

BISMARCK VERSUS BEVERIDGE REVISITED

**DOES THE MODEL
SHAPE THE OUTCOME?**

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FOREWORD

The NHS has never lacked defenders. Politicians of every stripe compete to proclaim their commitment to a free at the point of use health service, built on the principle that care follows need rather than the ability to pay. That consensus, however warm and wide, has not been enough. It has not translated into the sustained investment, reform, or political candour that a service under this degree of pressure requires. In 2025, more than half of British adults expressed dissatisfaction with how the NHS runs.

Into this crisis of confidence, an old question has re-emerged with renewed force: whether the NHS's funding model is itself the problem. In parliament and in the press, senior figures – some of whom should know better – have reached for structural answers before consulting the evidence. The social insurance systems of France, Germany, and the Netherlands are regularly invoked as superior alternatives, with little scrutiny on what those systems actually deliver or what it would take to replicate them here. That is precisely why this report matters.

When the health secretary asked me to investigate the NHS in 2024, I found a service in serious trouble: a system facing rising demand from a society in distress, with insufficient resources, inadequate capital investment, and without the transformative reform its condition required. Whether the funding model itself bore responsibility lay beyond my remit. IPPR has taken up that question directly, and with a rigour the public debate has so far largely lacked.

The evidence is clear: there is no evidence that social health insurance models outperform tax-funded systems, or vice versa. Performance varies more within funding model categories than between them. The best-performing tax-funded systems, particularly in Scandinavia, compare favourably with the best social insurance systems on most measures.

Tax-funded systems, including the NHS, tend to have genuine structural advantages on equity: lower out-of-pocket costs, less reliance on voluntary insurance, and stronger financial protection for those on lower incomes. On efficiency, the picture is similar: tax-funded systems carry lower administrative overheads and deliver comparable outcomes relative to spending. A transition away from the NHS model would not only be enormously costly, it would mean surrendering advantages that are real and hard-won.

None of this should be read as complacency. The NHS's performance, measured against comparable systems, is sobering. On treatable mortality – deaths from conditions where timely care should prevent a fatal outcome – the NHS is the second-worst performer among the 22 countries analysed, ahead only of the USA. Capital formation in the NHS stands at roughly half the basket average. The NHS carries fewer hospital beds and less diagnostic equipment per head than comparable systems. These are not abstract statistics: they translate directly into the waiting times and unmet need experienced by patients every day. The problem is not the model, but chronic underinvestment, a failure to reform, and a system that has been run too hard for too long without the resources to recover.

This report does not merely diagnose. It sets out where targeted investment and reform will make the greatest difference: sustained capital investment to address the NHS's long-standing infrastructure deficit; a genuine shift towards primary

and community care, where the evidence shows consistently better outcomes at lower cost; serious resourcing of long-term and social care, where the gap between England and comparable countries is striking; and a more ambitious approach to public health. These are the priorities that will determine whether the NHS is able to serve the next generations as it has those before.

The NHS turns 78 this year. I do not merely want to see it survive. I want to see it thrive, with the confidence that it will still be there to celebrate its centenary in 2048. That ambition is achievable – but only with honesty about where we are and the courage to act on evidence rather than ideology. At a time when the NHS needs honest friends more than ever, IPPR has been exactly that.



**The Rt Hon professor the Lord Darzi of Denham
PC KBE FRS FMedSci HonFREng**

SUMMARY

The NHS is under serious pressure. In this context, old questions have re-emerged with renewed force: are the NHS's core principles – free-at-the-point-of-use and funded through general taxation – still fit for purpose?

In this report, we analyse data from 22 OECD countries to examine evidence on alternative funding approaches – principally social health insurance (SHI) systems, as used in France, Germany and the Netherlands – and their relationship to performance indicators across five domains: capacity, access, equity, quality, and efficiency. We find the following.

- **There is no evidence that SHI systems outperform tax-funded systems, or vice versa.** Performance varies more within funding model types than between them.
- **Tax-funded systems hold advantages on equity and administrative efficiency.** Out-of-pocket spending on health is lower (3.2 per cent in tax-funded systems vs 3.5 per cent in SHI systems). Administrative costs consume 2.2 per cent of health spending in tax-funded systems compared to 3.5 per cent in SHI systems.
- **The NHS performs poorly against comparators on key quality indicators** – on treatable mortality, it records 71 deaths per 100,000, the second-worst in our basket of countries.

The causes of poor NHS performance are not structural but practical. Capital formation in the NHS stands at just 0.4 per cent of GDP, roughly half the average of our comparators, and the system has been run at unsustainable pressure for too long. Spending increases have been poorly targeted and failed to address the drivers of weak performance.

The evidence points to four areas where targeted investment would make the most difference for the NHS.

- **Capital investment:** sustained investment is needed to address the NHS's long-standing infrastructure deficit. The government should revisit the capital settlement set out in the 2025 spending review.
- **Primary and community care:** a genuine shift towards neighbourhood care, with better access, more personalised support and more effective management of long-term conditions.
- **Long-term and social care:** serious resourcing of an area where the UK lags far behind comparators – the Netherlands spends around three times more on social care per capita than the UK.
- **Public health and prevention:** a more ambitious and better-resourced approach is necessary, given that generating improved outcomes through public health budgets is far more cost-effective than through NHS spend.

Even with progress on all four, difficult questions remain about what a publicly-funded health system can and should provide as the costs and capabilities of medicine continue to expand. That conversation can no longer be deferred.

1. INTRODUCTION

The NHS is in serious trouble. In 2025, more than half of British adults (51 per cent) were dissatisfied with how the service runs (Taylor et al 2026). Core targets for elective care and A&E performance have not been met for more than a decade (NHS England 2026a, 2026b), and staff feel undervalued and exhausted (NHS England 2025a).

The government has been frank about the scale of the challenge. Lord Darzi's independent investigation exposed deteriorating performance across multiple domains (Darzi 2024) and laid the groundwork for an ambitious 10-year plan for health (UK Government 2025), backed by average annual budget growth of 3 per cent between 2025/26 and 2028/29 (HM Treasury 2025).

Given the depth of the crisis this government inherited, rapid NHS turnaround was never realistic. However, there are signs of recovery. In 2025, the NHS delivered record levels of activity; the elective waiting list has fallen to its lowest level in three years, and productivity growth now exceeds the 2 per cent annual target (NHS England 2026c, 2026d).

Despite this progress, critics argue that structural pressures – sluggish growth, rising costs, and an ageing population – make the NHS model itself unsustainable. While 89 per cent of the British public believe that the NHS should remain free at the point of use and 81 per cent believe that it should be predominantly tax-funded (Taylor et al 2026), these foundations are increasingly contested politically.

In 2025, former health secretary Sajid Javid argued that “a serious conversation with taxpayers about how we continue funding their favourite national institution is long overdue” (Bootle et al 2025). More strikingly, for the first time in decades, the leader of an electorally competitive party has openly questioned the NHS's core principles. In a 2024 interview, Nigel Farage argued that the NHS's funding model was a “total failure” and pointed to France as a superior alternative (Bagot 2025).

To evaluate these challenges, in this report we review the evidence on alternative funding models and analyse their relationship to key performance indicators. We also consider alternative approaches to improving access and quality within the current model.

2. HOW DO DIFFERENT COUNTRIES FUND THEIR HEALTH SYSTEMS?

Almost all health systems in high-income countries are built around compulsory participation in collective health financing. Whether through general taxation, employment-based contributions or mandatory private payments, people are obliged to insure against illness (Toth 2021).

2.1 BISMARCK VERSUS BEVERIDGE

A key distinction between systems is how revenue is raised (Gabani et al 2022). Two models dominate across high-income countries: tax-funded national health systems ('Beveridge') and social health insurance (SHI) systems ('Bismarck') (table 2.1).

TABLE 2.1
System funding models

System	Features
Social health insurance	<ul style="list-style-type: none">• Funded primarily through earmarked employee and employer payroll contributions.• Usually, multiple insurers pool risk.• Insurers pay private or non-government providers for services.• Benefits package defined by statute.
Tax-funded	<ul style="list-style-type: none">• Primarily financed through general taxation.• Universal entitlement, usually based on residency or citizenship.• Government tends to own or exert strong control over providers.• Central or regional planning of budgets and services is common.

Source: Authors' analysis of Toth 2021

In practice, few systems conform neatly to either model. Funding arrangements are rarely the result of single, deliberate policy decisions, developing gradually through long processes shaped by political compromises, economic conditions and existing welfare institutions (Thorlby and Buzelli 2024).

2.2 HOW DO SOCIAL HEALTH INSURANCE SYSTEMS WORK IN PRACTICE?

Although SHI systems share key features, they differ in practice. France, the Netherlands and Germany – illustrate this variation. Table 2.2 summarises how these systems compare across four dimensions.

TABLE 2.2

Institutional arrangements of systems

Domain	France	Netherlands	Germany
Insurer competition	None: single dominant insurer	High: multiple competing not-for-profit insurers	Medium: multiple sickness funds; limited competition on price and plan design
State role	Strong: sets prices, benefits and spending targets	Limited: regulates market and defines benefits package	Medium: corporatist model defined by collective negotiation between funds, providers and state
Funding/cost-sharing	Payroll contributions and broad income tax; co-payments on most services covered by supplementary insurance	Individual premiums and employer payroll contributions; mandatory deductible; high supplementary insurance uptake	Payroll contributions split between employer and employee; limited copayments on some services; general taxation funds capital investment
Opt-out	No	No	Yes: higher earners can opt into risk-rated private insurance

Source: Authors' analysis of Blümel et al 2024, Kroneman et al 2024 and Or et al 2023

2.3 ADVANTAGES AND DISADVANTAGES OF FUNDING MODELS

Proposals to shift funding models are often justified with reference to theoretical advantages associated with different systems. Table 2.3 summarises the main arguments on both sides of the tax-funded vs SHI debate.

TABLE 2.3

Advantages and disadvantages of models

System	Potential advantages	Potential disadvantages
Social health insurance	<p>Funding stability: insurer independence buffers health budgets from short-term political pressures; earmarked contributions may build support for higher spending.</p> <p>Longer-term investment: political insulation supports investment in infrastructure, technology and prevention.</p> <p>Insurer competition: choice between funds may drive performance improvements.</p>	<p>Administrative complexity: multiple insurers and contractual arrangements generate higher overheads.</p> <p>Labour market dependence: heavy reliance on payroll contributions increases labour costs and makes revenues vulnerable to unemployment and demographic change.</p> <p>Fragmentation: multiple insurers and provider competition creates barriers to care integration for patients with complex conditions.</p>
Tax-funded	<p>Progressivity and equity: revenue is raised in proportion to ability to pay.</p> <p>Administrative simplicity: fewer payers and contracting arrangements reduce overheads.</p> <p>Demographic resilience: lower reliance on payroll contributions makes funding more sustainable as populations age.</p>	<p>Short-termism: as the payer is a democratic political entity, funding decisions skew towards short-term pressures over long-term investment.</p> <p>Funding competition: healthcare must compete with other public services for general tax revenues, risking chronic underfunding.</p> <p>Weaker innovation incentives: lack of competition between insurers/providers, reduces incentives to improve performance.</p>

Source: Authors' analysis of Thorlby and Buzelli 2024

Many of these claimed advantages and disadvantages depend on institutional conditions that are not always present in practice. For instance, the benefits of insurer competition are limited where individuals have little real choice (eg, in France where almost all citizens are compulsorily members of the same insurer), or markets are highly concentrated and dominated by a few firms. Features attributed to SHI systems may, in practice, reflect other arrangements. Assessing the relative merits of different funding models requires moving beyond individual case studies to comparative evidence across a range of outcomes.

3.

HOW DO FUNDING MODELS AFFECT PERFORMANCE?

To assess the relationship between funding models and performance, we analyse a basket of 22 countries. We applied the following criteria for inclusion:

- **OECD membership:** to ensure data comparability, all countries are OECD members.
- **Income:** To maintain context comparability, upper-middle-income OECD members (Turkey, Colombia and Costa Rica) are excluded.
- **Population:** countries with populations below 5 million are excluded to avoid comparing systems substantially smaller than the NHS.
- **Context:** post-socialist countries in central and eastern Europe – whose healthcare institutions tend to be far more recent are excluded.
- **Classification:** the analysis focuses on systems classifiable as tax-funded or SHI. The US is retained in a separate ‘other’ category, given its complex mix of tax-funding, employment-based insurance and out-of-pocket payments.

TABLE 3.1

Comparator systems

Model	Countries
Tax-funded	Australia, Canada, Denmark, Finland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden, UK
SHI	Austria, Belgium, France, Germany, Israel, Japan, Netherlands, South Korea, Switzerland
Other	USA

Source: Authors’ analysis

3.1 PERFORMANCE INDICATORS

This analysis compares systems across five domains (see table 3.2), capturing the core objectives of all health systems: timely access to high-quality care; efficient resource use; adequate system capacity; and equitable access and outcomes. Equity is particularly salient, given strong public support in England for a free-at-the-point-of-use system funded through progressive taxation.

TABLE 3.2**Comparison domains**

Domain	What it represents	Comparative indicators
Capacity	Financial, workforce and physical resources available to deliver care.	<ul style="list-style-type: none"> • Health expenditure (as a percentage of GDP) • Health expenditure per capita (PPP) • Healthcare capital formation (as a percentage of GDP) • Hospital beds (per 1,000 people) • Diagnostic equipment (per million people)
Access	The extent to which people can obtain healthcare when they need it.	<ul style="list-style-type: none"> • Waiting times for elective procedures • Waiting times for GP appointments • Population reporting unmet medical needs • Percentage satisfied with access to high-quality care
Quality	Effectiveness, safety and outcomes of healthcare services.	<ul style="list-style-type: none"> • Treatable mortality • 30-day mortality after acute myocardial infarction • Avoidable hospital admissions (diabetes, asthma/COPD, heart failure)
Efficiency	How health systems translate resources into outcomes.	<ul style="list-style-type: none"> • Treatable mortality relative to spend • Administrative spend (as a percentage of total healthcare expenditure) • Average length of hospital stay
Equity	The extent to which access and outcomes are distributed fairly.	<ul style="list-style-type: none"> • Out-of-pocket spend (as a percentage of household consumption) • Voluntary health insurance (VHI) uptake

Source: Authors' analysis

3.2 COMPARING SYSTEMS

The evidence on health system performance and funding models is mixed – neither model consistently outperforms the other. Table 3.3 summarises performance on the core domains.

TABLE 3.3

Summary of performance

Domain	Tax-funded systems	SHI systems	NHS position
Capacity	Slightly lower spend and fewer physical assets	Higher spend, more beds and equipment	Below average on most metrics
Access	Less satisfaction with waits, higher reported unmet need.	Lower unmet need, higher satisfaction with access	Poor comparative performance on waiting times
Equity	Lower OOP spend, less reliance on VHI	Higher OOP spend; higher VHI uptake	Low OOP spend; low VHI uptake
Quality	Fewer avoidable admissions, similar level of treatable mortality and AMI outcomes	More avoidable admissions, similar level of treatable mortality and AMI outcomes	Worse on treatable mortality; Worse than average on AMI outcomes. Strong performance on avoidable admissions.
Efficiency	Lower admin costs, shorter hospital stays	Higher admin spend, longer hospital stays	Higher than average hospital stays; low admin spend

Key	Performs well	Average performance	Performs poorly
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Source: Authors' analysis

3.3 SYSTEM CAPACITY

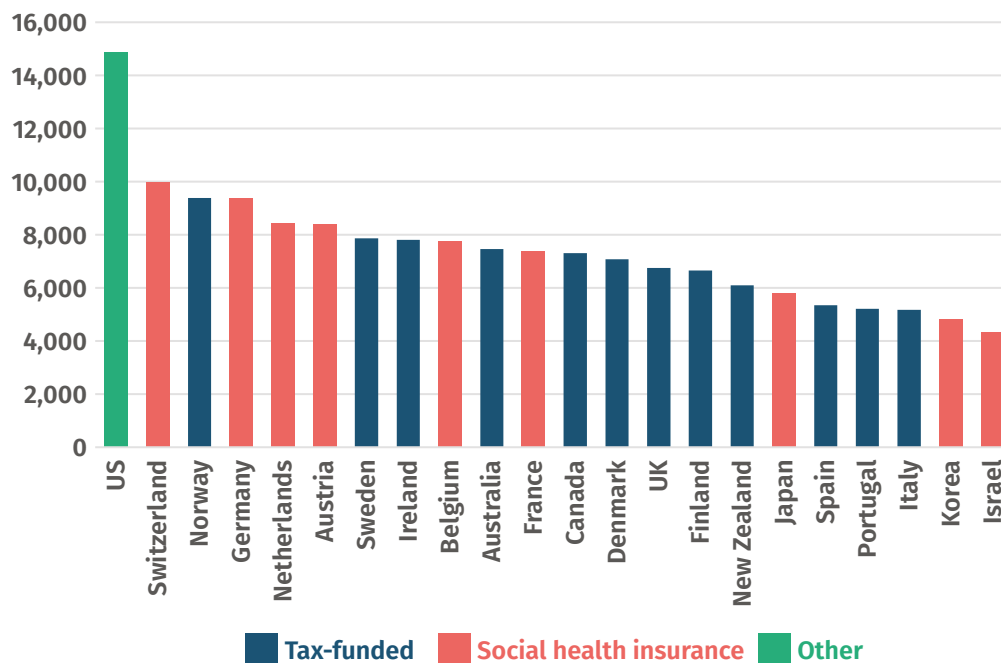
SHI systems tend to have more capacity, possibly because contributions are collected through dedicated payroll mechanisms rather than competing for resources within general government budgets, buffering health spending from short-term fiscal pressures.

3.3.1 Health expenditure

SHI systems spend an average of 10.3 per cent of GDP on health, compared to 9.7 per cent in tax-funded systems. Per capita, SHI systems spend \$7,358 (all figures are purchasing power parity adjusted, as per OECD (2026)) on average, compared with \$6,845 in tax-funded systems. The UK (\$6,747) is slightly below the basket average (\$7,420). That said, several northern European tax-funded systems spend at comparable or higher levels than some SHI systems, reflecting political choices about taxation and expenditure rather than structural funding features.

FIGURE 3.1

Many tax-funded systems spend at comparable levels to SHI systems
Health expenditure per capita (USD PPP), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

It is important to note that additional expenditure may 'buy' additional capacity, but not necessarily superior outcomes. The USA, for instance, performs poorly across almost all of our indicators, despite its far higher level of spend. The relationship between resources and performance is real but not linear.

3.3.2 Capital investment

A persistent concern about tax-funded systems is their tendency to under-prioritise long-term investment. Governments face pressures to direct resources towards current services and may put off long-term decisions impacting productivity and outcomes.

This hypothesis is not borne out in our data. Though healthcare capital formation represents a slightly higher percentage of GDP in social insurance systems (0.73 per cent) SHI systems than in tax-funded systems (0.67 per cent), Germany drives much of the difference. In Germany, capital expenditure in healthcare is financed through taxation raised by state governments (länder). If Germany is removed from our basket, SHI systems in fact fare slightly worse (0.66 per cent).

The UK is a particularly poor performer – capital formation (0.4 per cent) is a little over half of the basket average (0.7 per cent), and less than half that of high-performing, tax-funded comparators (eg Australia, Norway and Denmark at 0.9 per cent).

3.3.3 Physical assets

SHI systems have, on average, more than double the hospital beds of tax-funded systems (6.7 vs 2.7 per 1,000 population). They also have more diagnostic equipment (68 vs 50 PET, MRI and CT scanners per million), though Japan (184 units per million), drives much of the gap. The UK is significantly below average on both metrics (2.4 beds per 1,000; 19 diagnostic machines per million)

Greater bed and equipment capacity is not inherently desirable and may add to unnecessary hospitalisation and over-investigation. However, low capacity can create bottlenecks in access, contributing to the waiting time pressures discussed below.

3.4 ACCESS TO CARE

It should be noted that there are few objective, standardised indicators of healthcare access, and we tend to rely heavily on survey evidence to determine access levels. Given challenges with the use of survey data, particularly in comparative research, we should treat the findings below with some caution. The evidence we do have presents a nuanced picture on the relationship between funding model and access.

3.4.1 Satisfaction with access

The OECD uses Gallup World Poll data to assess the percentage of the population satisfied with the availability of high-quality healthcare (OECD 2025a). Generally, SHI system users are more satisfied (77.7 per cent) than tax-funded system users (64.7 per cent). However, these headline figures mask substantial variation within models – the UK and France record roughly the same level of satisfaction (60 per cent).

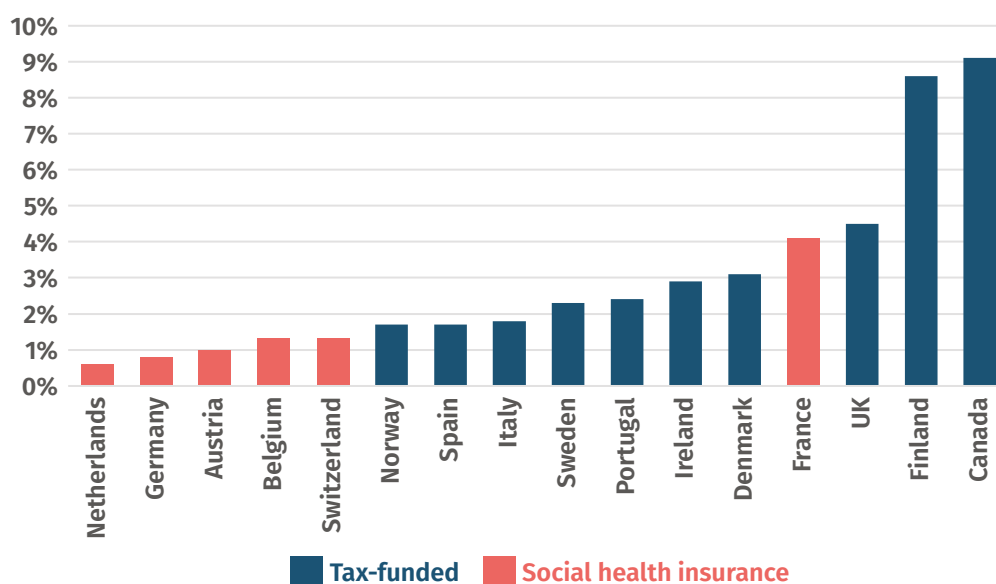
3.4.2 Unmet care needs

The percentage of the population reporting unmet healthcare needs is generally lower in SHI systems (1.5 per cent) than in tax-funded systems (3.8 per cent), though two tax-funded systems, Finland (8.6 per cent) and Canada (9.1 per cent) account for the majority of the difference (see figure 3.2).

FIGURE 3.2

The number of people saying their medical care needs aren't met is generally higher in tax-funded systems

Population reporting unmet needs for medical care (%), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

3.4.3 Access to GP and specialist care

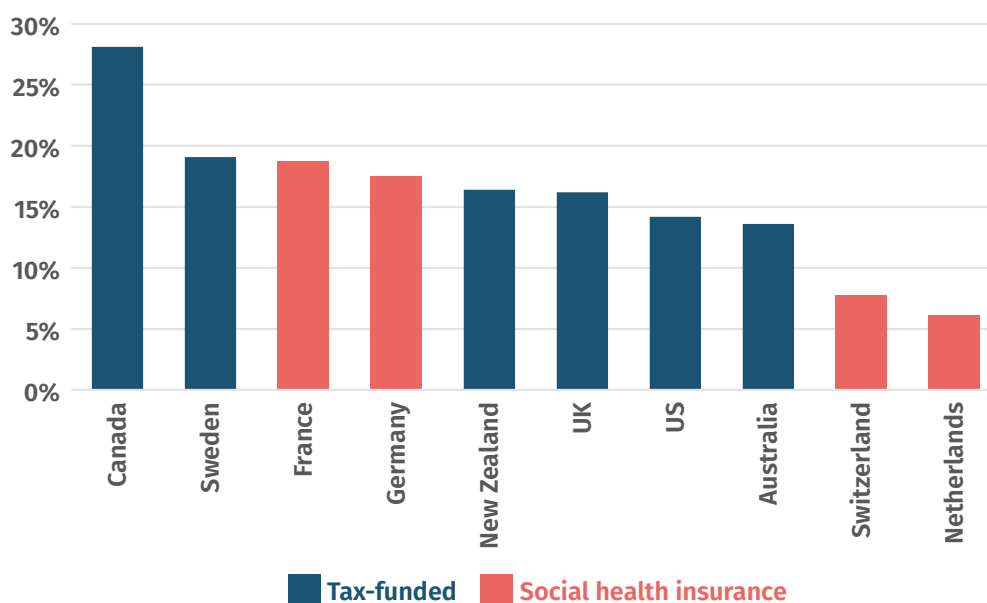
The Commonwealth Fund’s International Health Policy Survey provides data for 10 countries on access to general practice, surgery and specialist appointments. On average, in the tax-funded systems, patients waited slightly longer for GP appointments (19.3 per cent of patients waited more than a week for an appointment compared to 12.5 per cent in SHI systems).

However, the data is skewed by Canada’s exceptionally poor performance (28 per cent of Canadians report waiting more than a week). Removing Canada from the basket takes the average down to 16.3 per cent. The UK is a relatively high performer, performing better than France and Germany on GP access.

FIGURE 3.3

The UK performs relatively well on access to GP appointments

People waiting more than a week for a GP appointment (% of survey respondents), 2023 or nearest year



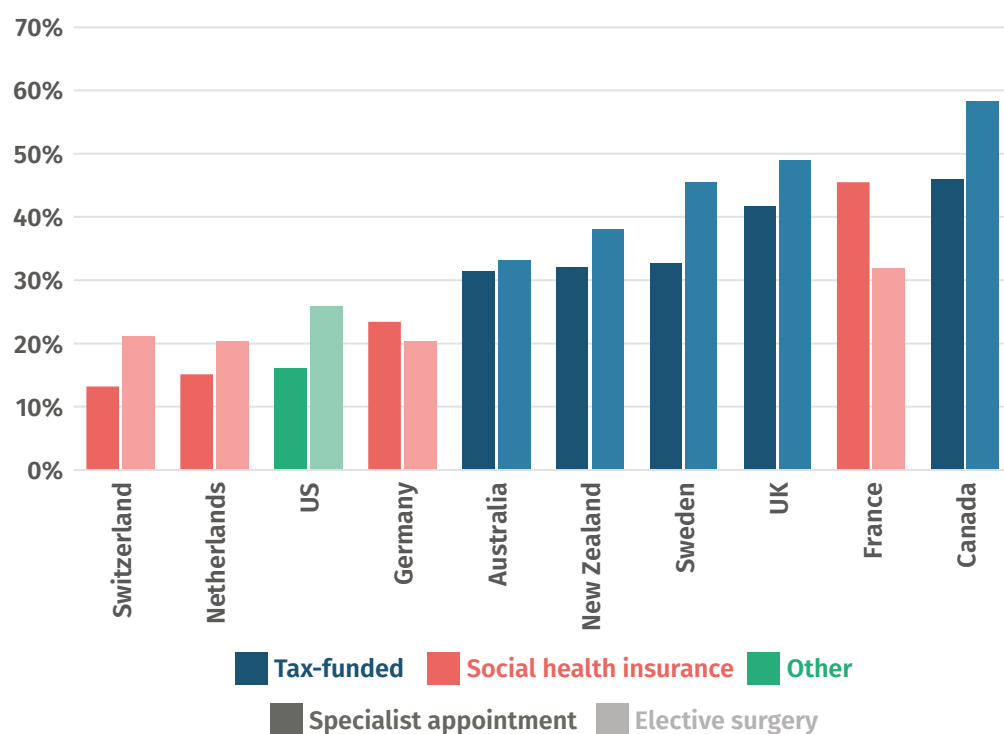
Source: Authors’ analysis of CIHI 2024

Waits for specialist care in SHI systems are generally lower than in tax-funded systems. On average, in this smaller basket, 24.3 per cent of those using SHI systems wait more than two months for a specialist appointment and 23.4 per cent wait more than two months for elective surgery, compared to 36.7 per cent and 44.8 per cent in tax-funded systems respectively.

Figure 3.4 shows the percentage of people who waited more than two months for specialist appointments and elective surgery across the 10 countries analysed by the Commonwealth Fund.

FIGURE 3.4

Waits for specialist care are generally lower in SHI systems than tax-funded systems
People waiting two months or more for elective surgery or specialist appointments (% of survey respondents), 2023 or nearest year



Source: Authors' analysis of CIHI 2024

These statistics should be treated with caution. Sample sizes in the Commonwealth Fund Survey are small (no country submits more than 5,000 responses); faster specialist access may reflect fee-for-service incentives that drive volume rather than outcomes; and other institutional features – such as strong primary care gatekeeping – may affect access more directly than the underlying funding model (OECD 2025b).

3.5 EQUITY

On equity, the evidence more consistently favours tax-funded systems. In particular, evidence shows that SHI systems tend to have greater financial barriers to accessing care than tax-funded systems.

3.5.1 Out-of-pocket expenditure

The OECD collects comprehensive data on out-of-pocket (OOP) expenditure on health as a proportion of total household expenditure. On this measure, households in tax-funded systems (3.2 per cent) spend less of their total income on healthcare than in SHI systems (3.5 per cent). The UK (2.6 per cent) performs better than the basket average (3.3 per cent).

3.5.2 Voluntary health insurance uptake

Alongside OOP spend, many health systems rely on users taking out voluntary health insurance to cover co-payments for care or areas not covered by statutory schemes. Uptake of voluntary insurance is generally higher in social health insurance systems (61.4 per cent) than in tax-funded systems (33.7 per cent). The UK (12 per cent) has a

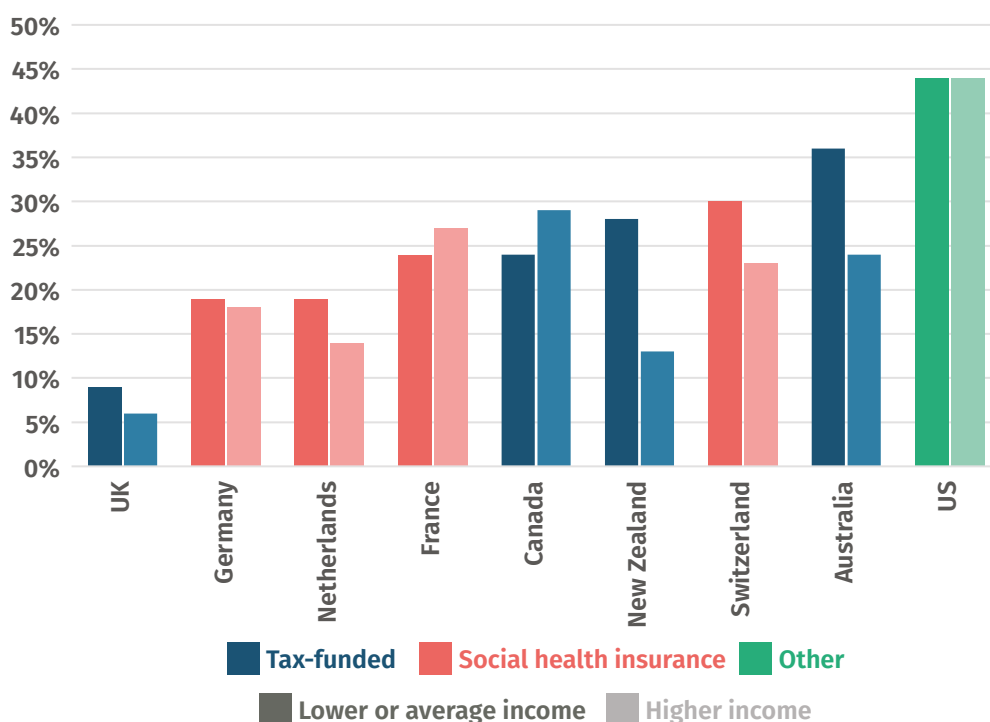
much lower average uptake of voluntary insurance than the basket average (44 per cent).

3.5.3 Billing and payment

A further dimension of equity is the extent to which patients encounter billing and payment issues when accessing care. The Commonwealth Fund collects survey data on patients' experiences of billing and payment processes. Figure 3.5 presents the percentage of respondents who said they had experienced any of the following in the past 12 months: problems paying or unable to pay medical bills, spending a lot of time on paperwork or disputes related to medical bills, or insurance denying payment for medical care or not paying as much as expected.

Survey respondents were provided with their country's average household income and asked to assess their own relative to it. This enables analysis of how billing and payment issues vary across incomes groups. In Figure 3.5, the first column represents respondents with average or below-average incomes, while the second column represents those with above-average incomes.

FIGURE 3.5
The UK has substantially fewer issues relating to billing and payment
Percentage reporting issues with medical billing and payment



Source: Author's analysis of The Commonwealth Fund 2023

Across these measures, tax-funded and social insurance systems perform broadly similarly. However, the UK stands out as an outlier. Its relatively simple payment structure and low level of user charging is associated with substantially fewer report issues related to billing and payment compared with other systems of both types.

3.6 CARE QUALITY

Three sets of indicators provide reasonable proxies for overall care quality in health systems: treatable mortality, acute care outcomes, and avoidable hospital admissions.

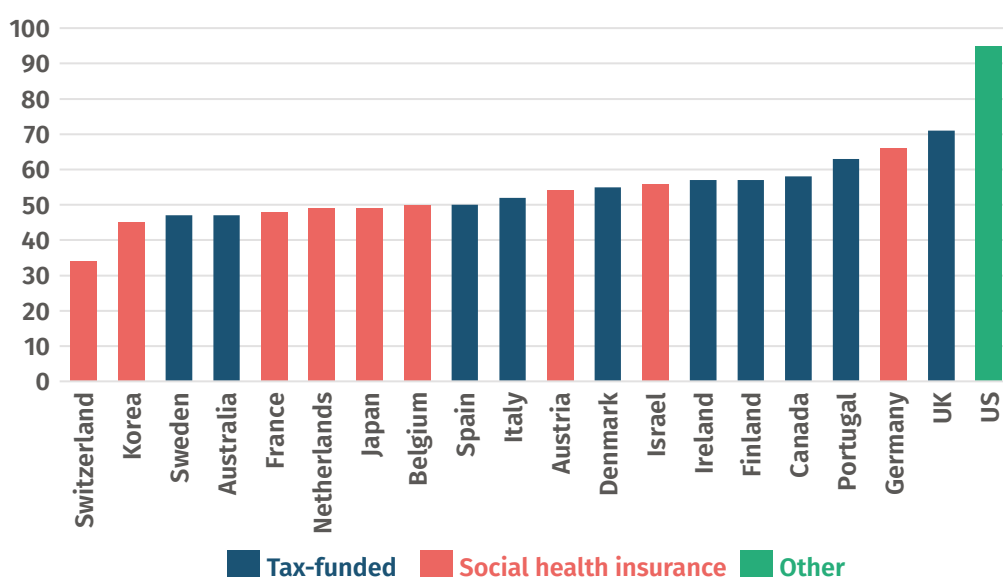
3.6.1 Treatable mortality

The number of deaths that could have been avoided, given timely and effective healthcare is one of the most widely used summary indicators of care quality. On average, systems perform relatively similarly on this metric – social health insurance systems record 50.6 deaths per 100,000 compared to 55.8 in tax-funded systems. The UK is the second-worst performer in our basket on this measure with 71 deaths per 100,000, ahead only of the US (95).

FIGURE 3.6

Only the US performs worse than the UK on treatable mortality

Treatable mortality per 100,000 people (age-sex standardised), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

3.6.2 Acute care outcomes

Thirty-day mortality following a heart attack (acute myocardial infarction, AMI) provides a targeted measure of the effectiveness of acute care. The OECD collects age-sex standardised data on mortality after an AMI per 100 admissions for people aged 45 and over.

On this metric, tax-funded systems (5.02 deaths per 100 admissions) perform slightly better than social-insurance systems (5.94 deaths), and seven of the top performers are tax-funded systems. Again, the UK's performance on this metric (6.4) is worse than the basket average (5.4).

3.6.3 Avoidable hospital admissions

Hospital admissions for conditions which can and should largely be managed in primary care, are good indicators of the effectiveness of community-based care and of health system coordination. Table 3.4 shows that generally, tax-funded systems perform better on these measures.

TABLE 3.4**Avoidable hospital admissions**

System	Asthma and COPD admissions, per 100,000	Congestive heart failure admissions, per 100,000	Adult diabetes admissions, per 100,000
Tax-funded	187.2	158.4	76.9
SHI	188.0	189.9	115.7
UK	254.1	111	82

Key	Performs well	Average performance	Performs poorly
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Source: Authors' analysis of OECD 2025a

3.7 EFFICIENCY

Efficiency measures how effectively systems translate resources into outcomes. If SHI systems do not 'get' more for what they invest, the case for structural change is considerably weakened. On core measures of efficiency, tax-funded systems perform better than SHI systems.

3.7.1 Spending relative to outcomes

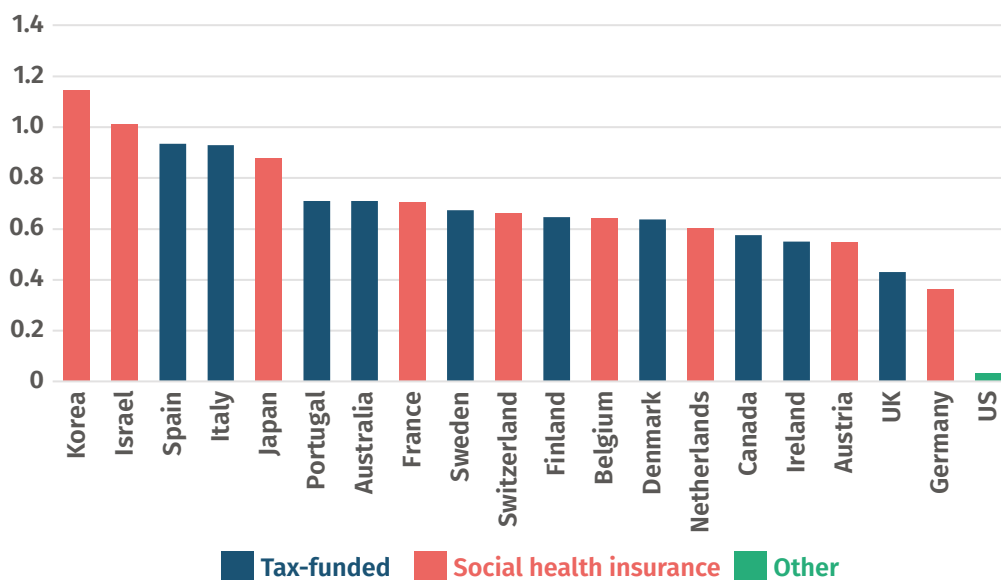
There are a range of indicators that can be used to demonstrate the efficiency of healthcare delivery (see below), but considering spending relative to outcomes is a useful way to determine overall efficiency (OECD 2025b).

To more specifically examine healthcare efficiency, we construct a metric relating health spend per capita to treatable mortality to consider how much additional spend 'buys' in terms of reduction in deaths. SHI and tax-funded systems perform roughly equally, with high levels of efficiency in the Korean and Israeli systems driving slightly superior performance among SHI systems, and the UK performing relatively poorly (figure 3.7).

FIGURE 3.7

The UK performs poorly when comparing health spending and treatable mortality

Ratio between treatable mortality and health spend per capita (PPP), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

3.7.2 Length of stay

A number of healthcare process indicators provide a picture of how efficiently care is delivered. The average length of a hospital stay is a common indicator of hospital efficiency – systems with a shorter length of stay tend to manage resources more efficiently. On this indicator, tax-funded systems (6.4 days) tend to perform slightly better than SHI systems (7.2 days). The UK (7.5 days) performs slightly worse than the basket average (6.7 days).

3.7.3 Administrative costs

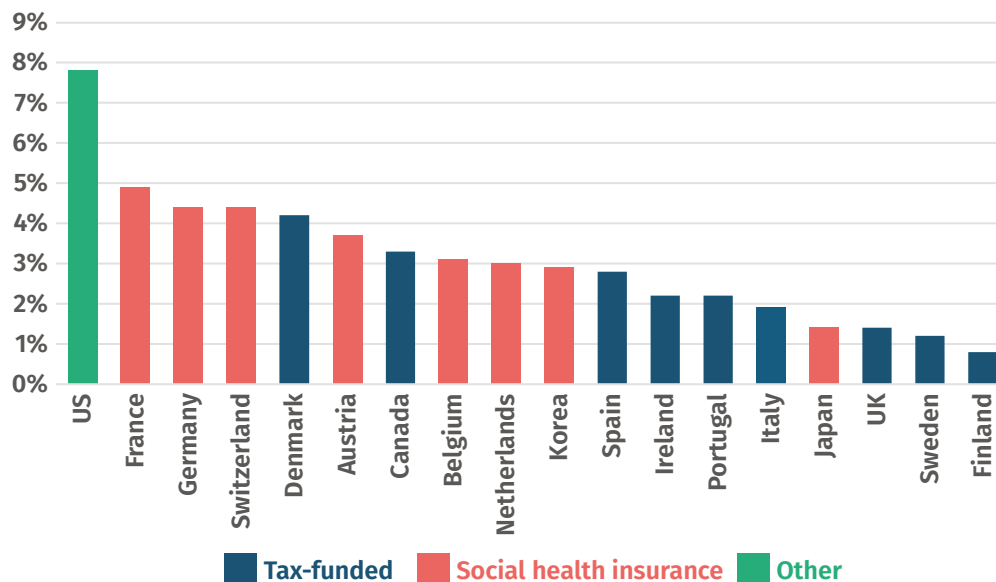
One domain where tax-funded systems have a clear advantage is in administrative overheads. As a rule, the larger the number of payers in a system, the higher the spend on admin related to contracting, processing claims and regulating insurers. On average, 3.5 per cent of all health spending in SHI systems goes on administration and governance, compared to 2.2 per cent in tax-funded systems.

The UK is a very low spender on this metric (1.4 per cent), reflecting the relative simplicity of its payer model. Were the UK to match the average SHI system spend on governance and administration, we would spend an extra £7 billion on these functions annually (Authors' calculation based on OECD 2025a).

FIGURE 3.8

Tax-funded systems generally spend less on administration and governance

Administration and governance spend (% of total health spend), 2023 or nearest year



Source: Authors' analysis of OECD 2025a

3.8 WHAT THE EVIDENCE SHOWS

Taken together, the comparative data do not support the claim that SHI systems systematically outperform tax-funded systems (or vice versa). A few conclusions stand out:

- SHI systems tend to be slightly better resourced and provide faster access to care. However, several tax-funded systems – particularly those in Scandinavia – also demonstrate high capacity and comparable access.
- Quality is broadly similar across system types, though tax-funded systems tend to perform better on avoidable admission indicators.
- Variation within each model type is large: the best-performing tax-funded systems (particularly those in Scandinavia) outperform SHI systems on most core dimensions of performance.

A limitation of our analysis is that it does not consider the likely costs of transition to an alternative model. Very few health systems ever switch their funding models, but box 3.1 provides a summary of the evidence on system transition.

BOX 3.1: WHAT DOES EVIDENCE ON SYSTEMS TRANSITIONS SHOW?

Fundamental transitions between financing models are rare outside periods of extraordinary political upheaval – for instance, Spain’s post-Franco shift from SHI to a tax-funded model. In stable systems, the path dependencies created by existing institutional arrangements make wholesale reform exceptionally difficult.

Implementing a new financing model would require building insurer infrastructure, defining a statutory benefits package, constructing risk-adjustment systems, redesigning provider contracts with thousands of different entities, establishing new regulatory bodies and securing public consent for co-payments and supplementary insurance. Each of these constitutes a major reform programme in its own right. Taken together, they amount to decades of institutional work.

Even where reforms fall short of a full transition in financing model, large-scale restructuring is itself costly and disruptive. Experience in the NHS shows that repeated reorganisations generate substantial transitional costs, management distraction and loss of institutional memory. Staff must adapt to new governance arrangements and reporting lines, while organisations renegotiate contracts and rebuild relationships. Evidence suggests that such processes have high short-term costs, can reduce system performance for many years and delay improvement, particularly when undertaken at scale. The 2012 NHS reforms alone were estimated by the Department of Health and Social Care to have cost £1.5 billion, almost certainly an underestimate once wider system disruption and opportunity costs are considered (Walshe 2014). As Lord Darzi observed, these reforms, which did not alter the NHS’s underlying funding model, amounted to “a calamity without international precedent”, the effects of which are still being felt.

The most instructive recent example of a major funding shift *within* a system is the Netherlands. The Dutch transition from a hybrid insurance system to regulated competition between private not-for-profit insurers began in 1987 and was not fully completed until the early 2010s. The process took three decades, despite building on pre-existing insurance infrastructure that does not exist in the UK.

Though the Netherlands has a high-performing healthcare system, the verdict on the reforms themselves is mixed. According to two Dutch health financing experts, “the high expectations of market reform have, at least to a great extent, not come true” (Maarse and Jeurissen 2024). Dutch health policy is moving back towards greater state coordination and cooperation, not competition between providers.

Overall, the evidence suggests that transition costs are high, timescales long and outcomes uncertain. As the OECD concludes: “‘big bang’ reforms, that require considerable political capital and financial resources, are to be designed and implemented with caution” (OECD 2025b).

4.

WHERE TO NEXT?

This analysis confirms the finding of other studies: no group of health systems systematically outperforms another (OECD 2025b).

The findings are nonetheless sobering from an NHS perspective. The NHS's traditional strengths – low financial barriers to access and low administrative overheads – remain intact. But it performs poorly across too many indicators of care quality, access and overall, including when compared with other tax-funded systems.

These patterns point to particular features of the NHS as key drivers of poor performance: long-term undercapitalisation, a short-termist approach to efficiency in which the system has been run at unsustainable pressure, and underinvestment in administrative capacity that enables effective delivery. Changing the funding model is highly unlikely to resolve these challenges and would be a distraction from the solutions that might.

4.1 GETTING WHAT WE PAY FOR

While funding models themselves do not determine performance, the evidence points to a more straightforward relationship: countries broadly get what they pay for. Higher-spending systems tend to have more capacity and, in turn, better access to care.

The NHS sits below the average on most capacity metrics, not just relative to SHI systems, but to comparable tax-funded systems. Closing that gap, with discipline about where resources go, is a necessary condition for meaningful improvement.

The position the current government inherited in 2024 – defined by years of constrained public investment, a substantial debt burden and acute pressures across all public services – was extraordinarily difficult. Significantly more public expenditure on healthcare, while desirable, would come at the cost of investment in other public services, which are foundational determinants of health. The case for additional NHS investment must be made honestly, within the constraints of what is fiscally achievable.

4.2 WHERE WILL TARGETED INVESTMENT MAKE THE MOST DIFFERENCE?

Given these constraints, the evidence points to four areas where additional spend and policy attention will make the biggest difference.

4.2.1 Capital investment

Low capital investment is the NHS's most persistent weakness. Capital formation in the NHS (0.4 per cent) stands at just over half the basket average (0.7 per cent) of countries we analysed.

The average annual capital expenditure limit across this parliament (£14.1 billion) falls short of the NHS's estimated maintenance backlog (HM Treasury 2025, NHS England 2025b). Sustained capital investment will be required to put the NHS back on its feet before progress can be made on long-term transformation. While attempts to bring additional capital into the service through public-private co-

investment models are welcome (Barron 2025), given the scale of the NHS’s capital deficit, the government should consider revisiting the capital settlement agreed in the 2025 spending review.

4.2.2 Primary and community services

International evidence consistently shows that systems with stronger primary care services achieve better outcomes at lower cost (Fisher and Alderwick 2024).

The government’s neighbourhood-first approach is well-aligned with this evidence. Its implementation must be a strategic priority in this parliament. Strengthening primary and community care must begin with improving the delivery offer: better access, more personalised support, and more effective management of long-term conditions before they escalate. Structural reform may aid these efforts, but recent NHS history suggests that reorganising institutional boundaries and contracting models often absorbs management capacity without directly improving care. Structural change should be tightly sequenced and explicitly justified in terms of clear delivery improvements.

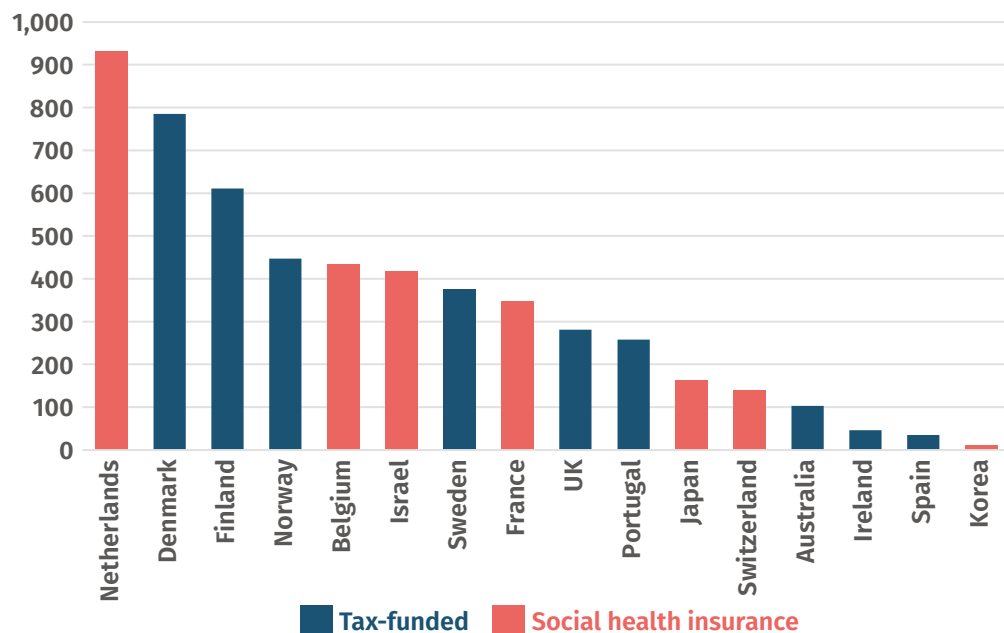
4.2.3 Long-term and social care

Higher-performing systems invest substantially more in long-term and social care than the UK. The Netherlands spends around three times the amount that the UK does per capita on social care, and Denmark and Finland spend more than double. Figure 4.1 shows estimates of social care spending across our basket of countries.

FIGURE 4.1

Higher-performing systems invest significantly more in social care

Spend on social care (USD per capita PPP), 2023 or nearest year



Source: Authors’ analysis of OECD 2025a

The consequences of underinvestment are felt throughout the health system: preventable admissions, increased acute demand, delayed discharges and poor post-discharge outcomes. The establishment of the Casey Review into social care represents a positive step in setting out a bold long-term vision for social care

reform (DHSC 2025), but addressing acute capacity shortages in social care is a health system efficiency imperative in the short term.

4.2.4 Public health and prevention

The UK's relatively poor population health marked by lower life expectancy and healthy life expectancy, and a higher preventable disease burden, means that the NHS is managing a population in worse health than most of its peers (Thomas et al 2024).

This government has made a promising start on public health: legislating for a generational ban on tobacco and setting out a 'moonshot' to end obesity. But ambition has not consistently been matched by action. On alcohol harm, one of the largest contributors to avoidable illness and NHS demand, policy has been timid. And on obesity, the government must deliver on its commitments to limit junk food advertising to children in full (Bone et al 2026).

The funding picture tells a similar story. It is welcome that the local authority public health grant (PHG) has increased over the last two years and a multi-year allocation has been set for the remainder of the parliament. However, the PHG will still be lower in real terms by 2028/29 than in 2016/17. This is hard to square with the evidence: generating an additional quality-adjusted life year through public health budgets costs around £3,800 compared to approximately £13,500 through NHS spend (Martin et al 2020)). If the government is serious about boosting healthy life expectancy, the PHG must grow at least as quickly as NHS spending.

4.3 WHAT ARE WE WILLING TO PAY FOR?

Even if these priorities are pursued consistently, hard fiscal questions remain. Health spending has outstripped economic growth across high-income countries for decades. The core driver of increased spend has not been demographic change (ageing or an increase in chronic conditions), but "the relentless increase in the volume and intensity of clinical practice" (Eddy 1993). The scope of what medicine can do has expanded rapidly, and the costs of providing healthcare have grown with it (Licchetta and Stelmach 2016).

This dynamic is accelerating. The coming decades will bring transformative advances in gene therapy, AI-assisted diagnostics and novel pharmaceutical treatments. These may offer profound benefits for patients, but they will place demands on health systems, particularly in terms of their financing arrangements, that no model can easily accommodate.

This is ultimately a question about collective priorities: what we fund through compulsory contributions, what we ration and how we protect equitable access to innovation. These are not questions that can be resolved by changing the funding model or securing incremental efficiency improvements alone. They require open deliberation about system priorities, opportunity costs and the limits of publicly financed healthcare – a conversation that has been deferred for too long.

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