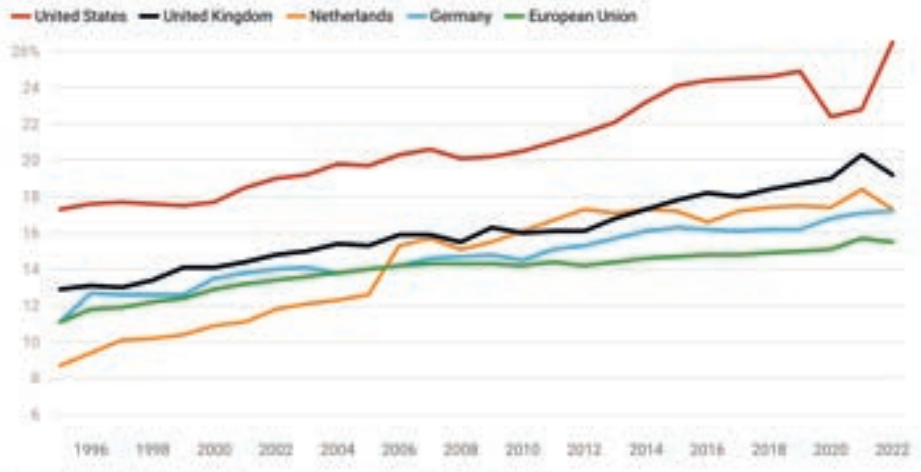
309. Patrick Jeurissen and Hans Maarse, *The Market Reform in Dutch Healthcare: Results, Lessons and Prospects*, 2021 p52.

310. S1744133123000385jra 1..12

311. Do independent treatment centers offer more value than general hospitals? The case of cataract care - Kruse - 2019 - Health Services Research - Wiley Online Library

312. S1744133123000385jra 1..12

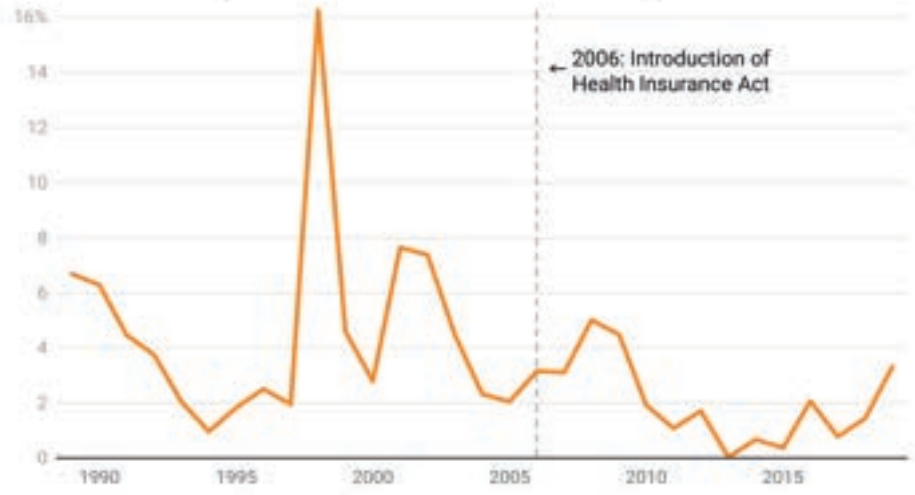
Chart 103: Government expenditure on health in a selection of countries (% of government expenditure), 1995 - 2022



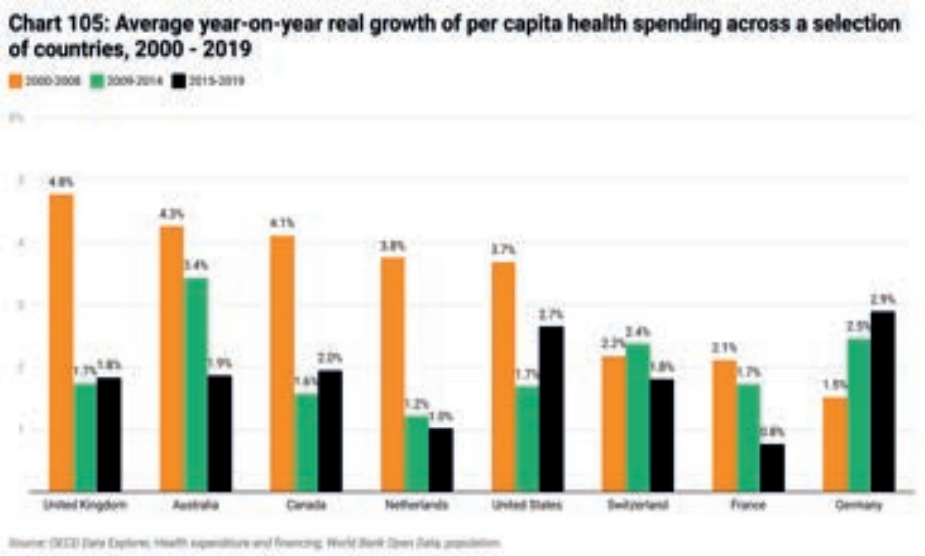
Source: OECD Data Explorer, Annual government expenditure by function (COFOG)

Chart 104 also shows that, since its introduction, the HIA has proved effective at holding down growth in healthcare expenditure. From 2006 to 2019, real healthcare expenditure grew at an average annual rate of 2.1%, compared with 4.6% from 1989 to 2005.

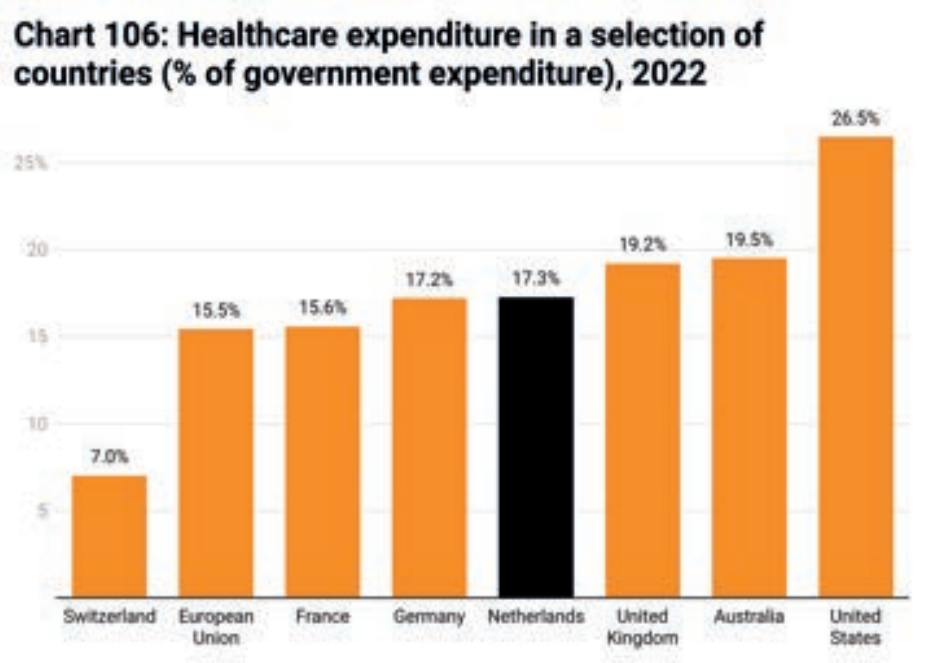
Chart 104: Year-on-year percentage growth of real healthcare expenditure in the Netherlands, 1989 - 2019



Source: OECD Data Explorer, Annual government expenditure by function (COFOG)

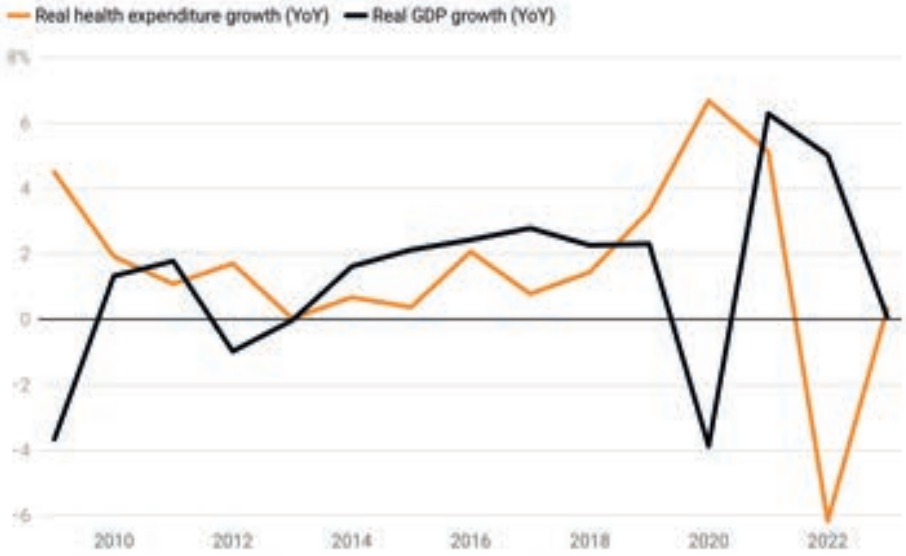


The Dutch reforms have also played a role in keeping the overall proportion of government spending on healthcare under control. Chart 106 shows government healthcare spending as a proportion of overall public expenditure in a range of countries. Historically, the Netherlands has maintained a relatively low proportion of government spending on health at about 17%, the same as Germany but significantly lower than the UK (19%) and the US (27%).



Source: OECD Data Explorer, Annual government expenditure by function (COFOG)

Chart 107: Real health expenditure and GDP growth in the Netherlands, 2009 - 2023



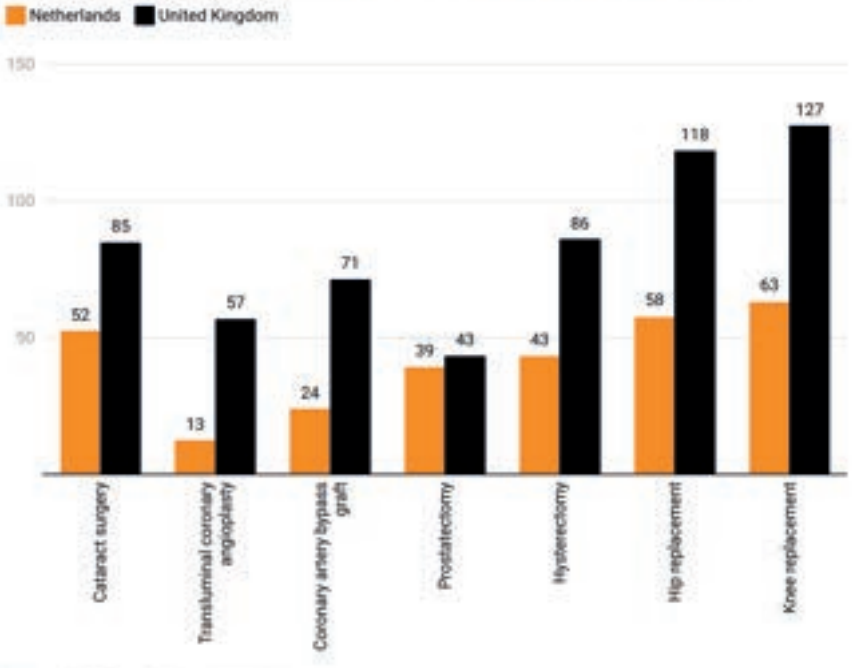
Source: OECD Data Explorer, Health expenditure and financing; World Bank Open Data, GDP growth (annual %).

Effects on Health Outcomes

Healthcare outcomes in the Netherlands have improved vastly too – not in spite of the HIA, but because of it. The structural changes and reforms have promoted innovation, efficiency, and better demand management.

Waiting times fell almost across the board after 2006, and although they have been on the rise again since 2013, they remain vastly lower than in the UK across a range of treatments. (See Chart 108.)

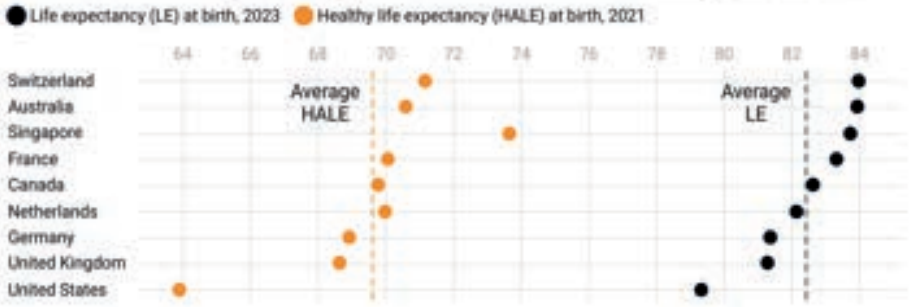
Chart 108: Mean waiting times from specialist assessment to treatment in the Netherlands and UK (days), 2019



Source: OECD Data Explorer, Waiting times

The Dutch system also performs well across a range of other indicators. While, at 82, life expectancy is marginally lower than the average of our selected countries, the Netherlands has an above average *healthy life expectancy* of 70. (See Chart 30.) This is despite spending relatively less, both at a state and economy-wide level, compared to other comparable nations.

Chart 30: Life expectancy in a selection of countries, latest data

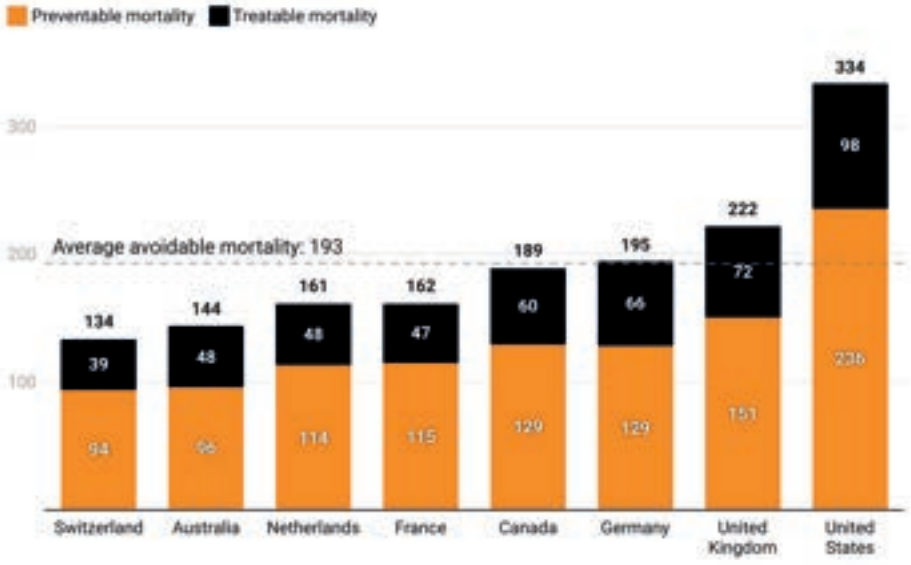


Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

The Netherlands performs favourably in avoidable mortality rates. It is the joint third-best ranked country and 16% better than the average of our selected countries. (See Chart 32.)

Chart 32: Avoidable mortality across a selection of countries (deaths per 100,000 inhabitants), 2020

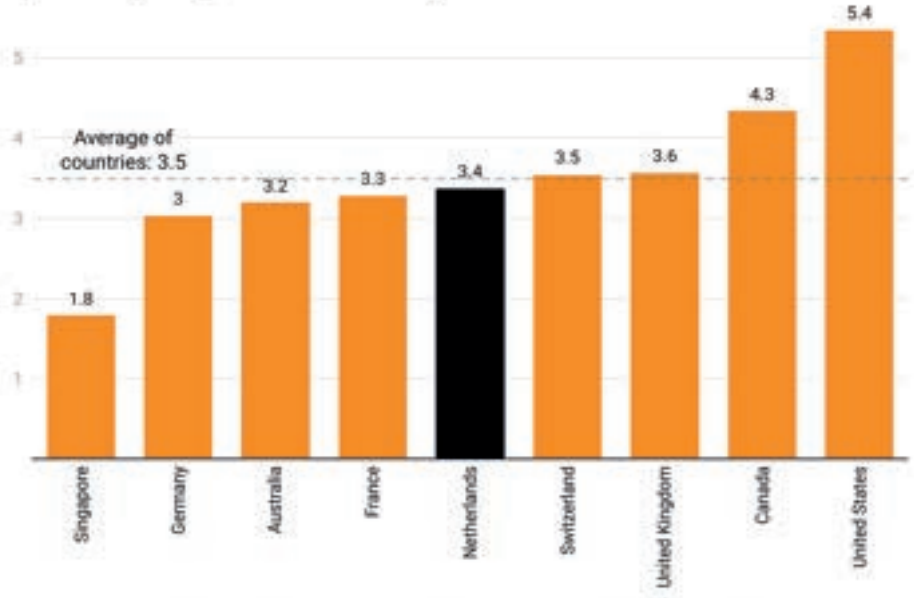
Avoidable mortality is the sum of preventable mortality (avoidable before the onset of diseases/injuries) interventions) and treatable mortality (avoidable after the onset of diseases/injuries)



Source: OECD Data Explorer, Avoidable mortality. Totals may not sum due to rounding.

Relative to our selection of countries, the Netherlands is slightly better than average when it comes to infant mortality rates. And finally, at 15%, the Netherlands has a relatively low proportion of adults who are obese, compared to an average of 22%. (See Charts 109 and 110.)

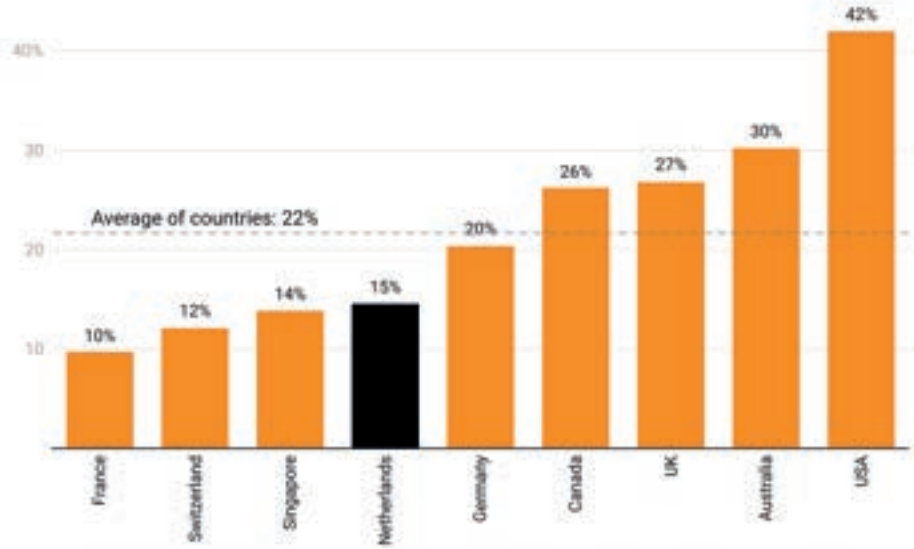
Chart 109: Infant mortality rate across a range of countries (deaths per 1,000 live births), 2022



Source: World Health Organization, Infant mortality rate (between birth and 11 months per 1000 live births).

Chart 110: Prevalence of obesity amongst adults in a selection of countries, 2022

Percentage of adults with a body mass index (BMI) greater or equal to 30



Source: World Health Organization, Prevalence of obesity among adults, BMI >= 30 (age-standardized estimate) (%)

Lessons for the UK

Dutch healthcare is certainly not perfect, and the demand side pressures confronting all ageing western societies are just as acute in the Netherlands. But the Dutch case shows that it is possible to move from a more state-orientated model to a more market-orientated system, and that doing so can help control costs *and* improve healthcare outcomes at the same time.

Four important details about the politics of healthcare reform, however, are worth drawing out. Firstly, it took two decades for reform to move from a discussion in the public sphere to reform legislation. The ground was prepared over a very long period, and intensive consultation took place.

Secondly, reform did not precipitate a "big bang" moment of transition. Many residents didn't switch providers immediately, which lent a sense of continuity to the provision of healthcare, even while its fundamental operating logic was being changed. The state also remained involved in the provision of healthcare and in the regulation of both insurers and providers. However, its role has shifted away from "planning" healthcare and towards ensuring a functional market.

Thirdly, the Dutch model has involved a wide mix of funding sources to finance healthcare provision. Mandatory insurance does the heavy lifting and underwrites the majority of healthcare expenditure. Co-payments and deductibles work to dampen demand and signal the real price of healthcare to consumers. Income-linked contributions and taxpayer subsidies are essential in reducing the premiums of high risk individuals and delivering universal coverage. All of these mechanisms are integrated carefully to deliver sustainable finance and incentives for efficiency in healthcare provision.

Appendix G. How the Australian healthcare system operates

The Australian healthcare system is a hybrid model combining the public and private sectors to provide universal healthcare access to all citizens and permanent residents. It operates under a shared responsibility framework involving the federal, state, and territory governments, alongside private entities such as hospitals, general practitioners, specialists, and community health services.[313]

It also includes Primary Health Networks (PHNs). These are independent organisations funded by the federal government. They coordinate local health services to meet community needs.[314]

The core of the healthcare system is Medicare, a publicly funded universal healthcare programme established to provide free or subsidised medical and hospital services. It covers the following:

- Free treatment in public hospitals for patients.
- Subsidised out-of-hospital services through the Medicare Benefits Schedule (MBS).

313. Dixit, S., & Sambasivan, M., 'A review of the Australian healthcare system: a policy review', *SAGE Open Med*, April 2018

314. *ibid*

- Subsidised prescription medicines via the Pharmaceutical Benefits Scheme (PBS).

Public hospitals, primarily managed by state and territory governments, offer free treatment for patients, while private hospitals charge fees often partially covered by private health insurance or Medicare subsidies. Patients can choose private care for faster access to elective procedures or additional services.[315]

Australia's healthcare expenditure is approximately 9.7% of GDP.[316] It is funded through the following sources:

- Federal Government (approximately 41%): Funds Medicare, the PBS, and part of public hospital services via the National Health Reform Agreement. It also invests in health research and innovations through the Medical Research Future Fund.
- State and Territory Governments (approximately 27%): Primarily fund and manage public hospitals and community health services.
- Patients (approximately 17%): Cover out-of-pocket costs for unsubsidised services, co-payments, and private hospital fees. Out-of-pocket costs for out-of-hospital services.
- Private Health Insurers (approximately 9%): Subsidise private hospital care and some allied health services.
- Other Sources (approximately 6%): Include non-government organisations and charitable spending.[317]

Positive aspects of the Australian healthcare system

The Australian healthcare system has historically performed relatively well. For example, it was ranked first in a study comparing the healthcare systems of highly developed nations and scored particularly highly for 'Equity', 'Health Outcomes', and 'Administrative Efficiency'.

Both life expectancy and healthy life expectancy in Australia are among the highest in the world. (See Chart 30.)

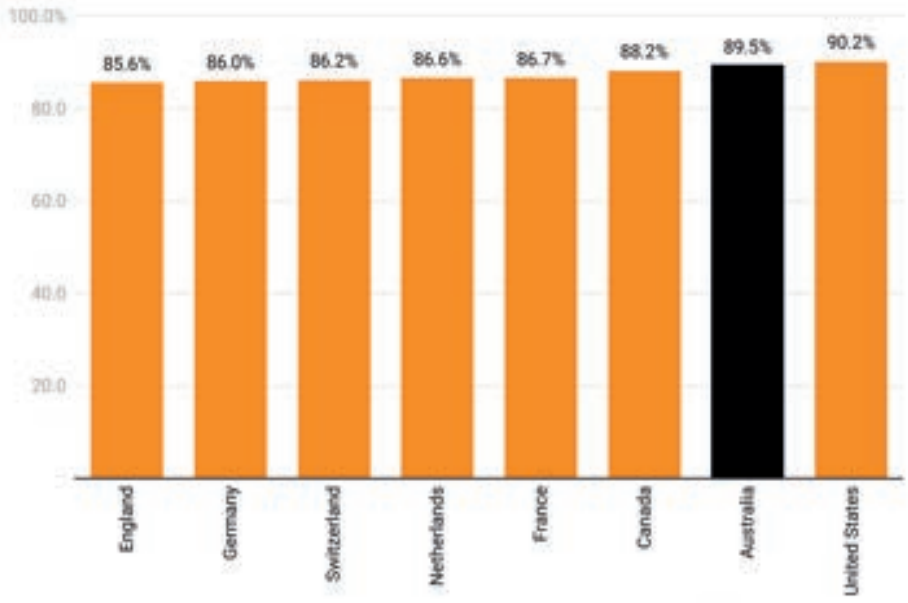
Chart 30: Life expectancy in a selection of countries, latest data

Source: UN WPP (2024); HMD (2024); Zijdeman et al. (2015); Riley (2005) – with minor processing by Our World in Data; World Health Organization, The Global Health Observatory. Averages are the mean of these countries. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

315. Australian Government: Department of Health and Aged Care, 'The Australian Health System', May 2025
316. Australian Government: Australian Institute of Health and Welfare, 'Health Expenditure', November 2024
317. Australian Government: Department of Health and Aged Care, 'The Australian Health System', May 2025

Moreover, cancer survival rates are high compared to similar countries. (See Chart 111.) For example, the five-year survival for breast cancer at 89.5% compared to Germany (86%) and France (86.7%).

Chart 111: Breast Cancer Five-Year Survival Rate across a selection of countries, 2015



Source: The Commonwealth Fund, Breast Cancer Five-Year Survival Rate using data from OECD. Data is from 2015 or latest year.

The five-year survival rate for cervical cancer is 66.4%, higher than in other highly developed nations such as France (65%), the UK (63.8%), and the United States (62.6%). It also has one of the highest five-year survival rates for colon cancer at 70.7%. This is higher than in other highly developed countries such as Japan (67.8%), the United States (64.9%), France (63.7%), and the UK (60%).[318]

This relatively high survival rate for cancers is supported through initiatives such as the National Bowel Cancer Screening Programme and efforts to achieve early detection of cervical cancer.[319]

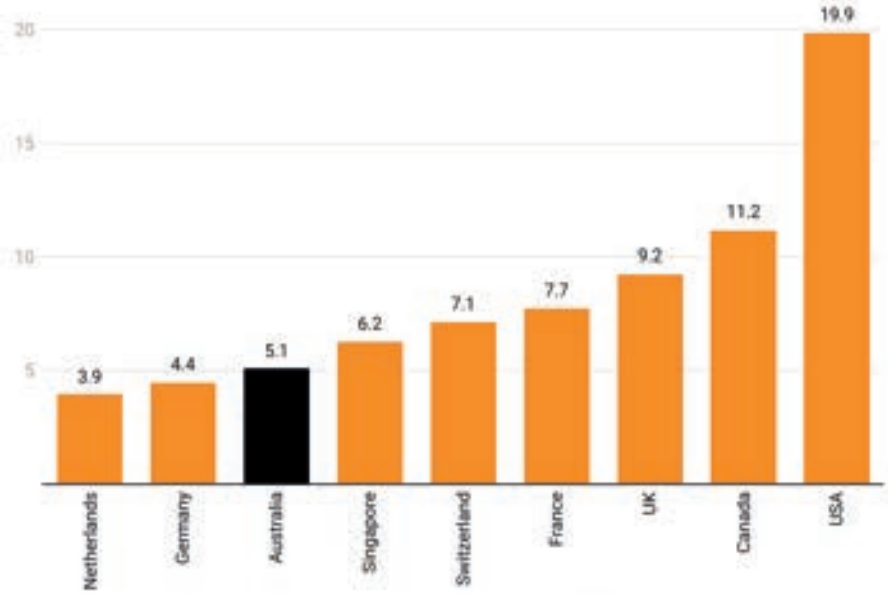
Chronic conditions are well-managed through primary care and hospital services. For example, cardiovascular disease care supports advanced interventions such as bypass surgeries. As a result, Australia has a relatively low rate of deaths from cardiovascular disease (72 per 100,000) compared to Canada (79.1 per 100,000), the UK (90.8 per 100,000), and the United States (134.2 per 100,000).[320]

Australia also has one of the lowest infant mortality rates in the world at 2.9 per 1,000 births, compared to Germany and France at 3.1, the UK at 3.8, Canada at 4.3, and the United States at 5.1.[321]

What's more, Australia also has one of the lowest maternal mortality rates in the world at 5.1 per 100,000, compared to Singapore at 6.2 , France at 7.7, the UK at 9.2, and the United States at 19.9. [322] (See Chart 112.)

318. Nuffield Trust, 'Cancer Survival Rates', June 2024
319. Lew, J., *et al.*, 'Long-term evaluation of benefits, harms, and cost-effectiveness of the National Bowel Cancer Screening Program in Australia: a modelling study', *The Lancet*, July 2017
320. Dattani, S., Samborska, V., Ritchie, H., & Roser, M., 'Cardiovascular Diseases', Our World in Data, 2023
321. CIA, 'Infant Mortality Rate', 2024
322. World Health Organization, 'Maternal Mortality Ratios', 2019

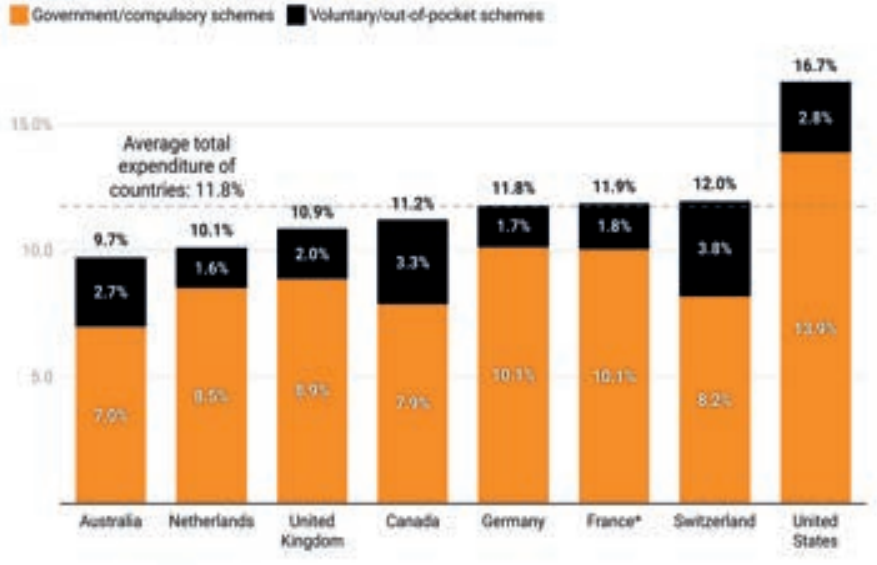
Chart 112: Maternal mortality rate across a selection of countries (deaths per 100,000 live births), 2019



Source: World Health Organization Data, Maternal mortality ratio (per 100 000 live births). Number of maternal deaths during a given time period per 100,000 live births during the same time period. Data selected for 2019 to reflect pre-pandemic outcomes.

Australia also spends relatively little on healthcare compared to similar countries. (See Chart 10.) It spends approximately 9.7% of GDP on healthcare, compared to the UK on 10.9%, Germany on 11.8%, and France on 11.9%. This has resulted in it being ranked highly for Healthcare performance relative to spending.

Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



*Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.*

A key driver of cost containment within the Australian system is its administrative efficiency. It has one of the highest rankings for this among comparable countries.[323]

Table 15: Ranking of administrative efficiency of healthcare systems, 2024

Country	Rank
UK	1
Australia	2
New Zealand	3
France	4
Canada	5
Netherlands	6
Sweden	7
Germany	8
US	9
Switzerland	10

Source: Commonwealth Fund, Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System: Health Care System Performance Rankings

Negative aspects of the Australian healthcare system

The healthcare system in Australia is now facing immense challenges. When the current system was designed, it was supposed to combine the very best of the NHS and the US healthcare system. While it achieved some initial success, it is now failing to provide adequate care for many Australians.[324]

While the level of treatment available is often excellent, there are significant barriers in place for patients in Australia who want to access this care. For example, Australia ranked second from bottom in a review of the healthcare systems of ten highly developed countries. The problem is particularly acute for older people with the 2021 Royal Commission into Aged Care highlighting systemic failures, including inadequate funding and staffing, impacting chronic disease management for elderly patients.[325]

This is due to a number of factors. For example, the country faces a shortage of healthcare workers, particularly in rural areas. In 2023, the

323. Blumenthal, D., Gumas, E., Shah, A., Gunja, M., Williams, R., 'Mirror, Mirror 2024: A Portrait of the Failing US Health System', *The Commonwealth Fund*, September 2024

324. Butler, S., Daddia, J., & Azizi, T., 'The Future of Health in Australia', *PwC*, March 2024

325. Australian Government Department of Health, 'Australian Government Responds to the Final Report of the Royal Commission into Aged Care Quality and Safety', May 2021

Australian Medical Association reported a 20% shortfall in GPs in remote regions, delaying diagnosis and treatment.[326]

Rising mental health issues, exacerbated by the pandemic, have overwhelmed services. Relatively little is spent on mental health care leading to wait times of over eight months for psychiatric care.[327]

Furthermore, a significant proportion of patients are facing cost-related barriers to accessing healthcare. Out-of-pocket costs for medicines and other treatments are commonly cited as a reason for this with patients delaying appointments, medical tests, and treatment due to financial pressures. Moreover, due to health insurance premiums rising, more Australians are now reliant on the public healthcare system which exacerbates pressure on the system.[328]

Conclusion

The UK could learn much from the experience of Australia. For example, the system has excellent patient outcomes in part due to its emphasis on early detection of cancers through screenings and the emphasis placed on preventative care.

Moreover, Australia spends less as a proportion of GDP than comparable countries. This is driven by its administrative efficiency.

However, public satisfaction with the system is falling. While the care that patients receive is excellent, many Australians are now finding it increasingly difficult to access this care in a timely fashion due to staff shortages and high out-of-pocket costs.

Appendix H. The system in Canada

Canada's healthcare system is decentralised, delivered through its provincial and territorial systems, each responsible for organising and administering services. The Federal Government sets national standards, ensuring that all Canadians have access to medically necessary hospital and physician services without direct charges at the point of care.[329]

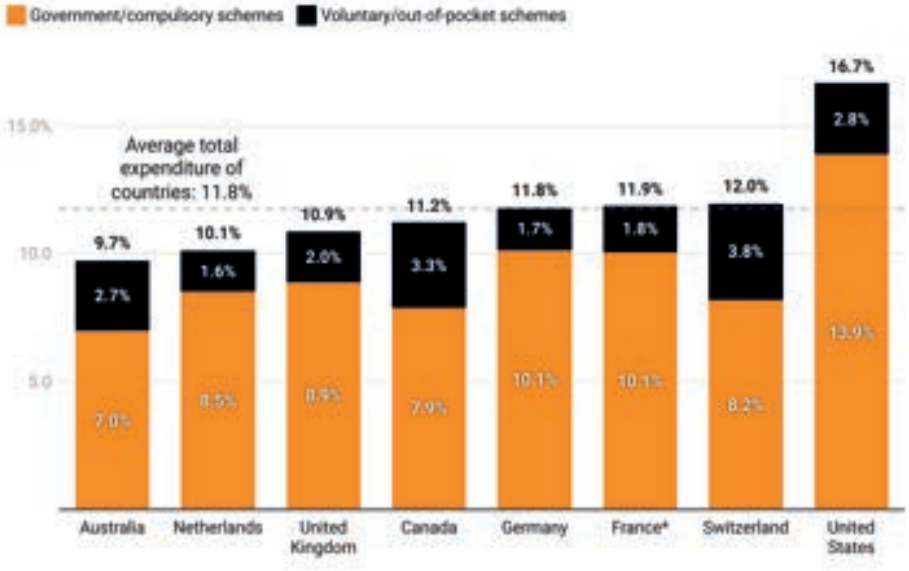
All legal residents are covered under provincial or territorial health insurance plans, which provide prepaid access to hospital care, physician services, and certain diagnostic tests. Services like prescription drugs, dental care, vision care, and mental health services are partially covered or funded privately through out-of-pocket payments or private insurance.[330]

The Canadian healthcare system is predominantly publicly funded, with approximately 70% of total health expenditure coming from public sources (Federal, Provincial, and Territorial Governments) and 30% from private sources (out-of-pocket payments, private insurance, and employer-based plans).[331] In order to cover gaps in public provision, approximately 65% of Canadians have supplementary private insurance, often through their employer.[332]

At 11.2% of GDP, Canada spends around the OECD average on healthcare. (See Chart 10.) This is higher than the UK, the Netherlands, and Australia but lower than Germany, France, Switzerland, and the United States.[333]

326. Australian Medical Association, 'The general practitioner workforce: why the neglect must end', November 2022
327. Zhang, Y., & Yang, O., 'Australians can wait at least 258 days for their first psychiatric appointment, our new study shows', *University of Melbourne*, February 2025
328. Callander, E., 'Out-of pocket fees for health care in Australia: implications for equity', *Medical Journal of Australia*, April 2023
329. Tikkanen, R., Osborn, R., Mosslalos, E., Djordjevic, A., & Wharton, G., 'Canada Health Care System Profile', *The Commonwealth Fund*, June 2020
330. *ibid*
331. European Observatory on Health Systems and Policies, 'Health Expenditure', June 2019
332. Martin, D., 'Canada's universal healthcare system: achieving its potential', *The Lancet*, February 2018
333. OECD Data Explorer, 'Healthcare Expenditure', 2023

Chart 10: Healthcare expenditure in a selection of countries, by financing scheme (% of GDP), 2023



Source: OECD Data Explorer, Health expenditure and financing. *Data for France comes from 2022.

Positive aspects of the Canadian healthcare system

As with most healthcare systems around the world, Canada strives for universal coverage. It performs relatively well in this regard with all citizens being able to access healthcare regardless of their income and without patients facing up front costs.[334]

The country also performs well compared to other highly developed countries for 'care process'. This takes into account patient preferences, preventative care, and care coordination.[335]

This goes some way to explaining Canada's relatively high rating for health outcomes. Recent studies have shown it scoring highly compared to other wealthy nations.[336]

Negative Aspects of the Canadian Healthcare System

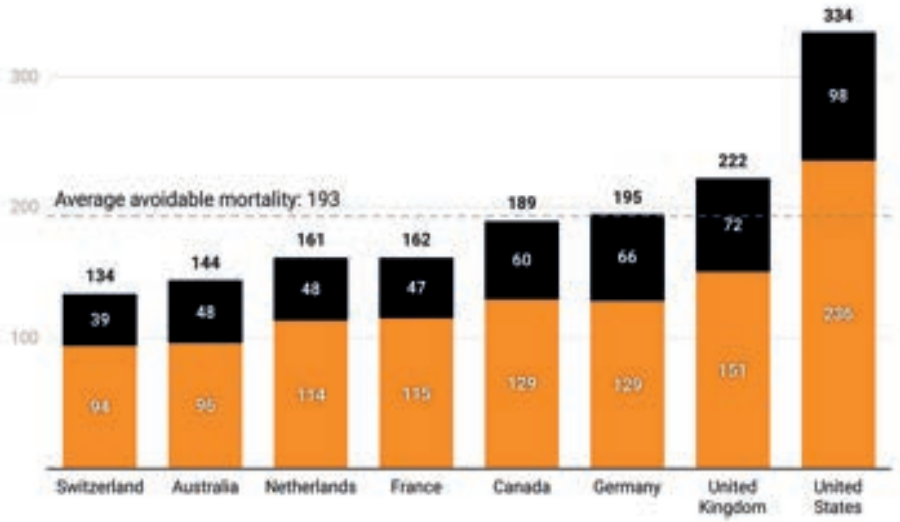
Despite attempting to provide access to all citizens regardless of their socio-economic status, the Canadian system is relatively bad at this. For example, analysis by The Commonwealth Fund placed the country in seventh place compared to ten other highly developed countries for both 'Equity' and 'Access to Care'.[337]

Canada has a higher avoidable mortality rate than many comparable countries. (See Chart 32.) Although it is lower than Germany, the UK, and the United States, it is considerably higher than France, the Netherlands, Australia, and Switzerland.

334. Martin, D., *et al.*, 'Canada's Universal healthcare system: achieving its potential', *The Lancet*, February 2018
335. Schneider, E., *et al.*, 'Mirror, Mirror 2021: Reflecting Poorly', *The Commonwealth Fund*, August 2021
336. Blumenthal, D., Gumas, E., Shah, A., Gunja, M., Williams, R., 'Mirror, Mirror 2024: A Portrait of the Failing US Health System', *The Commonwealth Fund*, September 2024
337. Blumenthal, D., Gumas, E., Shah, A., Gunja, M., Williams, R., 'Mirror, Mirror 2024: A Portrait of the Failing US Health System', *The Commonwealth Fund*, September 2024

Chart 32: Avoidable mortality across a selection of countries (deaths per 100,000 inhabitants), 2020

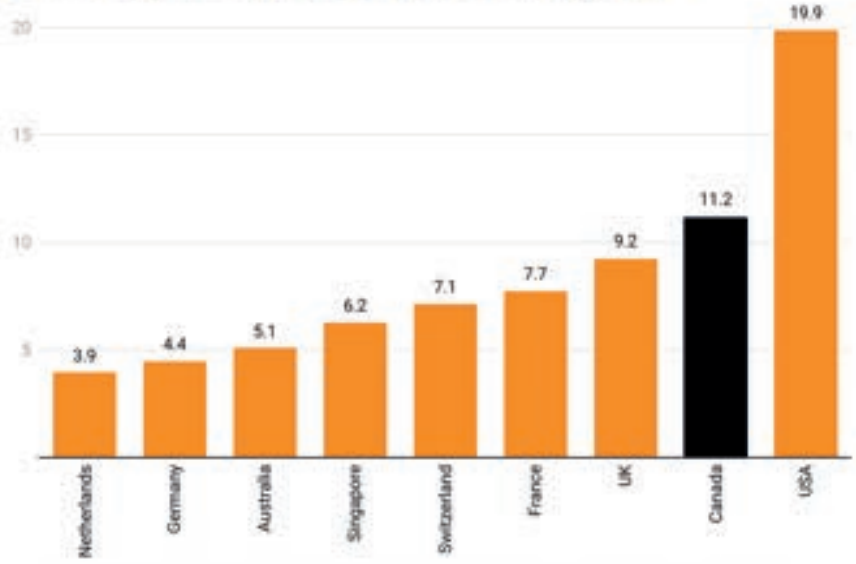
Avoidable mortality is the sum of preventable mortality (avoidable before the onset of diseases/injuries) interventions) and treatable mortality (avoidable after the onset of diseases/injuries)



Source: OECD Data Explorer, Avoidable mortality. Totals may not sum due to rounding

Canada also has a high maternal mortality rate compared to similar countries. The ratio is 11.2 per 100,000 which is higher than the Netherlands (3.9 per 100,000), Germany (4.4 per 100,000), Singapore (6.2 per 100,000), France (7.7 per 100,000), and the UK (9.2 per 100,000).

Chart 113: Maternal mortality rate across a selection of countries (deaths per 100,000 live births), 2019



Source: World Health Organization Data, Maternal mortality ratio (per 100 000 live births). Number of maternal deaths during a given time period per 100,000 live births during the same time period. Data selected for 2019 to reflect pre-pandemic outcomes.

Moreover, Canada has relatively high infant mortality rates compared to other highly advanced economies. This is particularly the case among indigenous communities.[338] For example, in Canada the rate is 4.3 per 1,000 compared to Japan (1.7), Australia (3.2), the Netherlands (3.4), and the UK (3.6).

Patients in Canada face lengthy waiting times. For example, waiting times for elective surgery and specialist care are considerably longer than in many other wealthy nations. (See Chart 39 and Chart 40.) [339]

Chart 39: Responses to the question 'How long did you wait for non-emergency or elective surgery?' across a selection of countries (% of respondents), 2023

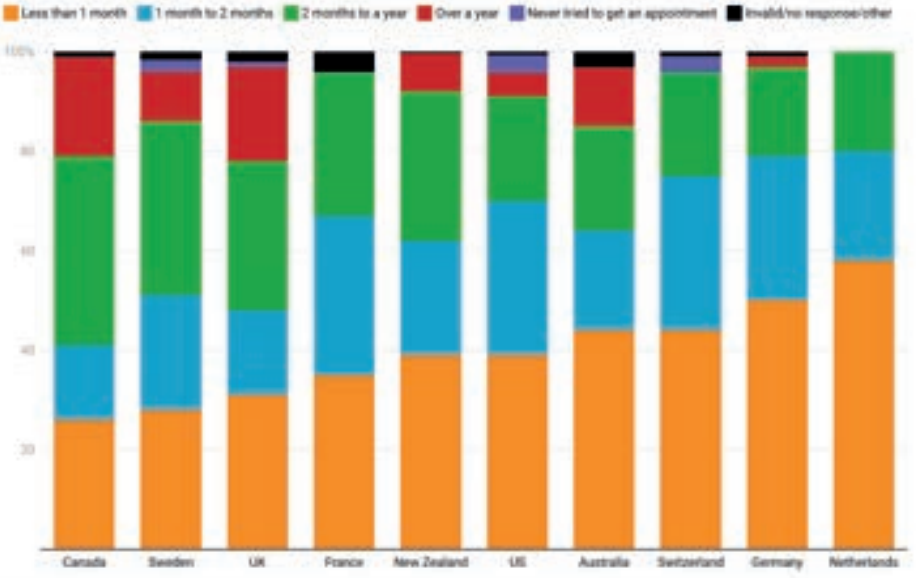
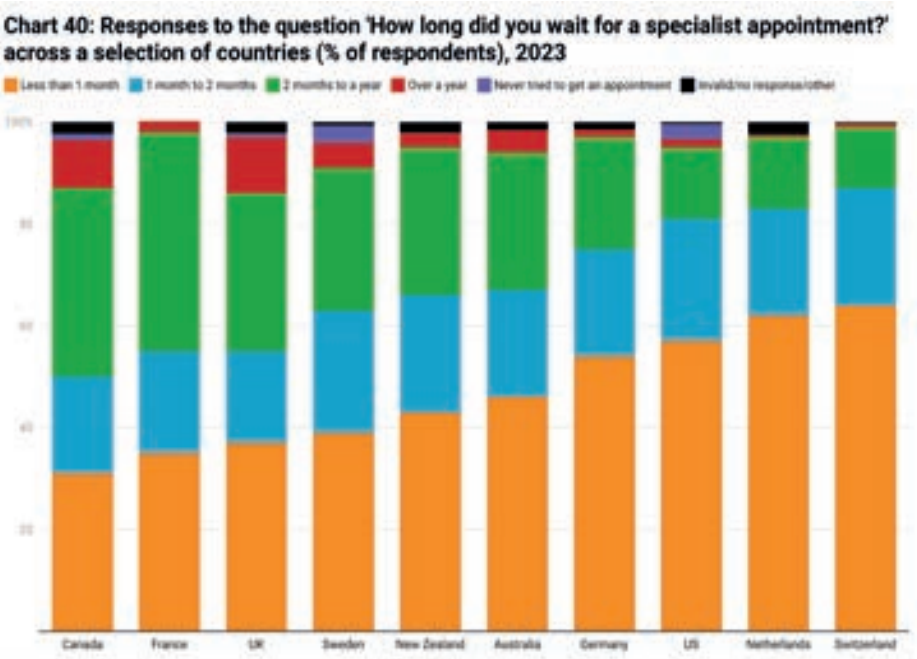


Chart 40: Responses to the question 'How long did you wait for a specialist appointment?' across a selection of countries (% of respondents), 2023



338. World Bank Group, 'Mortality rate, infant (per 1,000 live births), 2023

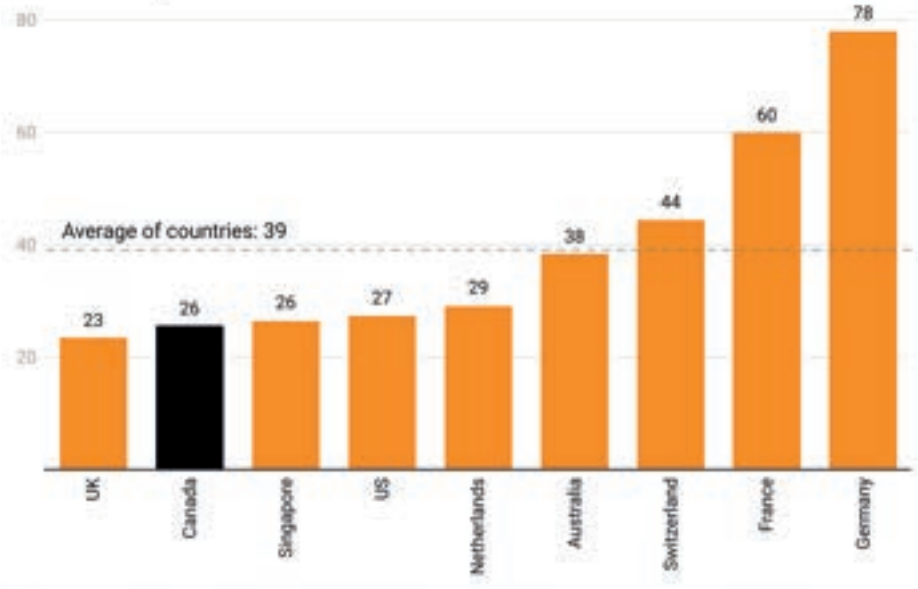
339. Marshall, E., Miller, L., & Moritz, M., 'Challenges and impacts from wait times for specialist care identified by primary care providers: Results from the MAPP study cross-sectional survey', *Healthcare Management Forum*, July 2023

Canada's healthcare system faces significant workforce challenges, including shortages of doctors, nurses, and allied health professionals. Approximately 17% of Canadians lack a regular family doctor, forcing reliance on walk-in clinics or emergency rooms.[340]

This is partly due to the underfunding of primary care. For example, Canada spends only 5.3% of its healthcare budget on primary care compared to the OECD average of 8.1%. Burnout among healthcare workers has led to high turnover and early retirements. Rural areas are particularly affected, with some communities relying on locum doctors or telehealth.[341]These shortages contribute to long waiting times and reduce the system's capacity to handle growing demand, driven by an ageing population and increasing chronic disease prevalence.

Moreover, there is not only a shortage of doctors but also a shortage of medical resources. For example, Canada has a much smaller ratio of hospital beds to its population than other comparable countries. (See Chart 114.) It only has 26 hospital beds per 10,000 people compared to the Netherlands (29 per 10,000), France (60 per 10,000), and Germany (78 per 10,000).

Chart 114: Hospital beds per 10,000 across a selection of countries, latest data

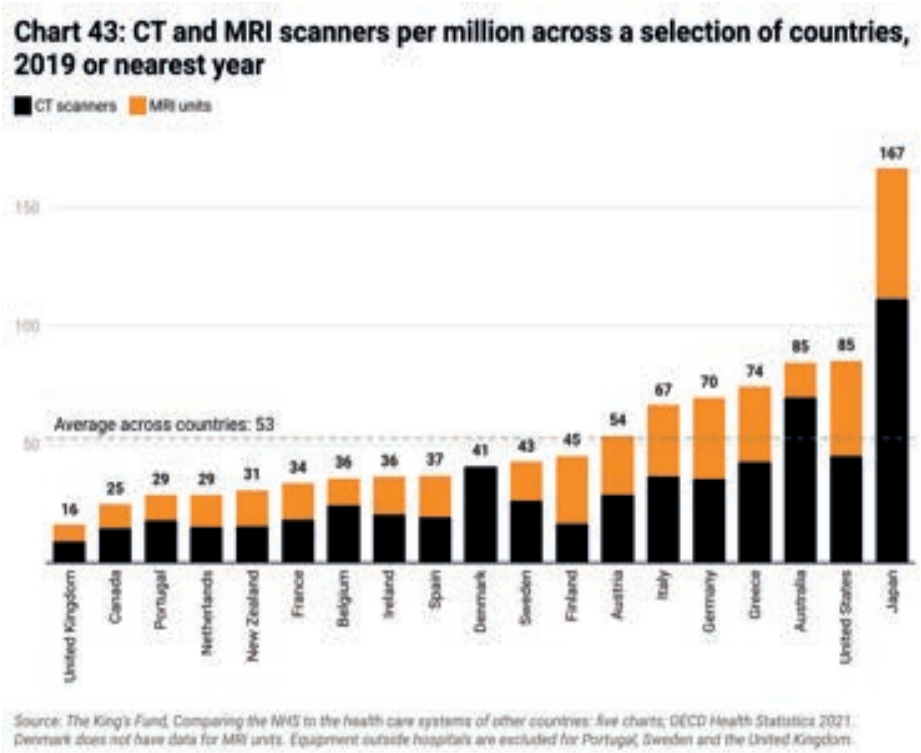


Source: World Health Organization, Hospital beds (per 10,000 population). Data for the UK, Switzerland and Singapore is from 2021. Data for the US, Canada, the Netherlands, France and Germany comes from 2020. Data for Australia comes from 2016.

Furthermore, Canada has far fewer CT and MRI machines per patient than other wealthy nations. (See Chart 43.) It only has 25 machines per million compared to France (34), Sweden (43), Germany (70), the United States (85), and Japan (167).

340. CIHI, 'Better access to primary care key to improving health of Canadians', October 2024

341. Shahaed, H., *et al*., 'Primary care for all: lessons for Canada from peer countries with high primary care attachment', *CMAJ*, December 2023



Source: The King's Fund, Comparing the NHS to the health care systems of other countries: five charts; OECD Health Statistics 2021. Denmark does not have data for MRI units. Equipment outside hospitals are excluded for Portugal, Sweden and the United Kingdom.

This low proportion of equipment such as CT and MRI scanners, coupled with lengthy waiting times, is one of the reasons why many Canadians are deciding to seek healthcare in other countries. For example, a commonly cited reason for people from Canada travelling to the United States in order to receive treatment is because they believe that they will be able to receive a medical scan more quickly.[342] [343]

Conclusion

There is a clear lesson for the UK from the Canadian example. Deprioritising primary care by underfunding it compared to other areas of healthcare clearly leads to negative outcomes. Moreover, a shortage of medical staff and medical scanning equipment leads to patients becoming frustrated as they cannot access the care which they need.

If the UK is to learn from the failings of the Canadian system, it would ensure that it allocates sufficient funding to primary care while also ensuring that it attracts enough medical professionals to the workforce.

Furthermore, it is striking that the only highly developed country with a smaller proportion of CT and MRI scanners than Canada is the UK.

342. Moir, M., & Bacchus, B., 'Waiting Your Turn', *Fraser Institute*, 2024

343. Dangerfield, K., 'Would you cross the border for healthcare?', *Global News*, March 2024

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