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How should we pay for health care in future?

Results of deliberative events with the public



Key points

- An informed public debate is needed about both the level of future spending on health and social care, and how that spending might be funded. With this in mind, The King's Fund, in collaboration with Ipsos MORI, held two deliberative events with members of the general public.
- Participants strongly supported the founding principles of the NHS, and yet recognised the shortcomings and challenges it faces. There was good understanding about how the NHS is currently funded, but people wanted to know more about how that money is spent.
- Most participants argued that access to health care should continue to be based on need rather than the ability to pay. Some supported introducing user charges for 'not clinically necessary' procedures and for needs resulting from inappropriate lifestyle choices or misuse of the system.
- Means-testing was unpopular both in principle and for practical reasons. However, there was some support for the very rich paying for some services and for insurance schemes, particularly voluntary insurance.
- Any reduction in the quality of care was seen as unacceptable. Paying to secure preferential treatment was strongly resisted, but there was support for being able to pay to enhance non-clinical aspects of care (for example, hotel-style facilities).
- Both younger and older groups supported the collective funding of health care, appreciating that health care costs can be high.
- Overall, many accepted that the NHS is under pressure, but few accepted that this is on a scale to justify changing the fundamental principles on which the NHS is based.
- Key lessons for politicians considering changes to NHS funding were that:
 - people would need to be convinced that the current system is working as efficiently as possible before considering more radical changes
 - people want to be involved in decisions about NHS funding, and any changes would need careful explanation and a public debate
 - the public's attachment to the founding principles of the NHS and reluctance to embrace radical change to the current funding model suggest that an incremental approach is likely to be more acceptable.



Introduction

I love our NHS, I think it is a fantastic institution, a great organisation, it says a great deal about our country and who we are.

(Cameron 2013)

In the past 50 years, spending on the NHS in the United Kingdom has increased from 3.4 per cent to 8.2 per cent of gross domestic product (GDP) (Appleby 2013). If the next 50 years follow the same trajectory, the United Kingdom could be spending nearly one-fifth of its entire GDP on the public provision of health and social care.

Appleby (2013) suggests a need for engaged and informed public debate about the choices to be made about both the level of future spending on health and social care and how increased spending on the NHS might be funded. With this in mind, The King's Fund, in collaboration with Ipsos MORI, held two deliberative events with members of the public, one in London on 20 October 2012, and one in Leeds on 10 November 2012, to discuss how we will pay for health care in future. This paper summarises the key themes from those events. We hope that the insights generated by them will help shape and inform the public and political debate on this important societal issue.

Aims and objectives

The main aims of the deliberative events were to:

- understand participants' current views on health care funding
- challenge participants to explore the fundamental principles on which the NHS is based
- explore various options for the funding of health care in future.

Methodology

A deliberative approach was deemed appropriate for this piece of work as we wanted to introduce participants to a large amount of relatively complex and unfamiliar information and to understand how this might affect their views. Moreover, we wanted to gauge reactions to a number of difficult choices, all of which required some explanation.

The discussion guide (Appendix A) and materials used at the two events can be found in the appendices.

Limitations

The nature of deliberative events means that participants are exposed to a great deal of information. Any attempt to generalise from these findings to the general public must take this into account, along with the sample size (40 participants at each event). The findings indicate how the public might react if presented with similar information about the funding of the NHS and possible future funding challenges.

Anonymous verbatim comments made by participants during the discussions have been included throughout this report, attributed by location and age range. These should not be interpreted as defining the views of all participants but have been selected to provide insight into a particular issue or topic.

Recruitment

Members of the general public were approached in the street by experienced Ipsos MORI recruiters and asked if they would like to take part. They were asked a number of questions to ensure that those selected to participate in each event were broadly reflective

of the socio-demographic profile of the local population, but also include a proportion who met the following criteria:

- carers and those with long-term conditions
- people with private health insurance
- people with high or low usage of the NHS
- a spread of political affiliations.

These criteria were felt to be important as they have been shown to affect people's experiences and views of the NHS.

Participants were required to have been resident in England for at least three years to ensure that they would be familiar with the NHS.

The following people were excluded from the research:

- those who had attended a discussion group for market or social research during the previous year
- those who work in the media, public relations, advertising or market research
- those working for the NHS in any capacity
- those with a close relative working in health care.

A total of 50 participants were recruited for each event, on the assumption that 40 would attend. Participants were offered £65 in consideration of their time and to cover any expenses they might have incurred.

Event structure

Before the event, participants were told only that they would be discussing how the NHS should be funded and who should pay. This approach enabled us to elicit participants' uninformed views about how health care is funded and their awareness of the funding challenges facing the NHS. It also enabled us to judge how people absorbed information about the future funding challenge and what shaped their opinions as the day progressed.

When they arrived at the events, participants were split into five separate discussion groups, each comprising 8–10 people, grouped according to age. This was because data from other studies suggested that different age groups may have contrasting views on this subject.

Participants were given electronic voting devices on which to give their answers to a series of questions displayed on a screen (Table A1, Appendix B). The results were then displayed to all participants. The questions were chosen both for their relevance to the issues being discussed (they covered views about the NHS and attitudes towards funding), and because polling data already existed for them, enabling comparisons to be drawn with the answers given by our participants.

The voting was followed by a general discussion within each group about perceptions of the NHS, the challenges it faces and how it is funded.

This was followed by a series of presentations and group discussions of the issues raised, supported by the use of exercises. The first of the presentations was on the funding challenge facing the NHS; subsequent presentations offered three potential solutions to this challenge:

- paying for some services
- means-testing
- reducing the standard of care.

At the end of the day, each group discussed the issues raised, decided what they thought were the best solutions to the funding challenges, and then presented their views to the others in a plenary session.

Finally, participants answered the same questions that they had been asked at the start of the day to gauge how much the presentations and discussions had changed their opinions (Table A2, Appendix B).

Context

In this type of research, the context in which it takes place, particularly current media coverage of the issues under discussion, can influence participants' views. It is therefore worth briefly considering what was in the media at the time.

The NHS in general has been a major focus of the media since the general election in 2010, with the debate about the government's health reforms, in particular, dominating the news throughout 2011 and the early part of 2012.

Media coverage has also focused on the impact of the financial squeeze on services, caused by the need for the NHS to make £20 billion in productivity improvements by 2015. Quality of care has been another topic hitting the headlines, with widespread coverage about the mistreatment of older people in hospitals and the Winterbourne View scandal, where patients with learning disabilities were abused by staff.

The opening ceremony of the Olympic Games in London in 2012 featured a tribute to the NHS, raising its profile in the public consciousness still further.

Specifically around the time of the deliberative events, NHS-related stories in the news included the following.

- In October, the Mail on Sunday ran a high-profile campaign against cuts to accident and emergency (A&E) department services.
- On 3 October 2012 (a couple of weeks before the London event) the BBC's current affairs series *Panorama* broadcast a programme entitled 'Britain's Secret Health Tourists'. Several participants in the London event raised the issue of the cost of foreign nationals to the health service.
- On 15 October, Malala Yousafzai, the Pakistani schoolgirl shot in the head for promoting the education of girls, was admitted to the Queen Elizabeth Hospital in Birmingham for specialist treatment.

All this took place against the backdrop of austerity, a political narrative centred on 'strivers' and 'scroungers' and, around the time of the events, widespread media coverage about tax avoidance.

Analysis

The discussions by every group at both events were recorded (with consent), although note-takers were also present on each table to record participants' views.

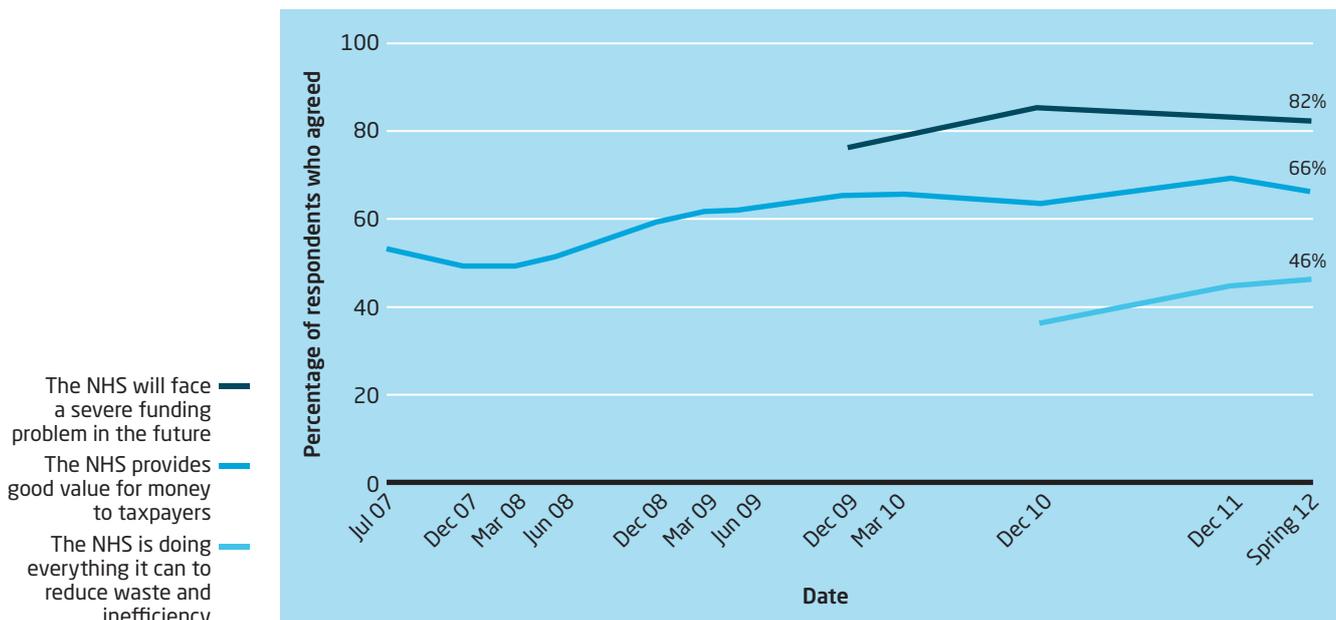
Following the second event, the core project team and all the moderators met to analyse the responses. Participants' responses to the funding challenges and their attitudes towards potential solutions were evaluated thematically, and this, along with the audio files and notes made at the two events, were used as the basis of this report.

What do the public think about NHS funding?

In this section, we consider what polling and surveys can teach us about public attitudes to NHS spending, possible cuts and alternative models of funding, in order to provide some context for the findings of the deliberative events.

Figure 1, below, shows that most people think that the NHS will face a severe funding problem in the future. What this data does not tell us, however, is whether people have a clear understanding of the scale of the challenge – and this was something that we were keen to explore in the deliberative events.

Figure 1 Asking what the public thinks about the NHS: ‘On the whole, do you agree or disagree with the following statements?’



Note: base = adults aged 16+ in England (c 1,000 per wave)

Source: Ipsos MORI/Department of Health (2012)

Although two-thirds of people think that the NHS provides taxpayers with good value for money, fewer than half think that the NHS is doing everything it can to reduce waste and inefficiency.

Data from the British Social Attitudes 2012 report shows that 68 per cent of people choose health as their first or second priority for extra government spending, placing it above education, housing, and police and prisons (NatCen Social Research 2012).

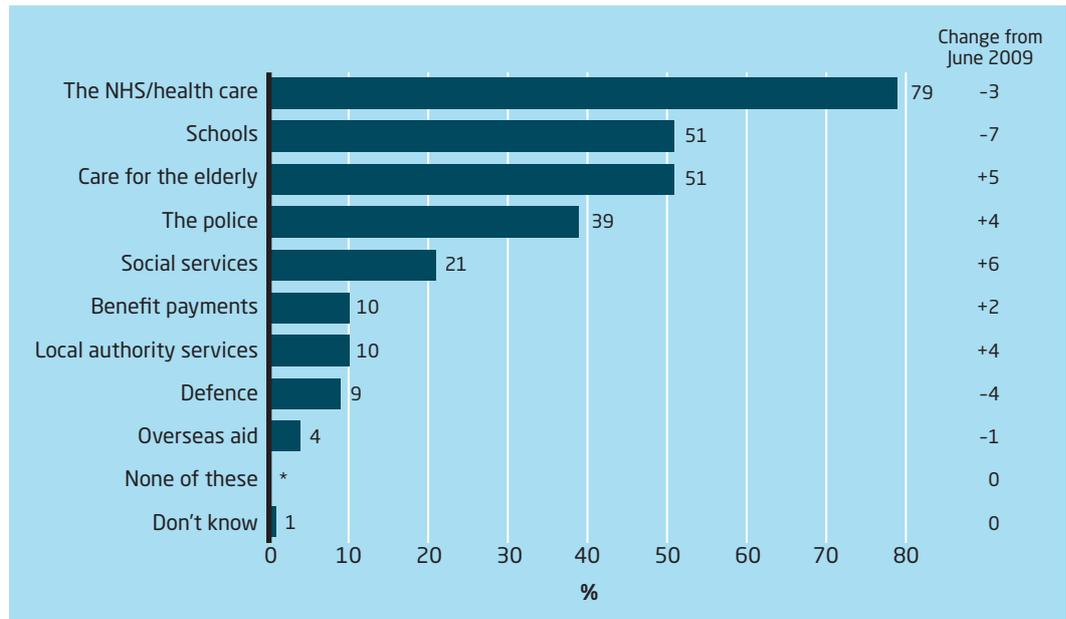
Polling carried out for the Nuffield Trust (Ipsos MORI/Nuffield Trust 2012) shows that 79 per cent of people think public spending should be protected from cuts, even if that means bigger rises in taxation and/or deeper cuts in other areas of public spending. As Figure 2, overleaf, shows, when asked which areas of public spending should be protected from any cuts, most people (79 per cent) chose the NHS/health care.

What is also clear is that people can have an unrealistic view about how much can be spent on the NHS. Figure 3, overleaf, shows that around 40 per cent of those surveyed think that there should be no limits on what is spent on the NHS. However, it is interesting to note that when the question was asked in 2006, a greater number of people thought there should be no limits on NHS spending, which suggests that more

people are starting to accept that there might need to be limits and that public spending is not infinite.

The reluctance among many people to contemplate cuts to the NHS or even, for a significant minority, to refuse to accept any limits on spending, reflects the priority the public place on health care.

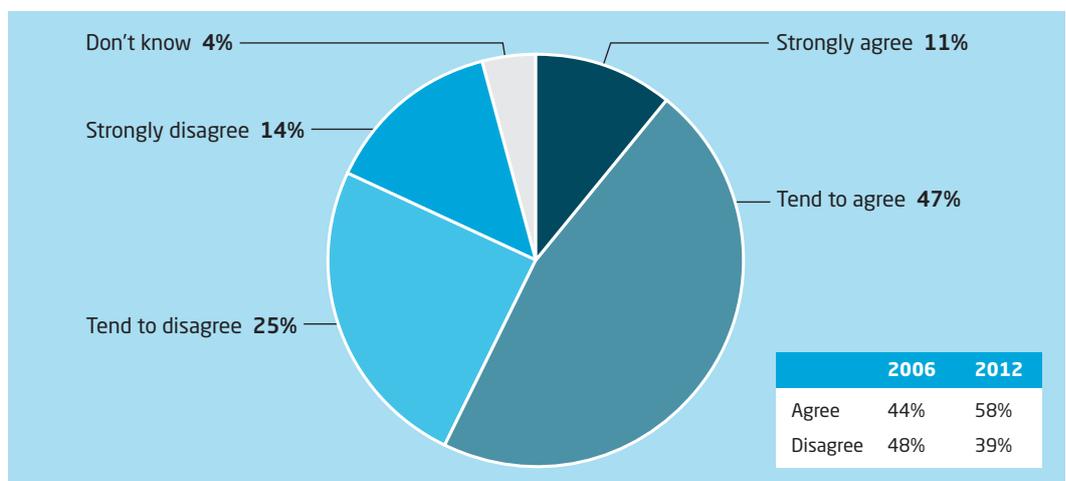
Figure 2 Asking the public which areas of public spending should be protected from cuts: 'Which two or three, if any, of the following main areas of public spending do you think should be protected from any cuts?'



Note: base = all who think some services should be protected (809)

Source: Ipsos MORI/Nuffield Trust (2012)

Figure 3 Asking the public if there should there be limits on what is spent on the NHS: 'On the whole, do you agree or disagree with the statement: "There should always be limits on what is spent on the NHS"?'



Note: base = 1,015 adults aged 16+ in England, May 2012; 1,001 adults aged 18+ in Great Britain, January 2006. Percentages may not total 100% due to rounding.

Source: Ipsos MORI/Institute for Public Policy Research (2006); Ipsos MORI/Department of Health (2012)

What are the challenges facing the NHS?

At the start of the day for each deliberative event, participants were asked some general questions to give us an understanding of their initial views about the NHS. They discussed which words they associated with the NHS, what challenges the NHS was facing, and how the NHS is funded. Some groups also covered how they would address the future funding challenge.

There was a range of answers given to the question about which words were associated with the NHS, both positive and negative. 'Free' was one of the most common positive associations, although 'care', 'advice' and 'support' were also suggested.

Among those participants with knowledge or experience of health care in other countries, 'proud', 'privileged' or 'lucky' were also common associations. These participants felt that the NHS is a better system than those operating elsewhere, and that the care offered by the NHS is simply not available in many other countries.

I feel privileged. My friend in Singapore had an accident, and doctors at the scene were asking everyone if they were insured.

(Leeds, age 38–50)

In the light of this, some participants felt that the NHS is 'taken for granted' in the United Kingdom, where people fail to recognise how fortunate they are.

However, although participants identified some positive aspects of the NHS, there were also a number of negative associations, including 'spending cuts', 'overworked' or 'insufficient' staff, 'top-heavy management', 'infections' and 'waiting lists'.

Some participants also associated the NHS with poor levels of care. These participants often had direct personal experience of the NHS, and had received care that they felt had fallen short of what they expected.

I am so grateful for the NHS, but some of the people skills throughout my treatment have been absolutely horrific, the staff are under pressure and I've never seen the same doctor twice in 11 months of very intense personal treatment. There's been no continuity, no getting to know me, the people who treat me know nothing about me and I feel like a TV set on a production line.

(Leeds, age 38–50)

Participants, therefore, had mixed feelings towards the NHS. They praised the idea of a publicly funded service providing health care that is free at the point of use, but often criticised the way that it functions in practice. However, as the inclusion of 'spending cuts' in the negative associations suggests, criticisms were also tempered by an awareness of some of the challenges the NHS faces.

Funding was seen to be a challenge in two principal ways. First, the issue of the cuts was raised at both events, with participants saying that, as a result, there is not currently enough money to maintain standards of care in the NHS. Second, the funding challenge was seen by some to be linked to the cost of drugs and medical technology. Some participants noted that the cost of new treatments is very high and represents a considerable burden on the NHS, particularly given the degree of expectation among the general public that these treatments should be available to all.

Participants also saw the United Kingdom's ageing population and, less commonly, the increasing size of the population as a whole (partly as a result of immigration), as posing a considerable challenge to the NHS. Some participants explicitly linked this to funding pressures, as a result of both the cost of caring for older people, and the burden placed on resources by the sheer number of people using the NHS.

The exponential improvement in medical science causes a strain, which is mainly coming from the older population. Many now live to over 100 and they are the biggest drug takers. The NHS has to do something for people who it did not used to treat.

(London, age 58+)

The foundations of the NHS were based on sustaining a certain number of people. Now the NHS is smaller and we have more people, it's common sense [that] it's not going to work.

(London, age 25–35)

Although funding and demographic factors were seen as the greatest challenges, others were identified, including the inefficient use of resources leading to waste, problems attracting and retaining staff of sufficiently high quality, and rising expectations among those using the NHS.

The case for change

At each deliberative event, a presentation was given that included information about the basic principles underpinning the NHS, how much is spent on health care, and how this has changed over time. Information was also given about the pressures that may increase the spending on health care in future, and how much that spending might amount to. Participants were then asked to discuss the presentation within their groups.

Understanding the issues

Current funding system

All participants broadly understood the current NHS funding model and everyone was aware that health care is funded through taxation. However, as the discussions progressed it became clear that there were a number of unanswered questions and less knowledge about specific details.

About a third of salary each month goes on tax – so I think a lot would go from taxpayers to pay for the NHS.

(Leeds, age 27–37)

Most, but not all, also spontaneously mentioned National Insurance. However, there was some confusion as to whether this is earmarked for health care and entitled people who had paid in all their lives to get services.

User charges and exemptions

Most groups also spontaneously mentioned services for which users were charged. Some groups discussed what sort of services people have to pay for and also explored which types of people are exempt from paying charges.

There was quite a high level of awareness of charges being made for dental services and prescriptions. Fewer groups mentioned charges for optical services such as eye tests and spectacles, or car parking at hospitals. A number of services were mentioned that are not usually accessible on the NHS and must therefore be paid for privately, such as specialist physiotherapy, chiropractic, vaccinations for overseas travel, and alternative medicine.

Most groups included people who were well informed about co-payments and exemptions policy in the NHS, for example, most knew that those who are unemployed or on benefits are exempt from paying charges. Some participants were also aware that patients with certain conditions, such as diabetes and cancer, and people in full-time education are exempt. Others mentioned pregnant women and pensioners as being exempt, and a couple of people were aware that people who use a lot of prescriptions are able to pre-pay on an annual basis.

Voluntary health insurance

Most groups were aware that people can choose to pay for health care themselves or through private health insurance. However, not everyone was clear about whether or not this takes pressure off the NHS.

Many people have private health – does this help the national system? I would have thought this helps us save some money.

(London, age 58+)

My parents-in-law are in their 80s – they have private health care up to their eyeballs – private hospitals are nice hotels – when something serious kicks in they go to the NHS.

(London, age 58+)

Perceived drivers of spend

A few participants were aware that people from overseas are supposed to pay for using the NHS. A number of people, however, were quick to suggest that so-called ‘health tourists’ were a cause of pressure on health services, and saw immigration as the main cause of the population increases presented to them earlier.

The NHS is meant to question whether people are eligible for free health care, for example [people from] overseas, but in practice they very rarely do so. It is important to remember why. There are emotional reasons – you must treat people in need.

(London, age 58+)

Comparisons with other health care systems

Participants wanted more information about how health care is funded elsewhere. Some participants had lived abroad and had first-hand experience of another country’s health system, which they drew on to inform discussions and highlight differences between the NHS and other systems.

I come from Greece. If you don’t pay your stamps, you can’t use the hospital.

(London, age 48–57)

In Russia, you couldn’t get an appointment unless you pay.

(London, age 48–57)

Other people mentioned America as a point of comparison, usually in a negative light.

We are very fortunate – look at America.

(London, age 48–57)

Reactions to the case for change

Desire for information

Despite a basic level of understanding of NHS funding, there was a desire to know more. Participants were generally very interested and engaged.

It would be interesting to know what percentage of our tax goes to the NHS.

(London, age 25–35)

Although many felt removed from the decision-making process at present, there was a sense among some participants that the public should have more influence on how the government allocates funding.

How many of us here are clear about what the budget is, how it is arrived at and how we can influence how it is spent? It should be us here around the table.

(London, age 48–57)

Participants wanted to know more about where the money goes, including what the NHS spends money on, how much NHS staff are paid, and what proportion of the taxes they pay are allocated to different areas of government spending. Although many people were surprised by how much government does spend on the NHS, others found it hard to imagine what else public money is spent on.

£1 in every £5 goes to the NHS – where does the rest go? (Leeds, age 27–37)

Participants felt that there needed to be more information about the cost of different areas of public expenditure, and a more open debate about how to prioritise spending between these competing areas.

One in five is going to health – should we spend two in five? If we reprioritise – prevention rather than cure – this might be rebalanced.

(London, age 58+)

Reactions to the figures presented

There were different reactions to the information on how much is spent on the NHS. The overall figures looked large and people said they were ‘scary’ and ‘overwhelming’, with one person commenting that they were ‘shocking but enlightening’.

The numbers involved are massive. (Leeds, age 38–50)

Some felt that the quality of the services is not good despite the large amount being spent, while others thought it justifiable to spend that proportion of the country’s wealth on health.

Eight per cent of GDP to keep everyone fit and healthy, 92 per cent on everything else sounds fine to me.

(London, age 25–35)

Some participants resisted the idea that rising health care spending will mean people having to pay more taxes to cover it, with a figure of as much as £570 per annum for every household being suggested in the presentation.

The problem is that if taxes go up then people haven’t got spare money to spend in shops etc.

(Leeds, age 27–37)

The fact that £1,500 is spent on average per person per year made a strong impact. Most participants recognised that this is not distributed evenly across the population because some people have greater needs than others. There was also recognition that some people, such as the unemployed, are not contributing, raising the ‘bill’ for others.

The NHS used to be from National Insurance and now it is tax – so it begs the question about retirement and employment generally. There are lots of younger people coming out of school, if they can get a job (they will pay tax), if not they start costing. They are also part of the problem. It is the people in the middle who are paying tax.

(London, age 58+)

However, when it came to thinking that they might have to pay more for health care, participants were concerned that the amounts discussed would be unaffordable for individuals and households.

Drivers of spend

Although many participants knew that the population is ageing and understood that this will increase spending, few people were aware of other factors driving spending up. For example, when comparisons were drawn between spending levels today and when the NHS was set up in 1948, there was some surprise that the main cause of increased spending is related to the availability of new technologies.

What she said about new technology being the biggest cause of expenditure surprised me. I thought people in 1948 were much healthier; people these days eat chemicals.

(Leeds, age 38–50)

Some people did understand that new technologies and drugs are fuelling rises in expenditure and recognised that there may need to be limits, such as using only generic drugs or technologies that have been proved to be effective.

We shouldn't be using experimental technology; we should use technology that is proven.

(Leeds, age 51–62)

Sense of urgency

There was a strong sense that a lot of money has been invested in the NHS but that it has not all been spent wisely. It was clear that participants would need to be convinced that inefficiencies had been dealt with before they would accept that they should pay any more towards the costs.

Until we deal with the problems, we shouldn't talk about paying more. We have been throwing money at things for so long and it hasn't helped. We are spending a hell of a lot. Why are we throwing more money at things?

(London, age 25–35)

There was a view that too much money is 'wasted' on managers and that the loss of 'matrons' and too few clinical staff, particularly nurses, is to blame for the problems the NHS is facing.

Pen-pushing managers – the matrons should be bought back; managers are only there because they know about managing people and economics and have no health care experience.

(Leeds, age 51–62)

Most thought that the NHS needs to make cost savings.

Why is the NHS exempt from austerity measures? Every household has to look at how it's spending every pound. Why can't the NHS try to trim the fat? It goes back to overspending. It's like me saying the loaf of bread is cheaper in Tesco's than another supermarket, so I buy the cheaper one.

(London, age 25–35)

There was some scepticism about the case for change. This seemed to be coloured by participants' political views, and was often connected to an unwillingness to accept that there is a genuine need to make big changes to the NHS.

I don't know if it is urgent. The current focus on shifting the NHS is being delivered by a government who didn't include it in its manifesto. I am not going to go along with the idea that there is a problem as it hasn't been demonstrated that there is one.

(London, age 48–57)

Others did believe that the pressures faced by the NHS are genuine and that change is needed. The sense of urgency for most people was stronger once they had heard the evidence.

A few participants recognised that NHS resources are not limitless and were worried about unemployment rates rising, as there is a clear link between the economy and the affordability of the system.

Economy is the driver of this – more people working, more taxes in.

(London, age 58+)

Fundamental principles

Participants were asked to think about the three fundamental principles on which the NHS was founded to gauge their reactions if these were challenged.

Those three principles were:

- comprehensive – access is based on need and not the ability to pay
- universal – it is there for everyone
- high quality – care that is safe, effective and personalised.

Comprehensive

Participants were told that although access to most NHS services is currently free at the point of use, if funding pressures should become worse, or the electorate decided against paying more in tax in order to continue to ensure that all NHS services remained free, one option would be to charge people for some services. This could simply mean providing a more narrowly defined package of benefits under the NHS, but it could also involve more widespread co-payments for services that are currently free of charge.

Group discussions followed, and then participants were taken through an exercise in which they were shown a number of lists of different types of health services (Appendix C) from which they had to choose the three that they would be most willing to pay for. Once they had chosen, they were given the estimated cost of the services and were asked if this changed their previous decision.

Willingness to pay

As many participants had previously noted, there are already charges for some services within the NHS. Some participants did not accept that this is right and argued that ‘everything should be free’, that charging is ‘ethically wrong’, and that it runs counter to the principles of the NHS. However, many participants reluctantly accepted charges for some services. That being said, there was considerable surprise that the current charges contribute only 1 per cent of the NHS budget.

It is not acceptable for people to have to pay, as they pay already. (London, age 25–35)

Principles for priority-setting

It emerged that participants’ decisions about charging were guided by a number of principles. These included whether services were perceived as necessities or luxuries, whether the service being used was elective or an emergency, whether the person could be said to be responsible for their ill health, and whether providing a service free now might prevent higher costs later.

There was a general view that things that are not medical necessities should be charged for.

I think if something is not life threatening there should be some sort of contribution, if you are that miserable and you are prepared to put something towards it.

(Leeds, age 38–50)

For many participants, cosmetic surgery was initially seen as an area for which it would be appropriate to ask patients to pay as it was widely viewed as a choice, rather than a medical necessity. However, as discussions progressed, it became clear that this issue is not as straightforward as participants had initially thought.

Many participants felt that breast augmentation surgery and gastric bands should not be free on the NHS, but others argued that in some cases these interventions could be a necessity – for example, if a cancer patient required breast reconstruction following a mastectomy, or if an obese patient had unsuccessfully tried every other avenue to lose weight. Most participants also argued for cosmetic surgery to be allowed on the NHS for someone who has had an accident and requires reconstructive surgery, or where some aspect of their appearance is making them so unhappy that they are unable to lead a normal, productive life.

If somebody is really dissatisfied with the way they look and it's affecting their life, then I do think it is justified.

(Leeds, age 38–50)

Moreover, it was also observed that withholding certain treatments might simply result in higher costs for the NHS in the future; for example, if someone were refused a gastric band, was unable to lose weight and subsequently required joint replacements and/or treatment for diabetes resulting from their obesity.

Many participants felt that it would be appropriate for elective caesarean sections to be charged for. However, participants felt that emergency caesareans, or those arising from medical need, should be free. As in the initial discussion about cosmetic surgery, choice was felt to be a key factor in determining whether or not someone ought to pay.

A few participants argued that walk-in centres are a 'luxury' and should be paid for. They offer a service that has more accommodating hours and quicker access, and that people should pay for such a 'commodity'.

Some participants suggested that services that are not directly related to health care should be paid for – for example, meals on wheels, ambulance trips for planned hospital appointments and hospital food were seen as 'extras'.

When it came to routine health checks, there were mixed views. A number of participants argued that as they are preventive services, they should remain free as they save costs in the long term. However, others thought that taking care of yourself is 'your responsibility'. When it came to routine health checks for those with chronic conditions, many agreed that these should be free, as they represent a recurring expense.

Diabetics can't help it, they shouldn't pay.

(Leeds, age 19–26)

Misusing health services

When thinking about who should pay, and for what, many participants discussed those who are perceived to 'abuse' the system. Discouraging or penalising this was seen as important. Almost all groups mentioned drunks in accident and emergency (A&E) departments at weekends.

In Australia, you pay for an ambulance. Over here I don't think we should pay for an ambulance but if you get drunk and you get an ambulance and your stomach gets pumped... If you know you have to pay for it, then it might change your behaviour.

(London, age 25–35)

Another category of people mentioned was those whose illnesses are self-inflicted, such as those who do not exercise or control their diet and, as a consequence, are obese, or those who smoke and have lung cancer. Many thought these people should be responsible for the consequences of their decisions.

If parents realised the cost of treatment, they might not let children get obese.

(Leeds, age 19–26)

Others mentioned people who miss planned hospital and general practitioner (GP) appointments and those who do not make good use of the system, for example, those who go to the A&E department when they should be going to their GP first. To prevent this from happening, some thought investing time and effort in educating people on how to use the health service appropriately would save money in the long term.

I think we all agree planned appointments could be charged but not the full price, just a contribution.

(Leeds, age 51–62)

How much do things cost?

During this part of the exercise, participants were presented with rough estimates of how much services cost (Appendix C). There was a clear lack of awareness of the cost of services among participants, many of whom expressed shock when the sums were revealed, both because they were higher and lower than expected. Those who had health insurance were less surprised by the costs, although in some instances participants with health insurance observed that they had paid more for certain services privately than the costs set out in the exercise.

The widespread surprise at the cost of services affected discussions in two ways. First, there was agreement that more widespread awareness of how much things cost would lead to more discriminating use of services. It was suggested that this could be promoted by a list of costs being put up in doctors' surgeries, or patients receiving an itemised bill after using NHS services.

Second, the cost of an individual service had an impact on whether participants were willing to consider paying for it. Services like health checks and GP appointments, which had lower costs were seen as something patients could pay for, but when the costs were very high, for example, a surgical procedure costing thousands of pounds, participants were less willing to countenance charges, often because they themselves would not be able to afford them.

The cost examples also made some reconsider the principles of charging. For example, preventive services, which cost relatively little, were seen as appropriate to charge for. However, having to pay for a GP appointment, for example, might result in some people delaying seeking help, potentially costing the NHS more in the long term.

I don't think people should be penalised for being on low incomes. If people have to pay for health checks then people wouldn't come. Prevention is better than cure.

(Leeds, age 51–62)

Some participants suggested that rather than paying for the full costs of services, people could be asked to pay a contributory charge. However, participants did not suggest a maximum charge or how much of a contribution should be made. One participant felt that it would be 'reasonable to ask for £20–30', although one group thought £10 was more acceptable.

If we were to set payments for some services, it would be important to understand which range of services these should be. You would not want the same individual to have to pay for three or more services. You should try to create a balance, everyone having to pay for an aspect of their care.

(London, age 58+)

Universal

In this part of the day, participants were told that the NHS gives everyone access to care regardless of how wealthy they are, whereas in some countries people who earn above a certain income threshold have to purchase private insurance. The example of social care in England was also mentioned; this is means-tested, ie, only those with assets below a defined value can have social care funded by the local authority.

Participants were asked for their reaction to the idea of people on high incomes paying for their own health care. They were then given a set of profiles of different people with information about their income, what they currently contribute towards their health care through tax, and whether they have private health insurance. We then asked whether these people should expect to pay for all or part of their care in future (Appendix D).

Means-testing

The idea of introducing means-testing into the NHS was very unpopular among participants, and they struggled to envisage scenarios in which they would be able to accept it.

Some objected on the grounds that means-testing is contrary to the core principles of the NHS – the idea that the NHS is free at the point of use for all was frequently referred to as one of its most important foundations. Means-testing was felt to undermine this by placing people's economic circumstances above their need, and it was suggested that it might prevent them from seeking help when they needed it.

Moreover, some participants thought that anyone with a high income who pays tax and National Insurance already contributes financially to the NHS and that means-testing would, in effect, result in some people paying twice.

However, although universalism was the main argument against means-testing, other objections were raised. There was a widespread view that it would add to the financial burden on middle-earners, who would be required to pay more for the same services. Many participants also felt that those who could afford to pay more were likely to access private health care and would therefore bring only a limited amount of additional money into the NHS.

It's the people in the middle who will be stuck... the people at the top don't pay tax anyway, the people at the bottom will think 'Oh well, it won't affect me'; it's the people in the middle who will be affected.

(Leeds, age 38–50)

Some participants felt that means-testing would be socially divisive. They argued that those who were being asked to pay would resent others receiving the service for free, and, because they were being asked to pay, they would demand a higher standard of service, raising the possibility of a two-tier health service.

If I was paying extra costs, I'd expect things to be covered straight away, I'd expect an x-ray, etc, straight away... a different level of service.

(Leeds, age 27–37)

Some participants also queried the financial viability of means-testing, questioning how much the administrative costs would be and how effective current means-testing schemes were.

Participants considered that ‘the wealthy’ were most likely to be able to contribute. However the point at which individuals were felt to qualify as wealthy was set very high – participants discussed people such as Richard Branson or Wayne Rooney, and, even when the bar was lower, it still excluded the majority of society (the figure discussed in one group was an income of £150,000 per annum, in another it was £70,000).

Moreover, the arguments against means-testing for people on very high incomes were generally seen as relatively powerful.

In reality they pay a higher percentage anyway. If you spoke to the average rich person who pays 50 per cent tax they don't use the NHS, they use a private doctor. They are still paying for other people but not using the NHS themselves.

(London, age 25–35)

People in one of the groups of older people suggested that it would be more acceptable to means-test the young than the old. It was argued that older people are used to the current situation and would find a shift to means-testing very difficult, particularly as they have been contributing to the NHS for most of their lives on the understanding that they would have access to care, free at the point of use, when they needed it. Younger people, it was suggested by this older group, not only have less emotional attachment to the NHS, but also have not contributed to it financially to the same extent and would therefore find it easier to accept means-testing.

We've paid into it all of our lives... It's what we are used to. But what if people turn round and said if children are growing up, from the age of 30 they would start to fall into a new system... People would expect to pay so it wouldn't be a challenge for them.

(Leeds, age 51–62)

Finally, there was some suspicion that the introduction of means-testing might be the ‘thin end of the wedge’, and that although it might be limited at first, the number of people required to pay would continually increase, until everyone was required to pay for their health care.

Resistance to means-testing was not universal, and in some instances participants suggested practical ways to make it work. One idea was that means-testing could be based on the level of general taxation being paid, with people in higher bands paying for a certain proportion of the cost of their care. However, for most participants, the concept of means-testing was unpalatable and raised serious questions both about fairness and how it would work in practice. For these reasons, it was rejected as a potential solution by most participants.

Alternatives to means-testing

In some instances, participants sought to identify alternatives to means-testing. For some, the concept of allowing people to ‘top up’ care appeared to be a more palatable option, and others raised the issue of insurance. A small number of participants felt that mandatory health insurance might be a solution, particularly for people earning more than a particular (unspecified) income. It was suggested that the responsibility for this could fall on either individuals or employers, although there was some resistance to the idea of requiring individuals to take out insurance. Furthermore, many participants were aware of the limitations placed on existing health care policies, such as insurers’ policy of not covering the cost of treatment of pre-existing conditions, and were concerned about these remaining under a new system. *Encouraging* the taking out of health insurance was therefore felt to be preferable to *requiring* it.

Quality

In the next session, participants were told that the NHS aims to deliver high-quality care and to provide equity of access. Although waiting times, standards of facilities, quality of care and availability of some treatments vary across the NHS, there are national guidelines, standards and targets that providers are expected to meet.

If funding became tighter, one option presented to participants for discussion was that the NHS would offer only a basic standard of care and anything above that would have to be paid for by individuals; for example, that patients might have to pay to be seen more quickly, for a better drug or prosthesis, for a private room, or for a bed on a single-sex ward.

Many participants found this a very difficult concept, and thought that lowering the standard of care to a basic package was not acceptable – nearly everyone taking part, both young and older generations, thought that the NHS is already offering standards of care that are too low.

This is the antithesis of aspiration. If we are going to supply a basic standard of care, then it will get worse. The NHS should aspire to the same care as the private sector.

(London, age 58+)

Despite strong initial resistance to variations in levels of care, some attitudes shifted during the course of the group discussion – for example, older groups recognised that a two-tier system already exists.

Many were worried that lowering the standard of care to a basic package would be socially divisive and does not fit in with the ethos of the NHS. Some participants questioned how this would work in practice, offering varying levels of service in the same hospital, for example. However, there were some who accepted the idea.

I just think if we go that way health follows wealth. Treatment will differ. It already does in very slight measure. This will divide us more. I am for keeping the status quo.

(London, age 58+)

When challenged, many conceded that a two-tier system would be acceptable as long as the baseline provided an appropriate clinical service. A ‘good’ and ‘better’ model was less controversial, although the principle of universalism remained strong, with a desire that safety and fairness should not be compromised.

My problem with a two-tier [system] is that it shouldn't be a bottom tier, but standard and a bit higher.

(London, age 36–47)

Some expressed the view that the lowering of standards would lead to a slippery slope, resulting in the complete fragmentation and privatisation of the NHS.

Moderators asked participants to discuss three aspects of quality:

- speed of service
- hotel facilities
- clinical care.

In all these areas, there was a clear division about what was and was not acceptable.

Speed

The idea that patients might be able to pay to move up a waiting list was ‘shocking’ to some participants. It was felt that allowing ‘queue jumping’ would cause suffering to

patients who could not afford to pay, and that those with the money should go to a private hospital, which would not have negative consequences for patients within the NHS. It was argued that speed of treatment should depend on the severity of illness and not the ability to pay.

Speed of treatment can affect the quality of care. (London, age 16–24)

However, not all participants shared these objections, and a minority were willing to accept the idea of paying to avoid waiting lists (with some suggesting that this is exactly the role currently filled by the private sector).

It's like getting an upgrade to first class. You can get on the train on a second class ticket and then upgrade to first class. (London, age 16–24)

Waiting times have gone down, but participants had a sense that it still takes a long time to get an appointment for certain services, and others mentioned that it is difficult to get an appointment with their GP, which sometimes forces them to seek private health care.

It's so difficult to get an appointment. Once every six weeks I'll make an appointment as I know someone in the family will need it. I will cancel it if no one needs it. (London, age 48–57)

Hotel facilities

This was the least contentious of the suggestions for how people might 'top up' non-clinical aspects of their care. Almost all participants felt that they would be willing to pay for what was termed 'hotel facilities', which included: finer quality bed linen, a private room, better food, a television, and the availability of other 'premium' choices that were clearly distinct from clinical need.

You need clean service. If you want extra luxury you should pay for it. (Leeds, age 27–37)

Clinical care

Some participants felt strongly that the NHS is already 'running to stand still', and that the standard of care could not get any lower. This idea was supported by personal experiences of poor clinical care, and reports in the press.

Standards have already been lowered. I've been put on generic drugs and also stayed in mixed wards. (Leeds, age 51–62)

I saw an old woman in a ward, they just left her soup at the end of the bed and it took an hour and a half for a nurse to come and feed her. It was stone cold by then. (London, age 36–47)

There was a general consensus that people's wealth should not influence their treatment. If that were to happen, then many more would opt for health insurance. However, some argued that it is acceptable to pay for certain extras, such as a titanium hip or a branded drug, because this would help the NHS to stretch the money available to it. These participants felt that the NHS is not there to provide the best available products or treatments.

My friend has a prosthetic leg. It is OK and works. The NHS could have paid thousands more and given her one that is more comfortable and easier to walk in. But the NHS is there to fix you. It would be like crashing a 'normal car' and replacing it with a Lamborghini. (Leeds, age 27–37)

Trading off the fundamentals

In the next session, participants were asked to think about all the issues and options that had been discussed. They were asked to consider the sustainability of funding health care in future and what trade-offs they would be willing to make to maintain the NHS in England.

It is important to note that we did not specify in great detail how the various changes would be applied, so different participants may have had different things in mind when considering options. For example, when discussing charges, most people seemed to be thinking about nominal co-payments rather than paying the full cost of expensive treatments.

Challenging the fundamental principles

Groups were reluctant to support any of the fundamental changes to the NHS that they had discussed. It was clear that, given a choice, participants wanted to retain the NHS as a service that is universal, comprehensive and high quality.

It has to be kept as universal. Personally, I would feel if that changed, society would have taken a notch down. I understand society is selfish but we need to ask fundamental questions: how much to spend on ending lives and how much on saving them.

(London, age 25–35)

The NHS was often referred to as a ‘national treasure’, and some people saw the NHS as bound up with their identity as Britons, as something they were proud of and that should be defended.

There was a clear belief that, because of these fundamental principles, the NHS is better than the health system in other countries.

It's true because... you've heard the horror stories of America where you are bleeding out but they say you haven't got money.

(London, age 25–35)

Some participants recognised that there might need to be trade-offs or compromises in order to retain the system as a whole. However, most resisted this idea, and only when pushed hard were they able to express any views on what was the least-worst option.

Some groups did have a more in-depth debate about the distributional impacts of different changes. When discussing the pros and cons of the three scenarios for funding the NHS in future (means-testing, taking away some services, all services being available but only with a basic level of care), participants identified that poorer people would be at a disadvantage in the latter two because some services would no longer be available free of charge, and care would be provided at a lower standard unless you could afford to go private or top up. This led them, reluctantly, to support means-testing.

Other than the means-tested scenario, poorer people will suffer and rich people will benefit. If you lose some services, rich people can afford private care. If all services are available at a lower standard, rich people can afford top-ups but the poor can't. Out of the three, the only one where the poorest aren't affected is the means-tested scenario.

(London, age 16–24)

Bias towards the status quo

Participants' views appeared to be shaped to some extent by comparing the proposed change under discussion to their understanding of the present system. For example, some participants felt that we already have charges and pay for some types of care so extending

this would not be a big change. Others recognised that people with money can already go private to get better care. This suggests that the public support the status quo and may therefore be more prepared to accept incremental changes.

Don't we pay for things anyway? We do pay for some services, it wouldn't make too much of a change, you pay for chiroprody, acupuncture, etc.

(London, age 36–47)

Personal responsibility

Across many of the groups there was some acceptance that charges may be necessary or indeed desirable, particularly if people's own lifestyle choices are to blame for their ill health. Participants thought charges could encourage people to make better decisions and take more responsibility for their health, what one person called 'tough love'.

What should be done?

Participants, especially those at the London event, found it difficult to come up with solutions for the financial challenges the NHS faces. However, the group discussions did produce some ideas (Appendix E).

Quick wins: short-term gain

A few participants mentioned that not everybody needs to see a doctor, and in some cases lower-grade professionals would suffice, and that mapping need and matching resources is therefore important.

Better use of new technologies was also mentioned by some participants. For example, using Skype for certain clinical consultations could be more effective than face-to-face interactions. One participant mentioned the wastage of drugs, suggesting that leftover drugs should not simply be thrown away.

Another idea that came up in a few groups was that the NHS should be more proactive in earning money. Some participants mentioned that the NHS should start 'shaking tins' and collecting donations from people and others suggested that pharmaceutical companies should 'pay a fee' in order to access and trial their products on patients in the NHS. Another idea was that local businesses could sponsor their local NHS.

Despite a reluctance to see widespread charging, many groups mentioned charging for perceived irresponsible use of services, such as weekend binge drinkers calling ambulances and using accident and emergency (A&E) services, or people missing appointments.

Charging was also proposed in circumstances where people's ill health is a result of their lifestyles, for example, those who drink too much alcohol, those who are obese and those who smoke. Diseases that resulted from 'irresponsible' behaviour were seen as acceptable to be subject to 'user charges'.

Big society approach to delivery of health care

Some groups thought that voluntary and religious organisations and charities could play a more significant role in health care delivery, research and education.

Something like Comic Relief or Children in Need. You could do something like that for the NHS.

(London, age 16–24)

However, another participant argued against this approach.

I'm not keen on the big society idea – in the council they brought in volunteers and then sacked the workers, who were then unemployed and not paying taxes.

(London, age 48–57)

Taxation - individual and corporate

Many argued that if people are living longer, then they should also work for longer and, in turn, pay taxes for longer. This view was more strongly expressed by older participants, a few of whom felt that this would generate significant revenue. A few of those in London argued that National Insurance could be increased, and one or two others expressed some appetite for increasing taxation but ring-fencing the additional revenue for health. This idea was not universally accepted.

I wouldn't want to pay more, I already pay enough.

(London, age 25–35)

Many felt that the government should clamp down on tax evasion and avoidance, with a couple of participants feeling that this would generate significant revenue.

There was a sense that companies that are promoting unhealthy behaviour, including cigarette manufacturers and fast-food chains, should be taxed.

The idea of a mandatory health insurance for companies was also considered as an option. This would work like current pension schemes, where the employee makes a contribution and the employer matches it.

Resource allocation

Some participants thought that the allocation of resources within government should be revisited. The defence budget was mentioned as an area from which to cut further, although not everybody agreed with this.

I would prefer to pay more for the NHS than other things.

(London, age 25–35)

Two participants in London mentioned hypothecated tax (that is, ring-fenced for health care) as an option on the basis that:

People like knowing where the money goes.

(London, age 16–24)

Prevention: long-term gain

Education and prevention were discussed in all groups. Suggestions ranged from the basic principle of making people aware of the costs of services, to teaching children how to cook healthy food in school. Many participants felt very strongly that not enough time is spent on educating the public about healthy lifestyles and what the consequences of unhealthy behaviours will be. Many participants expressed the view that people are unaware of how their health care system works and that some time and effort should be spent on educating the public on how and when services should be accessed.

Specific ideas

Some individuals had specific and interesting ideas on how we could tackle the funding challenge.

In London, three ideas stood out. The first was a scheme to give unemployed people the chance to work in the health service and learn a skill. The second was a standard NHS hospital with basic facilities that people could walk into for their care, but with the option

of upgrading to 'hotel facilities' in a next-door building. Finally, was the suggestion of creating an NHS insurance scheme, which would offer features similar to those in private health insurance schemes but generating funding for the NHS.

In Leeds, in the older group, the idea of an NHS lottery was championed. They argued that many people enjoy the lottery, so why not create a lottery fund around the health service?

Implications for policy-makers

Demonstrating value

Participants at both deliberative events were wedded to the fundamental principles underpinning the NHS: that it is universal, comprehensive and of high quality. It was clear that the public will need to be convinced that waste in the NHS has been eradicated, that money is being spent wisely, and that all other options have been exhausted before they are ready to see any of these principles eroded.

This suggests that the current drive to improve efficiency and drive out waste needs to be visible to patients and the public. If the public perceives the NHS as wasteful, then they are likely to oppose strongly any changes that threaten these principles, such as increased user charges, means-testing, more explicit rationing of services or top-up payments for 'better' care.

Engage and inform the public

At both events, the level of debate and engagement with the issues was high, and there was a strong sense that the public want to be better informed about how much public money goes to fund the NHS, what that money is spent on, and how much specific health services cost. Participants were surprised by how much is spent overall on the NHS and by the proportion of spending on different services. Providing better information might have an impact on the public view on taxation, maintaining support for current or indeed higher levels.

There was also a sense that the public should be involved in the making of these difficult decisions rather than leaving it to politicians. This might simply reflect the people who were recruited to the events, but the government might need to consider how to engage the public in an active discussion at the point when such choices need to be addressed.

Tax resistance

The two deliberative events were conducted at a time when the issue of tax avoidance both by companies and wealthy individuals was receiving a lot of publicity. Any move to increase the personal tax contributions from middle- and low-income earners would be likely to meet with resistance if the government was not perceived to have made significant progress in closing tax loopholes and reducing tax evasion.

Modelling of how we will pay for the cost of care in future tends to focus on changes to National Insurance, personal income tax or value-added tax. Future modelling might usefully explore the contribution that changes in the levels of tax evasion and avoidance by companies and individuals would make to funding levels.

The received wisdom is that support for the collective funding of health care is weaker among younger generations, but our findings suggest that this group does support the concept, appreciating that the cost of health care can be high and therefore likely to be unaffordable.

International comparisons

Many participants had direct experience of other health systems, having lived or worked abroad at some point. They used these as points of reference, and on the whole their experiences led them to be grateful for the NHS.

Even among those who did not have direct experience, there was a strong desire for information about how things work in other countries. The United States was used as a counterpoint in discussions – with a widespread view that the NHS was better than the system there.

There is a strong view among the general public, often perpetuated by the media, that the NHS is unique, an idea used by both supporters and detractors of the NHS. In fact, however, most European countries have collective funding of health care and (near) universalism. Although user charges apply more widely in other countries, they are usually quite modest amounts. It might, therefore, be helpful to highlight the similarities between the NHS and the health systems in other European countries, particularly in terms of these fundamental principles, as well as explaining how and why they differ.

Personal experience

In polling and surveys generally, people who have had recent contact with the NHS are usually more satisfied, on average, than people who have not had recent contact. Our participants' views about the future funding of health care were coloured by their personal experiences or those of close friends or family members in two distinct ways: first, gratitude that the care was provided free of charge, and recognition that they might not have been able to afford to access that care if they had had to pay for it; but, second, a view that the quality of care was variable and that there is waste.

This suggests that those who have had contact with the NHS are likely to be more strongly wedded to the fundamental principles underpinning it, and will also want to see improvements in care and efficiency before any other changes are made.

Incrementalism versus 'big bang'

Participants found it difficult to imagine things being very different from the way they are at present. People seemed to have quickly recalibrated their expectations so that, for example, recent improvements in waiting times have become the new minimum standard.

Similarly, charges were more acceptable where they are currently in place, for example, for dental and optical services. Participants were able to have a principled discussion about the criteria for determining whether some types of services should be charged for and others not, but their views appeared to be influenced by the current charging system.

This suggests that any changes should be introduced incrementally. For example, small charges could be introduced for some services that are seen to be discretionary, such as walk-in centres. As acceptability of this grows, those charges could then be increased or extended to other services. Similarly, rather than undertaking a large-scale exercise to define a more limited benefits package for the NHS, the National Institute for Health and Clinical Excellence could gradually review existing services and recommend those that should be decommissioned.

Conclusions

When presented with facts and clear information, participants started to understand the size of the funding challenge. They expressed an interest in having more information on how the health system is funded and were willing to discuss the issues.

Most accepted that the NHS is under pressure, but few accepted that this is on a scale to justify changing the fundamental principles on which the NHS is based. It is interesting that despite the wider economic situation and the cuts being applied to other public services, there was a lack of urgency about the financial challenges facing the NHS. The numbers are so large that it may be difficult for the public to engage with this issue in a meaningful way. People greatly value the system as it operates at present and are conservative about change.

Although we might not need to face these issues and dilemmas immediately (Appleby 2013), the NHS is currently facing the most challenging financial period in its history and it is therefore likely that at some point the fundamental principles that underpin the NHS will be challenged. Preparing the public for this debate and understanding how to communicate these issues will be vital if we are to engage them in that decision-making process.

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Appendix A Discussion guide

Research objectives

- To assess to what extent participants accept that there is a need to change the way that health care is funded.
- To explore the acceptability of different options, including means-testing, top-up fees and limiting access on the basis of lifestyle choices.

Aims	Activities	Timings
To set the scene	Welcome and introduction <ul style="list-style-type: none"> ■ Anna and Amy to welcome participants, introduce The King's Fund, and explain why we are running the event. ■ Dan to introduce staff and their roles, explain the format of the day and that we will be discussing how we are going to pay for health care in the future, the choices we face as a society and what they think about these. ■ Each topic will be introduced in more detail as we go along. 	10.00–10.15
To warm up participants To assess awareness of funding issues in the NHS	Current perceptions and future funding issues <ul style="list-style-type: none"> ■ Aim: to gather baseline data on current perceptions of the NHS, and to start to move people towards the funding debate. ■ Ask quantitative questions about key perceptions of the NHS. ■ Dan to introduce task in plenary session before moving into groups. ■ In groups: participants to introduce themselves to one another and mention when the last time they used the NHS was. ■ When you think of the NHS, what are the first words that spring to mind? Explore reasons. ■ What do you see as the main challenges facing the NHS? ■ Probe: mentions of funding/financial difficulties/ageing population/cost of medicine/cost of care/cost of technology/patient expectations, etc. ■ What do you know about the way in which health care is currently funded in England? ■ Prompt: taxation, National Insurance, charging, etc. ■ What services do people pay for themselves? Are people exempt? ■ What do you think about the way health care is funded currently? ■ What pressures are you aware of on health care funding? ■ Probe: what kind of issues? Where have you heard about this? ■ If aware of issues: how do you think they impact on the NHS? How should we pay for health care in the future? Probe fully. 	10.15–10.45
	<ul style="list-style-type: none"> ■ Presentation: Anna to give a short presentation answering some of the questions above (ie, which services do we pay for, and then presenting the case for change including the question mark over future sustainability). ■ Any questions. 	10.45–11.10
To assess response to presentation and acceptance that funding will need to change	Responses to presentation <ul style="list-style-type: none"> ■ Dan to introduce next exercise looking at reactions to the presentation. Each group will be asked to give feedback to the room at the end of the session, detailing how they would address the challenges. ■ In groups: what did you think of that? Was there anything in that presentation that was new or surprising to you? ■ Probe: what surprised you? Why? ■ What do you think could be done about the issues raised? ■ Which of the ideas that we've come up with would be best? Why? ■ One participant from each table to summarise the debate and feedback solutions to the challenge. 	11.10–11.30
	BREAK	11.30–11.45

Aims	Activities	Timings
To determine which services should be free and the criteria for determining this	<p>What would you be willing to pay for?</p> <ul style="list-style-type: none"> ■ Anna to present on the idea of individuals paying for some services when they use them. Presentation should be conceptual initially – we will provide showcards to test individual services. ■ In groups: what did you think of that? Was there anything in that presentation that was new or surprising to you? ■ Probe: what surprised you? Why? ■ Showcards with services: participants to work individually on each showcard and tick three services on each showcard that they think it would be most acceptable for people to pay for. ■ Which of these do you think people could be asked to pay for? ■ Are there some services that you might be more or less willing to pay for? Why? ■ Each group to come up with at least three services that they think people could be asked to pay for. ■ Showcard to show prices for each service. ■ What impact does the price have on your previous decision? ■ Would you still choose the same three services? Why? Why not? 	11.45–12.30
LUNCH		12.30–1.15
To explore means-testing	<p>Anna to present on the idea of means-testing</p> <ul style="list-style-type: none"> ■ Dan to introduce plenary exercise – general reactions followed by case studies. ■ What did you think of that? Was there anything in that presentation that was new or surprising to you? ■ Probe: what surprised you? Why? ■ Is there anyone who should have to pay? Why some people and not others? ■ How should this be decided? ■ How much should they have to pay – part or all? ■ For each scenario: <ul style="list-style-type: none"> – What do you think of this? – Should this person have to contribute something to the cost of their care or not? Why? Why not? ■ For scenario A (Mary): <ul style="list-style-type: none"> – What do you think of Mary's current situation? – Should Mary receive tax relief for her spending on acupuncture? Why/why not? – In future, Mary may request a 'personal health budget' for her arthritis. She would be able to spend the money however she chooses. If she opted for the acupuncture, this could save the NHS money. What do you think about this? ■ For scenario B (Paul): <ul style="list-style-type: none"> – What do you think of Paul's current situation? – The NHS has decided that the cost of sports injuries have to be paid for privately. What do you think of this decision? – Private health insurance companies are offering a new 'sports injury cover' product. Do you think Paul should buy this? ■ For scenario C (Margaret): <ul style="list-style-type: none"> – What do you think of Margaret's current situation? – Margaret's insurance does not cover pre-existing conditions. What do you think of this? – In future, insurers would be required to cover pre-existing conditions. This would mean that Margaret would have to pay a higher monthly cost towards her insurance, which is currently covered by her company. What do you think about this? – In Margaret's company, only senior managers get health insurance. In future, employers of large organisations would have to provide health insurance for all their employees. What do you think about this? 	1.15–2.00

Aims	Activities	Timings
<p>To explore means-testing <i>continued</i></p>	<ul style="list-style-type: none"> ■ For scenario D (Jane): <ul style="list-style-type: none"> – What do you think of Jane’s current situation? – What do you think about the fact that Jane has to pay if she chooses the most expensive treatment? – In future, the NHS would pay the amount of the cheaper treatment, and if Jane were to opt for the more expensive one, she would have to pay for the difference herself. What do you think about this? – There is a new private health insurance product on the market that would cover the difference she will have to pay. Do you think Jane should have taken out this insurance product? ■ For scenario E (David): <ul style="list-style-type: none"> – What do you think of David’s current situation? – What do you think about David’s decision to take out health insurance and use the private sector for his knee replacements? – In future, people like David might be required to take out health insurance and use private facilities (rather than using an NHS hospital) in order to take the pressure off the NHS. What do you think about this? Do you think David should get tax relief since he is not using the NHS? Why/why not? 	
<p>To assess acceptability of paying to ‘top up’ care</p>	<p>Anna to present on the idea of a two-tier health care system</p> <ul style="list-style-type: none"> ■ What did you think of that? Was there anything in that presentation that was new or surprising to you? ■ Probe: what surprised you? Why? ■ A two-tier health system would involve a reduction in the basic level of quality offered by the NHS. For example, people might have to wait longer to see doctors, be offered only generic drugs, or have to use mixed-sex wards. What do you think is the minimum level of quality that we can expect from the NHS? ■ How would you make sure that people get this level of quality? ■ Which of these, if any, would you be willing to pay for? <ul style="list-style-type: none"> – Speed – Hotel facilities – Clinical upgrades ■ Is there anything on the list that you don’t think anyone should ever have to pay for? Why? ■ Are there any things not on this list that you think everyone should have to pay for? Why/why not? 	<p>2.00–2.30</p>
	<p>BREAK</p>	<p>2.30–2.45</p>
<p>Q&A</p>	<p>Q&A with Anna</p>	<p>2.45–3.00</p>
<p>To wrap up the event</p>	<p>Wrap-up</p> <ul style="list-style-type: none"> ■ Overall, what do you think of the issues we have discussed today? ■ We have looked at different options to address the sustainability of health care in the future – making some people pay; cutting back on some services; offering a basic package and using out-of-pocket payments for the rest – of these three solutions, which do you think would be the best? Why? ■ We also looked at other things we could do like increasing taxation, becoming more efficient, etc. Taking everything into consideration, how would you choose to pay for health care in the future? ■ Do you think this solution would solve the financial problem we have been talking about? Why/why not? ■ What do you think is the most important factor to consider when deciding how to fund the NHS? ■ Each group to present back to the room a summary of where they got to on best solution and how they decided this. ■ Activity: each participant to vote for their preferred funding method. ■ Ask quantitative questions about key perceptions of the NHS. ■ Any final questions? 	<p>3.00–3.40</p>
<p>To summarise the event</p>	<p>Summary</p> <ul style="list-style-type: none"> ■ Plenary: a brief summary of what has been covered. ■ Anna and Dan to thank and close. ■ Distribution of post-questionnaires/incentives. 	<p>3.40–4.00</p>

Appendix B Voting results (London only)

Table A1 At the start of the event

Question	Response (%)	No. of responses
1. Overall, how satisfied or dissatisfied are you with the running of the NHS nowadays?		34
a) Very satisfied	6	
b) Quite satisfied	53	
c) Neither satisfied nor dissatisfied	21	
d) Quite dissatisfied	12	
e) Very dissatisfied	6	
f) Don't know	2	
2. To what extent do you agree or disagree with the following statement: 'There should be limits to what we spend on the NHS?'		32
a) Strongly agree	6	
b) Tend to agree	38	
c) Neither agree nor disagree	22	
d) Tend to disagree	25	
e) Strongly disagree	9	
f) Don't know	0	
3. Which of the following statements best reflects your thinking about the NHS?		34
a) The NHS is crucial to British society and we must do everything to maintain it	65	
b) The NHS was a great project but we probably can't maintain it in its current form	35	

Table A2 At the end of the event

Question	Response (%)	No. of responses
1. Overall, how satisfied or dissatisfied are you with the running of the NHS nowadays? <i>This question was not asked again at the end of the event</i>		
2. To what extent do you agree or disagree with the following statement: 'There should be limits to what we spend on the NHS?'		32
a) Strongly agree	15	
b) Tend to agree	44	
c) Neither agree nor disagree	6	
d) Tend to disagree	26	
e) Strongly disagree	6	
f) Don't know	3	
3. Which of the following statements best reflects your thinking about the NHS?		36
a) The NHS is crucial to British society and we must do everything to maintain it	67	
b) The NHS was a great project but we probably can't maintain it in its current form	33	

Appendix C Examples of paying for services

What services would you **pay** for?

Tick *only three* of the services below

- Ambulance journey for a planned hospital appointment
- Ambulance journey from an accident scene
- Accident & Emergency visit
- Hospital admission (for an overnight stay)
- GP appointment
- Visit to walk-in centre
- Visit to a Family Planning clinic

A1

- Ambulance journey for a planned hospital appointment **£233**
- Ambulance journey from an accident scene **£344**
- Accident & Emergency visit **£111**
- Hospital admission (for an overnight stay) **£250**
- GP appointment **£32**
- Visit to walk-in centre **£63**
- Visit to a Family Planning clinic **£44**

* These are rough estimates of the average costs **A2**

What services would you **pay** for?

Tick *only three* of the services below

- Routine health checks (offered to people aged 30–64 years)
- Routine foot checks for diabetics
- Regular six-month dental check up
- Antenatal appointment

B1

- Routine health checks (offered to people aged 30–64 years) **£40**
- Routine foot checks for diabetics **£72**
- Regular six-month dental check up **£17.50**
- Antenatal appointment **£120**

* These are rough estimates of the average costs **B2**

What services would you **pay** for?

Tick *only three* of the services below

- Cosmetic surgery
- Surgery to reduce appetite (gastric band in morbidly obese patients)
- Hip replacement
- Routine birth
- Caesarean section

C1

- Cosmetic surgery (**for example, a tummy tuck = £14,000**)
- Surgery to reduce appetite (gastric band in morbidly obese patients) **£15,000**
- Hip replacement **£6,000**
- Routine birth **£825**
- Caesarean section **£2,000**

* These are rough estimates of the average costs **C2**

Appendix D Scenarios

Salaries, tax contributions and health care costs in these scenarios are approximations and used for illustrative purposes only.

Mary Jones, 87-year-old retiree

Occupation: pensioner

Pension: £3,900 per annum (state pension only; this is the average in England)

Health care insurance: none

Lifestyle: Mary lives in Nottingham in a two-up two-down house which she owned with her late husband John, who passed away 5 years ago. She pops over to her neighbour's house at teatime every other day and is still quite active in her local community

Health care needs: Mary suffers from arthritis which has been worsening over the past few years. As a consequence she is struggling to see to her daily household chores. At the age of 40, Mary suffered from heart failure. This was a consequence of a long-standing fatty diet. She underwent bypass surgery and has been well ever since. She no longer has heart-related health care needs, apart from a routine check-up every year

Health care costs: Mary is currently prescribed drugs to manage the pain of her arthritis, costing the NHS up to £6,492 per year. Mary has recently started having acupuncture and is finding that she needs to take fewer painkillers. Mary has paid for the acupuncture out of her own money at a cost of £50 per session but doesn't think she can afford to keep it up. She would rather not take a lot of drugs

A

Paul Baker, 38-year-old manager

Occupation: sales and letting manager

Salary: £55,000 per annum. Paul contributes an average of £4,124 per annum to health care through tax

Health care insurance: none

Lifestyle: Paul lives with his partner in a two-bedroom rented flat in Kensington. He prides himself on having a good work-life balance and enjoys meeting friends at the pub. He plays rugby twice a week and usually has a competitive match on Saturdays

Health care needs: Paul has suffered several injuries. He has broken his arm twice, nose once, and leg twice over the past 10 years

Health care costs: on one occasion, his broken leg was quite severe and required four operations and countless x-rays and physiotherapy. Fixing a broken leg costs the NHS around £2,000–3,500, and a visit to Accident & Emergency costs about £111. This gives an idea of how much Paul's treatment cost

B

Margaret Brown, 55-year-old businesswoman

Occupation: director of Fab Marketing plc

Salary: £120,000 per annum. Margaret contributes an average of £9,689 per annum to health care through tax

Health care insurance: yes (employee benefit)

Lifestyle: as a mother of two children, Margaret has a very busy lifestyle. Her husband is a freelance designer who works mostly from home. They live in Brighton and Margaret commutes into London daily

Health care needs: Margaret has been suffering from hereditary diabetes since the age of 26. She has managed to keep this under control. She has done this by regular insulin injections, diet management and routine checks of her blood-sugar levels, blood pressure and cholesterol levels

Health care costs: Margaret mostly manages her care herself but has regular contact with the nurse at her local GP practice and occasional outpatient appointments. The annual cost of her treatment is likely to be in the region of £1,000–2,233. Her insurance does not cover this condition so the NHS pays

C

Jane Miller, 35-year-old sales assistant

Occupation: sales assistant in a fashion outlet

Salary: £30,000 per annum. Jane contributes an average of £2,193 per annum to health care through tax

Health care insurance: none

Lifestyle: Jane is passionate about the fashion industry and has many creative interests. She lives in a rented studio flat in the heart of Manchester. She jogs three times a week and enjoys socialising with friends

Health care needs: Jane has a balanced diet and has just started visiting her GP for regular health checks. Recently, she discovered a lump in her breast and after several tests she has been diagnosed with early stage cancer. She is waiting for her chemotherapy plan and is currently discussing her treatment options with her doctor

Health care costs: depending on which treatment plan she undergoes, the costs of treating Jane's breast cancer could vary between £21,000 and £40,000. If she chooses the more expensive treatment, she will have to pay the whole cost herself

D

David Chamberlain, 80-year-old retiree

Occupation: pensioner (retired writer)

Pension: £15,000 per year (state + private pension). David contributes an average of £730 per annum to health care through tax

Health care insurance: yes. He took this out 10 years ago and keeps up regular monthly payments of £110

Lifestyle: David lives with his wife Catherine in a cottage in Oxfordshire. He has written two successful books which have given him financial stability. Since his retirement he has taken up painting. He and his wife enjoy going abroad at least twice a year – they are still both very active

Health care needs: David has always taken very good care of himself and to date has had no intense health needs. However, he recently had both knees replaced. These operations were successful and he is doing well

Health care costs: David's operations took place in a private hospital. The majority of the cost (£15,000) was paid by his insurer and he had to pay £1,500 himself. If this operation had been done by the NHS, it would have cost the NHS £10,000

E

Appendix E Group solutions - feedback session

The groups were asked: 'Taking everything we spoke about today into consideration, how would you choose to pay for health care in future?'. Each group summarised their main conclusions, which are shown below.

London, age 16–24 years

- Against top-ups within the NHS; do not accept the idea of a two-tier system.
- Maintain the same level of service for everyone, everywhere. Those who want something better should seek care in a private hospital.
- Support the idea of means-testing in the NHS. People on very high incomes might resist it but most people might support it.
- Work volunteering schemes into the NHS: people who are on benefits and are receiving care should give back some time to the NHS.

London, age 25–35 years

- Increase taxes and National Insurance.
- People should pay more if they can afford to.
- The NHS should aim to do things better.
- Education and prevention important.
- Prevention is better than cure.
- Idea of 'tough love' – people pay if they have irresponsible health behaviours.

London, age 36–47 years

- Get a better understanding of what the money is being spent on.
- Pay more into your health care if your lifestyle choices are affecting your health.
- Prevention is key and is the only way to get to the heart of the problem.
- Universality is the most fundamental principle.
- Allow people on very high incomes to upgrade.
- Those who come from other countries can only benefit from the NHS after they have paid into the taxation system for at least two years.

London, age 48–57 years

- Charge upgrades for better 'hotel facilities'.
- Not enough consultation on the NHS, we should be asked what we want more often.
- Some appetite for additional taxes.
- Keep costs down.
- Educate people coming into the country about the NHS and how to use it.
- 'Big society' approach – use more volunteering, community workers, no need to have expensive professionals doing some of the work.

London, age 58 years or older

- Acceptable to pay for 'hotel facilities' while in hospital.
- Tax relief for those who have private health insurance. This would encourage more people to take out such insurance plans.
- Educate the population about health and healthy lifestyles.

Leeds, age 19–26 years

- Basic package of care provided by the NHS and charge for better care (as long as basic package means the current service).
- Close tax loopholes.

Leeds, age 27–37 years

- Like the NHS as it is, no quick fixes.
- Educate children and adults about health and healthy eating.
- Charges: paying for health checks, a lot of people would not mind a small contribution towards this. Maybe £10.
- Paying for missed appointments.
- Small contribution for walk-in centres as they are seen as a convenient service.
- Charge for surgery that is a consequence of lifestyle, such as obesity and vanity.
- Making people aware of cost of services in the NHS.
- Allow the NHS to test and provide alternative treatments such as acupuncture (they might be cheaper for the NHS in the long run).
- Prevention is better than cure.
- Reallocation of money from other governmental departments, such as defence.

Leeds, age 38–50 years

- Options presented during the day unpalatable.
- No one comfortable with means-testing.
- Equally split about increasing revenue by paying for some services and having a two-tier system.
- Pay for things not medically necessary, for example, elective caesarean section.
- Education seen as very important (diet, exercise and knowledge of how much services cost).
- Tackle people who take advantage of the system.
- Address inefficiencies in the system.

Leeds, age 51–62 years

- Improve people's knowledge.
- Make people understand the size of the challenge.
- Lower services to a basic standard but do not compromise clinical care.
- Paying for non-essential services acceptable, although this should not be the whole cost, but a contribution.
- Increase people's awareness of costs of services.

Leeds, age 63 years or older

- Increase taxes.
- Everyone pays for better 'hotel facilities'.
- Everyone pays for their food, not just better food.
- 'Super people on very high incomes' pay for all services.
- Certain services should be paid for by everyone, for example, cosmetic surgery, walk-in clinics, anything related to irresponsible behaviour (missed appointments).

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