

Hypothecated funding for health and social care

How might it work?

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Introduction

Hypothecation – the earmarking of a tax to be spent on a specific area of public expenditure – is back on the political agenda. All the major parties seem agreed that a longer-term and sustainable settlement for NHS expenditure – and quite possibly one for social care as well – is now desirable. Hypothecation is being debated, across the political parties and by other think tanks ([Johnson 2018](#); [Tetlow 2018](#); [Keable-Elliott 2014](#)), as one of the routes by which the money for that could be found.

There are strong advocates and equally strong opponents of hypothecation.

This short paper examines both sides of the argument. It seeks to set out the problems hypothecation is meant to solve, and the conditions under which it might do so and provides a highly selective and brief history of hypothecation in the UK.

Options for hypothecation

Why hypothecate taxes for the NHS and social care?

At The King's Fund, we believe there are two key reasons that hypothecation has re-entered the political debate. The first is the increasingly obvious financial challenge facing the NHS. After nearly a decade of austerity and with the current state of public finances, increasing spending on the NHS by cutting funding to other government departments does not look feasible and neither does a surge of debt-financed growth. This means if the government is to spend significantly more on the NHS it will almost certainly need to increase taxes. One objective of hypothecation is to help persuade the public to accept such an increase by specifically linking higher taxes to increased spending on the NHS. Recent evidence suggests there is a strong degree of public support for such a move as long as people know that the proceeds will be spent on the health service ([Evans 2018](#)).

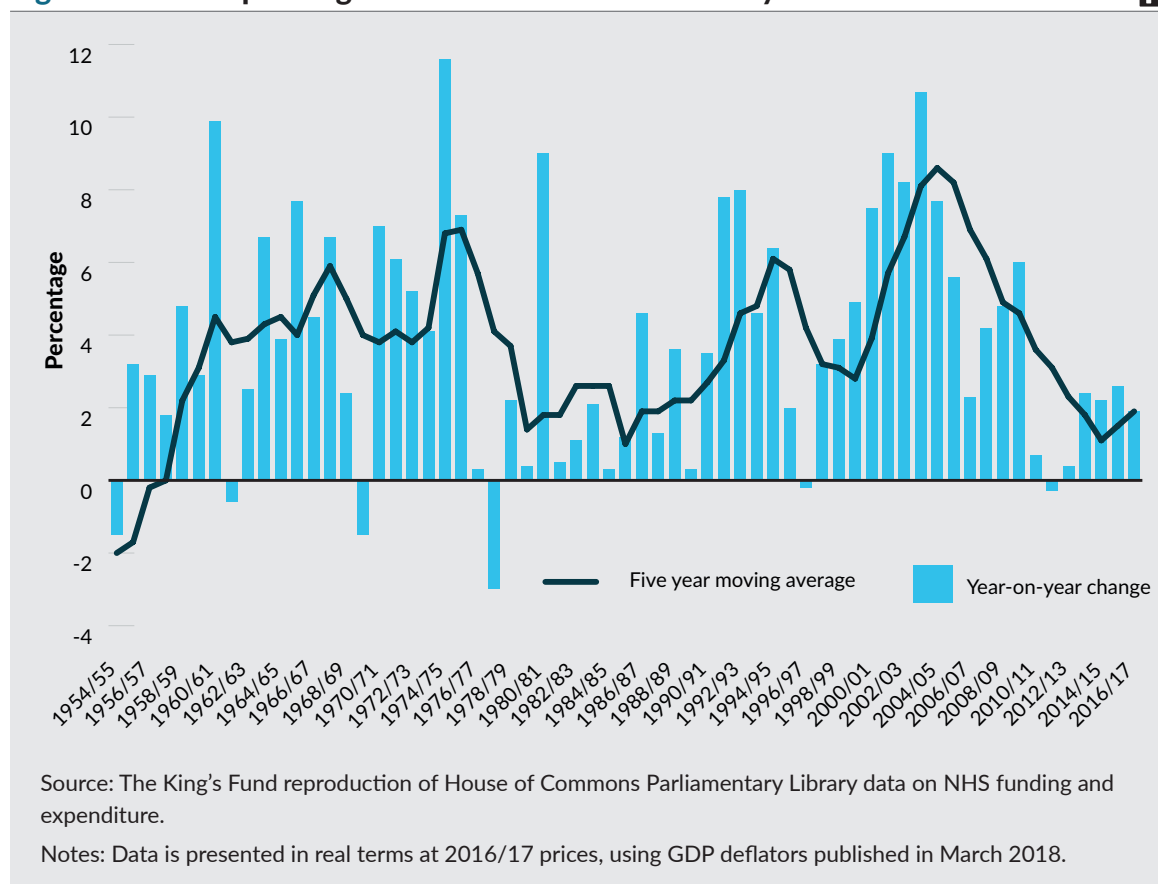
The second reason for hypothecation is more fundamental. The long-term rate of growth of health spending is around 4 per cent a year and the Office for Budget Responsibility (OBR) thinks it will need to revert to this growth in the long term ([Office for Budget Responsibility 2017](#)) to meet rising demand and costs. Yet as [Figure 1](#) shows, year-on-year growth in health spending (and even five-year rolling averages) shows prolonged swings in growth higher and lower than this average. Extended periods of drought are followed by years of (relative) plenty. This short-term approach to funding is no way to run a health service with its long lead times for staff training and long-lived assets like hospitals. Neither is it good news for those unlucky enough to fall ill in the periods of drought.

It is difficult to set out the long-term spending pattern for social care; we believe it would show a similar pattern, but with the added twist of actual real-terms cuts since 2010.

This leads to the second potential objective for hypothecation: if it receives guaranteed funding through a hypothecated tax (or taxes), the NHS and social care may be able to overcome the damaging cycle of boom and bust that has so marked the past and present.

As this paper will show, this second objective is much harder to achieve and simple hypothecation on its own cannot deliver it.

Figure 1 Health spending in the UK has a volatile history



Some definitions

We need to make a broad distinction between two types of hypothecation:

- partial hypothecation, where the tax pays for only part of overall spending with the rest coming from general taxation, ie, it is just a top-up to other funding; for example, partial hypothecation could include adding 1p to Income Tax specifically for the NHS, with the rest of NHS funding still coming from general unearmarked taxes
- full hypothecation, where the tax pays for all spending.

Full hypothecation, as this paper will show, is rare in the UK, though other countries that pay for health, and sometimes social care, through social insurance systems (rather than tax) do come closer to full hypothecation.

The arguments against

HM Treasury orthodoxy has long opposed full hypothecation for several reasons.

The more tax that is earmarked for a specific area of public spending, the less flexibility there is in deciding on other public spending priorities. The larger the part of public expenditure to which hypothecation applies, the harder it is to deal with the inevitable cyclical downturns in the economy, and indeed with structural ones of the sort that followed the 2008 financial crash – where output is lost permanently, rather than temporarily. And it is worth noting that health is a large part – more than 15 per cent – of government expenditure and around 35 per cent of spending on departmental programmes such as schools, agriculture and criminal justice (as opposed to financial transfers such as pensions, tax credits and benefits, and the payment of debt interest) ([HM Treasury 2018](#)).

When elements of tax and public expenditure are earmarked and protected, the result can be sub-optimal decisions on spending on other areas. That can happen, of course, even when spending areas are merely protected rather than formally hypothecated. For example, over both the previous parliament and this one, the relative protection given to spending on the NHS, to overseas aid, to pensions through the ‘triple lock’ and to school spending for 5–16 year-olds, has arguably resulted in bad settlements for other areas – for example, the criminal justice system and local government.

If spending is truly hypothecated – tied to the money raised by a particular tax – it becomes closely tied to the revenues that tax can raise. On the face of it, for full hypothecation, this is a rather devastating problem (it does not matter for partial hypothecation because there is nothing to stop governments topping up – or cutting – spending financed through other taxes). Tax revenues for a given year only become clear at the end of that financial year, long after the salaries of NHS staff and the medicines bill have been paid. Even if it became clear late in the financial year that tax revenues would fall short, there would be no way services like health and social care could make sudden, substantial savings. Neither, should tax revenues overshoot, could they rapidly increase spending (at least, not sensibly).

Even if it were possible, it would make little sense. In the case of the NHS, if a tax raises unexpectedly high revenues (perhaps because the economy does better than expected), there is no reason why the demand for health care would rise and hence no reason why health spending should either. If the tax raises less than expected, it is quite likely the government would find it politically impossible not to top up

spending to the level that had been anticipated or was judged necessary; in which case the hypothecation is broken.

Partial hypothecation usually takes the form of promising 'more' spending on a service than was otherwise planned. This leaves it up to the government to decide exactly what level of spending it was planning in the first place. This may have some meaning if a government has set out a spending plan over a number of years to which it can now add, but even the longest Spending Reviews look forward only a few years and, in any case, are themselves subject to review. For many economists this means partial hypothecation is essentially a lie – it does not determine spending on an area.

To sum up, the core argument against full hypothecation is that spending in any given area should be a matter of judgement for the government of the day, not subject to the inevitable booms and bust of the revenue from a given tax. As the Treasury Select Committee (2008) put it in a report that examined hypothecated environmental taxes, 'Setting taxes is one decision facing a government; spending this revenue is another, separate decision.' While partial hypothecation may step around this problem, it does not ultimately determine spending and could be seen as misleading.

The arguments for a hypothecated NHS tax

For the reasons set out above, most economists have tended to oppose hypothecated taxes. However, there are a number of arguments for hypothecation, some of which simply refute the arguments against.

Hypothecation may create more funding stability. A key argument against full hypothecation is the uncertainty around funding levels it creates. Yet, as Figure 1 shows, the current approach to NHS funding has also created uncertainty and prohibits long-term planning. Successive governments have repeated a cycle of holding down health spending until the service hits a crisis and then, in response, increasing funding. This 'boom-and-bust' approach to funding may have the effect of making hypothecation attractive to the public.

Critics also argue that full hypothecation may also prevent governments from adjusting health and social care spending in response to the economic cycle and public finances. Yet demand for health and care does not move in tandem with the upturns and downturns in public finances. Holding down health spending in the face of long-term increases in demand effectively means providing a poorer service to those that need it now or putting off needed investment (such as staff training),

which only leads to workforce shortages down the line. Recent work by The King's Fund shows this is why many members of the public are attracted to hypothecation, at least in health and social care (Evans 2018). Many of the public do not believe in a benign government wisely setting tax and spending revenues for the benefit of all. Rather, they want greater confidence that the taxes they pay will go to guaranteeing the service that they want.

Hypothecation may improve transparency. Julian Le Grand, a longstanding advocate of hypothecation, argues that a properly administered hypothecated tax can make citizens aware of the cost of public services, both in general and to them personally, and that hypothecation restricts the power of government relative to its citizens (Le Grand 2003). Another advocate, Richard Layard, argues that with a specific funding stream 'there could be a real public debate about how much people were willing to pay' (Layard and Appleby 2017).

It is also argued that the public has become increasingly resistant to tax rises – or, at the very least, politicians perceive that it has. Yet recent polling suggests that the public does want to see more spent on the NHS. The British Social Attitudes Survey 2017 showed that 61 per cent of respondents supported tax rises to increase funding for the NHS, up 21 percentage points from 2014 (Evans 2018). Of those, 35 per cent supported a separate tax, with 26 per cent happy to pay more through the existing tax system. The support for higher taxes for the NHS stretches across all age and income groups, including 61 per cent of the highest earners. It also stretches across party lines – 56 per cent of Conservative supporters were in favour. But if there appears to be a public appetite for increased NHS spending and for increased taxes to pay for that, politicians are clearly cautious about headline tax rises. For more than two decades now, both Conservatives and Labour have gone into successive general elections promising not to raise Income Tax, National Insurance or VAT, or some combination of elements of the three, when those are the three taxes that raise the most money.

The extent of 'tax resistance' – or politicians' perception of tax resistance – has led some economists and politicians who have long been hostile to hypothecated taxes to concede that they might have to be part of the answer. Among this group there has been a somewhat surprising convert, or partial convert. Nick Macpherson was, until 2016, Permanent Secretary to the Treasury and thus guardian of its flame. But he recently told a Commons committee that: 'The introduction of hypothecation could strengthen public understanding of the trade-offs between taxing and spending at least in relation to health spending. It might make more palatable the likely tax increases which will be necessary to deal with the demographic pressures which are likely to become increasingly visible during the course of the 2020s. At

a time when trust in government has declined, and many citizens feel a disconnect between the taxes they pay and the services they receive, it could help revive citizen engagement' ([Select Committee on the Long-term Sustainability of the NHS 2017](#)). It could also provide the funding certainty that would enable the money to be spent better, he said.

So if partial hypothecation is seen as a potential answer, what form could it take?

Partial hypothecation is easy and nothing new to UK politics. The problem is that it can only provide a short-term answer to funding problems. A few examples can illustrate both how common partial hypothecation is and how limited its impact is in the long term.

In 1996 the Conservatives introduced a landfill tax, promising that it would be 'revenue neutral', with employers' National Insurance contributions cut in return ([House of Commons Library 2009](#)). That happened in the first year. But in 1999, after a change of government, the landfill tax rate went up, but so did employer NI contributions. In 1997, Labour imposed a 'windfall tax' on utilities, essentially to fund its new welfare-to-work programmes ([HM Treasury 1998](#)). Most of the £5.2 billion raised was used for that. But some £1.3 billion of it was spent on backlog maintenance in schools.

The biggest single example in the health field was Gordon Brown's 2002 increase in National Insurance contributions to fund a very generous five-year settlement for the NHS ([House of Commons Library 2002](#)). The two were directly linked. But, after the first year, the nature of government accounts means that it is impossible to track how far the National Insurance increase raised NHS spending – because there is no counter-factual to tell you what the funding from general taxation would otherwise have been.

The inability to demonstrate after the first year that partial hypothecation has in fact increased expenditure in the areas for which it was intended means that it is, in the words of Paul Johnson, Director of the Institute for Fiscal Studies, 'inevitably dishonest and a fraud' ([Giles 2018](#)).

However, if partial hypothecation is not the answer to long-term funding for the NHS and social care, it can be a relatively easy answer to short-term funding problems. For example, the government has set out its spending plans for the next few years. It could now raise taxes and re-set those spending levels higher on the back of additional tax receipts. It may mean little for funding in 2025 but could mean a lot for funding in 2020.

If full hypothecation is a possible answer, what form could it take and what conditions would need to be fulfilled?

Full hypothecation genuinely seeks to tie a given area of expenditure to a particular tax or taxes in the long term. This is more difficult territory.

First, there needs to be decision about which parts of health and/or social care are going to be hypothecated. And then which tax, or taxes, will be earmarked to pay for that. And finally, there are important conditions that hard hypothecation must meet if it is to solve the long-term funding problems of health and care.

Which areas of spending should be covered?

The answer to this first question makes a significant difference to the sum that needs to be raised.

Health expenditure in England in 2017/18 was around £125 billion ([The King's Fund 2017](#)). But only around £110 billion of that was spent on NHS services ([NHS England 2017](#)). The rest was spent on public health, education, training, research and development and elements of infrastructure.

So, is it only NHS services that people want to protect by hypothecation? Or would they also choose to protect the many other areas of health expenditure that support these? In recent years other areas of health spending, notably public health, have been cut to help fund core NHS services, despite public health clearly being a long-term investment that affects the demands placed on the NHS. Other areas of spending are linked closely to other parts of the public sector, including prison health and school health services.

A clear boundary for hypothecation is needed as it will determine how much money the ring-fenced tax needs to raise and will prevent governments shifting services back and forth over the line in order to manage wider public spending.

More importantly, should social care expenditure be included? Social care, quite aside from what it does for the quality of life for its recipients, clearly has an impact on the NHS. The lack of it can see patients admitted to hospital unnecessarily and its absence can seriously delay discharges, leaving patients 'stranded' in expensive hospital beds. For many years, the goal of successive governments has been to better integrate health and social care yet hypothecating one without the other clearly risks driving them further apart. As both services face the same pressures of

rising spending as the population ages there is a good case for including both within any ring-fence, and this is the approach we take here.

Local authorities spent £16.8 billion on adult social care in 2015/16 ([National Audit Office 2017](#)). This figure, combined with money spent on public health, education, training, research and development and elements of infrastructure means the difference between just protecting core NHS services and protecting all health and adult social care is a difference of about £30 billion a year in current prices – the difference between £110 billion and £140 billion.

And that is just for England. The devolved administrations have their own budgets for these areas, in part funded through the Barnett formula ([House of Commons Library 2018](#)). But precisely how much of the Barnett distribution is spent on health is a matter for them, and there are significant policy differences not just in health but in social care. Deciding what was in the ring-fence would clearly be a matter for discussion with the devolved governments, as would be the share of the earmarked tax that they took. These would not be trivial negotiations.

Which tax or taxes could be used?

One option would be to construct an entirely new 'health and social care tax' and then to make adjustments to existing taxes, but it would seem far simpler to take an existing tax and adjust it.

The UK's 'big three' taxes are: Income Tax, which generates around £188 billion a year; VAT, generating around £130 billion; and National Insurance (NI), generating around £136 billion ([Office for Budget Responsibility 2018](#)). Note these are UK figures, not English ones.

Increases in each of these taxes would raise significant sums. For example, according to HMRC's tax take ready reckoner, a 1 percentage point increase in Class 1 NI contributions for employees (the PAYE contribution that most employees pay) would raise £4 billion in 2018/19 ([HM Revenue and Customs 2018](#)). A similar increase in employers' contributions would raise more than £5 billion. Combining the two gives just under £10 billion. An additional 1p on the basic rate of Income Tax would also raise £4 billion ([HM Revenue and Customs 2018](#)). All three taxes are of course subject to the upturns and downturns of the economic cycle.

While in theory the revenues from any one of these taxes could be earmarked for the NHS and social care, there are good reasons for looking to NI – partly because

many members of the public, particularly the older generations, believe it is already a ring-fenced contribution. It is, of course, no such thing.

There are two technical challenges with using revenues from NI as the basis for a new health and care tax. First, NI itself would need reform, not least as it was not designed for this purpose. This means many elements of the current system need review; for example, there is an earnings threshold above which individuals, though not employers, pay a reduced rate of NI. Currently, those earning about £45,000 a year pay only a 2 per cent employee contribution on earnings above that, against the standard rate of 12 per cent. This would mean, among other things, that as health and care spending rose over time, more of the burden would fall on lower income earners. In addition, those past State Pension age are also exempt from the employee contribution.

Higher rates of NI make it more expensive for employers to create jobs, and in a globalised economy it makes more sense to make it cheap to create jobs but then to tax the income and wealth they produce. This has led countries who use social insurance as the primary source of health funding to 'top up' payments from other tax sources.

Finally, while the link between NI paid and benefits received has been weakened over the years, payment of NI still entitles individuals with a sufficient contribution record to some non-means-tested benefits, eg, the State Pension, the first six months of Jobseeker's Allowance and Employment and Support Allowance, and Maternity Allowance. A decision would be needed on whether those benefits remained linked to NI if it was re-labelled as a health tax.

The second problem with NI is that it does not raise enough to hypothecate both health and social care spending. It raises some £136 billion for the UK, yet English health and social care spending alone is slightly higher. To address this, some areas of current health and care spending could be excluded from the ring-fence, but if that is not appropriate then more money must be found from somewhere.

There are some fairly obvious ways to raise the amount raised from NI.

- Employee NI could be applied to the earnings of those past state pension age at the current rate, and at current rates of employment (around 10 per cent of those past state pension age still work ([Office for National Statistics 2018](#))) this would raise in the region of £1 billion.
- Raising rates on higher earners, so that those earning above about £45,000 a year pay more than they currently do. Each percentage point above the 2 per

cent that they currently pay would raise about £1 billion. This would potentially raise £10 billion if the full standard rate of 12 per cent was applied, although that assumes there would be no behaviour change in the face of such a large increase.

- There are more radical changes to NI that could potentially raise additional revenue, though they would of course be even more politically challenging.
- Currently, employers do not pay NI on their contributions to employees' private pensions. Requiring them to do so would raise around £10.8 billion a year. Doing this would be very controversial: opponents would argue that it might lead to employers reducing their contributions to pension schemes and to reduced job creation.
- NI could be charged on private pensions, a levy that would raise about £350 million a year for each percentage point (Evans 2013). To avoid double taxation, however, changes would need to be made to employees' NI contributions when their contributions to private pensions are made, making this a complicated option.

Nonetheless, an element of increased NI contribution by those past state pension age – on either earnings, pensions in payment, or savings income – would likely be required for a reformed NI if it became a hypothecated tax for health and social care. Such changes would be needed in the interests of inter-generational equity given that NI currently falls only on those in work while the heaviest demands on the health and social care system are made by older people and children.

In summary, while NI could form the basis of a ring-fenced tax for health and care, there are a complex set of anomalies in its current form that would need addressing and this would include considering options to ensure it raises more than it currently does. An alternative would be to use more than one tax to fund health and care. For example, there have been suggestions, particularly for social care, that wealth or property of inheritance taxes could be used. But aside from the political challenges such a change would face, two taxes risks undermining the simplicity and transparency that many advocates of hypothecation seek.

Once a tax is chosen, what others conditions would be necessary?

There are two further challenges full hypothecation must address:

- how to smooth funding over time as tax revenues fluctuate with the economy
- who gets to set the tax rate, or who sets health and care spending.

As we noted earlier, it is not possible to raise or cut health and care spending each time tax revenues change. This means there must be some ability for funding to be moved from 'good' years to pay for the 'bad' years, only balancing the books over the cycle of the economy. This could be done in a number of ways, none of which is straightforward.

- The merged health and social care system could hold a notional account with government as its banker, building up surpluses in good years or borrowing in bad.
- This could go as far as establishing a separate 'fund' with its own accounts that would take in tax revenues and pay them out to the NHS and social care. While this could overcome the challenges faced from uncertain tax revenues, it could not run permanent surpluses (which could begin to look like a backdoor route to prop up wider public finances) nor permanent deficits that rely on the willingness of government to top up funding.

Neither option is straightforward. In very bad years – say a flu pandemic – these alternative routes to raise spending become more important.

But at what level should it be set?

Currently, the government of the day decides on health spending and the process is essentially one of judgement. Social care spending is more complex. Central government provides local authorities with a grant for social care spending, but the money is not ring-fenced. Councils can decide how much is spent in practice: more than the grant, or less. Central government also currently allows local authorities to choose whether they impose a 3 per cent precept on Council Tax to fund social care (a form of partial hypothecation), without that triggering a referendum on Council Tax rises. Like health, spending on social care is essentially a judgement but this judgement is exercised at two levels: central and local government.

If the government simply hypothecated taxes for health and care this would not change. Governments of the day could decide the level of health and care spending and then set the hypothecated tax accordingly. The governments that decided on the boom and bust in spending we have seen since the inception of the NHS may simply decide on more of the same. There needs to be some independent, non-political input into setting the budget for health and care, and the tax rates needed to finance it.

Some organisations including The King's Fund have already called for an 'OBR for health' – an independent body providing advice to government on appropriate

levels of health spending just as OBR provides advice on the economy and public spending. This may seem challenging but:

- the long-term growth rate in health spending looks remarkably like the forecast rate of growth in spending needed in the future to maintain current service levels (around 4 per cent)
- the OBR already forecasts the long-term rate of growth necessary to fund the health service and so perhaps is the obvious body to give this responsibility to.

Broadly, the OBR (or its equivalent) could be tasked to forecast the level of spending required to maintain the NHS (or health spending) as it is. Governments could choose to add or subtract from this NHS offer, but only do so by directly instructing OBR to, for example, remove dentistry from the coverage by the NHS.

Social care presents greater difficulties because most commentators agree that the current system for social funding is wrong. We will not rehearse the case here, but either an attempt needs to be made to reform social care before hypothecation or a route needs to be found by which government can formally change the 'offer'.

There are other variants that mix elements of hypothecation and independence. We could look to the OBR (or similar) to advise governments on health spending and rely on the greater transparency to force the hand of HM Treasury to fund the settlement or set out an alternative plan. A more complicated variant would leave existing spending funded from general taxation and fund any increases from specific taxes (possibly as promised by parties during a general election). There is, however, a word of caution on these more complex models: it is clear from recent engagement work on social care that the complicated mix of what the public sector will pay for and how social care is funded has confused the public. Simply inventing another complicated tax and spending system may not overcome the public's lack of understanding or trust.

History

If a full hypothecation option was agreed, would it be enough to guarantee a future of fair sailing for health and care? Sadly no. We have already provided some examples of soft hypothecation. But full hypothecation – or at least attempts at it – have also been tried before. The most well-known example is probably the road fund – Vehicle Excise Duty – that was introduced in the early 20th century to build and repair roads ([Mirrlees et al 2011](#)). But as the number of vehicles rose, the duty raised more money than was needed for road maintenance and the surplus was spent elsewhere. The full hypothecation simply did not stick.

And there are much more recent examples. NI, after the Second World War, was meant to be a hypothecated tax that entitled individuals to a range of non-means tested benefits – the so-called ‘contributory’ as opposed to means-tested ones. These included unemployment benefits and the basic State Pension, although a portion of NI also makes a small, if very variable, contribution to NHS expenditure. Over time, however, the link between contributions paid and benefits received has weakened. Some benefits have disappeared – Sickness Benefit, for example, has been replaced by Statutory Sick Pay. Others, such as the Widows’ Pension and Invalidity Benefit, were heavily cut in value or became entirely or partially means-tested. Unemployment benefits used to be paid to those with enough contributions for a year with no job search requirements. Its replacement – contributory-based Jobseeker’s Allowance – is now paid for only six months without a means test and carries job search requirements.

So, the link between contributions paid and benefits received has largely been broken, and over the years the notional NI fund (the fund necessary to balance receipts and outgoings over time) has become just a piece of government accounting. Currently, NI raises around £30 billion more than is spent on the insurance-related, or contributory, benefits. The additional cash is spent elsewhere ([Department for Work and Pensions 2018](#)).

At the end of the day, parliamentary sovereignty reigns supreme in the UK. Governments pass laws then repeal them and over time this has unravelled these attempts at full hypothecation. This is not to say full hypothecation cannot work: it may be that the combination of greater transparency, the public’s long-term loyalty to the NHS and a degree of statutory independence for an OBR-like body may all be sufficient to provide the extra degree of protection health and care have lacked since 1948. It is not, however, a done deal.

Conclusion

Where does this leave us? We have no doubt that the advocates of hypothecation are sincere in their wish to find a way of channelling more resources into the NHS and have been encouraged by evidence of growing public support for linking tax increases to additional spending on the NHS. However, as this paper demonstrates, it is essential to be clear on the objectives that are being pursued and the best means of delivering these objectives.

There are two key objectives for any hypothecation: first, to help overcome the current funding crisis in health and social care; second, to end the cycle of boom and bust in funding that has been such a recurrent problem over decades.

Hypothecation may appear simple, but it has many complexities and the difference between partial and full hypothecation is critical. The former only looks to top up current levels of spending, whereas the latter looks to set the budget as a whole.

The funding challenge for health and social care is with us now. The quickest and most obvious answer is to leave the current system as it is and require HM Treasury to put more money in. If hypothecation is used, the next most simple route would be partial hypothecation, which would link a tax rise to higher funding for health and care than is currently planned.

Whether partial hypothecation is used or not, the challenge to this approach is that it does not provide a long-term solution to the boom and bust in health and care spending. If a long-term solution is indeed what is wanted then full hypothecation may be part of the answer, and a reformed and expanded NI could form the basis of such full hypothecation. But on its own it is unlikely to be enough to guarantee a more stable future.

There also needs to be a clear demarcation over what is, and is not, within the hypothecation ring-fence. There needs to be a way to break the link between one year's tax revenues and spending, possibly through the creation of a 'fund' that can move money between years. Full hypothecation also needs to be supplemented by a degree of independence in setting health and care spending and the tax rates needed to finance it.

Lastly, as history shows, previous attempts at full hypothecation (admittedly not of the NHS) have not stood the test of time as governments unravel the decisions of their predecessors.

For all of these reasons, getting full hypothecation to work would be a complex task and should not be undertaken lightly. Its advocates need to demonstrate how hypothecation will be an improvement on current ways of funding the NHS, and not unintentionally fuel even greater public mistrust of politicians by failing to deliver its potential benefits. The arguments for and against hypothecation are finely balanced and an attractive idea could end up back firing unless the risks we have identified are tackled.

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