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Funding health care in England

Has the case been made for changing the NHS model?

Nicholas Timmins

Introduction

NHS waiting lists in England are at an all-time high. Despite some recent improvements, waiting *times* are also, for too many people, far too long. Hospitals are crumbling, there are staff shortages and general practice is struggling to meet demand. The service has been, and still is, beset by industrial action over pay. None of this is lost on the public, whose satisfaction with the NHS as measured by the British Social Attitudes survey is at its lowest since the series started in 1983.[1]

Despite all that, the same survey shows that public support for the NHS model remains remarkably high. More than 80% believe the NHS should "definitely" or "probably" remain free of charge, available to all and primarily tax funded. Only 15% believe that its services should "definitely" or "probably" not be available to all. A similar proportion (14%) seriously question whether it should remain primarily tax funded. But a mere 6% say that it should "definitely" or "probably" no longer be free at the point of use.

The NHS's recent travails have, however – and perhaps unsurprisingly – led once again to claims that the model is "broken" and that the answer is some alternative means of funding England's health care.

Those making the case have not just been the usual suspects who have never been reconciled to the NHS model. They have included a recent health secretary, Savid Javid, who has canvassed a switch to social insurance and/or the introduction of new charges; for example, for visiting the GP.[2] Even Kenneth Clarke, another former health secretary and usually seen as a staunch defender of the NHS model, has said: "We may have to look at some means of making the better off patients making some modest contribution to their healthcare." That could involve a charge to see the GP or for more minor procedures.

Clarke was at pains to state that he was not converted to the idea, and that either proposition would require much research before implementation.[3] Which somewhat illustrates the point that what the advocates of new charges, or of a switch to social insurance, have yet to do is spell out just what such a move would involve – and how far, if at all, it would meet the challenges facing the NHS. This paper addresses some of those gaps.

The different ways of funding health care

Academics have found many and varied ways of classifying health care systems.[4] But in essence there are only three ways of funding health care:

1. **Private expenditure**: health care is paid for either directly out of the individual's own pocket ('self-pay'), or through private health insurance, which may or may not attract tax breaks (a subsidy through the tax system).
2. **Tax funding**: health care is largely funded by general taxation as in the UK, as well as in much of Scandinavia, Canada, New Zealand and Australia, among others.
3. **Social insurance**: this typically involves the bulk of the funding coming from employee and employer contributions, with some additional funding from the taxpayer, not least to cover the unemployed. Used by countries such as France, Germany and Belgium.

In practice, however, no country uses an entirely pure version of any of these systems.

Both tax-funded and social insurance systems can also draw on some private expenditure (charges), which may or may not prove to be insurable, rather than paid entirely out of pocket. Australia, while chiefly tax-funded, has private insurers. France and Germany have some charges in their social insurance systems, as do systems that are mainly tax-funded; New Zealand and Sweden charge to see a GP. Even England has charges for prescriptions and dental care, despite its tax-funded, largely free at the point of use nature.

In the US, which among developed countries relies the most heavily on private health insurance, half of all expenditure is in fact tax-funded through Medicare (the system for the elderly), Medicaid (for the poor) and the Veterans Benefits Administration (for former members of the armed forces).

So it is worth grasping that no country's health care system is entirely like that of any other. All are products of their own history and culture.

How is health care in England currently funded?

The NHS dominates health care spending. Most of NHS England's expenditure – some 80% – comes from general taxation. Charges, chiefly for prescriptions and dental care, account for just over 1% of the budget. The remaining fifth or so comes from National Insurance contributions (NICs). The proportion, however, is not fixed, and NICs – which effectively are just another tax – are not earmarked for the NHS (see section on hypothecation below). The relative contribution of charges and National Insurance has varied over the years. At their peak, charges accounted for 5% of the English NHS budget in the 1960s. The contribution from National Insurance has been as low as 6%.

In addition there is private expenditure in England, the cost being met out of the individual's own pocket (self-pay) or by insurance, with the majority of private medical insurance being employer subsidised.*

Across the UK, around one in 10 of the population are covered by private medical insurance.[5] Cover is far from comprehensive, however. Typically it does not include accident and emergency or maternity care. Some policies have restrictions on which private hospitals can be used. A few policies are condition-specific, covering only cancer and cardiac, for example, and some contain caps on overall pay-outs. Premiums are health-related – they increase with age because of the higher risk of illness, and are higher for those with pre-existing conditions. Those who take out private cover still contribute to the NHS via general taxation.

The pandemic distorted both NHS expenditure (which spiked) and the private market (which saw self-pay crash during lockdowns). However, the long-run trend has been that between the financial crash of 2008 and 2019, the proportion of the population having some form of private medical insurance was broadly flat (less than a 1 percentage point variation either way).[6] Most recently, in what may well be a reflection of NHS waits, there has been an increase in people paying for procedures directly out of their own pocket. The percentage increases – 35% or so – are large, although the absolute numbers remain relatively small.

There are around 270,000 self-pay admissions a year to private hospitals at the most recent rate, against 200,000 in 2019 immediately before the pandemic.[7] To provide some sense of scale, total private admissions (self-pay plus insured) are running at around 800,000 a year.[8] The nearest equivalent NHS measure is a "finished admission episode" of which there are about 16 million a year in England. Around 6 million of these are emergencies, which the private sector does not cover.[9] This means private hospital activity is about 5% of the NHS total, or roughly 8% of elective admissions, although the percentage will be appreciably higher for some specific surgical procedures such as joint replacement.

The private sector faces its own challenges. The most recent edition of the annual private health market survey from LaingBuisson warned that the cost of medical advances, like new drugs and procedures, "threatens to make private medical insurance unaffordable".[10]

* Most out-of-pocket expenditure, which amounts to many billions, goes on over-the-counter medicines (currently around £3.2 billion a year) plus spending on appliances, other remedies, spectacles and contact lenses, private hearing aids, private wheelchairs and much else. The broad focus here is on the core clinical services and their private equivalents.

What changes are being canvassed?

Whenever the issue of alternative funding mechanisms for health care is debated – and that has happened at least once in pretty much every decade since the NHS was founded – four main options are canvassed:

1. subsidies for private medical insurance
2. a hypothecated tax
3. additional charges
4. a switch to social insurance.

This time round, tax breaks (subsidies) for private medical insurance is a dog that has not barked. Possibly because the UK has tried it before. Margaret Thatcher was keen on such tax breaks during the year-long review into the funding and operation of the NHS that she launched in 1988. Her chancellor, Nigel Lawson, was bitterly opposed, pointing out that the private sector shared its consultant workforce with the NHS (this is still the case). Without a significant increase on the supply side – many more doctors and nurses – the result of subsidising demand would be "not so much a growth in private health care, but higher prices".[11] Very reluctantly, he agreed to tax relief on individual premiums for those aged over 60. This took effect in 1991.

There was a deadweight cost from giving the tax subsidy to those who already held such insurance. There was no great increase in the numbers taking out such policies. And when the tax relief was abolished in 1997, the Institute for Fiscal Studies calculated that the Treasury saved more from its abolition – £135 million – than the likely extra NHS costs of treating those who gave up their private cover.[12]

More recently, in 2018, there was a flurry of interest, led by a group of Conservative MPs, in switching the funding of the NHS to National Insurance – using the tax as an earmarked one for the NHS.[13]

This is well-trodden ground and the Treasury, for good reasons, has always opposed such hypothecation.[14] A partial version has been used, notably when Gordon Brown raised National Insurance in 2002 as part of the Labour government's big injection of funding into the NHS – which did indeed lead to large-scale improvements in the service and its highest public satisfaction ratings ever in the British Social Attitudes survey. The move was politically popular. But the additional spending on the NHS soon outstripped the money raised from the increase, and the link was pretty much an illusion. The Johnson government tried a similar thing in September 2021, announcing a 1.25 percentage point increase in National Insurance as a separate "health and social care levy". However, this was cancelled a year later, before it took effect.

Full hypothecation – switching the whole of NHS spending to a modified form of National Insurance, for example – would mean that in any given year, chiefly depending on the state of the economy, the tax would raise either more or less than was judged

necessary to be spent on the service. Some sort of balancing fund would be needed if expenditure were not to go up and down each year, both illogically and inefficiently. And that, inevitably, would break the allegedly firm link. The actual amount spent annually would remain a political decision.

Partial hypothecation can provide a short-term political fix. However, neither that nor full hypothecation offers a long-term solution. The Institute for Government has previously described hypothecation as "no more than a convenient mirage to help sell tax rises to a sceptical public".[15] Past and current directors of the Institute for Fiscal Studies have variously called it "an exercise in deceiving voters" and "inevitably dishonest and a fraud".[16]

New NHS charges

These could take many forms but could include a charge for visiting the GP, for A&E attendance, for outpatient appointments, for hospital stays – a so-called 'hotel charge' – or for missed appointments. It is perfectly possible to have charges within something that remains recognisable as the NHS. England already has some and even in Scotland and Wales, where prescription charges have been abolished, there are still charges for dental treatment.

The most common proposition, certainly currently, is a charge for GP visits. Even a few back-of-the-envelope calculations, however, raise questions that those advocating for it have yet to answer.

Charges can have two primary aims. One is to raise money. The other to deter frivolous demand. There is no good evidence on the scale of 'frivolous' use of general practice, and no one presumably is in favour of deterring *necessary* demand.

In practice any charge is likely both to deter an element of use and raise some money. The question is how much? There are roughly 350 million appointments in general practice a year in England. So a £10 charge for these would nominally raise around £3.5bn. That is decent money.

But that, of course, would be before any exemptions, and it is almost inconceivable that there would not be some. Take prescription charges. Some 40% of the population are liable to pay prescription charges, but almost 90% of prescriptions are in fact dispensed free. That is because those who are exempt are among the heaviest users of health services. The main exemptions are for those under 16, or under 18 in full-time education, those over 60, those on low income, those who are pregnant or have had a baby in the previous 12 months, and those with some specified medical conditions; these include cancer, some forms of diabetes and epilepsy.[17]

So the first thing those advocating a charge for a general practice appointment need to spell out is which of those exemptions would they honour or remove? Honouring all would likely reduce the income by something close to 90%, reducing it to perhaps £350m to £400m.* That would certainly appear a less decent return.

What can be said is that it would be a brave minister who proposed such a charge without exempting children up to at least some age, without exempting those on low income, and without at least some exemption for older people, even if the age for free consultations were to be raised from the current 60 used for prescriptions, or an attempt was made to means-test the charge for this group.

Furthermore, the call is usually phrased as "a charge for visiting a GP". But of the 350 million or so appointments in general practice, only around half are actually with a GP. The remainder are with practice nurses, pharmacists and other members of the practice team. Similarly, telephone and internet consultations are also increasingly common. Would the same charge apply for these, or would it be lower? As the NHS became more transactional – as this would, by definition, make it – would the public view it as value for money if the charge was the same for seeing a non-GP clinician as opposed to a GP?

This would, of course, come with some bureaucracy. It would involve not just a means of payment at the general practice (including, at least for now, the ability to handle cash) but a billing and follow-up system for remote consultations, and – as with prescription charges – a system to tackle fraudulent claims for exemption. That is not an insuperable objection. But the smaller the sum raised because of exemptions, the larger the administrative costs would loom.

Then there is a question of who would keep the money. If the practices themselves, then those in better-off areas, with fewer exempt patients, would do better than those in more deprived areas. Would it just go into the general NHS budget? Or would a formula be devised to redistribute it around general practice?

If a low charge with no or very few exemptions looked unappealing, another option would be a much higher charge but with more extensive ones. A £50 charge for all general practice consultations would nominally raise £17.5bn. A much more serious sum although, again, it would inevitably be eaten into significantly by whatever exemptions were applied – and the higher the charge the greater the political pressure for these would be.

A charge at that level would raise real concerns about people forgoing necessary consultations (with potentially worsening conditions and higher costs for health care in the long run as a result). It would hit hardest those who, so to speak, are 'doing the right thing' – families who are in work but with incomes just too high to qualify for whatever low-income exemption was applied.

* There does not appear to be sufficiently good data in the public domain on appointment numbers by age, disease, income and so on to allow any precise calculation to be made of the impact of removing or altering each category.

As a result, some sort of annual cap on the charge would almost certainly be needed. There is already a form of cap on prescription charges in that those who have to pay can buy a three-month or annual pre-payment certificate – a sort of 'season ticket' covering all their prescriptions – for £31.25 or £111.60 respectively. Such a cap on charges for a general practice consultation would, of course, reduce the theoretical maximum income generated.

In other words, those advocating 'a charge to see the GP' need answers to these questions.*

There appears to be a core dilemma: a low charge with very few exemptions that would be likely to raise only a couple of billion pounds; or a high charge with larger exemptions in an attempt to raise a more significant sum – although to do that the exemptions would have to be much more restrictive than those currently applied to prescriptions.

Finally, it is almost certain that in England, a charge to see the GP would have to be accompanied by a charge for attending A&E departments, to avoid yet more patients going to overcrowded casualty departments rather than to the GP – often for the minor afflictions better served in general practice. The challenges of administering a charge in casualty departments barely need to be spelt out and one thing is certain: it would not be a significant money-spinner. There are typically around 16 million A&E attendances a year. So even say a £20 charge would raise only £320m or so before exemptions and, again, no exemptions is inconceivable.

Social insurance

Classic social insurance involves mandatory contributions from employers and employees topped up by the state via more general forms of taxation. Given that contributions are mandatory, they are in effect a tax, although collected and dispersed by 'sickness funds', which operate more independently of government than the NHS does. Contributions are usually related to income, not to health status. And, depending on its precise design, social insurance is perfectly capable of providing the same sort of comprehensive care as the NHS. Plenty of countries that England might want to compare itself to use it.

But there is no one model. Take a few examples from countries that use it and often score well on health outcomes. France has three main schemes and a few additional very small ones. Individuals cannot choose their scheme or insurer and there is no competition between them.[18] By contrast Germany has more than 100 sickness funds and patients can choose between them (some offer additional benefits such as homeopathy and health promotion beyond the standard package). The German system both allows, and in some cases requires, those on the highest incomes to opt out of the statutory scheme and instead enter into one of 42 private health insurance schemes.[19] Coverage is mandatory.

* A decade ago, a paper from the Reform think tank sought to answer some of these but, understandably, without the detail needed to turn a proposition into a policy. See: https://rb.gy/wsemq

In the Dutch system, compulsory contributions go to a number of competing but heavily regulated private health insurers, between which patients can choose.[20] And none of this brief summary even begins to address the differing ways these systems then fund the complex mix of public, private, for profit, not for profit and, in some cases, faith-based health providers that exist in the various countries.

In other words, there is no off-the-shelf model that England could just adopt in 'a switch to social insurance' – and no one should pretend that simply switching the funding of the NHS to a reformed version of National Insurance (the hypothecation discussed above) would be a social insurance system that any of the countries that currently use it would recognise. Decisions would be needed on how many 'sickness funds' would be created, whether patients could choose between them, whether they would be mutuals or for profits, or a mix of the two – and what their relationship would then be with NHS hospitals, general practice, community services and the private sector. How would they be paid, and on what contracts? Would NHS hospitals remain publicly owned?

A benefits package would need to be defined (the NHS does not currently have one), and contribution levels and who should pay them would need to be decided.

In addition, while NHS England currently spends around £160bn a year, the Department of Health and Social Care spends more than an additional £20bn on a wide range of items that include capital and public health, spending on arm's-length bodies that include the National Institute for Health and Care Excellence and the Care Quality Commission, as well as expenditure on training and on research and development. Would that be covered by the social insurance contributions or would those elements remain tax-funded?

A switch to social insurance would also involve a massive change to England's current system of taxation. As noted, funding for health comes chiefly from general taxation and National Insurance; taxes would need to be reduced to offset the compulsory contributions into social insurance, with decisions needed on which taxes would be cut. While that might provide an opportunity to tackle the many flaws in the current system of taxation – see a recent report from the Institute for Fiscal Studies[21] – that in itself would be a huge undertaking.

To put it at its simplest, a switch to social insurance would be the mother and father of all machinery of government changes. It would take years to design and implement amid much heated debate, with the added complication that health is a devolved issue. Under their current political leadership the governments of Scotland and Wales would not favour such a move. Could the current NHS model be preserved in those countries while England changed?

Three further points are worth making. One is that a drawback of classic social insurance is that being based on employer and employee contributions, it has a narrower and less progressive tax base than general taxation, which includes some contribution from older and retired people – among the biggest users of health care – through, for example, income tax and VAT. The employer contribution in social insurance also makes

it more expensive to create jobs; indeed, such concerns have led some countries that use social insurance to inject more general taxation into their health systems.[22] France, for example, has more than doubled its contributions from tax revenues since 2016.[23]

Should England switch to social insurance, contributions would be needed from older people as well as from employees and employers – in the interests both of inter-generational fairness and of limiting how far the tax base gets narrowed by the change.

The second is that while social insurance systems are capable of producing good outcomes (some appreciably better than the NHS currently manages) there is variation between them. Tax-based systems similar to the UK's, in Scandinavia and elsewhere, also produce good results (again with variations between them) – and as a result there is no good evidence that one health care model works systematically better than another.[24] A 2010 study by the OECD that looked at the cost-effectiveness of the different types – a study that included some measures of health outcome in that definition – concluded: "There is no health care system that performs systematically better in delivering cost-effective health care – big-bang reforms are therefore not warranted."[25]

It is sometimes argued that social insurance systems have the advantage of distancing politicians, at least to a degree, from the day-to-day management of health care (it would be a myth to believe that their health ministers do not get involved). And it is certainly true that the NHS is an unusually centralised and politicised system, quite possibly to its detriment. However, other countries with tax-funded systems, sometimes because they are more regionalised, achieve less day-to-day political involvement than the UK. And given 75 years of history the question has to be asked of how far English politicians would in practice step back after a switch to social insurance, and indeed how far the public would be in favour of that.

Finally, it is worth noting that outside of war and revolution, examples of countries radically changing the way they fund health care are rare. Two arguable exceptions are the US and the Netherlands. In the US, tax funding was used to extend coverage to many millions who did not have it through the introduction of Medicare and Medicaid in the 1960s and Obamacare in 2014. The Dutch moved from a hybrid mix of social and private insurance that lacked comprehensive coverage to its current, somewhat unusual version of social insurance. Agreeing that change took 20 years from the original call for a universal system in the Dekker report of 1987.

Conclusion

In the Cold War thriller *Bridge of Spies*, the captured Soviet spy Rudolf Abel is asked by his lawyer why he appears so unworried about the prospect of either the US electrocuting him or the Soviet Union executing him on his return. In each case, Abel's impassive reply is "would it help?"

And that is the fundamental question that needs to be asked about changing the way health care is funded in England. Which if any of the options explored above would help meet the current NHS challenges around waiting times, workforce and capital investment in both buildings and equipment?[26]

The conclusion here is that neither subsidies for private medical insurance nor hypothecation are good ideas. A case can, of course, be made for charges. But those advocating them have yet to spell out what level of charge, with what exemptions, and with what mitigations to limit the impact of a charge deterring necessary health care. Or indeed how much they would in practice expect to raise. Money is always helpful. But on the evidence here, the sums raised are unlikely to be transformative, and there is little public appetite for them.

A switch to social insurance, aside from being heavily contested, would be the most monumental of changes to both the NHS and to the tax system for an uncertain gain – while also raising issues around devolution. It would take years while doing nothing to address the current challenges.[27] More likely it would be a distraction from tackling issues that include not just waiting times and the workforce, but better IT systems and the service's relationship with social care.[28] For both charges and social insurance, the case has yet to be made.

Nicholas Timmins is a senior fellow at the Institute for Government and The King's Fund. Between 1996 and 2011, he was public policy editor of the *Financial Times*. He is also the author of *The Five Giants: A Biography of the Welfare State*, and an honorary fellow of the Royal College of Physicians.

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enquiries@instituteforgovernment.org.uk

+44 (0) 20 7747 0400

@instituteforgov

Institute for Government, 2 Carlton Gardens
London SW1Y 5AA, United Kingdom

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