The Future of the NHS in England

Deliberation for the Health Foundation – appendices

May 2024

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1 Introduction

The Health Foundation commissioned Ipsos to undertake deliberative research with the public in England, in order to:

- Build upon the Health Foundation/ Ipsos survey programme, to provide deeper qualitative insights around the quantitative findings.
- Generate evidence on the public perspective of the NHS, to feed into discussions about the future of the NHS at this critical time.
- Provide policymakers with evidence and insight to inform their decisions and communications with the public about NHS reform particularly given the context of an election in 2024.

The research comprised three workshops, each taking place over the course of a weekend in a different location and with a different cohort of the public (28-29th October 2023 in King's Lynn, 11-12th November 2023 in Leeds, and 25-26th November 2023 in London). In total, 72 participants were included in the research, broadly reflecting the wider population living in England.

These appendices provide the discussion guides and stimulus used in the workshops. Please refer to the report for further details on the deliberative methodology and findings.

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2 Discussion guide – day 1

HF future of the health system deliberation: day 1, London

Saturday 28th October – 9:30am-4pm. DISCUSSION GUIDE

Prompts in bold text are priority to ask.

Time	Discussion structure	Questions and materials
9.30-10.00	**Arrival and registration**	**Participants arrive at the venue and are signed in and are allocated to a table, of which there will be 3 tables of 8 participants.**
10.00-10.05	**Introduction and scene setting** **Plenary.**	**Ipsos Chair to welcome the room to the session:** Introducing HF, Ipsos, expert commentators, observers, moderators and note takers. Explaining the purpose and ground rules of the deliberation and the role of participants over the weekend. Explaining this is day 1 of 2, and providing a high level overview of the weekend. Also covering ground rules and housekeeping – i.e. breaks, toilets, lunch area and fire alarm. Chair to introduce the 'mythbusting wall' – a wall with some key facts about the NHS (e.g. about levels of waste within the NHS and numbers of managers) that participants/facilitators can refer to through the weekend.
10:05 - 10:15	**Meet and greet at tables** **Table discussion**	**Table introductions and ice breaker (10 mins)** • *Facilitator introduces themselves and the table's note taker, thanks participants for coming.* • *To introduce us all to each other, facilitator asks participants to turn to the person next to them and spend 30 seconds each finding out about each other (name, where they live and one thing they appreciate about the NHS). Participants then introduce their neighbour to the table by sharing their answers* (<u>10 mins</u>).
10:15 - 10:40	**Participants' understanding of the current situation and its causes** **Table discussion**	**Table discussions (25 mins)** Facilitator to ask people to express words that come to mind when they think of the current situation in the health system. Facilitator to write words on flipchart and to group them in themes and cluster themes under 'positive' and negative' on the flipchart. Prompt questions (<u>10 mins):</u> • **What word first comes to mind when you think of the current state of play in the health system?** • **Why do you think this word came to your mind?** • If we were having this conversation ten years ago would you have chosen a different word?

<table>
<tr><td></td><td></td><td>What other words on the flipchart do you agree with? Are there any you're not sure about?
How do you feel when you look at all these words on the flipchart?
Facilitator to ask people to think about what might have caused the current state of play (whether they think the current situation is good or bad).

Prompt questions (<u>10 minutes</u>):
What factors do you think have contributed to the current state of the health system?
Are there any particular (i) decisions (ii) past events (iii) changes that you think have had a big impact on the current situation?
(if they have a negative view of the current situation): How deep do you think the problems are? How far back do they go? How long do you think it would take to address the problems? Do you think these problems can ever be fully addressed?
(if they have a positive view of the current situation): Are you feeling positive about the future of the health service? Has your view about the health service changed over time or stayed the same?
Facilitator to ask participants whether they have any questions based on the discussion so far. Facilitator to note down questions. (<u>5 mins</u>)

Facilitator to explain that we are now going to learn more about how the health system works.</td></tr>
<tr><td>10:40 - 10:45</td><td>How the health and care system works

Plenary</td><td>Presentation on the makeup of the NHS (5 mins)</td></tr>
<tr><td>10:45 - 10:55</td><td>Specialist Q&A

Plenary</td><td>Plenary Q&A (10 mins): Opportunity for participants to ask Qs to allow for any misperceptions to be corrected, and also to provide complete clarity on how the health system works. Facilitators to encourage people on their table to ask Qs they noted down earlier in the day.</td></tr>
<tr><td>10:55 – 11:05</td><td>BREAK</td><td>10 mins</td></tr>
</table>

<table>
<tr><td>11:05
–
11:20</td><td>Participants' basic expectations and principles regarding the health service

Table discussion</td><td>Table discussion (15 mins)

Prompt questions (<u>15 mins</u>):
• What basic expectations do you have of the NHS? What are the most important things you would expect? Do you think that's a reasonable expectation?
• What emotions should be associated with receiving care in the NHS?
• Where do you expect to receive care in the NHS and from who?</td></tr>
<tr><td>11:20
-
11:35</td><td>Constraints for the NHS due to limited finances, workforce and capacity

Plenary</td><td>Presentation (15 mins)

Presentation introducing the constraints facing the NHS: presenter outlining pressure on different parts of the system (e.g. mental health and community services as well as GP and hospital care) and explaining that there will be constraints on what the NHS can do due to supply-side challenges (i.e. assuming the NHS has to work within the current funding plans sharing the difficulties associated with recruitment and retention and capacity issues) and demand-side challenges (larger population, older population, growth in long-term conditions and multi-morbidity and health inequalities). Presenter to make clear that no additional money has yet been promised by either major party.</td></tr>
<tr><td>11:35
-
11:45</td><td>Specialist Q&A

Plenary</td><td>Plenary Q&A (10 mins): Opportunity for participants to ask Qs to allow for any misperceptions to be corrected</td></tr>
<tr><td>11:45
-
12:05</td><td>Initial responses to NHS constraints

Table discussion</td><td>Table discussion (20 mins)

Facilitator to ask for participants' initial responses to the presentation. Prompt Qs (20 mins):
• Does the presentation leave you with any questions, reflections or concerns?
• Think back to our earlier conversation about the state of the NHS and what has caused this. Reflecting on the previous presentation, how do you feel now?
• How do you feel about the future of the NHS?
• (facilitator to hand deck of 'NHS priorities cards to every pair on the table with a series of 'NHS priorities' and to ask participants to select the three highest priorities and the three lowest priorities). These challenges place limits on what it is possible for the NHS to do in the short term. Having heard about these challenges what do you feel should be a priority for the NHS? What should not be a priority for the NHS?

Facilitator to explain that it is time for lunch and that the session will restart at 12:45pm.</td></tr>
</table>

<table>
<tr><td>12:05
-
12:45</td><td>LUNCH</td><td>40 mins

Chair to welcome people back and introduce the session.</td></tr>
<tr><td>12:45
–
12:55</td><td>Introduction to first topic: community and primary care vs hospital care

Plenary</td><td>Presentation (10 mins)

Introduction to the topic covering the distinction between primary/community care and hospital care and how they fit together; the dilemma about where to focus attention and resources; examples of how targeted approaches in each of these areas may lead to better patient outcomes; potential trade-offs between these two options.

The dilemma: NHS capacity is constrained, with more resources going to hospitals at the expense of other services. With limited resources, we face a choice about where to focus and the balance between primary and community care, or hospital care.

Introducing the first key topic of deliberation: Working within its current constraints, what should the NHS's focus be to improve services for patients: primary and community care or hospital care?</td></tr>
<tr><td>12:55
-
13:10</td><td>Spontaneous view on the trade-off

Plenary</td><td>Plenary (15 mins)

Lead facilitator to ask participants to physically position themselves on a spectrum in the room according to where they think the focus for improvements in the NHS should be. The right side of the room represents increased focus on hospital care, the left side of the room represents an increased focus on community/primary care and 2/3 of the way to the right-hand side represents a continuation of the status quo (i.e. slightly more skewed to hospital care).

Facilitator to ask for volunteers on either extreme, and participants in the middle, to share why they chose their position. Experts to be on hand to probe participants on some of the trade-offs of all three positions:

People on primary care side:
Why did you choose to stand in this position?
How do you feel about the possibility that:
Prioritising primary and community care may mean less focus can be given to services that respond to urgent needs and life-threatening conditions that are traditionally treated in hospital
Prioritising primary and community care may mean many people continue to experience very long waits for hospital treatment
Prioritising primary and community care may also mean there is less capacity in hospitals, which could mean that GPs spend more time managing patients who are waiting for specialist care.</td></tr>
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<table>
<tr><td></td><td></td><td>
(Facilitator to try to choose a few people, raising one of the preceding trade-offs with each)

People on hospital care side:

Why did you choose to stand in this position?
How do you feel about the possibility that:

Prioritising hospital care may mean less focus on conditions and issues that affect a much larger number of people in England.
Prioritising hospital care may mean that GP appointments may remain hard to get for many people.
Prioritising hospital care may also mean there is less capacity to help people manage their conditions, which could mean that more people end up needing hospital care which costs more money for the NHS.
(Facilitator to try to choose a few people, raising one of the preceding trade-offs with each):

People in the ’status quo’ position:

Why did you choose to stand in this position?
Think back to what you said earlier about current situation in the NHS. Spreading resources across both these areas, as they currently are, could mean a continuation, and perhaps a worsening, of this situation. How does that make you feel?
In the absence of additional funding see all the downsides associated with the other two positions (i.e. problems seeing a GP, long waits for emergency and planned hospital treatment) plus wider issues with patient flow, higher risk of failures in care quality and more staffing issues because no part of the system is working well. How do you feel about this?

Lead facilitator to summarise by explaining that this exercise shows there is no perfect or ‘correct’ way of striking a balance between these two positions. Making a decision requires balancing priorities, and all options have associated strengths and drawbacks. This is as much the case with the ‘status quo’ position as any other, and participants should view the status quo also as a genuine choice with risks and drawbacks. The rest of the day will be spent discussing in greater depth how to strike this balance.

Participants to return to their original tables.
</td></tr>
<tr><td>13:10 - 13:30</td><td>Initial discussion about the trade-off

Table discussion</td><td>
Table discussions (20 mins)

<u>Note:</u> It is possible that participants will reject the premise of this trade-off and say they want money prioritised for particular treatments or conditions rather than in primary or secondary care. In this case it would be helpful to (i) remind participants that we are simply discussing where the primary focus should be, not where all funding goes, and (ii) to ask participants which aspect of
</td></tr>
</table>

		treating this condition they would like to be prioritised (I.e. diagnosis and ongoing management of the condition in primary care or more targeted treatment in secondary care). Note: Participants may bring up the role of social care and ask why we are not discussing it. In this case it is worth probing people on the links between primary/secondary care and social care, but also explaining that due to limited time we have to primarily focus on the NHS during this process. Facilitator to probe participants on the trade-offs of different options: • **Breadth/depth of impact: Primary and community care services reach higher numbers of people (such as GPs which provide comprehensive healthcare to a wide range of patients in the community), but the benefit for each patient may be lower because their needs are less acute or urgent. Hospital care reaches smaller numbers of people, but the benefit for each patient may be higher because their needs are more acute or urgent. How does this make you feel?** • **Future demand: Health conditions that are usually diagnosed and managed in primary and community care are expected to increase at the fastest rate, reinforcing the need to invest in general practice and community-based services. But the amount that people need hospital care is expected to increase too. How does this make you feel?** • **GP wait times vs hospital wait times: Focusing on primary and community care may make it easier to get a suitable appointment at your local GP practice if you need it. Focusing on hospital care, on the other hand, is likely to reduce how long you wait for hospital treatment if you need it. How does this make you feel?** • **Cost: Primary and community care can be less expensive to deliver than hospital care. For example, it is estimated that in 2021/22 the average 9-minute in-person GP consultation cost £42, whereas the average A&E visit cost £86-418 (depending on the level of investigation and treatment needed), and £367 for an ambulance call out where the patient is transferred to hospital. How does this make you feel?** • **Long/short-term impact on waiting lists**: By helping people to manage their conditions, primary and community care can help to bring hospital waiting times down in the longer-term as it can mean that fewer people get to the point of needing hospital care (note that most hospital stays happen when a chronic illness that would generally be treated in primary care has got much worse). Focusing on hospital care, on the other hand, may bring hospital waiting times down in the shorter-term but without impacting on how many people might need to go to hospital in the future or improving the population's overall health. How does this make you feel?

<table>
<tr><td></td><td></td><td><u>Managing conditions vs responding to acute need</u>: Primary and community care services can help to promote good health for all, prevent illness and support people to stay well and live independently for longer, which can have positive impacts on their lives (i.e. on their work situation and families). However, hospital care can help to diagnose, treat and manage more complex conditions that need specialist expertise, including people in potentially life-threatening situations, which may also have positive impacts on their lives. How does this make you feel?
<u>Where care is delivered:</u> Focusing on primary and community care may mean more services are delivered in the community and closer to where you live, in General Practice, local pharmacies, care homes, local clinics and other community spaces. Hospital care is more likely to be delivered further from home, in hospitals and specialist care units. How does this make you feel?
<u>Generalist vs specialist care:</u> Primary and community care is organised around providing ongoing care for all common medical conditions and coordinating care for people with more complex needs. Hospital care is organised around providing more one-off care for patients who require specialist attention, focusing on diagnosing, treating or managing a specific medical condition. How does this make you feel?
Facilitator to ask participants which of the ‘factors we need to consider’ (on page 43 in participants’ packs) are most important to them.

Facilitators to finish by gathering any questions from participants to pose to experts.</td></tr>
<tr><td>13:30
-
13:45</td><td>Specialist Q&A

Plenary</td><td>Plenary Q&A (15 mins): Opportunity for participants to ask Qs to allow for any misperceptions to be corrected, particularly on the primary/community vs hospital care discussion. Facilitators to encourage people on their table to ask Qs they noted down in the previous session.</td></tr>
<tr><td>13:45
-
14:00</td><td>Break</td><td>15 mins</td></tr>
<tr><td>14:00
-
14:10</td><td>Presentation on specific policy approaches

Plenary</td><td>Presentation (10 mins)

Presenter to cover key factors to consider when weighing up policies and to give an overview of several policy approaches for both primary and community care:

Primary/community:
Continuity of care</td></tr>
</table>

		• Extended teams in general practice • Urgent community response services Hospital: • Same day emergency care • Virtual wards • Elective surgery hubs
14:10 - 15:35	**Group discussion on specific policy approaches** **Table discussion**	**Table discussions (1h 25 mins)** Facilitator to start by asking participants to imagine they are on a policymaking committee, made up of professionals and patients, recommending how to allocate a set amount of funding between different proposals. Facilitator to hand each participant a quote card, chosen to reflect different priorities and positions. Facilitator to ask participants to take a quote card, to take on the persona on the quote card they are given, and to introduce their persona to the group (10 mins) From 14:20: Facilitator to explain that the rest of the time will be spent learning about and comparing different policy options (set out on 'fact files' featuring an overview of the policy and some key information on workforce impacts, where people receive care, impact on health inequalities, breadth vs depth of impact, cost of approach and how long it will take for benefits to be realised). Facilitator to explain that the table will be comparing primary/community care approaches with hospital care approaches to understand if our views about how to balance primary and hospital care change when we consider specific policies. Facilitator to acknowledge that these are very different types of interventions, but that the purpose of this session is for them to decide which they would invest a set amount of money in, if given the choice, and why. Facilitator to explain that we will be swapping in and out different approaches (each on a card) to compare and contrast them (see order of rotations below). Each approach will be rated according to several common 'factors' – these factors will have been introduced during the previous presentation and will be set out on an a3 poster on the table. Facilitator to explain that the table will start by considering one approach on its own. Facilitator to hand a deck of cards ('factfiles') to every pair on the table – there will be five decks on every table (including 1 for the facilitator)

Facilitator to start by reading through one of the primary/community care approaches (see order for groups below). For all approaches start by asking participants (approx. 10 mins):

- How do you feel about this idea?
- Which of the 'factors' on the fact-file do you think your persona would find most important? How do you feel about this?
- How do you feel the person on your quote card would feel about this idea?
- Do you and your 'persona' feel the same? If so, why?
- Do you and your 'persona' feel different? If so, why?

Facilitator to introduce a hospital care approach to enable a comparison with the original primary care approach (see order below). Start each comparison by asking more general prompt questions (approx. 15 mins in total to compare):

- How do you feel about this idea?
- Look at the information on the right-hand side of the fact-file. Can you spot any notable differences between this approach and the other approach card on the table? How do you feel about these difference(s)?
- How do you think your 'persona' might feel about these difference(s)? Does this differ from your view and why?
- As a policymaking committee do you have a view on which of these you would prioritise? Why?

After asking the more general questions about each approach and comparison, the facilitator can ask more detailed probes that hone in on particular contrasts between the approaches.

This process of swapping in and out approaches will repeat 2 more times. Each time the facilitator will start by asking more general questions (set out above) before delving into the more detailed questions (set out below)

See specific rotations and more detailed prompts below. It will help to ask these questions of the participants themselves and of the persona on their 'quotecard'.

	Group 1		**Group 2**		**Group 3**	
14:20-14:30	Continuity of care	n/a	Extended teams	n/a	Urgent community response services	n/a
	See general prompts above		*See general prompts above*		*See general prompts above*	

		14:30-14:45	Continuity of care	Same Day Emergency Care	Extended teams	Virtual wards	Urgent community response services	Same Day Emergency Care
			• CoC would place more strain on GPs whereas SDEC would ease pressure in hospitals. How do you feel about this? • CoC may be harder to deliver in poorer areas, but would benefit older patients and patients with LTCs the most. SDEC could benefit poorer people the most, but perhaps focus on fixing a single issue rather than looking at the bigger picture for a patient. How do you feel about this? • CoC would have largest impact on smaller groups with highest need (older people with LTCs). SDEC would have a positive impact on all in hospital by reducing pressure on beds and treating those with lower need more quickly . How do you feel about this? • How do you feel about the differences in the time it may take to realise impacts? • Both these approaches are relatively inexpensive. How do you feel about that?		• ETs would rely on recruiting new staff which could pose challenges because of staff shortages. VWs would seek to take strain off hospital staff. How do you feel about this difference? • Both of these approaches involve enabling people to stay in their communities and treating them at or close to home. How do you feel about this? • ETs would help to improve access to general practice for all patients, whereas virtual wards are focused on a smaller number of people who may be eligible for early discharge from hospital. How do you feel about this difference? • Virtual wards may be able to deliver benefits more quickly (though there is currently not much evidence on this). How do you feel about this?		• How do you feel about getting quick support to people in their homes and communities versus dealing with people as quickly as possible when they end up in A&E? • Both these approaches have the potential to reduce inequalities. How important is that to you? • Do you support prioritising approaches that target care where there is larger and more complex need, or do you think we should prioritise things that will impact on everyone who arrives in hospital? • Both these approaches will take a long time to deliver impact. How much does that matter to you?	

<table>
<tr><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2">14:45-15:00</td><td>Extended teams</td><td>Same day emergency care</td><td>Urgent community response services</td><td>Virtual wards</td><td>Continuity of care</td><td>Same Day Emergency Care</td></tr>
<tr><td colspan="2">• ETs rely on the availability of new staff (i.e. from already stretched areas like community pharmacy), whereas SDEC would ease pressure on hospitals. How do you feel about this?
• ETs would deliver care locally in GPs, homes or care homes, whereas SDEC would be in A&E departments. How do you feel about this?
• ETs could be harder to establish in more deprived areas, whereas SDEC could benefit people in deprived areas the most. How do you feel about this?</td><td colspan="2">• Both of these approaches involve enabling people to stay in their communities and/or at home. How do you feel about this?
• Both of these approaches could have a very significant impact on a relatively small number of patients. How do you feel about that compared to approaches that may have a smaller impact on a larger number (i.e. SDEC)?
• UCRSs could help to reduce health inequalities and promote access for individuals. Virtual wards could do the same but may exclude people who are less tech savvy. How do you feel about this?
• Virtual wards may be able to deliver benefits more quickly (though there is currently not much evidence on this). How do you feel about this?</td><td colspan="2">• CoC would place more strain on GPs whereas SDEC would ease pressure in hospitals. How do you feel about this?
• CoC may be harder to deliver in poorer areas, but would benefit older patients and patients with LTCs the most. SDEC could benefit poorer people the most, but perhaps focus on fixing a single issue rather than looking at the bigger picture for a patient. How do you feel about this?
• CoC would have largest impact on smaller groups with highest need (older people with LTCs). SDEC would have a positive impact on all in hospital by reducing pressure on beds and treating those with lower need more quickly). How do you feel about this?
• How do you feel about the differences in the time it may take to realise impacts?
• Both these approaches are relatively inexpensive. How do you feel about that?</td></tr>
</table>

15:00-15:15	Extended teams	Virtual wards	Urgent community response services	Elective surgery hubs	Continuity of care	Elective surgery hubs
	• ETs would rely on recruiting new staff which could pose challenges because of staff shortages. VWs would seek to take strain off hospital staff. How do you feel about this difference? • Both of these approaches involve enabling people to stay in their communities and treating them at or close to home. How do you feel about this? • ETs would help to improve access to general practice for all patients, whereas virtual wards are focused on a smaller number of people who may be eligible for early discharge from hospital. How do you feel about this difference? • Virtual wards are likely to deliver benefits more quickly. How do you feel about this?		• UCRS would allow people to be treated at home or near home, whereas people would have to travel within regions to access elective surgery hubs. How do you feel about this? • UCRS are likely to support those who need help close to home, whereas elective surgery hubs could disadvantage those less able to travel. How do you feel about this? • Elective surgery hubs would target people waiting for routine surgery, and would have a big impact on these individuals and shorten waiting lists. ICRSs would focus on a smaller number with more complex needs, helping them to maintain independence. How do you feel about this? • Elective surgery hubs would be costly to implement. How do you feel about that?		• CoC would see care being delivered in patients' usual GP practice, whereas ESHs would see care delivered regionally. How do you feel about this? • CoC would place more strain on GPs whereas ESHs would ease pressure in hospitals. How do you feel about this? • CoC may be harder to deliver in poorer areas, but would benefit older patients and patients with LTCs the most. ESHs could be less accessible people in less affluent areas (where people are, as research shows, less able to travel for surgery). How do you feel about this? • How do you feel about the differences in the time it may take to realise impacts? • Elective surgery hubs would be costly to implement. How do you feel about that?	

Before going into the final 15 minutes of this discussion, the facilitator may want to give participants a 5-minute break. It is up to the facilitator to decide whether participants may need a short breather before going into the final 40 minutes of the day.

Final 15/ 20 minutes depending on whether participants take a 5-minute break. (15:15-15:35):

<table>
<tr><td></td><td></td><td>Which do you think your ‘persona’ would be most and least likely to prioritise? Why?
Out of all the ideas we have looked at, which would you be most likely to prioritise? Why?
Which would you be least likely to prioritise? Why?
(Facilitator to arrange and rearrange the factfiles on the table in order of priority)
Looking at the ‘factors we need to consider’ slide in the participant packs, which factor do you think is most important in guiding decisions about healthcare? Why?</td></tr>
<tr><td>15:35
-
15:55</td><td>Revisiting the trade-off between primary care/ community care and hospital care

Table discussion</td><td>Table discussion (20 mins)

Facilitators to explain that, having considered more specific policy options, the group will now be returning to the overarching question of how to balance primary/community care and hospital care.

Prompt questions (20 mins):
Look at the approaches you chose to prioritise. Is there any pattern (i.e. are they mostly primary and community care or hospital care or a mix)? Why do you think this is?
Let’s think back to some of the trade-offs we discussed earlier. Have your thoughts on any of these changed since?
Breadth/depth of impact: Primary and community care services reach higher numbers of people with less acute needs. Hospital care deals with a smaller number with more acute or urgent needs.
Managing conditions vs responding to acute need: Primary and community care services can help people to manage their conditions and promote health, which can have positive impacts on their lives (i.e. on their work situation and families). However, hospital care treats people in potentially life-threatening situations when they have an acute need, which may also have positive impacts on their lives.
Demand: Health conditions that are usually diagnosed and managed in primary and community care are expected to increase at the fastest rate, reinforcing the need to invest in general practice and community-based services. But for the amount that people need hospital care is expected to increase too.
Long/short-term impact on waiting lists: By helping people to manage their conditions, primary and community care can help to reduce the pressures on hospital care in the longer-term as fewer people get to the point of needing hospital care (note that most hospital stays happen when a chronic illness that would generally be treated in primary care has got much worse). Focusing on hospital care, on the other hand, may bring hospital waiting times down in the shorter-term but without impacting on how many people might need to go to hospital in the future or improving the population’s overall health.</td></tr>
</table>

		○ **GP access vs hospital waiting times:** Focusing on primary care may make it easier to get a suitable appointment with your local GP practice. Focusing on hospital care, on the other hand, is likely to reduce hospital waiting times. ○ **Where is care delivered:** Focusing on primary and community care may mean more services are delivered in the community, in General Practice, pharmacies, care homes, local clinics and other community spaces. Hospital care is more likely to be delivered in hospitals and specialist care units. ○ **Generalist vs specialist care:** Primary and community care is organised around providing ongoing care for all common medical conditions and coordinating care for people with more complex needs. Hospital care is organised around providing more one-off care for patients who require specialist attention, focusing on a specific diagnosing, treating or managing a specific medical condition. ○ **Cost of care:** Primary and community care can be less expensive to deliver than hospital care. For example, it is estimated that in 2021/22 the average 9-minute in-person GP consultation cost £42, whereas the average A&E visit cost £86-418 (depending on the level of investigation and treatment needed), and £367 for an ambulance call out where the patient is transferred to hospital. Facilitators to ask participants to consider overnight whether their views on how to balance primary and community care vs hospital care have changed as we will return to this on Sunday morning.
15:55 - 16:00	**Thanks and close**	**Chair to close the day (5 mins) covering:** • An overview of the objectives of today and what we have covered. • A 'sneak preview' of Sunday • A reminder to arrive promptly at 9:30am on Sunday morning

3 Discussion guide – day 2

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HF future of the health system deliberation: day 2, London

Sunday 29th October – 9:30am-4pm. DISCUSSION GUIDE

Prompts in bold text are priority to ask.

Time	Discussion structure	Questions and materials
9.30-10.00	**Arrival and registration**	**Participants arrive at the venue and are signed in and are allocated to new tables (as these will be mixed up for this workshop), of which there will be 3 tables of 8 participants**
10.00-10.05	**Introduction and scene setting** **Plenary**	**Chair to welcome everyone:** Remind participants of the purpose of the deliberation and the ground rules. Re-anchoring participants in the first question: "working within its current constraints, what should the NHS' focus be to improve the nation's health: primary and community care or hospital care?"
10:05 - 10:15	**Meeting new tables** **Table discussions**	**Table introductions and ice breaker (10 mins)** • *Facilitator introduces themselves and the table's note taker, thanks participants for coming.* • *To introduce us all to each other, facilitator asks participants to introduce themselves and share one big thing they took away from day 1* (10 mins).
10:15 - 10:25	**Final views on the trade-off between primary/ community care and hospital care** **Plenary**	**Plenary activity (10 mins)** Chair to ask participants to once again position themselves in the room according to where they think the government and NHS should place its focus: the right side of the room will be hospital care, the left side of the room will be primary/community care, the two-thirds towards hospital will be the status quo. Facilitator to then remove the status quo option, asking those participants to pick a side. Facilitator to ask whether anyone has changed their views and if so why. Facilitator to ask whether anyone's views are unchanged and if so why.
10:25 - 10:35	**Presentation on the NHS's current funding model**	**Presentation (10 mins)** Presentation on the current NHS model, its strengths and drawbacks and how it compares to Private health insurance and social health insurance models.

	Plenary	
10:35 - 10:55	**Participant reflections on the NHS's current model** **Table discussion**	**Table discussion (20 mins)** **Facilitator to ask for participants' reflections on the presentation.** Prompts (5 mins): • Was there anything in that presentation that was new or surprising to you? • What stood out to you most? • Does it leave you with any questions or concerns? **Facilitator to read through stimulus outlining pros and cons of the current model (page 8 in stimulus packs). Prompts (10 mins):** • Is any of this new or surprising to you? • Do you have any questions about the strengths and drawbacks of this model? • Can you think of any other advantages or disadvantages of the current model? **Facilitator to ask participants to compare the NHS model with social health insurance and private health insurance. Prompts (10 mins):** • *(facilitator to go over the two 'alternative models' from the presentation on pages 10-11 & 12-13):* **Do you have any initial thoughts on how the NHS model compares to the private health insurance and social health insurance model? How do you think things might feel different to you personally under one of the other models?** Do you have any questions about these models?
10:55 - 11:05	**Presentation on the funding levels vs service levels trade-off** **Plenary**	**Presentation (10 mins)** Presentation covering: a recap of the demand and supply side challenges facing the NHS; an overview of the trade-off between improving NHS services and increasing funding levels; a forecast of how much more people might individually need to pay; a comparison between the 'status quo' scenario and the 'modernised' scenario; 'mythbusting' why we can't simply 'spend the current money better; an overview of the different options for raising money before focusing on tax.
11:05 - 11:25	**Participant reflections on the funding**	**Table discussion (20 mins)**

	levels vs service levels trade-off
	
	Table discussion
		<u>Note</u>: The funding levels vs service levels presentation sets out the 'recovery' and 'stabilisation' scenarios. The 'stabilisation scenario' denotes a restoration of pre-pandemic levels of service and performance. To contextualise this, it may be worth reminding participants that at the time essential parts of the NHS were experiencing the worst performance against waiting times targets since the targets were set. This included the highest proportion of people waiting more than four hours in A&E departments since 2004, and the highest proportion of people waiting over 18 weeks for non-urgent (but essential) hospital treatment since 2008. However, it is also worth noting that pre-pandemic performance was still far superior to current performance.
		
		Facilitator to ask for participants' reflections on the presentation. Prompts (25 mins):
		
		• **Was there anything in that presentation that was new or surprising to you?**
		• **What stood out to you most?**
		• Does it leave you with any questions or concerns?
		• **Given everything you've learned so far, do you feel the NHS needs more money, or not?**
		• **How do you feel about the trade-off between improving/ maintaining services and increasing funding levels?**
		• **Let's assume it would cost your household an extra £2,200 a year by 2030/2031 to fund modest improvements to the NHS, as HF have predicted. How would you feel about this?**
		  o *(if happy with it):* **Why are you okay with this?**
		    ▪ Is there anything that would change your mind?
		    ▪ Why do you think others might feel differently?
		    ▪ Would you be willing to pay more than £2200 extra p.a.?
		  o *(if not happy with this):* **Why are you not okay with this?**
		    ▪ Is there anything that would change your mind?
		    ▪ Without increased funding for the NHS, access to healthcare services will get worse and there will be more unmet needs – i.e. people needing healthcare that they are not able to get via the NHS. How do you feel about this?
		    ▪ Look back at the 'long term outcomes' of the stabilisation scenario (page 21): how do you feel about this? Why do you think others might feel differently?
		• **Let's assume that this additional money is going to be raised over the coming decade. What do you think would be the best way to raise this money?**

11:25 – 11:40	**Break**	**15 mins**

11:40 - 11:50	**Presentation on different options for raising revenue via taxation** **Plenary**	**Presentation (10 mins)** Presenter to explain that the next discussion will focus on *how* additional revenue could be raised through taxation – noting that there are various ways of doing this. We want to hear from the group which taxes they think would be most suitably increased in order to raise extra revenue. The presenter will go through several different options, covering their 'pros' and 'cons' (which will also be included in participants' stimulus packs). These might include: • Recapping pros and cons of income tax • An additional tax earmarked for the NHS • VAT
11:50 - 12:40	**Group discussion on different options for raising revenue via taxation** **Table discussion**	**Table discussion (50 mins)** Facilitator to read through the different options and ask participants for their views (15 mins on an additional tax earmarked for the NHS, 15 mins on VAT and 10 mins to recap income tax). Note: When we're sharing stimulus on how much additional tax someone might be paying under the different scenarios, we should remind participants that 1) these numbers are what is estimated to be needed in five years (not now), 2) that these increases would likely be phased in over that time and 3) that their income would be expected to increase over time as the economy grows so the impact shouldn't be quite the same as it would be now (provided this is the case). Note: if participants feel raising tax to this extent is simply impossible, it's worth explaining that similar tax rises have happened previously (i.e. between 2010 and 2011 the government raised VAT from 15%-20% after it was dropped to 15% after the 2008 crash). It is also worth explaining that raising large revenue via taxation can happen via stealth: not increasing the thresholds at which different income tax and NICs rates kick in to match inflation is expected to raise an additional £52bn by 2027/28 – more than our recovery scenario requires by 2030/31 – without increasing the headline rate of those taxes. Note: If participants ask why individuals pay less under the earmarked tax, this is because our model is based on the Health and Social Care levy which came out of NICs which are paid by both employees and employers. Therefore it's important to probe participants on the possible downsides of employers paying more (in the pros and cons slide on page 36), and the possible knock-on impacts for individuals. Note: People may ask why we have chosen the taxes that we have and not other taxes (i.e. corporation tax, inheritance tax etc). There are a few reasons for this (i) the three taxes we've chosen are by far the biggest revenue raisers across tax receipts; (ii) HF and IFS did work on these taxes a few years ago which has provided us with illustrative scenarios of what will happen if we raise

		these taxes (this is not available to the same extent for other taxes); (iii) there are very few precedents for upping health system funding via wealth/inheritance/corporation tax. If people ask about other taxes, or say they support them over and above the taxes we've chosen, it can help to redirect them back to our chosen taxes by asking participants to compare (i.e. 'what do you like about this tax vs the three we've chosen?' What problems does this tax solve that the others don't?')
		
		General prompt questions:
		• **How do you feel about raising money from this type of tax?**
		• **Do you have any reflections on the arguments for and against? Which do you find most convincing?**
		• What do you think about the revenue-raising potential of this tax?
		• **Who do you think might be positive and/or negatively impacted by raising money via this form of taxation?**
		• Do you think raising money this way might have an impact (positive or negative) on inequalities?
		• Can you think of any other advantages or disadvantages of raising money via this tax?
		• **What do you consider to be 'fairer': a progressive tax (i.e. income tax) or a flat rate of tax (i.e. VAT)?**
		• **Do you think employers should pay more as well as individuals (i.e. as was the case in the Health and Social Care levy)?**
		
		Prompts on an additional tax earmarked for the NHS (pages 36-37):
		• **How would you feel if you knew any additional taxes you were paying would go straight into the NHS? Would it make any difference to you?**
		• The UK's most recent experience with creating an additional tax earmarked for the NHS was the Health and Social Care Levy, established in 2021 and abolished in 2022. How much most people paid towards the Levy was equivalent to a 1.25 percentage point increase in the National Insurance contributions (NICs) paid by employees and employers. Under the Health and Social Care Levy, employees (including self-employment) and employers paid the increased rates of NICs. Using a similar approach to fund the extra spending required for the stabilisation and recovery scenarios would require the rate of NICs to increase by 2-3 times more than people actually paid under the Levy.
		    ○ **Facilitator to prompt using figures provided in stimulus on page 37** (i.e. how would you feel, if you earned £30k paying £37 more per month by 2028/9 for the stabilisation scenario? £56 per month for the recovery scenario?
		    ○ **Under the H&SC levy, people of pension age would have paid much less than people who are working. How do you feel about this?**
		• **The additional employee payments would also need to be matched by employers. How do you feel about this? Are you convinced by the arguments (on the 'pros and cons' slide) about the potential impact on employers?**

		Prompts on VAT (pages 38-39):
		• **(Where) do you think exemptions from VAT should be offered?**
		• Analysis by the Health Foundation and Institute for Fiscal Studies suggests that funding the extra spending in the stabilisation and recovery scenarios through VAT alone would require the standard rate to increase from 20% to around 24% and 26% respectively over the course of the next five years.
		    o **Facilitator to prompt using figures on slide 39** (i.e. how would you feel about paying this much more for these items?)
		    o **How do you feel about increasing the standard VAT rate vs adjusting the VAT rates on products that are harmful to health, such as cigarettes and alcohol?**
		        ▪ VAT and duty are paid on alcohol and tobacco and the Treasury estimates that increasing duty by one percentage point on: wine, beer/cider and cigarettes would raise an extra £50m, £30-£35m and £20-£25m per year respectively (i.e. a small amount). How do you feel about this?
		
		Income tax (pages 34-35):
		• Analysis by the Health Foundation and Institute for Fiscal Studies suggests that funding the extra spending in the status quo and modernised scenarios through increasing income tax alone would require increases of around 5 and 6.5 percentage points across all rates over the course of the next five years.
		    o **Facilitator to prompt using figures on slide 35.**
		• Having considered other options, have your thoughts on the current model (i.e. funding raised primarily via income tax) changed at all?
		
		Final 10 mins (12:30-12:40):
		• **Which of these taxes would you be most supportive of raising to bring new funding for the NHS? Why?**
		• **Which of these taxes would you be least supportive of raising to bring new funding for the NHS? Why?**
		• **Which of these taxes do you think is most likely to attract higher levels of public support? Why?**

12:40 - 13:20	**Lunch**	**40 mins** Facilitators to put up new posters around the room, at two stations, focusing on alternative NHS funding models: • Two stations on additional service charges (i.e. for GP appointments and/or A&E visits). • Two stations on moving to a social health insurance system. Chair to prepare three flipchart sheets for voting: status quo, additional charges and social health insurance.

13:20 - 14:40

Alternative NHS models: carousel

Carousel

Carousel (1hr 20 mins)

Chair explains that we are now going to discuss models for how the NHS model could change in the future.

The chair reminds participants of the overall question: *“Do alternative models hold promise for the future of the NHS, and how do these compare to the current NHS model?”*

As a table, participants will rotate between 2 different stations out of a total of 4 stations (approx. 40 mins at each). Participants will remain in 3 groups of 8, meaning the moderators/ experts at station two will have to cover both topics and move to station 4 after the first 40 mins. The two topics are:

- The status quo with additional service charges (e.g. for GP appointments and/or A&E visits)
- Moving to a social health insurance system

	Group 1	Group 2	Group 3
1: status quo with additional service charges	13:20-14:00		14:00-14:40
2: status quo with additional service charges		13:20-14:00	
3: social health insurance system	14:00 – 14:40		13:20-14:00
4: social health insurance system		14:00 – 14:40	

At the stations for both topics there will be posters and other material describing a future in which this model has been implemented, stylised to highlight the differences between these models. This will include pros and cons of the model and quotes in support and against.

For each topic, the expert starts by spending 5 minutes talking through the ‘overview’, ‘example(s)’ and ‘pros & cons’ slides. After this the moderator takes over and prompts discussion with a series of questions and by using the stimulus at the stations.

General prompts:

		• **Imagine a future in which this model has been implemented. How does this future look and feel to you? What are the differences?** • **Who do you think might be positive and/or negatively impacted in the future?** • **Do you have any reflections on the arguments for and against? Which arguments do you find most convincing? Which do you find least convincing?** • What potential challenges or concerns do you think there will be under this system? How might these challenges be addressed? • Do you think following this model might have an impact (positive or negative) on inequalities? • Can you think of any other advantages or disadvantages of this healthcare model? • **How do you think this model compares to the current tax-funded model? Do you have a preference between the models?** **Additional service changes:** • **How do you feel about the argument that additional charges would encourage people to thank more responsibility for how they use the NHS?** • **How do you feel about placing a cap on annual individual expenditure and exemptions, as they have done in Norway?** • **Who do you think should be exempt from paying some or all of the costs?** • **How do you feel about the argument that additional charges would make it harder for people with less money to afford healthcare?** • **How do you feel about the argument that charges can make people more hesitant to use preventative care or access health services later?** • **How do you feel about the argument that charges would require more administration in GP practices and other NHS services?** • How do you feel about the burden of additional funding for the NHS falling on a subset of people who are using services, but are not exempt? How do you think they would feel about that? • **We have previously discussed public support for the principle of the NHS being ‘free at the point of use’. That is despite the fact that there are currently some charges in the system. If we moved to a system of more charges would the NHS still be ‘free at the point of use’? Why/why not? How do you feel about this? Would having fewer exemptions change this?**

		• **We have previously discussed public support for the principle of the NHS being 'based on need, not ability to pay'. If we moved to a system of more charges would the NHS still be 'based on need rather than ability to pay'? Why/why not? How do you feel about this? Would having fewer exemptions change this?** • How would you feel about paying £20 every time you see the GP and £60 pounds every time you went to an urgent care centre without a referral? What impact would this have on you using GP services or urgent care centres? What impact do you think this would have on other people? (note: we will have stimulus explaining what an Urgent Care Centre is) • A £20 GP charge would create about £7 billion per year. However, once we factor in exemptions, assuming these will broadly reflect prescription charge exemptions (for those under 16 or under 18 in full time education; those over 60; those on low income; those who are pregnant or have had a baby in the past 12 months; those with some specified conditions like cancer), it would only raise approximately £700-800 million per year, which is much lower than the increases required to achieve either the 'stabilisation' or the 'recovery' scenarios. How does this make you feel? • How would you feel about charging more than £20 to increase the amount of money raised by an additional charge? • How do you feel about having fewer or no exemptions to increase the amount of money raised by additional charges? *Facilitator to introduce persona 1: a family with three young children* • **How do you think this family might feel about additional charges for GP and UTC visits? Do you agree with this position?** • **What impact do you think additional charges may have on this family?** • **(How) do you think additional charges might affect this family's use of health services? What might be the impact of this?** • **How do you feel about exemptions from charges having considered this family's situation?** *Facilitator to introduce persona 2: an older adult in full-time employment* • **How do you think Isaiah might feel about additional charges for GP and UTC visits? Do you agree with this position?** • **What impact do you think additional charges may have on Isaiah?** • **(How) do you think additional charges might affect Isaiah's use of health services? What might be the impact of this?** *Facilitator to introduce persona 3: someone with a severe headache* • **Meghan isn't too bothered about additional charges and doesn't think it will change how she uses health services? How do you feel about this?**

		• **Would you feel similarly if you were in her position?**
		• **When you compare this persona with the other personas what comes to mind?**
		
		Social health insurance:
		
		• **How would you feel about being able to choose between different health insurance policies?** How do you feel about competition between sickness funds? How do you feel about greater choice potentially creating higher administrative costs?
		  ○ ***(facilitator to point to stimulus on Netherlands comparison website):*** **How would you feel about being able to compare and choose between insurance policies like this? Can you think of any benefits of this? Can you think of any downsides?**
		  ○ **How would you feel about having no choice over your social health insurance policy, as is the case in France?**
		• **How do you feel about employers having to pay more of the costs than they do in the current system? What impact do you think that might have?**
		• **How do you feel about SHI being more independent from government?**
		• **How do you feel about SHI still meaning that some tax funding is needed to cover people not in employment?**
		• **How do you feel about the practicalities of the shift to SHI in terms of how complex it will be and how long it will take?**
		• **A small number of individuals may fall through the cracks. These individuals are typically not covered due to administrative barriers or issues with paying premiums. Who do you think these individuals may be? How do you feel about this? How do you think this is different to what happens in our system?**
		
		Facilitator to introduce persona 1: a young person in employment and generally in good health
		• **How do you think Sara feels about the SHI insurance model? Do you agree with this position?**
		• **What impact do you think the SHI model has on Sara's life?**
		• **Would you feel the same if you were in Sara's position? Why?**
		• How do you feel about Sarah having to pay a combination between student loans, taxation and SHI contributions?
		
		Facilitator to introduce persona 2: an older adult with a few different positions
		• **How do you think Charlotte would feel about the SHI insurance model? Do you agree with this position?**
		• **What impact do you think the SHI model has on Charlotte's life?**
		• **Would you feel the same if you were in Charlotte's position? Why?**

		• **How do you feel about Charlotte needing to pay to see services not covered by her SHI fund?** • **When you compare Charlotte's situation with Sara's situation what comes to mind?**
14:40 - 14:50	**Sticky dot voting** **Plenary**	Participants are given sticky dots and asked to use them to signal their preferences among the optional futures (on the stations set out during lunchtime): • The status quo (a service available to all, free at the point of use and funded through taxation) • The status quo with additional service charges (i.e. for GP appointments and/or A&E visits). • Moving to a social health insurance system. Preferences (they do not have to use all of the stickers): • Star sticky: IF people have a strong preference for a model • Square sticky: IF people have a strong preference against a model • Round dot: If people feel they could support but have some reservations or no strong reservations Chair to explain that we have one more discussion on how to build confidence in the government's approach to planning for the NHS's future. Chair to explain that confidence in the current government's approach is very low (and confidence in previous governments has been higher but rarely, if ever, a view shared by everyone) and ask why people to consider why they don't (or wouldn't) have confidence in the approach being taken by government. Chair to explain that ideas from the pre-workshop activity have been set out on a wall in the room and to invite participants to leave additional suggestions for things that don't (or wouldn't) give them confidence that government is planning well – either under the same themes or new themes. Chair to state that 'what would build public confidence in plans for the NHS' will be the final discussion after the break.
14:50 - 15:05	**Break**	**15 mins** Participants invited to leave comments on the wall during the break. Facilitators to start spotting and clustering common themes.
15:05 – 15:20	**What hits people's confidence in the future of the NHS**	Facilitators ask participants to share anything that does not give them confidence that governments are planning well for the NHS's future: • Is there anything that would not give you confidence that governments are planning well for the NHS's future:, or would cause you to lose confidence that governments are planning well for the NHS's future? • Is there anything that would make you feel less confident that governments are planning well for the NHS's future:? • What would knock your confidence that governments are planning well for the NHS's future:?

<table>
<tr><td></td><td></td><td>(Facilitator to read some themes from the wall): How do you feel about these comments left on the wall during the break?</td></tr>
<tr><td>15:20
-
15:25</td><td>Presentation on steps a government could take to boost and maintain trust

Plenary</td><td>Presentation (5 mins)

We are now going to talk about what might help to build our confidence in a government’s plans for the NHS.

Presenter to reiterate that confidence in the current government's approach is very low and explain that it is important to have confidence in plans because meaningful improvements in NHS services will take some time to show.

Presenter to state that there are a range of potential approaches that might help to overcome this, with why it may help, such as:
More long-term thinking and planning in decision making
More public engagement to inform decisions
Give the NHS greater independence from government
Greater devolution of decision making to local areas
Presenter to explain that we are now moving into the final discussion to consider how a government could build and maintain confidence in plans for the NHS’s future.</td></tr>
<tr><td>15:25
-
15:50</td><td>Participants’ views on maintaining public confidence

Table discussion</td><td>Table discussion (25 mins)

Facilitator to prompt discussion as necessary by raising common themes they spot on the wall during the break. Prompt questions (25 mins):
Thinking more generally first, rather than about the different approaches that were put forward, what would help to address your concerns and/or build your confidence that governments are planning well for the NHS’s future:?
Does anyone remember what they said when responding to the form we sent you last week? Has your view changed?
Given everything we have discussed, do you think a government should focus on short-term priorities or long-term reform?
I(If participants say long-term reform): What things would you need to see in the short-term and medium-term to have confidence that things are going in the right direction? Why is that important?
Let’s have another look at the ideas shared in the presentation (set out in the participants’ stimulus). Would any of these give you more confidence that governments are planning well for the NHS’s future:? Why?</td></tr>
</table>

		• Which of these ideas would have the biggest impact on your confidence that governments are planning well for the NHS's future:? • Do you have any other ideas? Facilitator to spend the last 5 minutes asking the table to prioritise one idea that would help to build their confidence in the Government's plans? This could be an idea from the stimulus/ presentation or something else entirely. Facilitator to explain that we will now be feeding the one idea to the rest of the group and to ask for a volunteer.
15:50 - 15:55	**Plenary feedback**	1 minute for each group to feed back their idea for how to build confidence that governments are planning well for the NHS's future.
15:55 - 16:00	**Thank and close**	**Chair to close the day (5 mins) covering:** • An overview of the objectives of today and what we have covered. • A huge thank you for participants' time and energy. • Asking participants to complete an evaluation form at their tables before leaving.

4 Stimulus – day 1

Introduction to the team

Notetakers

Facilitators

The Health Foundation team

You!

The Health Foundation

An independent charity dedicated to bringing about better health and health care for people in the UK.

Improving people's health and reducing inequalities

Supporting innovation and improvement in health and care services

Providing evidence and analysis to improve health and care policy

The Health Foundation is an independent charity. Its work is informed by evidence – they are not part of the government or the NHS, or aligned to any political party or movement.

Why are we here today?

Understanding the public's perceptions and experiences of health and care is a major part of The Health Foundation's work.

When current and future governments come to make difficult decisions about how to proceed, we want those decisions to be informed by the best available evidence

Including how people perceive the current state of the health services and your priorities for the future

Housekeeping

- Recording and note-taking
- Confidentiality
- Quotes in final report, no attribution
- Respect each other's views and be polite
- Turn off mobile or put on silent
- Breaks
- Grab a pen and some paper
- Quiet area available

Ground rules

1. Listen **respectfully**, without interrupting.
2. Listen actively and with an ear to **understanding others'** views. (Don't just think about what you are going to say while someone else is talking.)
3. **Any question is a good** question.
4. Criticise ideas, **not individuals**.
5. Commit **to learning**, not debating. Comment in order to share information, not to persuade.
6. Stay on topic and **try to be concise**.
7. **Avoid** blame, speculation, and inflammatory language.
8. Allow everyone the **chance to speak.**
9. **Avoid assumptions** about any member of the group or generalisations about social groups. Do not ask individuals to speak for their (perceived) social group.
10. **Be patient** with other participants and the team – we have a lot of information to get through.
11. Feel free to share your thoughts about this event with **friends and family**.
12. If posting **about this event on social media** please do not share any detail of the discussions.
13. Think and **act as citizens and not just individuals**.

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Agenda

9.30 – 10.00	Arrival and registration
10:00 – 10:15	Meet and greet
10.15 – 10.40	Your views on the current state of play in the NHS
10:40 – 10:55	Understanding the NHS
10:55 – 11:05	Break
11.05 – 11.25	What do you expect from the NHS?
11:25 – 12:05	Understanding the constraints faced by the NHS
12:05 – 12:45	Lunch
12:45 – 13:45	Primary & community care and hospital care
13:45 – 14:00	Break
14:00 – 15:55	Primary & community care and hospital care
15:55 – 16:00	Thank you and close

The Health Foundation Ipsos

Table discussion

Ipsos

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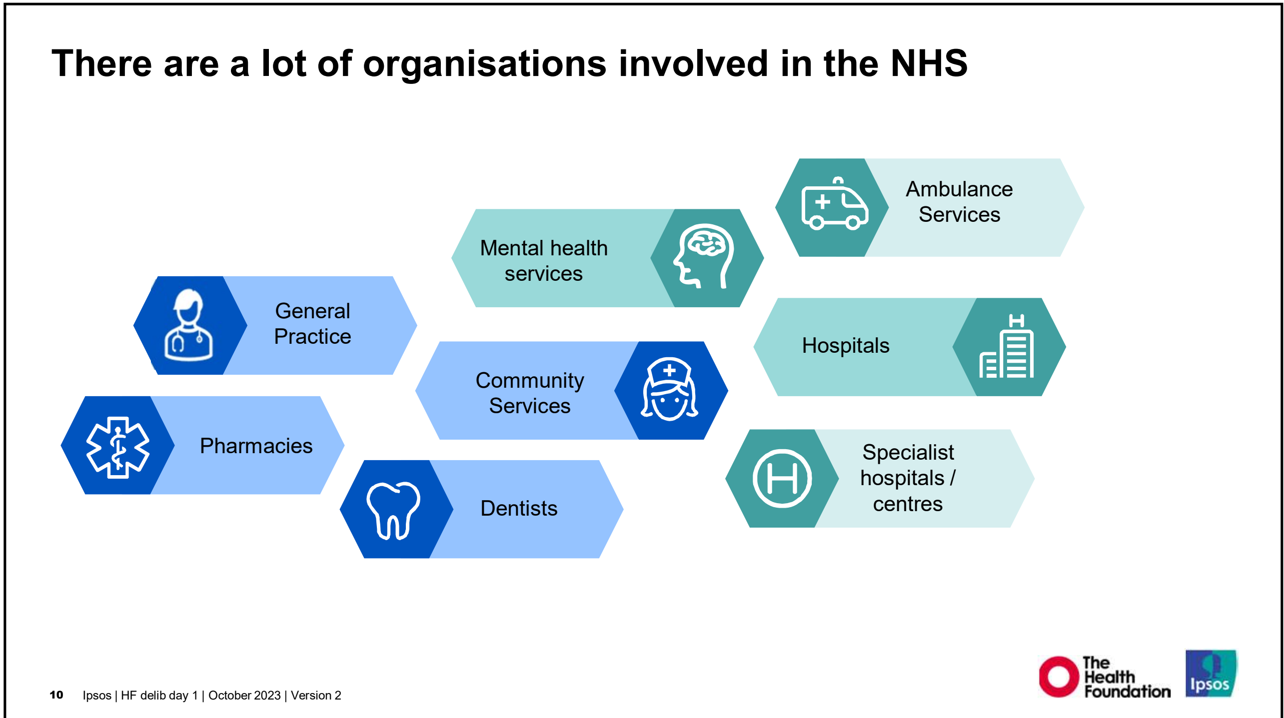
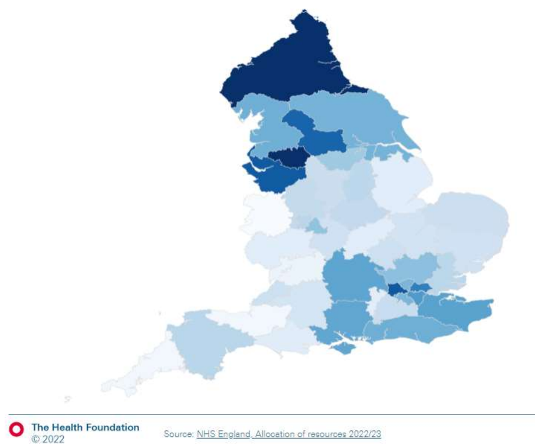
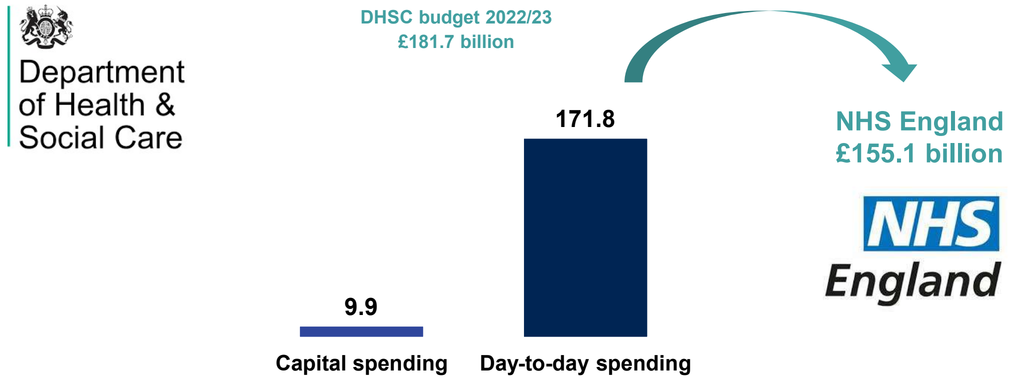


And there are other organisations that the NHS works with

These organisations have come together into Integrated Care Systems



The Department of Health & Social Care specifies what the NHS needs to deliver and provides the NHS's budget



These organisations have come together into Integrated Care Systems

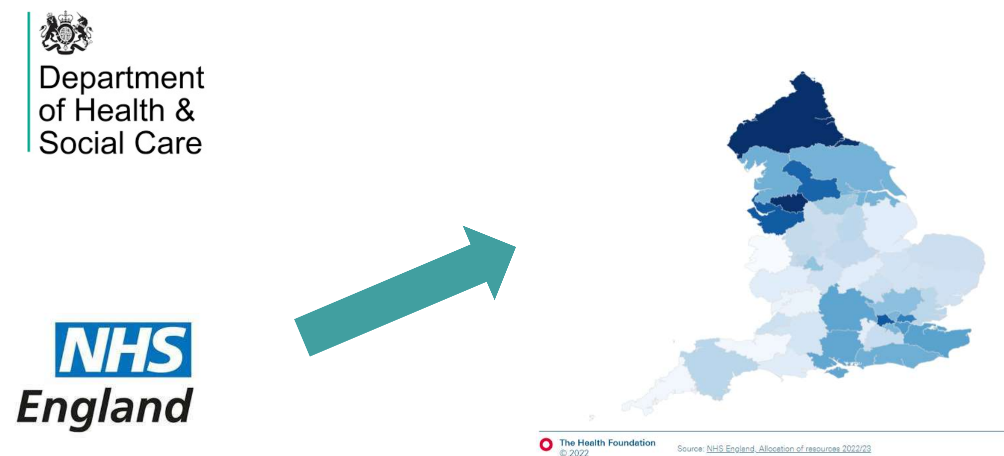


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Table discussion

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The current challenge facing the NHS

Rising demand, constrained capacity

Ipsos | HF delib day 1 | October 2023 | Version 2

18

The current challenge

The demands on NHS services are growing

1. **More people need healthcare**: As the population grows larger and older, the number of people requiring healthcare services for age-related and long-term conditions is increasing.

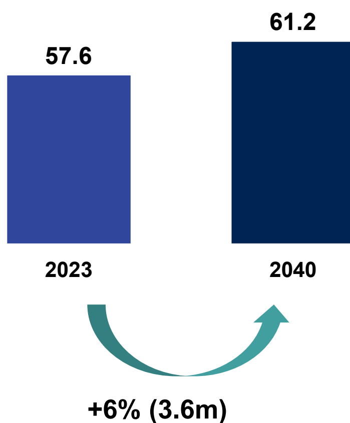
2. **Rise in long-term conditions:** Conditions like asthma, diabetes or heart disease are increasing. This means more people require ongoing care and treatment, which can strain the healthcare system.

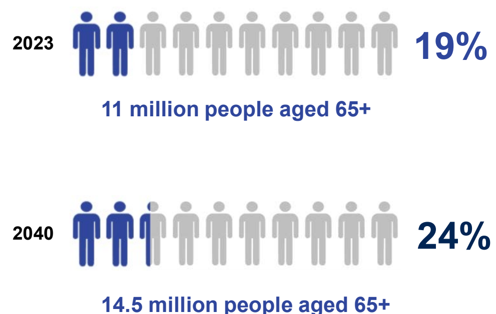
3. **Medicine can do more to treat ill-health:** Advances in science and technology allow more conditions to be treated, but this may require healthcare services to deliver more care.

4. **Inequalities in needs, access and experiences:** Some people have greater health needs and worse access to and/or experience of health care, leading to greater unmet need.

Demand: More people needing healthcare

The population is growing – and more of us will be older



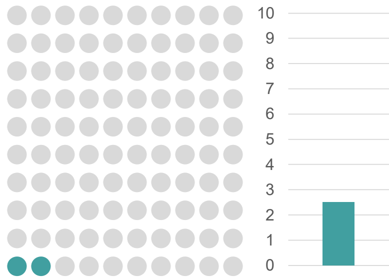


Demand: More people needing healthcare

And of course older people need more from health services

Admissions to hospital

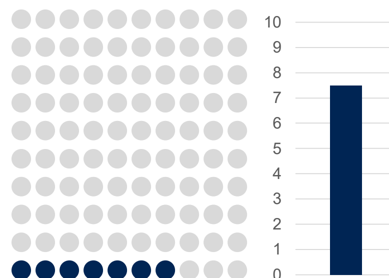
Age 30 – 34



2 people per 100

2-3 day long stay

Age 85+

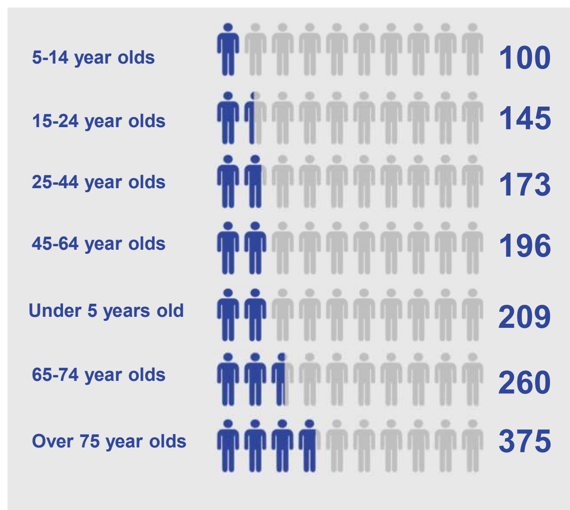


7 people per 100

7-8 day long stay

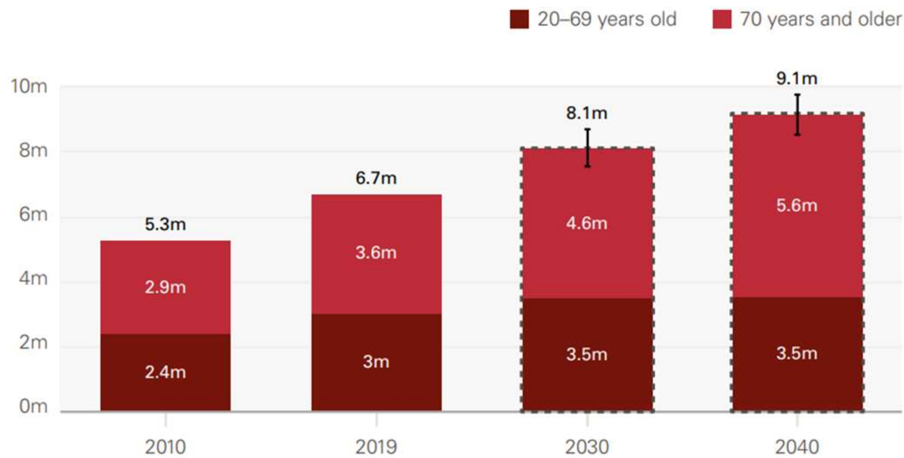
Demand: More people needing healthcare

Appointments in general practice



Demand: More people needing healthcare

The estimated number of people living with major illness in England, past and projected



Source: Analysis of linked health care records and mortality data conducted by the REAL Centre and the University of Liverpool.

Demand: health inequalities

While the NHS should be available to everyone, people's health is also impacted by social and economic factors, for example:

Where they live

Their income

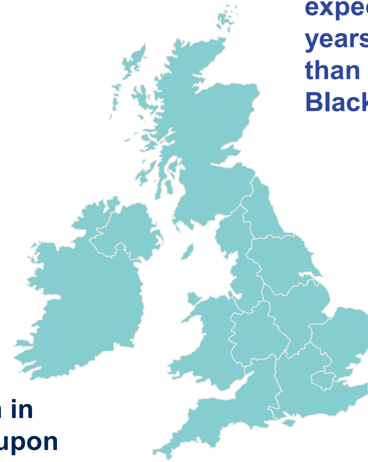
Their housing situation

Their level of education

18.5 more years

Someone living in the least deprived area of the UK is expected to live in good health to the age of 71, compared to 52 for those living in the most deprived areas.

A woman born in Wokingham can expect to live 15 more years in good health than a woman born in Blackpool



A man born in Richmond upon Thames can expect to live 17 more years in good health than a man born in Belfast

Women from Black ethnic backgrounds are **3.7 times more likely to die** during or up to 6 weeks after the end of their pregnancy than women from White ethnic backgrounds. Those from Asian ethnic backgrounds are **1.7 times more likely to die**.

People from South Asian backgrounds in Britain have a **40% higher death rate from heart disease** than the general population.

Source: MMBRACE-UK Report, 2022

The current challenge

Resources for providing healthcare are limited

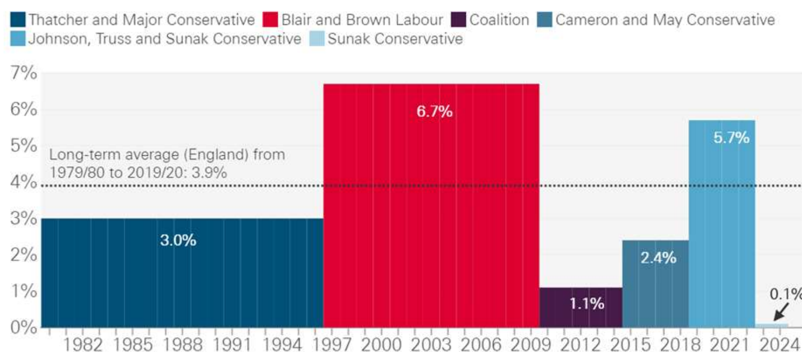
1. **Funding:** The NHS has limited budgets, set by the government, for providing healthcare services and investing in staff and new equipment, technology and facilities. This constrains what the NHS can deliver.

2. **Staff:** There are staffing gaps across the NHS, including clinical and managerial staff, and this can affect access to services and the quality of care.

3. **Facilities:** Hospitals and healthcare facilities need regular maintenance. When facilities need major repairs and cannot be used, this may affect access to services. Sometimes new buildings are needed, but these are expensive to build.

4. **Equipment:** The NHS has a limited equipment like beds, diagnostic machines, and supplies. When demand exceeds this capacity, it can create longer wait times for diagnosis and treatment.

Resources: Healthcare funding



REAL Centre

The Health Foundation ©2023

Source: HMT Spring Budget 2023 and House of Commons NHS Funding Expenditure (Briefing paper, January 2019). • The chart shows real-terms average growth rates for DHSC TDEL spending excluding COVID-19 spending in years 2020/21 and 2021/22, using the March 2023 GDP deflator. The long term average growth for England spending is 3.9%, slightly higher than the growth rate in UK-wide health spending (3.6%) calculated over the period 1949/50-2019/20.

Resources: Staff

- The number of staff in the NHS has increased but there are still gaps in the workforce the NHS needs to meet the healthcare needs of the population.
- One of the main issues is that the NHS hasn't been able to train enough new doctors, nurses and other healthcare professionals.
- Working in healthcare is also very demanding, and more staff are leaving the NHS.

The challenges facing the NHS cannot just be solved by putting more money into health services. New reforms will not be able to rely on increased staffing in the short to medium term.

Resources: Facilities and equipment

The NHS' buildings and facilities have not been receiving enough money for necessary upgrades and repairs.

Some of the technology used in the NHS is outdated and we do not always use the most up-to-date tech.

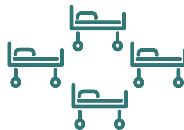
The UK has fewer hospital beds, CT and MRI scanners than comparable countries.

These challenges mean that adding more staff will not solve all of the NHS's capacity challenges. There are also constraints related to the NHS's buildings and equipment that need to be addressed.

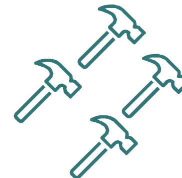
Resources: Staff, facilities and equipment

The Health Foundation | Ipsos

An extra 8,800 GPs and 6,400 practice nurses are estimated be needed by 2030



An extra 23,000-39,000 acute hospital beds are estimated to be needed by 2030



The total cost of backlog maintenance is estimated at £10.2 billion

1 There was a decade of low spending growth before the pandemic.

2 Spending jumped in the pandemic, but future spending is uncertain.

3 This has contributed to constrained capacity across the NHS.

4 There are NHS staffing gaps, but also shortages of modern buildings/ equipment.

5 So, the challenges are not just about money, but also the capacity of the NHS to improve and expand care.

6 And even with additional spending it will take time to improve services.

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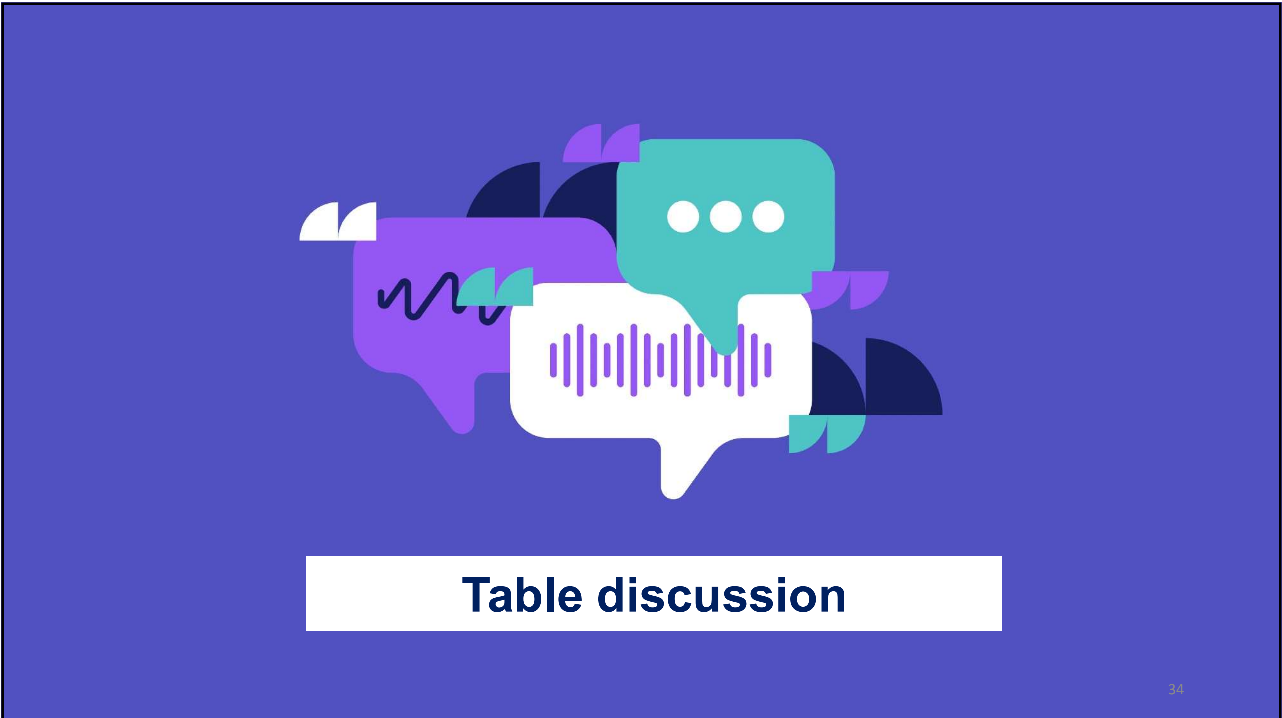

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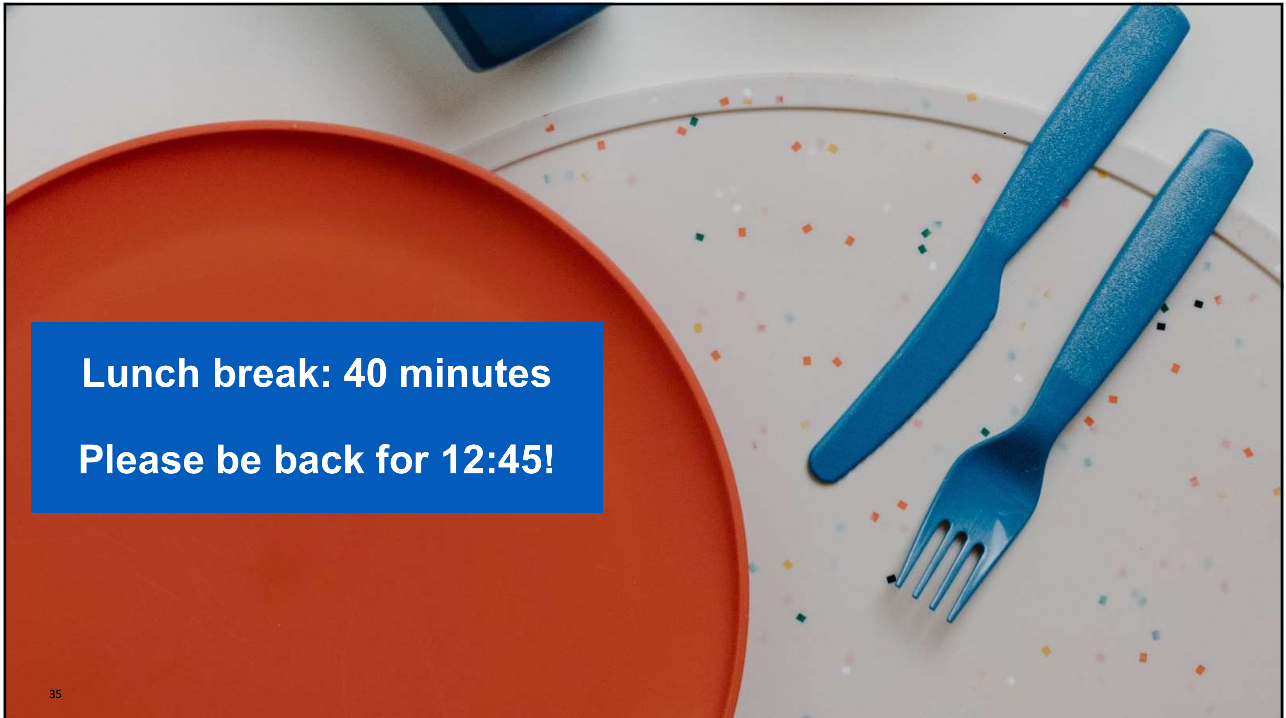

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Primary and community care

Care, treatment and support to local communities

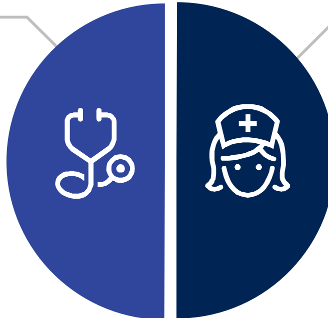
Primary care

Primary care is the **first point of contact** for people when they need health advice or treatment and is the 'front door' to specialist care.

Primary care is accessible online, by phone, by video and in-person, in a local community close to the patient's home.

It is provided by services such as:

- GP practices
- Dentists
- Community pharmacies
- Opticians



Community care

Community care covers a wide range of health services that support people to stay healthy and help people with complex needs to live independently at home.

Community care is mostly provided at the patient's home or in a local clinic close to home.

Community health services include:

- District nursing
- Community midwifery and health visiting
- Rehabilitation after leaving hospital
- Physiotherapy

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Hospital care

Specialist care for people who need it

- Urgent and emergency care (A&E)
- Maternity services
- Planned or elective care – routine diagnostic tests and operations
- Highly specialised treatment – such as transplants or neurosurgery

Hospitals provide **specialist services** are not typically available in primary or community care. For example, cancer treatment, major surgery or specialist care for severe asthma or diabetes.

Hospital A&E departments treat serious injuries and life-threatening emergencies, such as a heart attack, stroke or difficulty breathing.

Except for emergencies, patients generally need to be referred into hospital care from primary care or other services.

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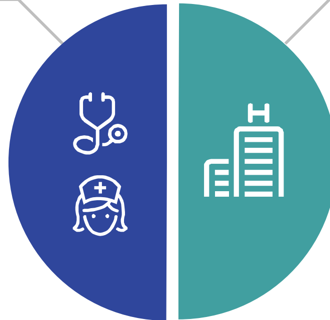
Scale of activity

In England, in a typical year

Primary and Community care

320 million
appointments in general practice

95 million
contacts in community health services



Hospital care

122 million
outpatient appointments

24 million
visits to A&E departments

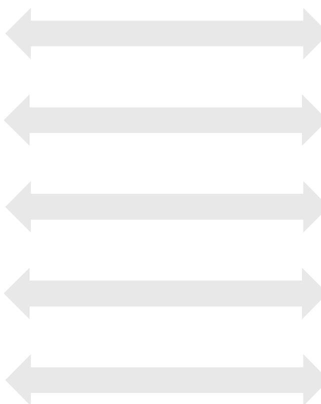
23 million
diagnostic procedures

8 million
planned admissions

6 million
emergency admissions

How they fit together

Primary and community care	Hospital care
First point of contact for advice, diagnosis and treatment	First point of contact for serious injuries and life-threatening emergencies only
Gatekeeper for referrals to hospital and other specialist services	Receives referrals for conditions that require specialist investigation
Works to promote good health, prevent illness and support people to stay well	Works to diagnose, treat and manage conditions needing specialist expertise
Provides ongoing care for all registered patients	Provides episodic specialist care for referred patients
Responsible for coordinating care for people with long-term conditions or more complex needs	Responsible for one-off or periodic care and treatment (such as surgery or specialist check-ups)



The dilemma:

NHS capacity is constrained, with **more resources going to hospitals** at the expense of other services.

With limited resources, **we face a choice about where to focus** and the balance between primary and community care, or hospital care.

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There are not enough staff to improve primary and community care, and hospital care

42 Ipsos | HF delib day 1 | October 2023 | Version 2

How focusing on improving primary and community services, or hospital services, may lead to improvements for patients

What can happen when investments of staff, facilities and funding are made

1 Primary care

GP practices extending their opening hours should allow more people to see a GP conveniently

2 Community care

After investment, more people can be supported to stay at home after a fall by community health services, potentially reducing need for visits to A&E and hospital admissions

3 Hospital care

Creating a national network of major trauma centres in England led to a 19% increase in survival rates among patients with severe or life-threatening injuries.

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How not focusing on improving primary and community services, or hospital services, may lead to worse outcomes

What can happen when health services do not have enough capacity to meet demand

1 Primary care

People's experiences of accessing general practice has gotten worse in recent years.

While GP practices are now delivering record numbers of appointments, public satisfaction with GP services has fallen to the lowest level in nearly 40 years.*

Source: British Social Attitudes Survey 2022

2 Community care

Overstretched community services are a substantial cause of delayed discharges from hospital care, leading to problems with rehabilitation and hospital capacity.

In parts of England where less is spent on community health services, there has been higher demand for hospital services.

3 Hospital care

While hospitals are treating more patients than before the pandemic, despite the recent industrial action, the waiting list for routine treatment is approaching a record 8 million.

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Factors we need to consider

WORKFORCE: How will this intervention impact an already overstretched workforce?

LOCATION: How does this intervention impact where people receive care or how far they will need to travel?

HEALTH INEQUALITIES: How might this intervention affect different groups of people? Could it increase or decrease inequalities in access to healthcare?

IMPACT ON PATIENTS AND OTHER NHS SERVICES: How many people will the intervention impact, and what is the extent of the impact for people? What impact will this have on other NHS services, and how could that impact patients?

COST: How much is the intervention likely to cost to implement? Could these resources be better spent in other ways?

TIMING: Is the intervention likely to benefit patients in the short-term or will improvements take longer to realise?

45

45

Working within these constraints, what should the NHS's focus be to improve services for patients?

Primary and community care, or hospital care?

46

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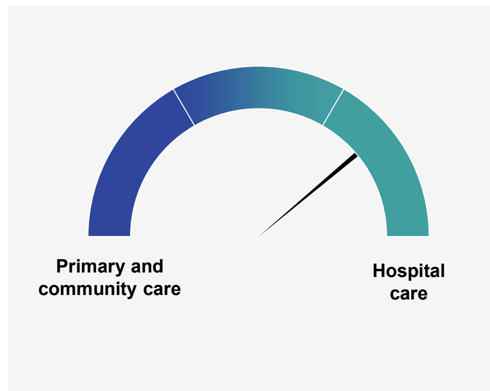
The current focus for improvements in the NHS

At the moment, the focus is towards improving hospital care more so than primary and community care



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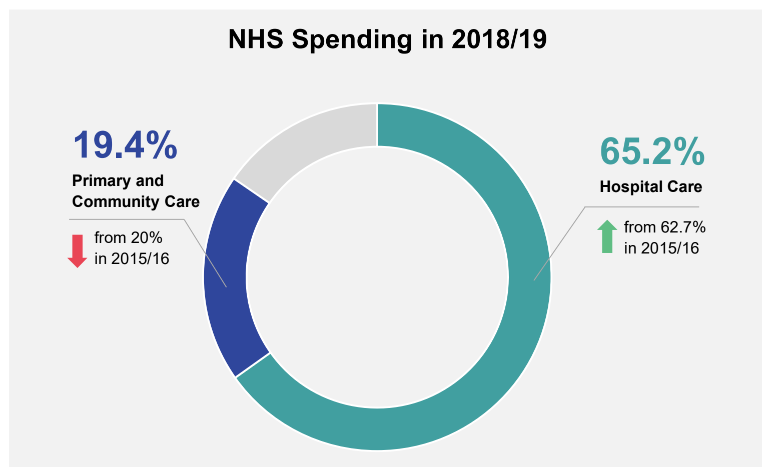
Ipsos | HF delib day 1 | October 2023 | Version 2

Between 2015 and 2019, the percentage of NHS spending for hospitals increased, while that for primary and community care decreased



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The number of hospital doctors has increased in the last five years, whilst the number of GPs has fallen*

+ 22%

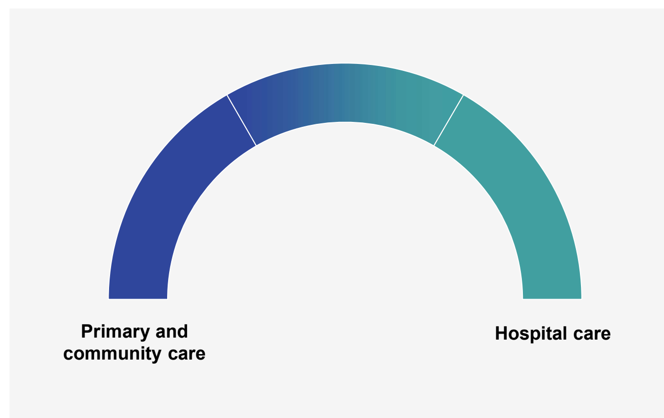
The number of **hospital doctors** has increased by almost a quarter in the last five years

- 7.2%

The number of fully qualified **GPs** has fallen by seven percent since 2016

* Please note that the source for the data on this slide is no longer available. More up to date percentages can be found at: https://commonslibrary.parliament.uk/research-briefings/cbp-7281/

What do you think the focus for improvements in the NHS should be?



Whole-group activity

51

Table discussion

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Primary and community care, and hospital care

Specific approaches to improve services

The dilemma:

NHS capacity is constrained, with **more resources going to hospitals** at the expense of other services.

With limited resources, **we face a choice about where to focus** and the balance between primary and community care, or hospital care.

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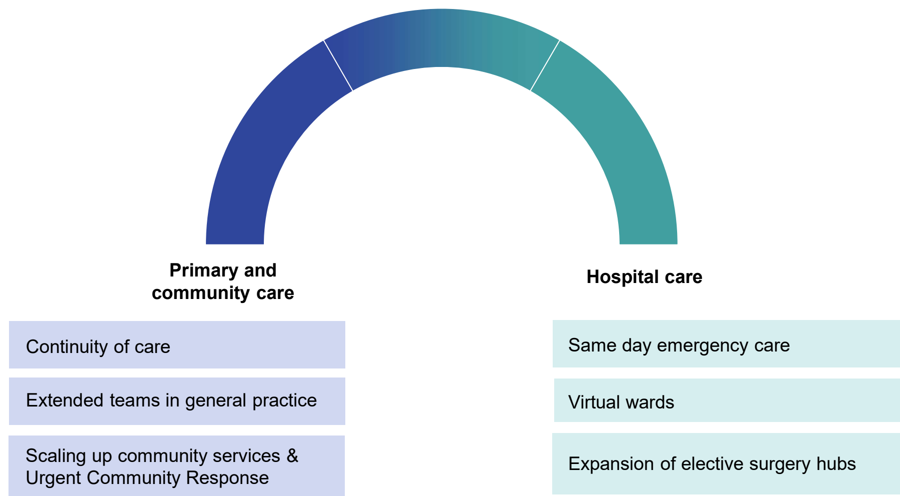
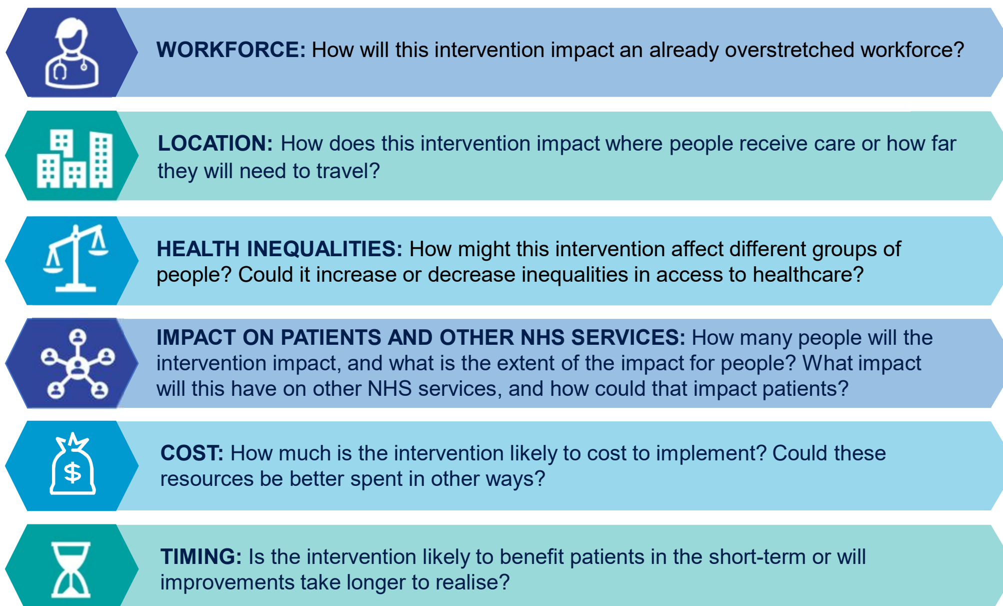
The approaches we will be considering



Factors we need to consider



Approaches for primary and community care

59

59

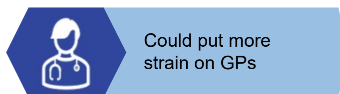
Primary & community care | Hospital care

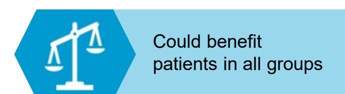
Improving continuity of care

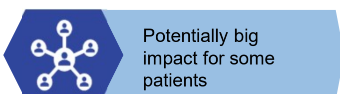
Overview

Improving continuity of care in general practice aims to allow older patients and those with more complex needs to **see the same GP more often**. It can help build a meaningful relationship between the patient and the GP, although there could be a longer wait for appointments.

It is associated with **higher patient satisfaction** and **fewer hospital admissions** for conditions that can be treated in primary care.







Primary & community care | Hospital care

Extended teams in general practice

Overview

Extra investment aims to allow practices, working together in local networks, to recruit **new clinical staff** such as pharmacists, physiotherapists and paramedics to pick up more routine work, and **non-clinical** social prescribers who would be able to **link patients to other services**.

Relies on availability of new staff

Care delivered locally

Recruitment could be harder in poorer areas

Could improve access for all

Medium/High

Long-term impact

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Primary & community care | Hospital care

Urgent Community Response services

Overview

Urgent Community Response (UCR) services aims to provide an **urgent response** to those who need it, with support from teams of nurses, physiotherapists, care workers and others. It can help patients with complex care needs or those whose health has suddenly deteriorated through a fall, infection, frailty or worsening of an illness such as diabetes. Scaling up UCR could make this support available **within two hours**.

Questions about staffing

Care delivered locally and at home

Could reduce health inequalities

Big impact for some groups of patients

Medium

Long-term impact

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Approaches for hospital care

63

63

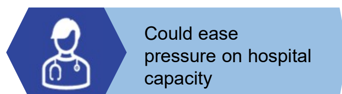
KD0 Primary & community care | Hospital care

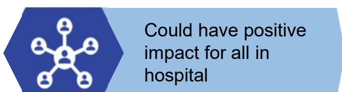
Same day emergency care

Overview

Same day emergency care (SDEC) aims to provide emergency care to patients who can be treated safely and effectively without requiring admission to hospital.

Suitable patients would be **rapidly assessed in A&E**, diagnosed and treated, and could be able to go home the same day.





Primary & community care | **Hospital care**

Virtual wards

Overview

'Virtual wards' aim to look after more patients at home rather than in hospital, following a stay or visit to the hospital. They would be in regular contact with health professionals, like a doctor or nurse, and sometimes given **technologies to help them monitor their health from home**.

Less strain on hospital staff

Care delivered at home

Better suited to tech savvy patients

Big impact for some groups of patients

Medium

Medium-term impact

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Primary & community care | **Hospital care**

Elective surgical hubs

Overview

Elective surgical hubs aim to focus on treating patients who need common procedures like hip replacements and cataract surgery. By focusing on a narrow range of non-urgent, relatively simple procedures, hubs should be **more efficient**, treating more patients and **cutting waiting times**.

Allows focus on planned care

Care delivered regionally

Some patients find it hard to travel

Big impact for people on waiting list

High

Long-term impact

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What do you think the focus for improvements in the NHS should be?

67

As we explore the dilemma and the different options, we want you to consider…

WORKFORCE: How will this intervention impact an already overstretched workforce?

LOCATION: How does this intervention impact where people receive care or how far they will need to travel?

HEALTH INEQUALITIES: How might this intervention affect different groups of people? Could it increase or decrease inequalities in access to healthcare?

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COST: How much is the intervention likely to cost to implement? Could these resources be better spent in other ways?

TIMING: Is the intervention likely to benefit patients in the short-term or will improvements take longer to realise?

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Table discussion

As GPs, we're overwhelmed and stressed. Whatever is done needs to take some of the pressure off us, it's not sustainable.

Sarah
42, GP

I can’t drive, and wheelchair access can be difficult on public transport. I really need my health services to be close to home.

Mark
24,
wheelchair
user

I am enraged by the health inequalities faced by my constituents. We really need to make sure we don’t deepen this problem.

Rowan
52, local
councillor of
a major city

Ipsos

I am sick of waiting for a GP appointment, I just want to see someone quickly without having to call so many times.

Nazeem
19, healthy young person

The NHS is under a lot of strain and I'm still waiting for my hip replacement surgery. It's so painful, I need it done as soon as possible!

Fiona
76, waiting for a hip replacement surgery

Ipsos

What's important to me is being able to get care near my home from someone who knows my situation as I need to see healthcare professionals every week.

Robert
59, diabetes and breathing problems

We end up caring for people here who don't need 24/7 care and would probably be more comfortable at home. We need to do something to get people out of hospitals more quickly.

Kanesha
48, hospital clinician

Ipsos

I think too many decisions are made about what's needed right now, instead of longer-term solutions. I'm worried I will have to pay for my care when I get older.

Noel
28, healthy young person

5 Stimulus – day 2

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Agenda

9.30 – 10.00	Arrival and registration
10:00 – 10:15	Meet and greet
10.15 – 10.25	Final views on primary/community and hospital care
10:25 – 10:55	NHS Current funding model
10:55 – 11:25	Funding levels vs service levels
11:25 – 11:40	**Break**
11.40 – 12.40	Different options for raising revenue via taxation
12.40 – 13.20	**Lunch**
13.20 – 14.50	Alternative NHS models: Carousel
14:50 – 15:05	**Break**
15:05 – 15:55	Building confidence in the future of the NHS
15:55 – 16:00	Thank you and close

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Ipsos

Ground Rules

1. Listen **respectfully**, without interrupting.
2. Listen actively and with an ear to **understanding others'** views. (Don't just think about what you are going to say while someone else is talking.)
3. **Any question is a good** question.
4. Criticise ideas, **not individuals**.
5. Commit **to learning**, not debating. Comment in order to share information, not to persuade.
6. Stay on topic and **try to be concise**.
7. **Avoid** blame, speculation, and inflammatory language.
8. Allow everyone the **chance to speak.**
9. **Avoid assumptions** about any member of the group or generalisations about social groups. Do not ask individuals to speak for their (perceived) social group.
10. **Be patient** with other participants and the team – we have a lot of information to get through.
11. Feel free to share your thoughts about this event with **friends and family**.
12. If posting **about this event on social media** please do not share any detail of the discussions.
13. Think and **act as citizens and not just individuals**

Table discussion

Whole-group activity

5

5

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The NHS's current model

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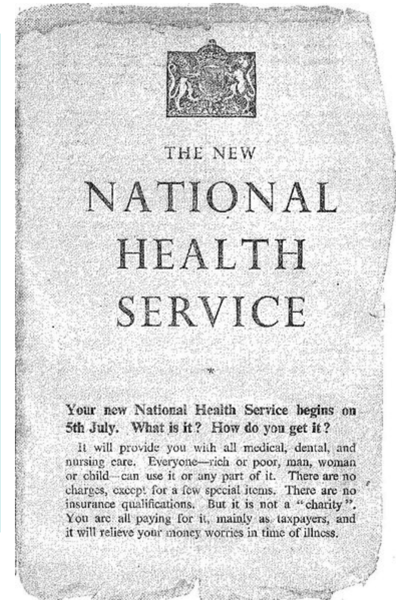
The current model

- The National Health Service (NHS) Act was passed in 1946 and came into effect on July 5, 1948.
- The founding principles of the NHS were to provide comprehensive **healthcare for everyone, free at the point of use, based on need** not ability to pay. These principles are still upheld and supported by the public.
- The NHS has been **funded primarily through general taxation and National Insurance** contributions.
- Patient charges for dentistry, glasses and some prescriptions were introduced in the 1950s, but they have remained a minor source of funding for the NHS.

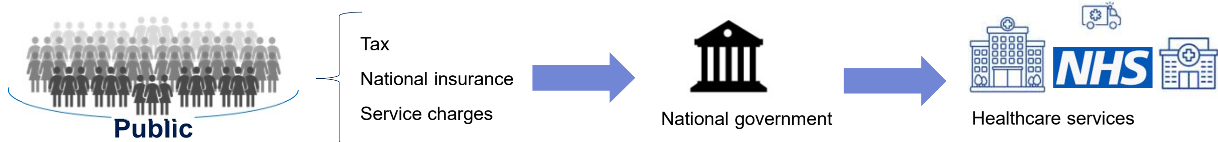

THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

The current model



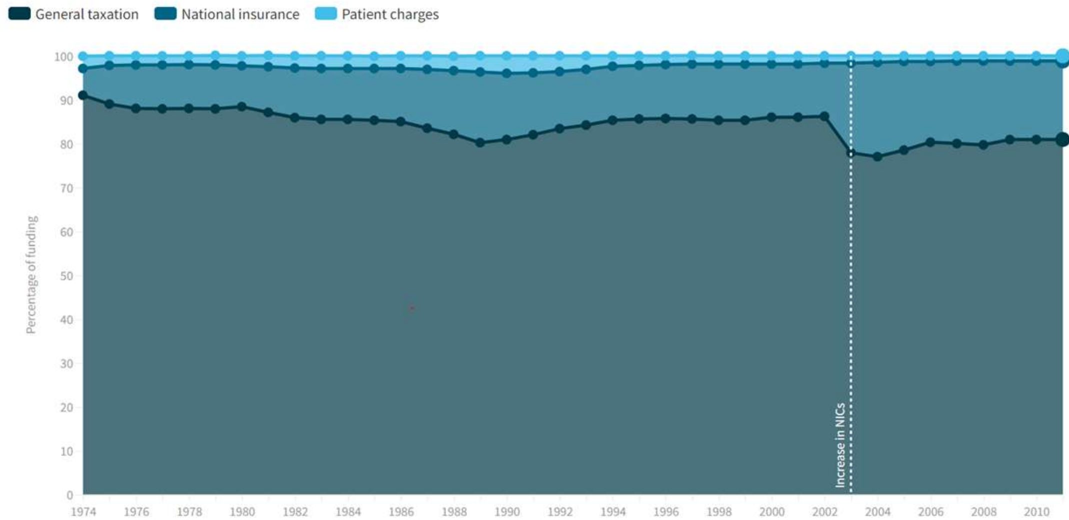
Strengths

- Many believe this system is fair: what people contribute is linked to how much they earn.
- Taxation can raise lots of money and is a reliable source of funding.
- Compared to other options, raising money via general tax is simple and does not cost much.
- There is strong public support: we all contribute to a service everyone can use

Drawbacks

- NHS budget is a political decision, which may not reflect funding needs.
- Hard for the NHS to plan long-term, as budgets rarely set for more than 1-2 years.
- Some argue that increased taxes discourage people from working hard.
- As health spending grows, other priorities (e.g. schools, policing, etc) may be squeezed.

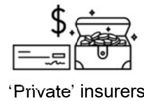
The current model



TheKingsFund>

Alternative models: Private health insurance

Employers may contribute, or individuals may take out their own policy



'Private' insurers

Healthcare services

Policyholders pay regular premiums to private insurers, how much may be linked to health status

People choose between insurance policies, which may offer different benefits at different prices

Health care services delivered by a mix of providers. Patients may be expected to cover at least part of the cost

Alternative models: Private health insurance

Arguments for

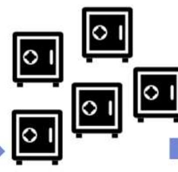
- Some argue private insurance promotes choice
- Some argue private insurance reduces the burden on public spending

Arguments against

- How much people pay is usually linked to health status, not income, which some consider to be unfair
- Without regulation, some people may not be able to get or afford insurance so are not covered - most systems are highly regulated to avoid this
- Administrative costs tend to be high
- Some argue that, where insurance is linked to employment, people are less willing to move jobs – making countries less competitive

Alternative models: Social health insurance

Portion of salary split between the employer and employee - supplemented by government tax revenues



Social insurance fund/s

Universal healthcare services

Employees and employers pay regular contributions to a social insurance fund, how much is linked to salary

People may get a choice of insurance fund or different benefits, government pays for people not in employment

Health care services delivered by a mix of providers, patients may be expected to cover at least part of the cost

Alternative models: Social health insurance

Arguments for

- Can provide comprehensive cover for all, with how much people pay linked to income not health status – like the NHS
- Employees, employers and government all contribute, with employers often paying more than in the UK
- Social insurance funds tend to be separate from government, which may provide more transparency
- Some countries allow people to choose between social insurance funds

Arguments against

- Administrative costs can be high, especially where people can choose between social insurance funds
- Some employers argue this makes them less competitive than countries where healthcare is funded by tax
- Ageing populations mean governments need to contribute more via tax, blurring the boundary between tax and social insurance.

Do alternative models hold promise for the future of the NHS, and how do these compare to the current NHS model?

Table discussion

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The trade-off between the level of services the NHS can provide and the amount of funding needed

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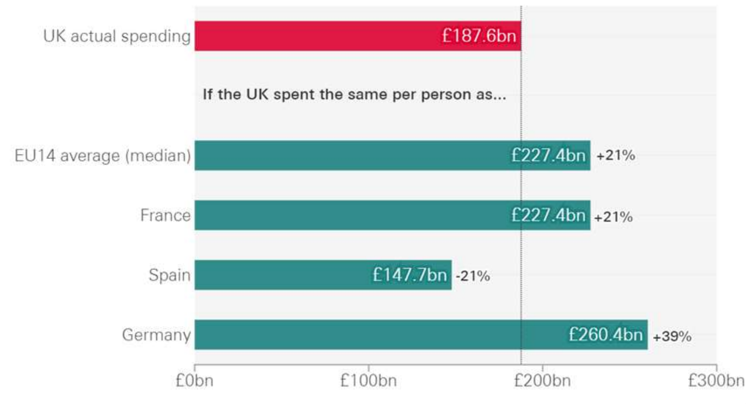
Resources for providing healthcare



More people need healthcare

The demands on NHS services are growing

1. **More people need healthcare** as the population grows larger and older.
2. **Rise in long-term conditions.**
3. **Inequalities in access.**
4. **Medicine can do more to treat ill-health** but this may require healthcare services to deliver more care to realise the benefits.

The trade-off

Improving NHS services	Increasing funding levels
People want to be able to access care when they need it. They want to receive high quality care that delivers a good patient experience and the best possible outcome. Improving NHS services may give people more choice over how to access NHS services, shorter waits, better patient experience and better health outcomes.	**In the long-term, improving NHS services would require increased funding for the NHS. This would generally mean individuals paying more towards the NHS**, most likely through increased taxes.

How much more money?

Long-term outcomes	'Stabilisation' scenario': Restoring pre-pandemic levels of service and performance	'Recovery' scenario: Higher levels of service and performance
Levels of service	Potential for: • Some expansion of capacity • Return to 2019 levels of service • Backlogs to be cleared slowly	Potential for: • Greater expansion of capacity • Levels of service better than 2019 • Backlogs to be cleared more quickly
Patient experience	Potential for: • Waiting times return to 2019 levels • Some improvements to patient experience • Some improvements to access/quality of care	Potential for: • Waiting times shorter than 2019 levels • Wider improvements to patient experience • Wider improvements to access/quality of care
Staff experience	Potential for: • Similar or slightly higher pay • Similar or slightly higher satisfaction • Some improvements in productivity	Potential for: • Higher levels of pay • Higher satisfaction • More improvements in productivity

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Key questions:

1. How do we feel about the trade-off between improving/ maintaining services and increasing funding levels?

2. How would any additional spending be funded?

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Why don't we spend the current funding better?

1. The NHS is generally seen as one of the more efficient health services in the world.
2. Compared to other comparable countries, the UK spent less than average on healthcare in the decade in the run-up to the pandemic.
3. Spending increased during the pandemic, but staffing gaps and capacity constraints make it harder for services to work more efficiently.

Please have a look at the 'mythbusting wall' for more information

Options for raising money within the current funding model

1 Increasing government borrowing

2 Moving money from other public services to the NHS

3 Raising more money from taxes

Options for raising money within the current funding model

1 Increasing government borrowing

2 Moving money from other public services to the NHS

3 Raising more money from taxes

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Table discussion

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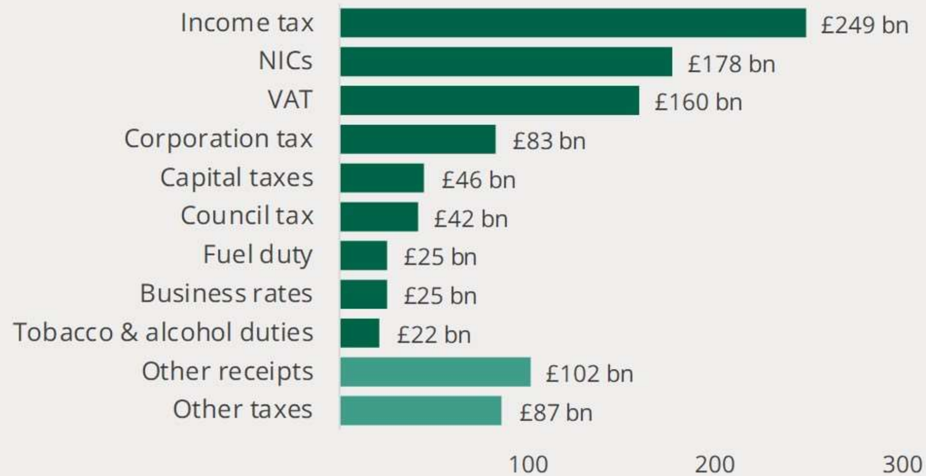
Options for raising revenue via tax

Public sector current receipts 2022/23: £1,017 billion

£ billion



Options for raising revenue via tax

Income tax

Overview

The NHS is currently funded mostly through the collection of taxes. The amount people are taxed generally **depends on what they earn**: the more they earn, the more they pay in tax.

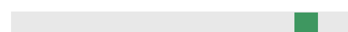
The tax that currently raises the most money is **income tax**. This is paid on all earnings above £12,570, including income from employment, profits from self-employment, some state benefits, income from private pensions and rental income from property.

Increasing income tax would be **sticking with the current system**. However, depending on how income tax were changed, this could mean **most of us pay more tax** from our income to raise more money for the NHS.

Trade-offs

- Income tax is a **progressive** system of tax, meaning the more you earn the more you pay. Some think this is fair; others think it's unfair.
- Income tax **raises a lot of money**. It currently raises more money than any other tax. However, some think higher levels of income tax would **discourage work** and may lead to **lower investment and economic growth**.
- Relying too heavily on income tax could also mean that the **amount of money collected can change** depending on economic conditions and political decisions.

Revenue-raising potential



High

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An additional tax earmarked for the NHS

Overview

A hypothecated tax is a special tax that is used to **raise funds for a specific and named area of public spending**, like healthcare. People who support this idea believe that it would make it clearer **how the increased tax is going to be spent**, so that the government and public services can be held accountable.

In 2021, Boris Johnson introduced the **Health and Social Care Levy**, a dedicated tax intended to raise £12 billion for NHS and social care services. The key characteristics of this levy were as follows:

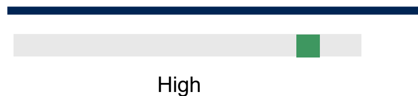
- A 1.25% **increase in National Insurance contributions** for employees and employers, including earners above the state pension age.
- A 1.25% tax rate rise for people who receive money from **stocks and shares**.
- **Changing the law** so the government was required to spend the money raised to fund NHS and social care services across the UK.

The levy was scrapped in 2022 by the then Chancellor Kwasi Kwarteng.

Trade-offs

- This system can **increase clarity and transparency** for taxpayers, but a separate tax could require **extra administration**.
- Using a dedicated tax for a specific purpose can also **limit flexibility in allocating funds** to other areas when priorities change or there are emergencies. The revenue raised may be linked to the state of the economy, not health needs.
- An earmarked tax **may be no more or less fair than any other tax**. Some criticised the Health and Social Care Levy for penalising lower paid workers while exempting wealthy, non-working pensioners.

Revenue-raising potential



High

Value Added Tax (VAT)

Overview

VAT is a **tax on the sale of goods and services**. It is a widely used tax system in many countries, including the UK. It is usually a percentage added on to the price of a product or service.

VAT rates can vary based on the type of product. In the UK the VAT rate for most things is 20%, but it is lower for some items (e.g. 5% for domestic energy) and is not charged on some essentials (like food and children's clothing). As VAT covers so many items, supporters think it could raise lots of money for the NHS.

To increase revenues for the health system in the UK, the government could consider further increasing the **standard VAT rate** or **increasing the tax paid for specific goods or services** that are generally seen as harmful to health – for instance increasing duty on cigarettes and alcohol.

Trade-offs

- VAT tends to **impact low-income households more** (as they spend a higher proportion of their income on goods and services), although **high-income households tend to pay more** overall because they buy more.
- Increasing VAT rates can lead to higher prices for goods and services, potentially **impacting the cost of living** for individuals.
- When prices rise due to increased VAT, individuals may buy fewer goods and services, which can have a **negative impact on the economy**.

Revenue-raising potential

Medium/ high

Table discussion

Options for raising revenue via tax

Income tax

Arguments for	Arguments against
• Many believe this is a fair system: how much people pay is linked to how much they earn. • Income tax can raise lots of money and provide a stable and fairly reliable source of funding for the NHS. • It would not cost much to raise more money via income tax, as all the systems and processes are already in place.	• Raising income tax puts the burden on the 60% of adults who pay this tax, rather than spreading the cost between everyone or sharing the burden with employers. • Some argue that increasing income tax can have a negative economic impact and make people less likely to work more – particularly if the rates are set too high.

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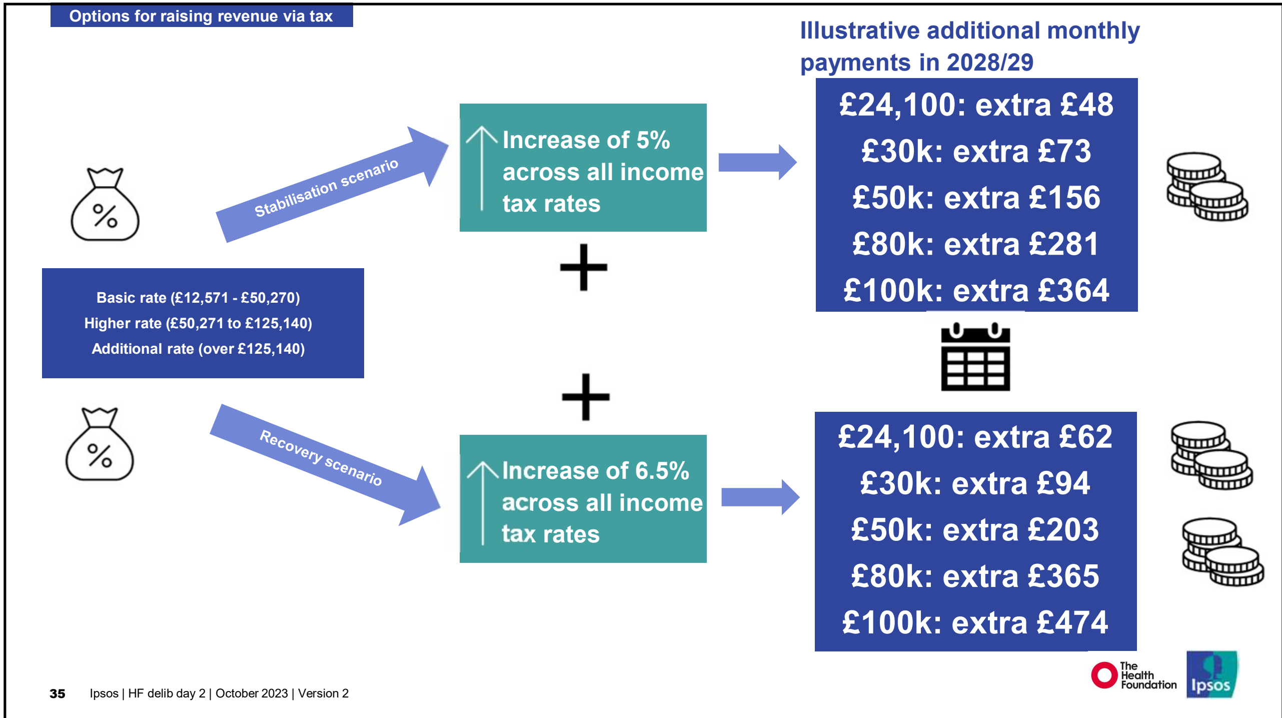

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Options for raising revenue via tax

An additional tax earmarked for the NHS

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Arguments for

- An additional 'NHS tax' could provide greater transparency and accountability, as taxpayers would see a clear link between paying tax and funding for the health service.
- A direct connection between higher taxes and extra investment in the NHS may also increase public support for the tax.

Arguments against

- Earmarking taxes for a specific reason limits the government's flexibility to move funds between different areas of public expenditure, such as education, defence or local government. This could mean that funds earmarked for the NHS could not be spent elsewhere, even in a national crisis.
- 'Hard hypothecation', where the NHS is exclusively funded by an additional tax, could be more vulnerable to economic downturns. This is because healthcare funding would depend on a specific tax, which could raise much less revenue during an economic crisis when there is often a greater need for healthcare.
- Earmarking the proceeds of a tax for the NHS could make the tax system more complicated and costly to run. It could also lead to increased pressure for tax reductions for people who pay for private health insurance.
- Some argue earmarked taxes are vulnerable to political changes. The UK has never had a 'hard hypothecated' tax before and experience suggests that 'soft hypothecated' taxes rarely last very long.

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Options for raising revenue via tax

*These amounts would be paid by both employees and employers

Annual income	H&SC levy monthly increase (2022/3)*	Stabilisation scenario (monthly, by 2028/9)*	Recovery scenario (monthly, by 2028/9)*
£24,100	£15	£30	£45
£30,000	£19	£37	£56
£50,000	£42	£84	£126
£80,000	£67	£135	£202
£100,000	£94	£188	£283

Options for raising revenue via tax

Value Added Tax (VAT)

+ Arguments for	− Arguments against
• VAT is charged on a wide range of goods and services, which means it can provide a stable source of funding. • Governments can soften the impact of VAT on lower-income individuals by providing exemptions or reduced rates for essential goods and services. • Raising VAT to generate extra funding for the NHS would spread the burden of the extra costs across all consumers and businesses.	• VAT is generally considered regressive as low-income households spend a higher proportion of their income on goods and services, so pay a larger percentage of their income on VAT. High-income households still tend to pay more overall because they buy more. • Increasing VAT rates can lead to higher prices for goods and services, potentially affecting how affordable essential items are. • Higher VAT rates can mean that consumers buy fewer goods and services, which could have a negative impact on the economy.

Options for raising revenue via tax

Value Added Tax (VAT)

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	A new boiler	Biro pen	New car		
20%	£2,500	90p	£15,000		Approx. £162 billion (per year)
24%	£2,583	93p	£15,500		Stabilisation scenario (by 2028/29)
26%	£2,625	95p	£15,750		Recovery scenario (by 2028/29)

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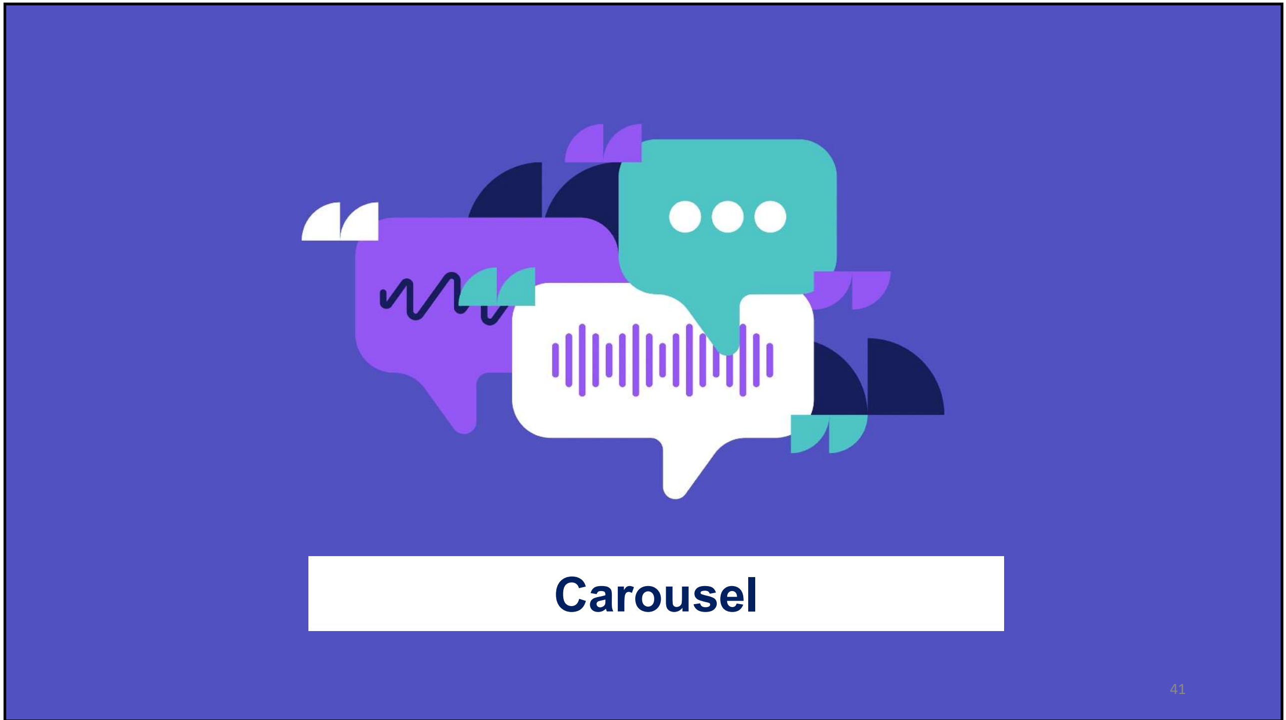
Carousel
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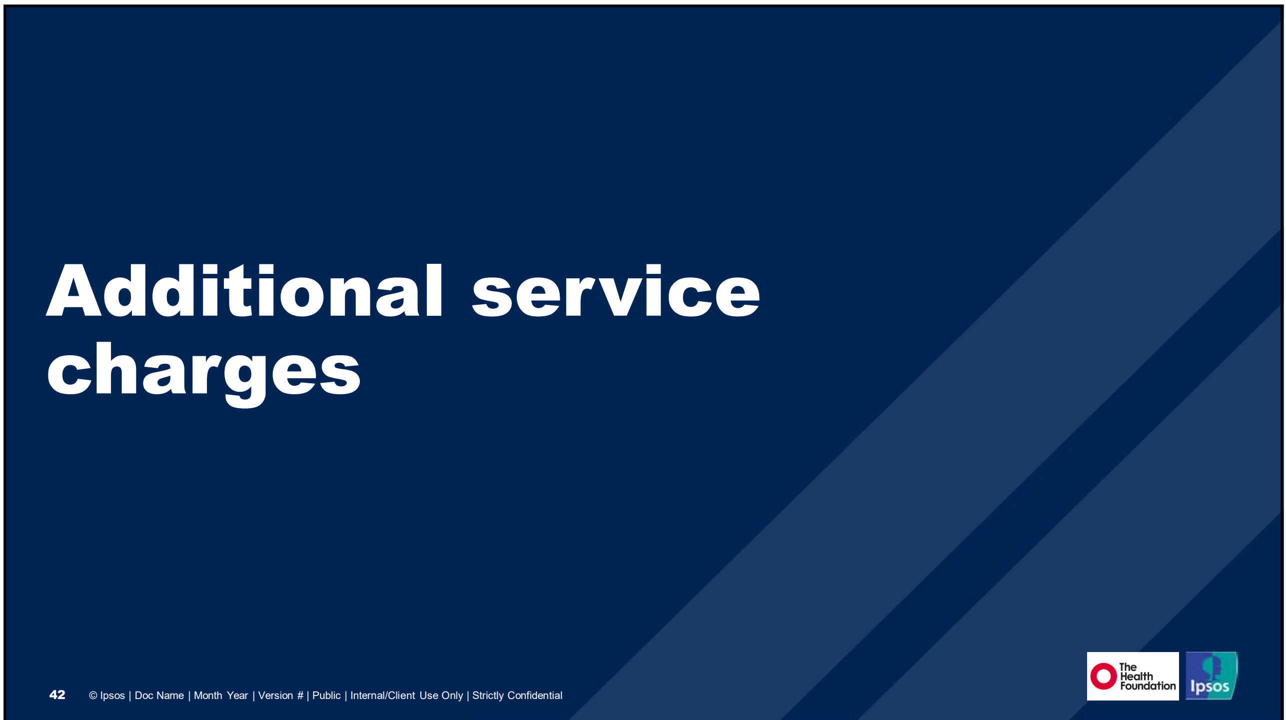
Additional service charges
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Alternative models

Additional service charges

Overview

In England, there are already charges for people using certain NHS services such as prescriptions, dentistry, and eye tests.

Some argue that **introducing a charge for seeing a GP or visiting the A&E department** would mean people would reduce use of these services. However, the evidence suggests charges would also lead to some people not using services even when they need them.

Charging for healthcare services can be seen to **increase overall funding**. However, there is some **doubt about how much this would raise**, as there would probably be at least some exemptions for people who need to use services more often.

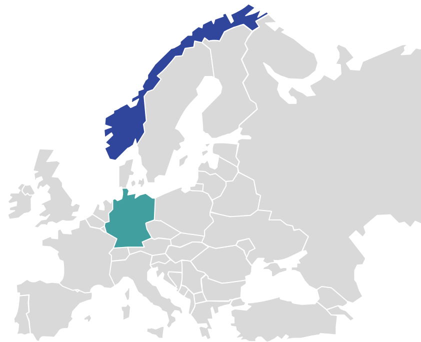
Trade-offs

- **Charges can reduce demand** for healthcare, but that includes **people not using services they need to stay healthy** the sickest and poorest patients are most affected.
- Charges can **discourage people** from seeking preventive care or delay seeking treatment, leading to delayed diagnoses and health problems getting worse – which could increase costs in the long-term.
- Exempting some people from paying (e.g. those on low incomes) **limits how much money** is raised. The **burden** of paying the extra costs would also fall on the subset of people using services without an exemption.
- Implementing and collecting service charges could be **complex and costly**, which is likely to be more expensive than increasing taxes.

Alternative models

In **Norway**, charges are in place for things like GP and specialist visits, physiotherapy sessions, prescription drugs, and certain diagnostic tests.

This includes €15 for a GP visit, €34 for an outpatient appointment with a specialist, and up to €50 for prescriptions. The country sets a yearly limit on out-of-pocket expenditure for individuals – €227 per year. Once individuals reach this cap, they pay no more. Exemptions are also in place to ensure access to healthcare services for specific groups.



In 2004 **Germany** imposed a new charge for visiting a GP or specialist of 10 euros per quarter.

Evaluations found that visits to GPs fell in 2004 compared to 2003 (although rose in subsequent years) and that the charge created an additional administrative burden on doctors. It also had an impact on health spending in all income groups, but particularly in less affluent groups. As a consequence, the additional charge was abolished in 2012.

Earlier this year Sajid Javid, the former health secretary, called for patients in the UK to pay for GP and A&E visits to tackle growing waiting times. He said that fees should be 'means tested' to protect people on lower incomes. He implied a model involving £20 fees for GP visits and £66 charged to people going to A&E without a referral.

Arguments for

- For supporters, charges can encourage personal responsibility, making individuals think about whether they definitely need to use a particular service.
- User charges can add to the current funding for services. However, the charges would need to be high enough to outweigh what the extra costs of administering and collecting them.
- Most supporters want exemptions (for instance for children, older people and people on low incomes) to reduce the risk of people being denied access to necessary services.

Arguments against

- Charges can make it harder for people with less money and/or more health needs to afford healthcare, which can create inequalities in access to care.
- It can be hard to know when to seek treatment for a medical condition and charges can make people more hesitant to use preventive care or delay seeking treatment, which may lead to delayed diagnosis and health conditions getting worse. This could mean increased demand for services that are costly for the taxpayer but provided free to the patient, like ambulance call outs or emergency surgery.
- Implementing charges adds complexity and costs to the healthcare system. Setting up exemptions would further increase the complexity of the system.
- The cost of administering charges needs to be balanced against the revenue they generate. Charges are used in many countries, but typically contribute only a small portion of the total revenue.

Social health insurance

Social Health Insurance

Overview

Social Health Insurance (SHI) is a system where **employees, employers and the government all contribute** to the costs of providing healthcare.

Money is collected by one or more **insurance funds** and is used to pay healthcare providers to provide care for the people covered by the fund. SHI contributions are usually **mandatory**, like taxes, but they are not directly collected or spent by the government. The amount individuals contribute is generally **based on their income**, rather than their health status. Not all healthcare needs are necessarily covered by all insurance funds, so sometimes extra payments are needed.

For individuals who are not employed, healthcare is often funded from **general taxation or statutory pension funds**. In countries with SHI, the reliance on tax funding is increasing due to ageing populations.

Trade-offs

- Designing, implementing and managing SHI in the UK would be **extremely complex**, with much higher administrative costs.
- **Retains some of the principles** the public like about the NHS, but **every SHI system is different** – having evolved over many decades, in the context of different cultures.
- **Employers may be expected to contribute more** towards healthcare costs, which can discourage job creation and cause extra problems for smaller businesses.
- An ageing population would mean **substantial tax funding** would still be needed.
- **Independence from government** can mean funding is less influenced by political change, but may also reduce democratic accountability.

Alternative approaches

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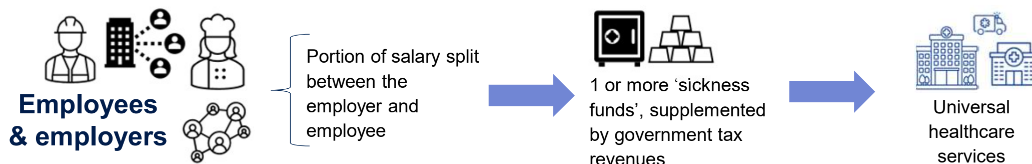

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Alternative models

France

- No competition between insurers
- Insurance is mandatory, but individuals can purchase supplementary private health insurance
- Employment-based contributions
- Supplemented by tax
- Principle of 'solidarity' (people pay according to their means and receive according to their needs)

Netherlands

- Several insurers offering a choice of various insurance plans
- Insurance is mandatory, but individuals can choose between different private insurers for their basic cover and can also purchase additional insurance for more coverage
- Everyone 18+ pays a premium directly to an insurer of their choice and those of working age also pay an employment-based contribution
- Supplemented by tax
- Principle of 'managed competition', where insurers compete on price and quality but with strict government regulation

Alternative models

Arguments for

- SHI has generally been a reliable way of providing access to healthcare in the countries with social insurance systems.
- Some SHI systems allow people to choose between different social insurance funds and different benefits, although this tends to increase administration and costs.
- Some argue that SHI means healthcare funding is less influenced by political change, because insurance funds are usually independent from government.
- Some argue SHI could provide greater transparency, as there would be a clear link between paying contributions and funding for healthcare.

Arguments against

- Moving to a SHI system in the UK would be extremely complicated and is expected to involve substantial reorganisation of healthcare services and take many years to put in place.
- There is no clear evidence that SHI systems provider better quality care or better health outcomes.
- In an ageing society, fewer people will be in employment and SHI would raise less money. This means government would increasingly need to top up SHI contributions from tax, reducing the differences with the existing system in the UK.
- SHI contributions are generally paid by employees and employers, leaving government to fund services for people not in employment.
- Some people argue that expecting employers to contribute more to healthcare costs means fewer jobs are created.
- Evidence so far does not suggest the funding levels are more predictable and consistent in SHI systems compared to tax systems, despite some making this argument.

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Whole-group voting

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Table discussion

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Building confidence that governments are planning well for the NHS's future

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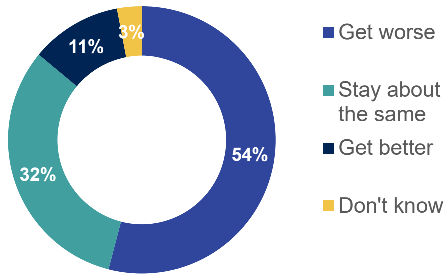
The public are not confident in plans for the NHS in the future

Just over half (54%) think the general standard of care provided by the NHS over the next 12 months will get worse



Only 12% agree the government has the right policies for the NHS

What are some approaches that a government could take to build public confidence in plans for the NHS's future?

1. More long-term thinking and planning in decision making

Purpose

- Improvements **take time to filter through** to patients, the public and staff. But governments are under **pressure to show quick results**. This means they often focus on short-term fixes than long-term planning.
- Independent evidence and analysis, free from political agendas, can provide a **neutral view on what is needed in the long-term.**
- This could help governments make **informed decisions in the best interests of the country**, rather than what is best for a government at any particular time.
- However, independent assessments can be time-consuming, and government may not always implement the recommendations.

Example: The Wanless Review, 2002

A one-off independent assessment of the NHS's likely future needs, and likely cost, over the next 20 years.

Example: An 'Office for Budget Responsibility' for health

Similar to the OBR's role in public finances, some experts argue for a permanent independent body to assess the NHS's long-term funding and workforce needs to inform and scrutinise government decisions.

2. More public engagement to inform decisions

Purpose

- Public engagement is the involvement of the public in decision-making processes and activities that affect them
- It can **promote transparency**, build trust, educate the public, innovate services, and enhance civic participation.
- It can help organisations to **understand and meet public needs** more effectively.
- It can help policymakers make **difficult decisions with trade-offs** because they better understand what matters to people.
- However, it is not guaranteed that decision-makers will always reflect the public input into their decisions.

Example: Our health, our care, our say White Paper, 2006

This plan for the future of community health services was informed by the views of 40,000+ people through local and national events and surveys, with a citizen's panel providing scrutiny of the consultation process.

Example: Citizen's Assembly on Social Care, 2018

A group of 47 representative citizens from across England came together over two weekends to consider how adult social care should be funded in the future.

3. Give the NHS greater independence from government

Purpose

- Make the NHS more independent to **reduce political control** over it.
- **Less political interference** in the operations of the NHS.
- This could mean that decisions are taken **based on patient and public needs** rather than political motivations – though achieving this in practice has proved challenging.
- This could facilitate more **long-term** planning.
- However, this could mean the NHS is **less accountable to taxpayers who fund the NHS**.

Example: The Health & Social Care Act 2012

This legislation created NHS England to oversee the commissioning of NHS services. It was intended to operate at arm's length from government, working to a mandate set by government.

4. Greater devolution of decision making to local areas

Purpose

- Devolution involves the **transfer of powers and funds** from the central government to local bodies so that decisions are made about health services closer to point of service delivery.
- It could enhance **accountability and transparency** as local bodies can be more directly answerable to local communities than a central government.
- Decisions are made **by people who understand the local community and can tailor services to them**.
- It could lead to **more innovation**, as areas can try different ways of delivering healthcare.
- This could help to focus attention on reducing inequalities locally. But could also lead to **greater differences in the quality and availability of services** across regions.

Example: Devo Manc

The devolution of control over the region's £6 billion health and social care budget to local authorities in the Greater Manchester region.

Discussion: "Would these approaches help to build confidence that governments are doing the right thing now that should lead to better health care in the future?

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Table discussion

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1. More long-term thinking and planning in decision making

An independent commission for the NHS – Overview

One way for a government to overcome the short-term focus of election cycles is by establishing an independent **commission or review** specifically for the NHS.

A (royal) commission or inquiry is an approach used in countries like Australia, New Zealand, Canada, and Ireland for various aspects of government policy. It has also been used many times in the United Kingdom in the past.

For example, the UK's 2002 **Wanless** Review provided an independent assessment of the NHS's likely future needs, and likely cost, over the following 20 years. Recommendations included budget increases, workforce expansion, and auditing healthcare spending.

Purpose

- Improvements **take time to filter through** to patients, the public and staff. But governments are under **pressure to show quick results**. This means they often focus on short term fixes
- Independent evidence and analysis, free from political agendas, can provide a **neutral view on what is needed in the long-term**
- This can help governments make **informed decisions in the best interests of the country**, rather than what is best for a government at any particular time.
- However, independent assessments can be time-consuming, and government may not always implement the recommendations.

An independent commission for the NHS

Benefits	Concerns
A review or commission can present a long-term perspective for the NHS and help policymakers understand the implications of different strategies and decisions	Reviews are costly and time-consuming – by the time of publication, the government or the pressures might have changed and that could delay action on well-known issues
A review or commission could be neutral, and therefore above political 'infighting'	The commission is a one-off, rather than an ongoing programme – how much is this likely to significantly influence public confidence?
A review or commission can increase transparency, promoting confidence among the public	A government could, in theory, try and influence the findings of the report to enact their own agenda
The intention would be for recommendations to be evidenced and informed through speaking with experts in the field, which may lead to support from politicians from all sides	Governments are not required to implement review recommendations
The hope is that the findings would be genuinely beneficial to the NHS in the long-run, breaking the short-term cycles of 'quick fixes'	There may be negative public perceptions if the review uncovers deep-seated problems in the system, which could undermine confidence in the NHS

2. More public engagement to inform decisions

A major public engagement initiative – Overview

Another option is a **major public engagement initiative** to establish and gain support for a new NHS Long Term plan.

Public engagement is the **involvement of the public in decision-making processes and activities that affect them**. The UK is recognised globally for its public engagement strategies, with successful initiatives in different sectors already in place.

health policy is engagement around the development of the White Paper **Our health, our care, our say** which heard from over 40,000 members of the public through local and national events and surveys.

Purpose

- Public engagement's purpose is to inform decision-making, promote transparency, build trust, educate the public, innovate services, and enhance civic participation.
- It allows organisations to **understand and meet public needs** more effectively.
- It can help policymakers make **difficult decisions with trade-offs** because they better understand what matters to people.
- However, it is not guaranteed that decision-makers will always reflect the public input into their decisions.

More public engagement to inform decisions

Benefits

- Ultimately the healthcare system is for the public, and public engagement can give the public a say in how it is run
- Public engagement can mean that concerns and issues that are important to the public are addressed, with decisions made in the interests of the public, free from political agendas
- Public engagement can provide greater transparency in decisions on healthcare operations and spending
- It could lead to greater trust between the public and healthcare institutions
- The approach may encourage long-term beneficial changes in the NHS, depending on the public perspective

Concerns

- It can be hard to make sure that all voices and perspectives are represented in public engagement processes, particularly for marginalised or underrepresented groups
- There could be a knowledge gap preventing the public from making informed decisions
- Ensuring nationwide representation in consultations would require significant resources and could slow down progress
- It can also focus on specific aspects of the healthcare system, because otherwise it would be too wide-ranging
- Decision-makers may not always reflect public input into their decisions, which can lead the public to think engagement is just tokenistic

3. Give the NHS greater independence from government

An independent NHS – Overview

An independent NHS, akin to the **Monetary Policy Committee at the Bank of England or the BBC**, is another option to consider. Several models for this change have been proposed.

An independent NHS would handle its own operations, free from short-term political pressures and government influence.

One example of this is under the **Health and Social Care Act 2012**, which created NHS England to oversee the commissioning of NHS services. It – alongside other national bodies like Public Health England and the Care Quality Commission – was intended to operate at arm's length from government, working to a mandate set by government.

However, removing politics from the NHS has proved challenging in practice and recent reforms to the NHS in 2022 strengthened political power over decisions.

Purpose

- Make the NHS independent to **reduce political control** over it.
- **Less political interference** in the operations of the NHS.
- This would mean that decisions are taken **based on patient and public needs** rather than political motivations.
- Could facilitate **long-term** strategic planning.
- However, this could mean the NHS is **less accountable to taxpayers who fund the NHS**.

An independent NHS

Benefits	Concerns
• Independence could shield the NHS from political agendas • Independence could increase transparency and openness about the NHS's performance • With an independent NHS managing operations, government ministers would be freed up for strategy and budget planning • An independent NHS could be more effective, fair and focused, as it is able to make decisions about resource allocations without political interference	• Organisational change to generate further independence could be costly and disruptive • Could this be seen as a step towards privatisation, and a move away from the founding principles of the NHS? • Professionals running the NHS reduces political accountability. There are questions about how far tough choices – for instance, about which services to prioritise – should be left to unelected officials • The NHS is funded by taxpayers, so political oversight is important to provide accountability to taxpayers and ensure the NHS meets the public's expectations • Critics argue the NHS's size and political significance is too great for independent operation

4. Greater devolution of decision making

"Devo Manc" model - Overview

Devolution involves the **transfer of powers and funds** from the central government to local bodies like local councils, to give more control over public services to local areas.

The Cities and Local Government Devolution Act, passed in 2016, allows for the transfer of certain powers and responsibilities from the national government to local authorities, including cities and regions. This can include the devolution of health services.

An example of devolution presently is "**Devo Manc**" in Greater Manchester. This transferred certain powers from the national government to the Greater Manchester region. This includes control over the region's £6 billion health and social care budget – meaning that local authorities in Manchester have more say in how health and social care services are planned, organised and delivered in the area.

Purpose

- Devolution means that decisions are made about health services closer to point of service delivery.
- It could lead to **more innovation**, as different areas can try different ways of delivering healthcare.
- It could enhance **accountability and transparency** as local bodies can be more directly answerable to local communities than a central government.
- Decisions are made **by people who understand the local community and can tailor services to them**. This could help to focus attention on reducing inequalities locally. But could also lead to greater differences in the quality and availability of services across regions.

Greater devolution of decision making

Benefits

- Devolution means that decisions about health care are made closer to the point of delivery – this could mean that services are better aligned with the needs and preferences of local communities
- Devolving powers could lead to a more integrated health and social care system, allowing for more coordinated care and more efficient use of resources
- Localised decision-making could lead to greater accountability and transparency, so local communities have a more direct influence on health service provision and policy decisions
- Devolution allows regions the freedom to trial new initiatives and innovate to meet the unique health needs and challenges of their local populations

Concerns

- Devolution could lead to greater differences in the quality and availability of services across regions – otherwise known as a 'postcode lottery'
- The transition towards a devolved system can be complex and costly
- Localising the health service could lead to increased political influence locally
- In case of service failure or issues, it could become difficult to determine who is held accountable. It might also make it harder for the national government to intervene if things go wrong

THANK
YOU

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This is the international market research specific standard that supersedes BS 7911/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a Market Research project. Ipsos was the first company in the world to gain this accreditation.

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This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

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