The Future of the NHS in England

Deliberation for the Health Foundation

May 2024

Contents

Executive Summary

This report presents the findings of a deliberative research project commissioned by the Health Foundation and conducted by Ipsos in October to November 2023. The topic was 'The Future of the NHS', with the following research questions:

- What are the public's perceptions of the NHS and the causes of the current challenges that it faces?
- Where do the public think the balance of focus should be between primary and community care, and hospital care?
- What are the public's views on funding for the NHS, including the balance between the level of services people want versus the amount of funding the NHS receives, and how additional funding should be raised?
- What do the public think is the best model for healthcare in the UK, considering the current NHS model alongside what are often proposed as better alternatives (the current model with user charges and social health insurance models)?
- How could the public's confidence in planning for the future of the NHS be built?

The deliberation comprised three workshops, one in each of King's Lynn, Leeds and London, with each workshop involving 24 members of the public (72 in total across the three). Participants deliberated over the course of a weekend through a combination of listening to expert presentations, asking questions, and table discussions in which the issues were debated and discussed at length.

As the workshops began, participants held a deep appreciation for the NHS related to its founding principles, but expressed dissatisfaction with its current performance and concern about its future.

Most participants felt a deep connection to the institution that was strongly related to its founding principles, in particular that everyone can access services and they are free at the point of use. However, many were dissatisfied with how the NHS is working at the moment, and they expressed significant concerns about its future. Their key concerns were perceived understaffing within the NHS, along with worries about the morale and wellbeing of NHS staff. They thought this was leading to long waiting times and a decline in the quality of care.

These concerns were perceived to be rooted in inadequate funding for the NHS, but also the mismanagement of NHS resources, which they saw as resulting in too much waste and inefficiency. They talked about the strain that an ageing population was placing on the NHS, with the need to care for more patients who have greater health needs. Participants also thought a lack of long-term planning was causing the challenges facing the NHS, which they linked to excessive political involvement in the NHS. While they thought the Covid pandemic had exacerbated the NHS's challenges, it was generally not thought to have caused these issues.

When participants were presented with additional information on the scale and nature of the challenges facing the NHS, these often shocked them. In particular, participants were concerned by the lower-than-average increases in real-term funding during the 'austerity years' and the planned lower-than-average increases for 2023/24 and 2024/25. They were also alarmed by the projected shortfall in GPs and practice nurses, and hospital beds, by 2030, and surprised by some of the information they saw about

health inequalities. This generally consolidated participants' frustration with politicians and a lack of long-term planning to address the issues within the NHS.

Regarding the balance between improving primary and community care versus hospital care, most participants initially leaned towards the belief that primary care needed more focus.

Participants deliberated the following question: 'with limited resources, we face a choice about where to focus, and the balance between primary and community care, or hospital care. What do you think the focus for improvements in the NHS should be?' Most participants started from the belief that primary and community care needed more focus than at present (having been told that hospitals had received proportionately more of the NHS budget and increases in the medical workforce in recent years). This view was largely shaped by their poor personal experiences of trying to access GP practice services and the assumption that improving primary and community care could potentially reduce demand for hospital care. They thought it would help prevent people needing hospital care in the first place by: preventing illness entirely; ensuring early diagnosis is possible; and intervening earlier to avoid a patients' condition deteriorating to the point of requiring hospital care. For participants, this represented a better use of resources and easing the strain on the system.

Following deliberations that included exploring six different approaches to improving primary, community and hospital care, many participants remained committed to a greater focus on primary and community care than at present. However, some participants consistently advocated for a continued focus on hospital care, on the basis that the patient needs served by hospitals are more acute and therefore these services should be prioritised. For the same reason, others thought there should be a greater focus on hospital care than they had initially thought at the start of the deliberations. Ultimately, participants found it difficult to deliberate different approaches within the current constraints, and would not accept a decline in the quality or availability of primary community or hospital care.

When discussing the trade-off between the level of funding for the NHS and the service levels it can deliver, most participants wanted the NHS to deliver better services than at present and therefore said they would be willing to pay additional tax in order to achieve this.

Reflecting on perceived poor service levels at present, most participants wanted to see improvements to the services that the NHS currently delivers, and said that they would be prepared to pay additional taxes to fund it. Of the options presented to them, they tended to favour a higher level of improvements in services, despite this requiring a higher level of tax increases.

However, while many participants recognised the need for increased funding to improve services and address the challenges facing the NHS, they were also very aware of the economic pressures that people are currently experiencing. This led to a strong consensus that the government should do everything it could before resorting to raising taxes, and to minimise any increases. In particular, they thought that the NHS could, and indeed should, improve how it utilises its resources, by reducing waste and inefficiency and organising resources more effectively. Participants suggested a wide range of practical examples where they thought resources could be better used, and struggled to accept that making these improvements would not release sufficient revenue to fund the service improvements needed. Many participants also wanted to see greater transparency and honesty around NHS budgets, and better long-term planning to maximise the impact of additional investment.

By the end of the deliberation on this topic, a small number of participants remained opposed to providing NHS with additional funding raised through taxation, often out of concern for the financial pressures on households during the cost of living crisis.

When thinking about three different options that were presented for raising additional revenue for the NHS, there was little consensus on the preferred approach, although a tax based on National Insurance but earmarked for the NHS (i.e. a hypothecated tax) or an increase in VAT were generally preferred to an increase in income tax. The key advantages of an earmarked tax based on National Insurance were seen as sharing the cost between employers and employees and the potential transparency of a direct link with NHS funding. An increase in VAT was favoured more because participants thought people would be able to better control the impact of an increase by varying their spending. However, many preferred a mix of two or all three approaches, as they thought it would mitigate some of the disadvantages of any one tax. This reflected the fact that the cost to individuals was the main driver behind participants' preferences, in the context of a cost of living crisis. In addition, participants questioned whether additional funding for the NHS could come from other sources, such as an increase in corporation tax or moving spending from other areas such as defence.

When presented with alternatives to the current NHS model, participants overwhelmingly favoured retaining the current model.

Participants discussed in detail the current NHS model alongside two alternatives: (1) the current model with additional charges, and (2) a model based on social health insurance. They expressed a strong preference for the current model, particularly appreciating that it is largely free at the point of use and available to all, as well as being largely supportive of healthcare being funded primarily through taxation. Participants saw these aspects as integral to the identity of the NHS and were resistant to changes that could potentially undermine them.

However, they also acknowledged that the current model is not perfect, with some existing inequalities in the healthcare that people have access to (for example, with some people being able to access private care). Many participants also questioned whether the current model was sustainable, given the scale of the challenges the NHS currently faces. In addition, many were critical of the lack of independence of healthcare from UK politics.

Looking at alternatives, the idea of the current model with additional charges was largely unpopular and made many participants uneasy. It felt like a move away from the NHS's founding principles, and participants were concerned about the impact on inequality. They often thought it would work better if charges were aimed at deterring 'abuse' of the health service, such as fines for missed appointments, rather than as a means of generating any significant revenue.

Participants were more divided about a social health insurance model, with the idea of purchasing insurance for healthcare worrying to many. For example, they were concerned about how they would select the best policy and what would happen if they had a condition that wasn't covered. In this context, the concept of choice generally made them feel uneasy, feeling there would be too much pressure on them to make the 'right' choices without having all of the understanding and knowledge they felt they needed. Participants were also sceptical about the potential involvement of profit-making companies in health and the impact this would have on patient care, as well as potentially leading to greater privatisation. However, a significant positive to this model was greater independence of healthcare from politics, identified as being a major downside to the current NHS model.

Participants generally expressed a significant lack of confidence in government's ability to undertake long-term planning for the NHS, with an independent commission and greater independence of healthcare from government seen as the best options for building their confidence in planning for the future.

From the very outset of the weekends' discussions, participants expressed mistrust in political involvement in the NHS, questioned whether decision-making is evidence-based, and blamed the electoral cycle for short-term decision-making that runs counter to the long-term sustainability of the NHS.

Of the different options presented to participants that may build their confidence in plans for the NHS's future, many favoured the NHS having greater independence from government and the establishment of an independent commission or review to inform and support long-term planning. They felt this would engender greater transparency and honesty, and more consistency in decision-makers with greater NHS experience, which they thought would lead to more stability and strategic, long-term decision-making.

Throughout the deliberations, views of how the NHS uses its resources and concerns about frontline staff repeatedly emerged and were influential.

Many participants thought the NHS mismanages its resources and identified ways in which they felt this could be improved. This view impacted many of the discussions, including the extent to which the NHS needs additional funding versus using the funding it does have better, and whether the focus of care should be towards primary and community care, or hospital care, with the former often seen as a more efficient use of resources.

Discussions about frontline staff within the NHS were also prevalent, from discussing the current challenges facing the NHS, through to what participants would need to see to have confidence in plans for the NHS's future. Reducing the pressure on frontline staff and increasing their number was often a priority for participants, as they saw it as central to addressing some of the sources of their dissatisfaction with the NHS, such as poor access and feeling like healthcare professionals were rushed, resulting in declining quality of care.

1 Background and methodology

This chapter of the report outlines the background to the deliberative research project conducted by the Health Foundation and Ipsos. It describes the objectives for the research, along with the methodology employed to meet these objectives.

1.1 Background to the research

The NHS in England is currently facing a host of complex challenges, with critical staffing gaps, insufficient capacity and inadequate buildings, equipment and IT, leaving people struggling to see their GP, long delays in urgent and emergency services, and record waiting lists for hospital treatment. Public satisfaction with the running of the NHS is at its lowest level in 25 years (according to the British Social Attitudes Survey[1]), with just 24% of the English public satisfied and 51% dissatisfied.

Since 2021, the Health Foundation has partnered with Ipsos to run a survey of public perceptions and expectations of the NHS and social care[2], surveying a representative sample of the UK public every six months. Focusing on the findings for the English public only, these surveys show that the public are pessimistic about the NHS. In November 2023, around half (54%) thought the general standard of care provided by the NHS would get worse over the next 12 months (compared with 12% thinking it would get better).

At the same time, the English public remain strongly committed to the founding principles of the health service. Most think that the NHS should continue to be free at the point of delivery (88%), provide a comprehensive service available to everyone (84%) and be primarily funded through taxation (83%). However, there are some early indications that support for this model may be starting to weaken, albeit from very high levels. In May 2023, while 71% of the English public thought that the NHS is crucial to British society and we must do everything to maintain it, this was down from 76% in May 2022. Support for the model is also tempered by a concern about whether it can be sustained – in May 2023, just one-quarter (23%) thought that healthcare will generally be free at the point of delivery in 10 years' time, as it is now. Meanwhile, some policymakers and commentators cite the public's affection for the NHS as a major barrier to changes that would meaningfully improve performance.

Addressing the challenges that the NHS faces requires a coherent long-term strategy, backed by stable investment to meet underlying demand and cost pressures. But making and sustaining meaningful improvements to health services will be complex and resource intensive. Even in the most favourable circumstances, it could take some time for those improvements to be felt by patients, and for public satisfaction with the NHS to return to higher levels.

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

- Build upon the surveys, to provide deeper qualitative insights around the quantitative findings.

[1] https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-social-care-2023#:~:text=The%20British%20Social%20Attitudes%20(BSA,and%20care%20questions%20reported%20here.

[2] https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-what-government-should-know

- Generate evidence on the public perspective, 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.

1.2 Research questions for the deliberation

The key research questions for the deliberation were:

- What are the public's perceptions of the NHS and the causes of the current challenges that it faces?

- Where do the public think the balance of focus should be between primary and community care, and hospital care?

- What are the public's views on funding for the NHS, including the balance between the level of services people want versus the amount of funding the NHS receives, and how additional funding should be raised?

- What do the public think is the best model for healthcare in the UK, considering the current NHS model alongside what are often proposed as better alternatives (the current model with user charges and social health insurance models)?

- How could the public's confidence in planning for the future of the NHS be built?

1.3 Deliberative engagement

Deliberative methods work best on challenging issues where there is no simple 'correct' answer but rather a range of possible options, with associated strengths, drawbacks, and complexities. Through engaging with balanced information and considering diverse viewpoints on a topic, participants can grapple with multiple potential solutions and perspectives to arrive at a series of nuanced views. Deliberative processes reveal not only what informed members of the public think should happen in response to a complex policy problem, but also shed light on people's starting opinions, how their views change through a process of learning and deliberation, why their views change, and the rationale for their final position.

1.4 The process design

The design of this deliberative exercise was closely informed by the Health Foundation team, whose input into the discussion guide and stimulus material helped to ensure the engagement process was evidence-based, robust and rigorous, and balanced.

The two-day process comprised a combination of:

- Plenary sessions in which participants listened to expert presentations and were able to ask questions.

- Table discussions in which the issues were debated and discussed at length.
- Plenary sessions in which facilitators or participants fed back on their tables' views to all participants.

The timings and details of the topics covered each day can be found in the discussion guides in the appendix.

Several members of the Health Foundation attended the workshops to contribute to the process as subject matter experts. These experts played a key role in providing participants with information through presentations and answering questions at the discussion tables. Prior to the start of the workshops, the experts were instructed to only join participant discussions when invited, to answer specific questions or offer contextual information, and to offer participants a balanced view throughout.

On both days of the workshop, participants were allocated to three tables of approximately eight participants per table. A facilitator was stationed at each table to moderate the discussion through the day. Table allocations were selected to ensure a mixture of key characteristics (age, gender, social grade, ethnicity, views of the NHS). The table allocations were different on days one and two to ensure participants were exposed to a variety of differing viewpoints and arguments. This approach aimed to minimise the potential influence of 'groupthink' or social desirability bias. Facilitators followed a comprehensive discussion guide throughout the two-day process to ensure consistent coverage of the same topics across all tables and locations. The materials used underwent several iterations with the Health Foundation team before being finalised. Please refer to the appendices for the stimulus materials that were shared with participants.

On day one of the process, participants received an introduction to how the NHS works. They learned more about how it is funded, and were presented with an overview of the current challenges faced by the NHS. This included increased demand as a result of a growing and ageing population, rise in long-term conditions, advancements in medical science, and health inequalities. It also included resource constraints as a result of funding levels, staffing levels, and capacity with regard to facilities and equipment. After learning more about the context in which the NHS is operating, participants spent the remainder of the day considering whether the focus of improvements should be on primary and community care, or hospital care – assuming the need to work within current financial and workforce constraints meant that such prioritisation was required. They learned about and discussed examples of specific policy interventions that would affect how people accessed different NHS services such as improving continuity of care in general practice, expanding Urgent Community Response services, and scaling up virtual wards, comparing these approaches using a number of factors.

On day two, participants received a presentation on the current funding model of the NHS and deliberated the trade-off between the level of services they desire and the amount of funding needed to deliver these service levels. They were then presented with potential options for raising additional funding, the pros and cons of which they compared: an additional tax earmarked for the NHS (based on the Health and Social Care Levy introduced in 2021), an increase in income tax, or an increase in VAT. In the afternoon of day 2, participants moved on to discuss two alternative healthcare models: the current NHS model with additional charges and social health insurance. They discussed and voted on their preferred model. The weekend ended with participants discussing different approaches that governments could take to build public confidence in plans for the NHS's future.

Throughout the weekend, participants were encouraged to read and consider posters aimed at busting common myths about the NHS with robust evidence. They addressed myths such as 'the NHS has too many managers' or 'the NHS is inefficient and wastes money'. In addition, some of the survey findings were placed on posters around the room, representing the 'general public' view of the NHS, which allowed participants to engage with them during breaks in between discussions.

Prior to the workshop, participants were asked to complete an optional pre-task, to note down what builds and hinders their confidence in the NHS. The responses were placed on paper in the room for participants to consider.

1.5 Sampling and recruitment

To manage the recruitment process, Ipsos worked with Criteria UK, a specialist recruitment agency. Criteria UK recruited 72 participants to take part in this deliberation (plus reserves). All participants took part in the first day of the process. In King's Lynn all 24 participants returned for the second day, and in Leeds and London 23 out of 24 participants completed the two-day process in each location.

Participants were recruited from across the areas close to workshop locations. Quotas were set based on demographic characteristics such as gender, age, ethnicity, socio-economic group as well as healthcare use and needs. Other quotas included a minimum number of participants with caring responsibilities, and a spread of voting intention, satisfaction with the NHS, and attitudes towards the NHS model. These quotas were set to ensure participation of individuals from a range of backgrounds, reflective of the areas they came from and the broad diversity of England. A full demographic breakdown of participants is included below.

In recognition of their time and to cover any expenses incurred through attending the workshops, such as travel or childcare, participants were provided with an incentive payment of £120 per day (£240 in total for two days).

Recruitment criteria	Achieved sample
Total numbers	72
Gender	35 female and 37 male
Age	11 participants aged 18-25, 20 participants aged 26-39, 25 participants aged 40-59, and 16 participants aged 60+
Socio-economic background	19 participants from AB socio-economic grades, 35 participants from C1C2 socio-economic grades, and 18 participants from DE socio-economic grades
Ethnicity	58 participants from a White ethnic background, 14 participants from a Black, Asian or mixed ethnic background

Location type	19 participants living in a rural location, 16 participants living in a suburban location, 37 participants living in an urban location
Healthcare use (in the last 12 months)	14 participants who used the NHS 0-2 times in the last 12 months, 21 participants who used the NHS 3-5 times in the last 12 months, 12 participants who used the NHS 6-9 times in the last 12 months, and 25 participants who used the NHS 10 or more times in the last 12 months
Healthcare needs	32 participants with a long-term condition, disability or illness, and 18 participants with caring responsibilities
Voting intention (how would you vote, if there was a general election tomorrow?)	Broadly in line with voting intentions at the time of the workshops, 21 participants who would vote Labour, 14 participants who would vote Conservative, 7 participants who would vote Liberal Democrats, 5 participants who would vote Green, 1 participant who would vote Other, 16 participants who were undecided and 8 participants who would not vote.
Satisfaction with NHS	25 participants who were satisfied with the NHS, 24 participants who were dissatisfied with the NHS, and 23 who were neither satisfied nor dissatisfied, or did not know.
Views on NHS model	42 participants who agreed with a statement ‘The NHS is crucial to British society, and we must do everything to maintain it’, 18 participants who agreed with a statement ‘The NHS was a great project, but we probably can’t maintain it in its current form’, and 12 participants who had other views or were not sure of their views.

1.6 Interpreting the qualitative findings

Qualitative research enables more in-depth and nuanced views of the NHS to be explored. Unlike quantitative surveys, it is not designed to provide statistically reliable data on what participants as a whole are thinking, but rather it is designed to be illustrative and exploratory, with findings presented thematically rather than quantified throughout this report.

However, the report indicates via ‘a few’ or ‘a small number’ to reflect views which were mentioned infrequently and ‘many’, ‘most’, ‘generally’ or ‘commonly’ when views are more frequently expressed. ‘Some’ reflects views which were mentioned some of the time, or occasionally.

Verbatim comments from the workshops have also been included in this report. These should not be interpreted as defining the views of all participants but have been selected to provide insight into a particular issue or topic expressed at a particular point in time.

The report reflects perceptions of the NHS rather than facts. In places, there are various misconceptions that participants expressed about questions of fact. These remain valid, since they are perceptions that the participants held, and understanding these views helps to inform knowledge about public views of the NHS.

1.7 Survey findings

Where relevant throughout the report, reference is made to the Health Foundation/Ipsos surveys. Each survey is conducted with a nationally representative sample of over 2,000 UK residents. The findings reported in this report are drawn from two surveys conducted using the Ipsos KnowledgePanel, a random probability online panel. The findings are provided for the English public only, with a sample size of c.1,800 in each survey. The surveys were undertaken in November 2023 and May 2023 – in this report, the charts for each survey finding provide the dates of fieldwork and the sample size. Further information about the methodology and results can be found at https://www.health.org.uk/programmes/public-perceptions-of-health-and-social-care.

1.8 Acknowledgements

Ipsos would like to thank the core team at the Health Foundation for their support with developing the discussion guides and stimulus materials, as well as for their contributions at the workshops. The core team included Gen Cameron, Hanan Burale, Luisa Buzelli and Tim Gardner.

We would also like to thank other Health Foundation colleagues who contributed to the materials, and attended the workshops as experts and observers. This includes Ash Singleton, Estera Mendelsohn, Hugh Alderwick, Lucinda Allen, Jake Beech, Kate Dun-Campbell, Leo Ewbank, Joe Hewton, Justine Karpusheff, Pete Stilwell and Stephen Rocks.

2 Perceptions of the NHS

This chapter of the report explores participants' initial perceptions of the NHS, prior to them being given any additional information about the NHS. It looks at their perceptions of the causes of the challenges facing the NHS at the moment, as well as participants' expectations of the NHS. Finally, the chapter details participants' initial responses to a presentation outlining the constraints within which the NHS is currently working.

Key findings

- At the beginning of the weekends, before any information was shared with participants about the NHS, the words most commonly used to describe the NHS were 'over-stretched', 'understaffed' and 'underfunded'.
- Participants were largely appreciative of the NHS, in particular around how it is available to all and free at the point of use, but they did express concern and frustration about the future of the NHS given the pressure it is currently under.
- They were particularly concerned about frontline NHS staff being over-stretched and their wellbeing and morale, the impact of this on quality of care, difficulties with accessing care, and the increase in online services.
- The primary causes of the challenges faced by the NHS were seen to be inadequate funding and mismanagement of funding, a lack of long-term planning often attributed to political involvement in the NHS, and an ageing population. While they thought the Covid pandemic had exacerbated the NHS's challenges, it was generally not thought to be the sole cause of the strain.
- Participants' basic expectations of the NHS included a personalised service with continuity of care and healthcare professionals having time to spend with patients, access to care within reasonable timelines, better prevention and education of the public in order to reduce demand on the NHS, and adequate funding particularly to maintain the workforce.
- Participants were provided with additional information about the factors causing increased demand for the NHS and the resource constraints it is operating under, which generally resonated with the challenges they had already identified.
- However, hearing the scale of the challenges caused alarm, particularly around the lower-than-average funding increases in recent years and the projected shortfall in NHS clinical staff and hospital beds. They were also surprised by some of the information about health inequalities.
- This generally led to anger towards politicians and a perceived lack of long-term planning to address the NHS's issues.

2.1 Overview of initial perceptions of the NHS

At the very beginning of the weekends' discussions, participants were asked to provide one word that they felt best described the NHS, which they then discussed in more detail. At this stage, participants' responses were entirely their own, with no prior input or stimulus, allowing us to explore their unprompted perceptions of the NHS.

While there was an overarching appreciation for the NHS, concerns regarding understaffing, underfunding and over-stretched services were prevalent.

Many participants expressed a deep appreciation for the NHS, sharing their positive personal experiences and the experiences of friends and family. For example, some participants spoke of timely access to cancer screenings and subsequent treatment, with a few saying they had been advised to seek their cancer treatment through the NHS over their current private healthcare provider.

> ***"I have private insurance and it's not cheap, but when I got my cancer I was actually told by the doctor I initially saw that it would be far better treatment if I use the NHS."***
> *(King's Lynn)*

Where participants were positive about the NHS, this often related to its widespread availability. They talked about the NHS being free at the point of use and available for all, with some making reference to other countries where healthcare is treated 'like a business', and where medical expenses can lead to bankruptcy.

> ***"Consistent, I'd say it's a positive thing. It's always there and hasn't changed in the sense it's consistently free and there, you don't worry if a hospital is open."***
> *(London)*

However, the single descriptive words provided by participants also painted a broader picture rooted in frustration and concern. Many participants highlighted perceived understaffing and difficulties with staff retention, concluding that this led to staff being overworked. There was a general concern for the wellbeing and morale of front-line NHS staff, the quality of their working environment with facilities that some considered to be 'run down and falling apart', and wages that participants often thought were not sufficient. Participants identified a number of indicators leading them to believe the workforce is unhappy, including industrial action, as seen in the media, and an increased difficulty to access appointments due to a lack of staff. As a result of this, they felt that the NHS is struggling to attract and retain staff, with highly-skilled staff who have been trained by the NHS now moving into the private sector or to other countries due to better working conditions and wages, and the next generation of workers not finding a career in healthcare attractive.

> ***"There isn't the prestige with working in the NHS there used to be. It used to be a really good job for someone in the past. But I think staff these days are so stressed and overworked, and they aren't paid very well. I don't know why people would want to go to university and get into that debt."***
> *(Leeds)*

Many participants felt issues around staffing within the NHS were a key factor in a perceived decrease in the quality of care they receive, as some went on to discuss feeling as though medical staff 'don't care' anymore. Participants had varied experiences of the quality of NHS care, which prompted a conversation around the variability in the quality of care across different parts of the service or different healthcare professionals, and across different regions accompanied by negative references to a 'postcode lottery'.

Participants also raised a range of concerns around access to NHS services. This included issues with long waiting lists for hospital treatment and hospital appointment cancellations, alongside challenges with accessing GP appointments. While areas like cancer treatment were highlighted for continuing to maintain timely access to care, others, such as mental health and physiotherapy, were seen to have been neglected. Some participants were keen to highlight that the NHS is much more responsive when patients need emergency care, though long waits in A&E were also noted.

> ***"Waiting lists for me, at the moment when you use the NHS you have to ring at 8am to even get an appointment. And you might not even get an appointment because they're done for the day."***
> *(Leeds)*

Another common concern that participants raised was the increasing reliance on online services. While some participants acknowledged that this represents a step towards modernisation, they felt it has inadvertently marginalised some parts of society, leading to a digital divide in healthcare access. With consistent reference to the struggle to secure appointments, these participants felt that the shift to online booking systems would likely further contribute to this challenge for certain groups.

> ***"[There's a] technology takeover, everything seems to be going online now. It's a bad thing because lots of people are not gonna benefit from that: the poor, elderly, disabled. They are not gonna be diagnosed properly."***
> *(King's Lynn)*

Some participants highlighted the evolution of public perceptions and media commentary regarding the NHS following the pandemic.

A few participants noted the initial surge of appreciation and support for the NHS at the beginning of the pandemic, epitomised by the nationwide 'Clap for our Carers' initiative. However, after the initial waves of the virus, this appreciation gave way to a more critical public stance. They noted a perceived decline in NHS performance and attributed this to media portrayal and online commentary on social media having a negative impact on public perceptions and expectations of the NHS.

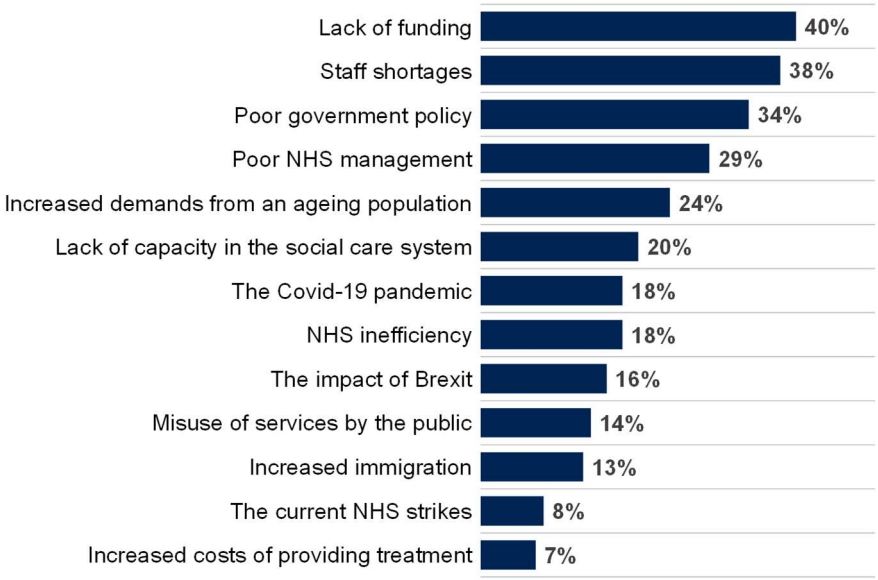
Notably, when participants were asked if their opinions would have been similar had the conversation taken place 10 years ago, many said they would have thought differently. Participants often concluded that the NHS has fallen victim to a variety of challenges that has seen its gradual decline. The sentiment across groups was largely empathetic with frontline staff, and sceptical and untrusting of senior NHS management and the government.

"Misinformation or disinformation. The government saying how wonderful it is, but the people who actually are working [for] it or using it for themselves know that that's not true."
(Leeds)

2.2 Perceptions of the causes of the challenges in the NHS

Following an initial discussion around their perceptions of the NHS, participants moved onto talk about their understanding of the causes of the challenges facing the NHS. This discussion was held prior to participants' exposure to workshop stimulus and was again solely reflective of their pre-existing understanding, opinions and experiences.

In nationally representative surveys conducted by Ipsos on behalf of the Health Foundation (see Section 1.7 for further details), the wider English public identify a range of different causes of the strain that NHS services are under. The main causes they cite are a lack of funding (40%), staff shortages (38%) and poor government policy (34%). However, there is a real spread of different causes, demonstrating public awareness that there is not any one cause of the strains on the NHS. Many of these causes were mentioned within the deliberative research at different points.



Q. There have been many reports in the media recently about the strain that NHS services are under. Which of the following, if any, do you think are the main causes of this?
Base: All participants in England, adults aged 16+ (1,878), conducted online via Ipsos KnowledgePanel 5-10 May 2023

Underfunding was also identified as one of the key causes of the NHS's current challenges in the deliberative research, alongside poor management of existing budgets.

In line with the general public surveys, perceived underfunding was raised early in discussions when participants were identifying words to reflect their perception of the NHS. Some participants felt that 'years of austerity measures' have had an impact on NHS funding, with an emphasis on the perceived decline in staff wages, which means that a career in the NHS is not attractive to the next generation of healthcare professionals. A lack of funding was therefore often linked to staff shortages.

> ***“There’s been a chronic lack of investment over many years, if you compare us versus France, Germany, we put in much less, than America as well.”***
> *(London)*

However, concerns about funding were not solely directed at the amount of funding the NHS receives. Many participants also asserted that the NHS budget is mismanaged, with excessive spending on things like administration and management at the expense of funding direct clinical care. They criticised NHS senior leadership for being too bureaucratic, believing that there are too many people in managerial and administrative roles, who were perceived not to be effectively fulfilling their responsibilities.

> ***"A lot of money is wasted that doesn't go on the frontline just on PR and that stuff you don't need."***
> *(London)*

The Covid pandemic was referenced as an example where the pressure to react to an urgent major threat led to extra funding being made available, but then being mismanaged. Stories they had heard in the media about corruption in the procurement of personal protective equipment (PPE), for example, had an ongoing impact on trust in how NHS funding is managed.

Many participants attributed the current challenges facing the NHS to a perceived lack of long-term planning, linked to political involvement with the NHS.

Participants did not generally trust the government regarding the NHS, suspecting that underlying political and personal agendas were influencing decisions, along with short-term planning to align with electoral cycles and a lack of expertise with regards to the NHS. They thought that political parties tend to blame their predecessors for the NHS's problems, leading to a cycle of reorganisation and inefficiency. They also assigned blame for a perceived lack of funding to government decisions. Some participants went on to suggest that the NHS should be run by a combination of business professionals and medical experts, rather than politicians, with a further unprompted call for a strategic, long-term approach in addressing the NHS crisis.

> ***“Which is why you need it to be separate from governments. How many health secretaries have we had in one government, never mind in a century or whatever? 'I want to put my stamp on it.' It needs to be somebody who was a doctor. It needs to be run by a business person and somebody who was a doctor.”***
> *(Leeds)*

Some participants also laid responsibility for the NHS’s challenges with the current government. There was a general mistrust in the government’s management of the NHS. For example, some participants were concerned about the potential privatisation of the NHS. They highlighted that some NHS services are being sub-contracted to private providers to meet demand, and feared this would continue to the point where the public sector was no longer involved in providing healthcare services. This linked to concerns about the links between politicians and healthcare. For example, some participants questioned why politicians are allowed to own shares in pharmaceutical companies, suggesting that politicians are profiting at the expense of the NHS and public.

> ***"Politicians have shares in the drug companies or private healthcare, they are profiting from our illness. I'm of the opinion that they [Conservative government] are trying to package the NHS for sale, that is my concern."***
> *(Leeds)*

Another commonly identified cause of the NHS's challenges was the ageing population and what this meant for how much people need the NHS.

Many participants recognised the ageing population as a key factor contributing to the strain on the NHS, showcasing a clear understanding of the term 'ageing population' as people living longer, with their healthcare needs becoming more complex and prolonged, resulting in an increased demand on NHS services. They expressed concern about whether the NHS is adequately staffed and funded to meet the challenges posed by an ageing population. Participants further questioned the sustainability of the current NHS model in the face of these demographic changes. A small number of participants mentioned other demographic changes such as immigration, stating that individuals migrate to the United Kingdom specifically for access to the NHS, though this notion was largely challenged by the wider group.

> ***"And we're getting older. And they're keeping us alive too long!"***
> *(London)*

The Covid pandemic was seen to have added to the strain on the NHS, though was never seen as the sole cause of the strain.

Some participants touched on the impact of Covid on the NHS, at times only after prompting. They often felt that the pandemic had exacerbated pre-existing issues, referencing hospitals being pushed beyond their capacity, and the burden on staff leading to strikes.

> ***"Covid was just pressing fast forward on it all."***
> ***(King's Lynn)***

Participants were unanimous in agreeing that the challenges faced by the NHS cannot be resolved overnight, and require long-term planning and a re-evaluation of its funding and delivery model.

2.3 Expectations of the NHS

Having now established an understanding of the group sentiment regarding the NHS, its challenges and their causes, discussions moved to participants' basic expectations of the NHS. Again, participants were yet to engage with any significant workshop stimulus, so their expectations were solely reflective of their personal understanding, opinions, and experiences. Participants' expectations were often nostalgic, reflecting on their wish to return to standards of care that they felt they had received previously.

Participants were generally keen to receive continuity of care, and for their healthcare professionals to have the time to spend with them.

Many participants expressed a desire for attentiveness and personalised care from their healthcare providers. This feeling was particularly strong in relation to general practice, with some feeling as though they are at times 'fobbed off with generic advice and leaflets'. They talked about GPs not taking the time to 'look up from their notes' and engage with their patients on a personal level. Participants attributed the decline in personalised engagements with their GP to a decline in continuity of care, which in turn they partly attributed to an increase in the number of locum staff, which could deprive patients of the opportunity to build a rapport with their GP in the same way they would have done previously. They also attributed a less personal service to the pressures within general practice, which they felt had resulted in rushed consultations and limited follow-ups.

> ***"I think the lack of continuity is a big thing – in my day you had a family doctor and they knew you, at my surgery you see someone new every time, the whole way healthcare is delivered is quite different."***
> *(London)*

Many participants also expected to be able to access care within reasonable timelines, and wanted access to care to be equitable, both of which they did not feel was currently the case.

Many participants acknowledged that some waiting for appointments is acceptable but emphasised the importance of reasonable waiting times for all appointments, particularly when they needed to see a GP. This expectation also extended to emergency services, with some participants fearful of long waiting times for an ambulance or while at A&E, if they are in critical need.

> ***"I live in fear that I'm going to need an ambulance in the middle of the night."***
> *(Leeds)*

Participants often wanted access to healthcare services to be equitable in general. This included dental care and eye tests, for example, with some feeling forced to access dental services privately in the last few decades. There was an additional call for increased provision of mental health services, with some referencing their children being on waiting lists for mental health support for extended periods of time. Participants identified it as an increasing need for younger generations. Some participants felt the UK was no longer able to boast about world leading healthcare provision (particularly in comparison to the USA), with a decline in timely access to care without needing to pay at the point of accessing services.

Among many participants, there was an overarching sentiment of guilt about using urgent and emergency care services, linked to perceptions of A&E departments and ambulance services being under immense strain. Participants often felt this resulted in people not attempting to access the care they need so as not to contribute to these pressures, as well as expectations of long delays.

> ***"As a 75-year-old, I hear that people are a burden living to a certain age, it makes you feel guilty that [I'm] still breathing."***
> *(Leeds)*

In response to the pressures the NHS is experiencing, an expectation was developed around better prevention and education of the public in order to reduce the demands on health services.

In recognition of the increased strains on the NHS as a result of causes such as an ageing population, there was an expectation that the NHS should focus its efforts on preventative measures by educating the public. Participants highlighted two key areas they felt should be of focus, healthier lifestyles to prevent long-term illness, and helping people to understand their needs and symptoms so they can access appropriate care. They believed that encouraging healthier lifestyles, targeting the root causes of health issues, and preventing diseases would have a positive impact on public health and correspondingly alleviate the strain on certain services within the NHS. Additionally, many participants thought that pressures on services might be alleviated if the public's understanding of the appropriate pathways for seeking care can be developed.

Many participants expected adequate funding, particularly in order to maintain the workforce that is needed.

Participants often took the opportunity to revisit the conversation around funding, and emphasised their key expectation of the NHS is that it should have access to adequate funding in order to function effectively. They noted that staffing models within the NHS have shifted, particularly within general practice (for example with patients seeing practice nurses rather than GPs for some conditions), and attributed this in part to funding, alongside many other causes. Participants often concluded that many of

their basic expectations of the NHS are not met due to a lack of funding and understaffing, the two of which they linked.

> ***"All of it should be basic really, all of it should it be given to us as people. But the problem is that it isn't right now. It's too hard, or there isn't enough money. It's not good enough really- like I said before, we're paying for this with our taxes."***
> *(London)*

2.4 Responses to the current constraints on the NHS

Following the unprompted discussions, a presentation was delivered which provided a detailed overview of the current and projected challenges faced by the NHS. This presentation highlighted:

- The increasing demands for NHS services due to[3] [4]:
    - A growing population that is also ageing, leading to greater demand for NHS services as older people tend to use health services more (with examples showing that older people have more hospital admissions per capita tending to last longer on average, and more appointments in general practice per capita).
    - A rise in the number of people living with long-term health conditions, with an estimated increase in the number of people living with major illness in England, and therefore increasing demand on health services.
    - That advancements in medical science mean that more conditions can be treated and people can live longer, but this may require health services to deliver more care.
    - Inequalities in the services that different communities have access to, with some communities needing more care and treatment than others, but having poorer access to services and poorer experiences of care. Examples included differences in life expectancy according to where someone lives, women from Black and Asian ethnic backgrounds being more likely to die during or up to six weeks after the end of their pregnancy, and higher death rates from heart disease among people from South Asian backgrounds.
- The limited resources for providing healthcare, including[5] :
    - Limits on funding levels that constrain what the NHS can deliver, with a description of how real-terms growth in health spending has changed from 1979/80 to 2024 (including a decade of low spending growth in the decade before the pandemic) and the current health spending plans of the two main political parties alongside the lack of certainty these offer.
    - Gaps in the workforce the NHS needs, despite increases in the number of staff working in the NHS, with some of the main reasons for this including not training enough staff and challenges with retaining them within the NHS. It was explained that this means that the

[3] https://www.health.org.uk/publications/health-in-2040
[4] https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[5] https://www.health.org.uk/publications/long-reads/health-care-funding

challenges facing the NHS cannot be solved simply by putting more money into health services, as these staffing gaps cannot be immediately resolved.

- A lack of investment in NHS buildings and facilities (meaning that some parts of the NHS estate are not suitable for providing services), while some of the technology used in the NHS is outdated (impacting on patient care), and the UK has fewer hospital beds, CT and MRI scanners than comparable countries (limiting NHS capacity). It was explained that adding more staff would therefore not solve all of the NHS's capacity challenges.

The presentation went on to highlight the projected need for additional healthcare professionals, acute hospital beds and backlog maintenance for facilities, given anticipated levels of growing demand[6] [7] [8].

Participants were initially 'shocked, 'angry' and 'didn't realise it was that bad' following the presentation, particularly with respect to funding levels for the NHS.

Participants' primary focus following the presentation was generally around funding allocation and political influence. Some participants were 'shocked' and 'surprised' that the government, rather than the NHS or an independent body, sets the budgets for the NHS and went on to again question the basis for making these decisions. However, most participants were aware that the responsibility for setting funding lies with government. They often reacted in particular to the information presented to them about how funding growth had varied under different governments from the 1970s to the present day. They particularly pulled out the lower spending growth in the 'austerity years' and the government's current spending plans that would see health spending grow by 0.1% in real terms from 2023/24 to 2024/25, in comparison to the historical average of 3.9%. This anger remained even when participants were reminded that the budget is still planned to grow in real terms. They also expressed frustration with the contrast between the NHS's funding needs and government spending in other areas, with some pointing to large-scale projects like HS2 and the Test and Trace app, which participants felt had received substantial funding despite public scepticism.

> ***"That angered me quite a bit I think, even though you can argue and have your political views, that Labour left our country in debt, but you can see from the slide [on funding growth], that the later ones [governments] have really affected the direction of where the NHS has gone."***
> *(London)*

Many participants were also alarmed by the projected shortfall in GPs and practice nurses, and hospital beds, by 2030.

This information reflected already-existing concerns that most participants had about staffing levels. They talked about staff to patient ratios, and whether those receiving hospital care are 'safe' and receiving the level of attention they need. Participants had already shared their views on the key challenges of attracting and retaining staff within the NHS, and how this should be addressed (as discussed throughout this chapter). The presentation prompted further discussion of what was contributing to this challenge. This included perceptions that junior doctors are expected to work 100 hours a week prior to qualifying, agency staff being paid more than if they were to be working for the NHS directly, and the reduction of financial support for those training to become health and social care

[6] https://www.health.org.uk/news-and-comment/news/a-quarter-of-gp-and-general-practice-nursing-posts-could-be-vacant-in-10-years
[7] https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2021-22
[8] https://www.health.org.uk/sites/default/files/upload/publications/2022/Final_Beds_analysis_July2022.pdf

workers. They also queried whether Brexit had an impact on the skilled workforce that the NHS is reliant on, by reducing pathways into the NHS for EU healthcare professionals.

> ***"I have colleagues who are vets and doctors and they expressed they were unable to recruit because people were not coming here to study and work because of Brexit."***
> *(King's Lynn)*

Participants were generally surprised about some of the information about health inequalities.

Participants across all the groups reflected on the existence of health inequalities, particularly that women from Black and Asian ethnic backgrounds are more likely to die during or just after pregnancy than women from White ethnic backgrounds. They also referenced what they considered to be a 'postcode lottery' model, with those from more affluent areas having longer life expectancy and better access to health services, while those in areas of deprivation, or rural areas, having fewer healthcare services available. A few also thought these areas had fewer other (non-NHS) services that could also impact on health, such as sports facilities.

> ***"It's all linked, the austerity over proportionately hit poor people, generally council budgets were massively cut, that means sports facilities, local play groups, they all shut. All of that has an impact on the NHS."***
> *(Leeds)*

However, some participants acknowledged that life expectancy and health outcomes are also influenced by a range of factors beyond the control of the NHS or the government, including environmental and socioeconomic conditions. Some older participants considered lifestyle choices to be a significant contributor to disparate health outcomes, expressing frustration with the lifestyle choices of younger generations, particularly their eating habits and engagement with substances.

The anger that many participants felt following the presentation was often directed at politicians and a perceived lack of long-term planning to address the NHS's issues.

This further fuelled pre-existing frustration and distrust of current and previous governments. They criticised the lack of long-term planning, for example asking why the projected ageing population had not been planned for. They reasserted the importance of better planning for the future, which they thought would require a reduction in political influence on the NHS.

> ***"My conclusion is the NHS's growth in progress is stunted by governments going for quick wins. If they were allowed to follow long-term plans, they wouldn't be in the mess they're in."***
> *(London)*

Participants were asked how they felt about the future of the NHS following the presentation, in comparison to earlier in the discussion. Perceptions largely stayed the same, in that they already had concerns regarding the sustainability of the NHS, and had identified a range of the challenges included within the presentation such as a perceived lack of funding and staffing gaps. However, many participants found the presentation on the extent of the challenges facing the NHS sobering and their concerns for its future deepened.

> ***"One of the things we were asked was… 'How do we feel about the future of the NHS?' And I put down, 'I'm unsure.' Having listened to the information we've got now, I think we're all doomed."***
> *(King's Lynn)*

While they found much of the information within the presentation concerning, they were grateful for the insight and expressed a desire for the same level of transparency and information sharing from key figures within the NHS and government.

2.5 Participants' views of what the NHS's priorities should be

Following an initial morning of discussions, including hearing and discussing the presentation about the growing demand for NHS services alongside resource constraints, participants were given a set of challenges faced by the NHS to prioritise.

The items that participants were asked to prioritise were drawn from the Ipsos/Health Foundation surveys of the wider public. The surveys show that improvements related to NHS staff consistently emerge as the English public's top priorities. This includes both addressing the pressure on or workload of NHS staff (40%) and increasing the number of staff (39%). The next tier of priorities are related to access, for example improving waiting times for routine services such as diagnostic tests or operations (34%).

Q. When it comes to the NHS, which two or three of the following do you think should be prioritised?
Base: All participants in England, adults aged 16+ (1,878), conducted online via Ipsos KnowledgePanel 5-10 May 2023

In the deliberative research, the common priorities that emerged were also related to NHS staff, though improving mental health services was also important.

The main priority for many participants was addressing the workload for NHS staff, with a few groups also prioritising increasing the number of NHS staff. Participants had been consistent in highlighting their concern for the sustainability of the current and future NHS workforce, and felt that prioritising the alleviation of pressure on staff would combat this by making a career in the NHS more attractive and aiding retention. This reflects the priorities for the NHS among the wider public in the surveys.

Improvements in mental health services were a second area that participants often prioritised, particularly for younger generations. A few participants also felt that improving mental health services

could have a knock-on effect on physical health, reducing the strain on GPs and emergency services. This high level of priority placed on mental health services is somewhat inconsistent with the surveys, in which just 17% of the public prioritised this.

Vaccinations against Covid and addressing the NHS's impact on climate change were considered to be low priority by most participants. This is in line with the survey findings, in which just 2% thought each should be prioritised. Some participants considered the Covid vaccine non-essential at this point, and thought it had already seen significant financial investment. Addressing the NHS's impact on climate change was seen as low priority across all participants, and considered to not have an impact on public health in the short-term.

3 Primary and community care, or hospital care

This chapter of the report explores views on the trade-off between primary and community care versus hospital care, in terms of where the focus for improvements in the NHS should be. It follows participants from their initial views, through a discussion of some specific examples of different types of care, to participants' final judgements of where the focus should be.

Key findings

- A deliberation question was posed to participants: with limited resources, we face a choice about where to focus and the balance between primary and community care, or hospital care. What do you think the focus for improvements in the NHS should be?
- Most participants started from the belief that primary and community care needed more focus than at present (having been told the balance was closer towards hospital care at the moment). This was based on their often poor experiences of trying to access GP practices, and a belief that improving primary and community care could reduce demand for hospital care.
- Initial priorities included the importance of preventing ill health, ensuring quick diagnosis and treatment, and addressing the root causes of wider issues in the system to invest where the money is most needed. Different people had different views on how this could best be achieved.
- When discussing and comparing a small number of specific approaches to improving primary, community and hospital care, the factors that were important to participants included: the perceived feasibility of implementation, desirability compared with current service provision, value for money, the evidence base for the approach, and the expected impact on patient outcomes and the health service overall.
- The proposal for Urgent Community Response teams was most frequently favoured, although not everyone agreed that this was a good investment as they were worried about the resources required.
- After deliberating these specific approaches, most participants remained committed to a greater focus on primary and community care than at present to help prevent people needing hospital care. However, some participants started to place more emphasis on the importance of focusing on hospital care because of the perceived severity of need of hospital patients.

3.1 Deliberation question

For this part of the deliberation, participants were asked to assume that there would be no real terms increase in funding over the next five years and reminded that, even with additional funding, the NHS's ability to increase activity to meet growing demand will be heavily constrained. The dilemma was presented to participants as follows:

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

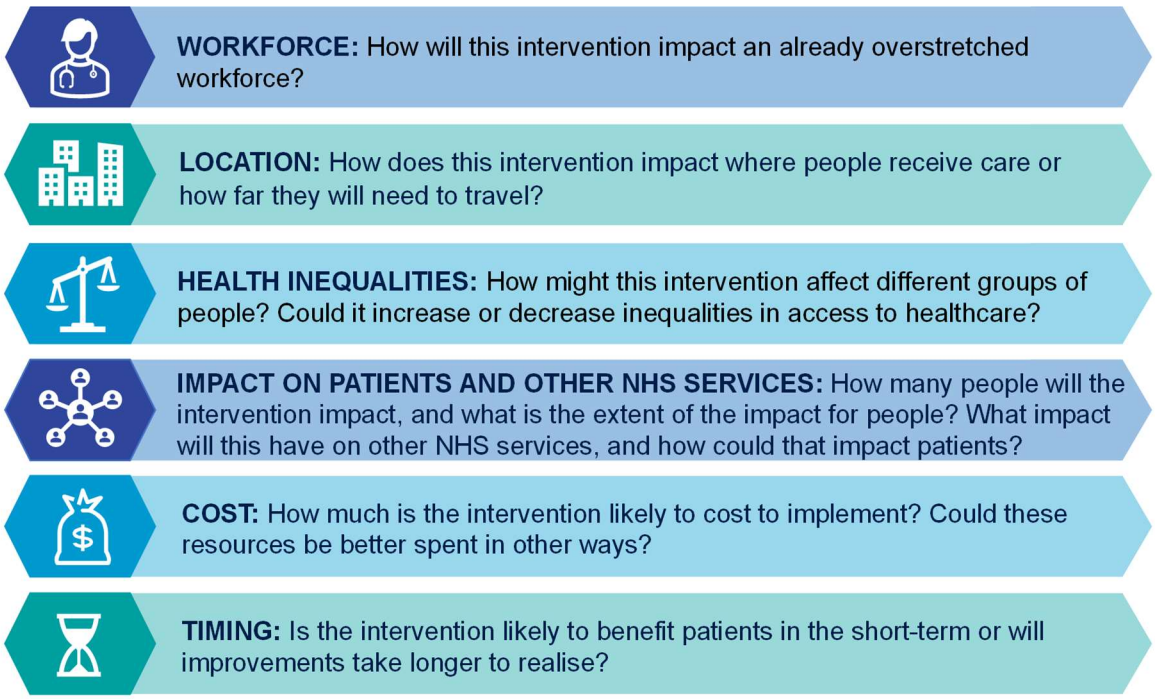
To support deliberations, participants were given further information about the different types of services in primary and community care and hospital care, along with how these services fit together. Examples were given on how a focus on improving each type of service could lead to improvements for patients, as well as how a lack of focus on each may lead to worse outcomes. Statistics were shared to illustrate the number of patient interactions with different services in a typical year. Participants were told that hospital care has been the main focus for improvements in the NHS in recent years, on the basis that hospital services had received a proportionately higher share of the NHS budget and a bigger increase in the medical workforce than in primary and community care in recent years.

Participants were asked to line up in the room to demonstrate where they initially stood on the trade-off between primary and community care, and secondary care. The left-hand side of the room represented primary and community care, with hospital care on the right-hand side of the room, and a chair to signify where the current focus is (between the middle and hospital care). Participants could stand at any point they wanted on this continuum between a focus on primary and community care, and a focus on secondary care. Following discussions as a whole group to explore why participants chose to stand where they did, they moved into group discussions to share their initial views.

After a high-level discussion, participants were asked to discuss the desirability of a number of different approaches to improving primary and community, and hospital care:

Primary and community care	Hospital care
• Increasing continuity of care in general practice	• Expanding same day emergency care
• Scaling up extended teams in general practice	• Scaling up virtual wards
• Scaling up community services and Urgent Community Response	• Expanding elective surgical hubs

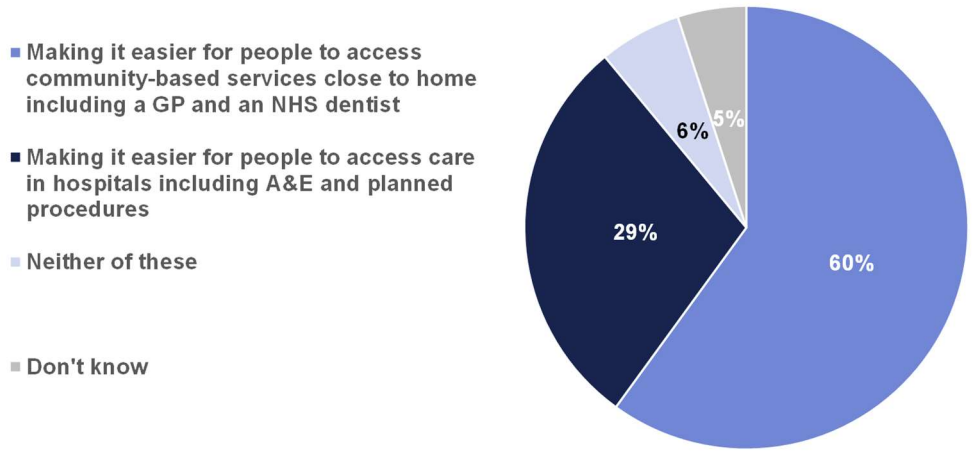
Participants were provided with evidence relating to the factors set out in the figure below, to enable them to compare these different approaches.



Following these discussions about specific approaches to primary, community and hospital care, participants were again asked to stand in a line in the room to reflect how they stood on the trade-off between a focus on primary and community care, or hospital care, to see if and how their views had changed.

3.2 Initial views of where the focus should be

In the Ipsos/Health Foundation surveys of the general public, without being given any information about the current balance between primary and community care, versus hospital care, the English public lean towards prioritising improvements in access to community-based services. Focusing on access to services, if the NHS budget is not increased, three in five (60%) think the government should prioritise making it easier for people to access community-based services close to home including a GP and an NHS dentist. In contrast, just under one-third (29%) think the government should prioritise making it easier for people to access care in hospitals including A&E and planned procedures.



Q. If the NHS budget is not increased, what should the government prioritise?
Base: All participants in England, adults aged 16+ (1,774), conducted online via Ipsos KnowledgePanel 23-29 November 2023

In the deliberative research, following an initial presentation, participants also favoured a greater focus on primary and community care over hospital care than at present.

As outlined above, participants were told that the focus had been towards hospital care in recent years, with increases in funding and staffing proportionately higher in hospital care than in primary and community care. Broadly speaking, this message resonated as most participants perceived GP services to be the gatekeeper to a lot of hospital care but also harder to access than hospitals, and potentially suffering from less investment. Although they were notionally aware of long waiting lists for elective surgery and long waits in Accident and Emergency departments, there was a perception that patients waiting for elective and emergency care would ultimately be seen, even if the wait might be very long, but those who were unable to get a GP appointment risked not being seen at all.

> ***"GPs now are more inclined to be directing towards hospital, because the resources for primary are not there. If there was more funding here, people wouldn't be getting told to get to A&E."***
> *(Leeds)*

When lining up in the room following the initial presentation, to demonstrate where they stood on the trade-off, many participants in all three locations initially thought that the focus should be rebalanced, with a greater focus on primary and community care in the future than is currently the case (with the current stance closer to hospital care than to primary and community care). Their initial reasons for this included:

- The importance of prevention and early intervention, which could potentially help reduce the demand on hospitals.
- The importance of improving access to GP services.

> ***"It shouldn't be one or the other, but if more money is in primary it could help to prevent people going to hospital."***
> *(King's Lynn)*

However, while many participants thought the focus should move closer to primary and community care than at present, they were divided about how far to move. They stood across the whole spectrum, from thinking there should be an absolute focus on primary and community care, to thinking that the focus should be evenly balanced between primary and community care, and hospital care.

A few disagreed with the need to prioritise primary and community care. Typically, their reason for prioritising hospitals was the perceived acuity of need for people who require hospital care. Some participants thought that any change to hospital funding could impact on waiting times for time-sensitive treatments such as cancer care, which they felt would be unacceptable. These reasons were also typically given by those who thought the focus should be evenly balanced between primary and community care, and hospital care. The fact that GP services tend to be private businesses that can make a profit was also raised as a potential concern about putting too much funding into primary care.

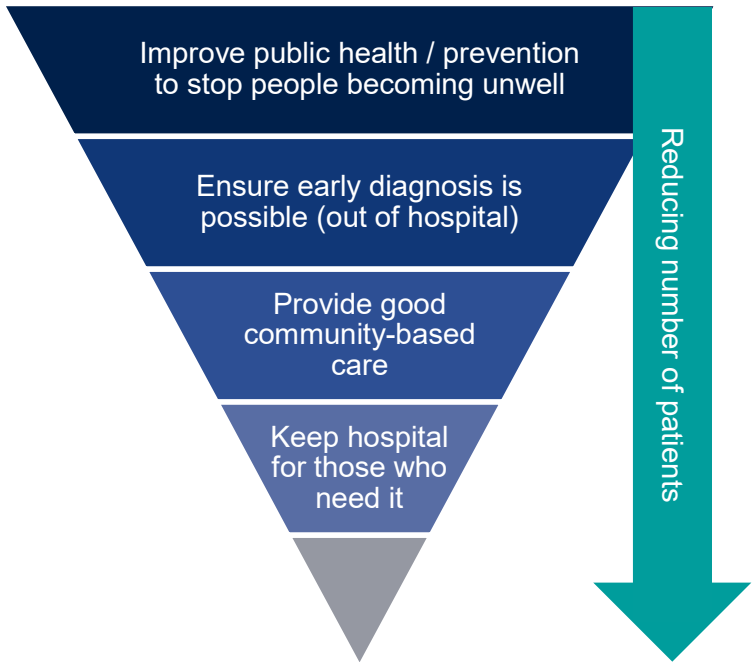
3.3 Principles that guided participants' initial discussions

Participants found it very challenging to make a decision about where the focus should be within the constraints of this discussion, which assumed limited real-terms funding increases (as is currently planned for the near future). In the initial discussions (prior to discussing the specific approaches to primary and community care, and hospital care) they appeared to be considering a large number of factors when weighing up the options, some of which led to tensions they found difficult to resolve. Their

underpinning values appeared to include what they thought would be the best value or most efficient way of either keeping people well or making people well. Some of their views were based on assumptions or personal experiences, which differed from person to person. These principles were also carried into later discussions about specific approaches to primary, community and hospital care (see Section 3.4 below), although these also raised new considerations.

Many participants thought that a greater focus on primary and community care would reduce demand for hospital services.

A strong recurring theme was the idea that prevention is better than cure, and that some of the demand for hospitals could be reduced with appropriate primary and community care interventions. There were a range of views about how much demand could be reduced, but most believed that better primary and community care could positively impact on health outcomes and demand for hospital care. The diagram on the right demonstrates the ways in which participants thought this would reduce demand for hospitals, with each stage leading to successively fewer people requiring hospital care.



"[Primary care] because it's preventative. If you start helping the people, it will stop people who have less need for hospital-, spend it at the root."
(Leeds)

Participants appeared to talk about prevention in three different ways:

- Some focussed on the value of keeping people healthy. This could be by ensuring they understand how to look after themselves, exercise and have a good diet. Some took this further and suggested investing in addressing the social determinants of health (such as poverty and education) should be part of any long-term strategy to improve the nation's health, although others thought it would be important to have evidence that this could work before spending the money.

- Some suggested that early intervention by a GP (for example in the case of promptly diagnosing diabetes or high cholesterol) could potentially help avoid a patient's condition deteriorating to the point of requiring hospital care. They therefore thought investment in GPs could reduce demand on hospitals.

  "Hospital care is treating the symptoms of the problems that could have been solved at the primary level."
  (London)

- Some discussed how limited access to primary and community care could result in more people going to hospital (A&E) or being stuck in hospital even though their condition could potentially be dealt with in a primary and community care setting. Again, they thought that more investment in primary care could limit this unnecessary demand on hospitals.

> ***"If you want to see a doctor, you've got the option to take yourself off to A&E when you might not even need that A&E appointment."***
> *(Leeds)*

However, in most cases the assumption was that, although they were prioritising primary and community care, there would still be hospital services available to those who needed them, and that waiting times must be kept short to ensure problems did not worsen and become more difficult to treat. A few participants thought it would be possible to significantly reduce hospital demand with the right approach to prevention, although most recognised that this could take some time to have an impact and that demand for hospitals would remain high in the meantime.

Quick diagnosis and treatment were important to participants, though this did not easily translate into a view on whether the focus should be on primary and community care, or secondary care.

Many participants emphasised the perceived importance of being seen quickly. This linked to the above point about prevention, because they felt that if people did not receive help quickly this could lead to deterioration. This would be bad for the patient but also more resource intensive for the NHS to treat.

There were different assumptions about how best to allocate resources to ensure quick diagnosis and treatment. As outlined above, some thought that this would entail investing in primary care so that people could access their GP. Others suggested that there was no point diagnosing people quickly if there was a long waiting list for further diagnostic tests or treatment which might need to be provided in hospitals.

> ***"If we pump all the money into screenings, then what happens when the numbers that are discovered go up? There will be nobody there to treat it."***
> *(King's Lynn)*

Additionally, a few raised concerns about the risk of missing something in a diagnosis. While they were not sure whether this risk could be mitigated with investment in primary and community care, or hospital care, they nonetheless raised it as a concern.

Some participants recognised that the NHS works as a system, and highlighted the importance of addressing wider issues across the NHS to invest where money is most needed.

Even before the sessions which explored NHS funding in more depth, participants were aware that resources were limited and prioritisation would be necessary. However, they were also very mindful that additional funding might not always be the answer. Instead, they were keen to diagnose the root causes of high demand and address them were possible, which may or may not require additional resource. In doing so, they often recognised that the NHS is a large system and identified where changes could be made in one part of the NHS that might impact elsewhere in the NHS.

For example, participants discussed:

- A&E may be busy because people are not using it 'correctly'. In addition to a perceived lack of awareness about when it would be appropriate to access urgent and emergency care services, they attributed this to two causes: difficulty accessing a GP and NHS111 taking an overly cautious approach and referring more people to A&E than necessary. Therefore, rather than putting more money and resource into A&E to address long waits, they thought instead work should be done to redirect patients to a more suitable service.

- Similarly, some participants did not want to see GPs being placed in A&E to support clinical streaming of patients (cited as an example of trade-offs earlier in the session) as they thought

this would perpetuate 'wrong' usage of the service and would limit the availability of GPs in GP practices for those trying to access services appropriately.

- How challenges within social and community care are perceived to lead to 'bed blocking', so rather than investing in more hospital beds, it would be more appropriate to address services that enable people to leave hospital when they are ready.

- A few were less comfortable with putting more funding into primary care as they believed that GPs were overpaid. This view was not widespread, but shows how people's pre-existing knowledge and assumptions shape their perspectives.

Some reflected that it was important not to remove a bottleneck in one part of the system only to create one somewhere else – for example, diagnosing people more quickly but without having the capacity to provide prompt treatment when needed. The knock-on effects of different decisions were a recurring theme throughout the deliberations.

> ***"There is no point focusing all the money on primary if they are referring people to treatment and there are 8 million people on the list because its underfunded."***
> *(London)*

Overall, many participants expressed a desire to rebalance the focus (and funding) towards where it was felt to be most needed. In most cases, their personal experience suggested to them that the greater need was outside of the hospital setting. Combined with the information provided that hospitals had received a growing proportion of the budget prior to the pandemic, this contributed to the perception that the balance needed to be changed, especially in the longer term. However, this did not necessarily mean that they would accept a decline in the quality or availability of hospital care for those who needed it – rather they thought that this readjustment should help reduce demand so that existing hospital provision would be sufficient.

> ***"Just dial it back a little bit [from hospitals], not an awful lot because then the hospitals would be awful which is not good for the ageing population."***
> *(London)*

Some participants thought it was important to prioritise the patients who need help most.

A few participants in each workshop felt strongly that hospitals were the priority as that is where they thought patient need was greatest. Specifically, they believed that the care in hospital was more likely to be life-saving. As such, they were keen to ensure that funding to hospitals was always sufficient to ensure that people would have minimal waits for hospital care. However, others did not have concerns about this because they felt that hospitals would always have sufficient resources to handle urgent cases, even if this meant making less urgent cases wait longer.

> ***"I think the more serious cases are in hospital and we should treat the more serious people first."***
> *(Leeds)*

Other factors were also raised in considering the balance between primary and community care, and hospital care, though these were less influential.

A few participants mentioned other considerations when discussing where to prioritise funding. These other considerations included:

- **Short-term versus long-term**: Some were willing to wait for improvements, suggesting it would be a good idea to make long-term investments, even if that meant things could get worse before they get better. Others were not prepared to see a dip in services while waiting for investment to pay off, so wanted to see some interim measures of progress in place as well as a longer-term strategy. Overall, all wanted to see the NHS planning for known changes to demographics so that the service was not unprepared for increasing demand in the future across both primary and community care, and hospital care. For some, achieving a better balance between short and long-term measures would only be possible if the NHS was de-politicised. As outlined above, some saw investing in primary care as a long-term investment which would reduce demand, but which might not be sufficient in the short-term to meet people's health care needs.

  "Most people would be happy to see the NHS get worse in the short-term and wait for improvements if they knew that in the future it would improve wait times."
  (King's Lynn)

  "I think it's unfair to forget about our generation now, to better the generation to come."
  (Leeds)

- **Where care is delivered:** Some participants were clear that having health services close to home was important to patients and would minimise the costs of patient transport. They thought this might matter more to older and disabled people. However, others thought that having more centralised services (even if it involved more travel time) would be more efficient for the NHS to deliver, and were potentially willing to travel further if this was the case. There were some questions on how centralisation could be used to reduce inequalities (see below) by strategically selecting where to place centralised services. Concerns about distance to services were potentially most salient in King's Lynn where fewer services are available locally and people talked about needing to travel further.

  "Having equipment in a centralised location – that must surely be more cost effective."
  (King's Lynn)

- **Impact on inequalities:** Others thought that it was important to consider how any proposed changes could increase or reduce inequalities in health. Discussions about inequalities included racism (in the presentations, participants were given specific examples of differences in health outcomes associated with race), ageism, the variation in services available depending on where people live, and links with socioeconomic circumstances and income. Some participants were very shocked by statistics which were provided during the workshop about some of the inequalities that currently occur. This topic was most likely to arise in London. Where participants discussed the impact on health inequalities in considering where the focus should be, they were not clear whether this meant there should be more funding in primary and community or hospital care. Some thought that deprived communities might be less well served (if new services were built predominantly in 'nice' areas) which could heighten inequality.

  "I think the health inequalities are important. With areas, race, that's where I think we should focus."
  (Leeds)

- **Mental health:** Some mentioned the importance of investing in mental health alongside physical health. A few suggested this was particularly an issue for younger people, and it was important to not only prioritise the needs of older people when planning for the health service.

- **Local decisions:** Some thought that local decision-making might be more beneficial than looking to make decisions at a national level, as different areas might have different local needs. While some areas may need a greater focus on primary and community care, others might need more of a focus on hospitals.

  "It needs to be localised… You can't just get one paintbrush and paint the whole country with the same brush."
  (London)

Other considerations presented to participants were explored, but were less influential on discussions about where the focus should be.

Some of the considerations presented to participants in the stimulus did not appear to immediately resonate when participants were initially discussing whether the focus should be on primary and community care, or hospital care. These included:

- **Workforce impacts:** This was not discussed much initially. Some thought there were not enough staff for current models of care delivery and therefore were concerned about where additional staff would come from for the new approaches, regardless of where they thought the focus should be. Participants were often unclear why more was not being invested in training the workforce required.

- **Cost:** In itself, cost was not discussed as an important consideration. Most participants wanted to avoid waste (hence investing money where it is most needed) and thought that improving services would not necessarily require spending more money overall, but they also recognised that some expensive solutions could be worthwhile investments.

- **Specialist or generalist care:** The split between generalist care (such as in general practice) and specialist care (as provided in hospitals) was not explored in much detail in discussions. However, there were some concerns about diagnoses being missed that suggests specialist care may be seen as preferable in this regard. For a couple of groups, specialist care was preferred, for one because of a perception that that is where 'problems actually get fixed' and the other because it was seen as an efficient way to make people better. However, other groups were concerned that specialists could be underutilised if there were too many compared with the number of patients needing their specialist care.

3.4 Impact of considering specific approaches

To help participants consider the potential trade-offs when deciding whether to prioritise primary and community, or hospital care, they were presented with different approaches that could be adopted in these areas. They were asked to compare a specific approach to primary or community care with a specific approach to hospital care, with each group undertaking three different sets of comparisons. The approaches are summarised in the table below.

Primary and community care	Hospital care
Increasing continuity of care in general practice: 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.	**Expanding same day emergency care:** 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.
Scaling up extended teams in general practice: 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.	**Scaling up virtual wards:** Aims 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.
Scaling up community services and Urgent Community Response: service 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.	**Expanding 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.

Participants introduced a range of additional considerations or principles when comparing the specific approaches.

It was apparent that participants were not necessarily seeing the exercise as a comparison between primary/community and hospital care options but rather a comparison between two specific options with different features. The specific feature of whether the service was being provided in primary/community care or hospitals was not the main consideration in most instances. Instead, people cared about:

1. **Feasibility:** When trying to decide between two options, a key consideration was whether participants thought it was feasible to deliver the solution as outlined. Concerns typically related to whether or not staff would want the new roles being created, whether the idea was politically desirable (i.e. had mass appeal) and whether the public would use the service as anticipated.

   "To mobilise these [elective surgical] hubs might be better but I don't know how feasible that would be."
   (London)

2. **Desirability:** Participants also considered how they, or people they knew, would feel about the proposed service and whether it was more or less desirable than the current NHS provision. They considered the needs both of those who might use the new services, but also of those who would not have access and the impact this could have on them. For example, the impact on patients

who were not allocated a GP to provide them with continuity of care or had difficulties travelling to a centralised hub. The potential impact on inequalities could also contribute to the perceived desirability of a proposal.

"[Urgent Community Response] is like care delivered in my home, but same day is like A&E. You'd still have to leave your home."
(Leeds)

3. **Good value:** Some ideas were characterised by participants as short-term sticking plaster solutions or gimmicks, which would not necessarily save money in the long-term or be efficient to deliver. Participants did not shy away from investment where they could see the long-term benefit, such as improving access to physiotherapists or social prescribing. However, they were more concerned where there could be a large one-off cost, for example investing in technology for virtual wards or creating a new space for an elective surgical hub to operate out of, where they did not feel the NHS would necessarily gain enough benefit from this outlay.

   "I think [virtual wards] means you can put more care into people that need it, as opposed to the people who don't need it. I think it's more efficient."
   (Leeds)

4. **Evidence base:** For all the approaches, participants were keen to hear whether the idea had been piloted and whether it had worked as intended. Before agreeing to a significant investment, they were keen to ensure that the decision was evidence-based.

5. **Impact on patient outcomes:** Related to the points above, participants were more supportive of ideas they believed could have a positive impact – for example by reducing demand or helping people get better quicker. They were particularly concerned if they felt there was a possibility that the proposed change could have a negative effect on patient outcomes – for example if something went wrong on a virtual ward or if a patient was not properly diagnosed because they saw an inappropriate healthcare professional in an extended general practice team. A few noted that it was more important to focus on life-saving treatments than providing elective care, although the idea of having to choose between these was unwelcome.

   "Sometimes you're doing it statistically on numbers, but they are quantity over quality. If I need a knee replacement but someone else is dying, I'd rather they live."
   (Leeds)

6. **Impact on the health service overall:** Ideas that were perceived to reduce the burden on services participants believed were over-stretched were particularly welcomed, if they believed this outcome could be achieved. Similarly, ideas that appeared to take resources from one place to redeploy them elsewhere were seen as shifting the problem, but not solving it, and therefore received less support.

After discussing and trading off the range of approaches, most continued to think it was important to prioritise primary and community care over hospital care to a greater extent than at present.

At the end of the session when people were asked to reflect again on the balance of focus between primary and community care, and hospital care, most continued to prioritise primary and community care, although more people noted the need to ensure continued funding for hospitals alongside this.

Fundamentally, participants were looking to reduce need in the longer term, both by preventing people from needing services in the first place and by addressing people's current needs (for example, ensuring

access to cancer services). However, they were conscious of constraints which would impact on the effectiveness of different proposals, specifically identifying sufficient funding and also the perceived difficulties finding the necessary workforce and ensuring jobs are attractive. They also concluded that investment in prevention would help, but would not be the whole solution, so investment in hospitals would also still be necessary.

> ***"I think because if patients are in really dire need, they need to be in hospital, there's no question about it."***
> *(King's Lynn)*

Some groups acknowledged that they could see how people on a waiting list for elective care would want that to be a priority. However, they also thought that the waiting list was only as bad as it was because people had not been able to access primary and community care sooner. Consequently, they felt that getting primary and community care right was the priority to prevent the situation getting even worse. However, when comparing the different approaches, some groups prioritised elective surgical hubs as they recognised that the current long waiting lists are unacceptable, even though they would prefer not to be in this situation.

> ***"It's difficult if you're not waiting on an operation on the NHS. I would think to invest it in primary care but I'm not waiting, and I don't know anyone waiting for operations."***
> *(London)*

Outside of London, nearly all the groups' preferred approaches related to primary and community care. In London, two out of the three groups preferred one or more of the hospital care approaches. However, the point above about not seeing the approaches primarily through the lens of primary/community care or hospital care is important: most chose their favoured option based on its individual merits and this might not align with what they perceived to be the overall priority.

> ***"I still think we need to tackle the primary care. But out of the options were shown the [elective surgical] hubs were the better option and would have the biggest impact on the NHS overall."***
> *(London)*

However, some reflected that they were not sure that investing in primary and community care was realistic. They were unsure where the resources would come from. Also, they were not clear how it could gain the support of politicians because they saw a focus on primary and community care as a long-term solution and they thought that politicians would want to see change more quickly.

> ***"It seems that there has always been more money put into the hospitals. I don't see that there is going to be sufficient staffing put in the community and in GPs. Not for many, many years, whereas there is going to be more development of the hospitals."***
> *(King's Lynn)*

Participants generally saw the tension between short-term and long-term objectives when deciding where to focus, and were not sure how to resolve these as they recognised that their preference would also be shaped by whether they personally needed a service while waiting for the changes to happen. They were unable to resolve this tension, with most feeling that it was important to be keeping people well, but unsure if that would be sufficient in the short-term.

Participant 1: "Long-term is always more productive, will help more people."
Participant 2: "But if I tell you your mums dying now, you wouldn't care about in 20 years… that's where you have an issue."
(Leeds)

3.5 Summary of the pros and cons of different approaches

This section summarises participants' perspectives of the specific approaches to primary, community care and hospital care that they compared. These approaches were introduced to help draw out the trade-offs between primary/community and hospital care, rather than to get detailed feedback on each one. This means the information shared was kept to a high level – further research would be required to fully understand public views of each of these approaches. The discussion below starts with the primary and community care approaches, followed by the hospital care approaches, within each category starting with the most widely supported approach through to those with a more mixed reception.

There was wide variation in responses to the different approaches based on the information participants received. Although all approaches are established within the NHS, albeit not universally, participants held very different views about how desirable they are and how well they would work. Some participants were aware that some of these solutions already exist in the NHS, and where they were familiar with them, this influenced their views on the desirability of the proposal.

Scaling up community services and Urgent Community Response (UCR) services

This proposal was one of the most widely supported of the approaches discussed. Many participants could see how this would be a good service, especially for older people and those with mobility difficulties who are less able to travel to services. As such they were hopeful it could potentially reduce inequalities in access for these groups. The preventative nature of this proposal also appealed, and people believed that if it was done well it could keep people out of hospital, enable them to be discharged earlier and reduce the burden on GPs, all of which were viewed as positive outcomes. Some suggested that this was a longer term and potentially more sustainable solution to some of the pressures likely to result from an ageing population.

"It would be useful for the older generation, it keeps them at home and they can access it easier."
(London)

However, support was not unanimous. Although most participants liked the idea in theory, they were concerned that politically it could be a hard sell as it is not a service that is available to everyone and, unlike a new hospital, there would not be anything physical to show for the money invested. As such, some also worried about whether it would have longevity, noting that the closure of such services could have a detrimental impact on continuity of care. Some participants were also concerned about the feasibility of the proposal – specifically participants were worried that the UCR teams might have difficulty recruiting staff and understaffing could reduce their ability to provide care within the target timeframes. A few were concerned that such a team could not address all the patient's needs and that sometimes they would still need to go to hospital, for example with a broken hip, and in these cases all the UCR team would be doing is adding an unnecessary layer of bureaucracy. Some raised concerns about the cost of having a team on call for a subset of the population and doing house visits as they thought this would take more resources than having patients travelling to the healthcare professional – specifically, they thought having a 2-hour target would require a high level of resource.

> ***"But it needs resources and they will come from what you would have had as a GP. Maybe one of your practice nurses has to be part of this."***
> *(London)*

There were also a few practical concerns including the safety of staff doing home visits, and whether or not the patient would be able to afford the electricity costs associated with being cared for at home.

Increasing continuity of care in general practice

Participants had mixed views about this proposal. On the positive side they could see how it could support better outcomes for patients and quicker recovery times (through more personalised care and earlier diagnosis). They also thought it could be efficient as it would reduce the need to keep taking the patient's history, while also making the experience better for the patient, which in turn could make them feel more comfortable and reduce anxiety. Some wanted to go further and ensure continuity of specialist care too.

> ***"If I go to see the same person over and over, they will notice that something is wrong. That could really help."***
> *(London)*

Again, the concerns related largely to how the proposal would be implemented. Some participants were concerned that it would not be feasible to deliver continuity of care, for example due to high staff turnover and a reliance on locums, which they thought would make it harder to achieve continuity. Some suggested that in bigger practices or those with high levels of need (such as practices in deprived areas) it would not necessarily be possible for the GP to remember their patients, even if they were technically providing continuity.

> ***"I think it works well in places like Norfolk. If you were to go into the centre of Birmingham, it's a different story."***
> *(King's Lynn)*

On a very practical note, some were also concerned that offering continuity of care to selected patients might make it harder for other patients to see their preferred GP, which they did not feel would be fair. Similarly, they were worried about what would happen if a patient was 'stuck' with a GP that they did not like. Some participants reflected that they believed some GPs are better than others and they wanted to have a choice over who they saw.

> ***"[It] might be that one [GP] is better for your care than another."***
> *(King's Lynn)*

Scaling up extended teams in general practice

The proposal for scaling up extended teams in general practice was also met with a mixed response, with some supporters but also some who thought that it would be a negative step. Those who were supportive focussed on the benefits of freeing up GP time for those who need it and reducing the need to travel for services such as physiotherapists, which might otherwise be accessed in a hospital. Some thought that the proposal could therefore reduce stress for patients and would also improve access to healthcare, especially for people in full-time employment. Specifically, some participants thought this proposal would be good for addressing minor ailments – especially if the extended team included a physiotherapist, pharmacist and social prescribing capabilities.

> ***"We talk so much about holistic care, what these extra people would do would be exactly that."***
> *(London)*

The biggest concern about this proposal was how patients would be allocated to the right team member. They were nervous that a receptionist would act as gatekeeper but might not be qualified to judge whether or not the patient needed to see a GP. Some commented that they already found they were being channelled towards seeing a paramedic in their general practice, who they felt was not necessarily best placed to help with their needs. Some were concerned that if the triage was incorrect the process could be inefficient as they would potentially still need to see the GP after first seeing another staff member, and at worst this could lead to poorer health outcomes if the non-GP staff were not able to spot concerning symptoms. Also, some participants noted that extended teams could mean that a patient would see a number of different healthcare professionals for their different needs, which would reduce continuity of care. As one of the other proposals was to increase continuity of care there was some concern that this proposal would do the opposite.

> ***"One of the main pitfalls is where it says staff would be non-clinical staff. They are not able to read test results because they are not clinical."***
> *(London)*

Again, there were also some practical concerns with this proposal. They thought it would be a big change which could require existing staff to sign new contracts and might be difficult to recruit for, especially if the team also offered extended hours. Some wanted evidence that this approach had been tried and that it could work, as they would not necessarily feel confident redirecting money from hospitals and potentially impacting on waiting lists to pay for this proposal. One group also expressed concerns about the potential impact on the business of private physiotherapists.

Expanding elective surgical hubs

This was the most popular of the three hospital care proposals. Those who were supportive thought that it could be efficient and as such it would be an effective way to clear the current waiting lists. This was seen as a good thing to do for patients and the NHS, but also valuable for the economy as it means people waiting for surgery would be able to get back to work faster. Some also saw this as a long-term investment as they thought demand for elective care was likely to continue to grow due to the ageing population.

> ***"A lot of people are living sub-par lives because they are on a waiting list to be seen. They need to plough through them."***
> *(London)*

In contrast, others were concerned that this was quite a short-term solution which might be high cost to implement and might not be required in the medium-term once the backlog had been dealt with. As such they saw it as an expensive sticking plaster that might not benefit most people. Some were concerned about the impact it might have on capacity in urgent and emergency care services if staff were transferred from these services to elective hubs; they felt it was important that capacity in urgent and emergency care was protected, so elective hubs would require new staff rather than 'borrowing' them from existing services. Lastly, a few were concerned that this service could be privatised in time.

> ***"If it is just a way to fund this by reducing the capacity of the emergency spaces it's not solving any issues."***
> *(London)*

There were also practical concerns about this proposal. Some were worried about the longer travel times and lack of family support which would be on hand if services were centralised. They were concerned this could impact on health inequalities as some people would find it harder to travel than others. Additionally, some considered the impact on staff and their morale when having to do lots of the same surgeries day after day. While some thought this might help them improve, others were concerned it could become monotonous and this could be dangerous for the patient.

> ***"Unless the hubs were put in the poorer socioeconomic areas they could have a negative effect on inequalities."***
> *(King's Lynn)*

Expanding same day emergency care

This idea was not particularly popular with participants. They could identify some benefits including that people would receive quick and timely care from appropriate professionals. Some saw it as an efficient service which would be cost-effective as the care would be centralised. They were hoping it would help reduce A&E over-crowding while also ensuring that hospital beds were reserved for those who most needed them.

> ***"I would go with the second one [SDEC rather than Urgent Community Response], in hospital being fixed up there, as in the hospital if they have people there to fix them up then perfect and it's more professional, there's a patient and a doctor, more of a professional angle to it."***
> *(London)*

However, the list of concerns was somewhat longer in most groups that discussed this approach. Some thought this was a gimmick which would shift the problem rather than solve it, and they were not clear on the benefits over and above the current model, or whether / when it would be appropriate to redirect someone to this service from the place they originally presented (GP or A&E). As such it was seen as a relatively short-term solution which would incur additional costs but which might not be cost-effective, compared with some of the primary care proposals. Again, participants were often concerned about the knock-on impacts on other teams and whether they would be able to find the staff and space to create this new service.

> ***"It's a gimmick. Why don't you just expand A&E?"***
> *(Leeds)*

Practical concerns for this proposal included the difficulty of accessing same day emergency care services if it required a GP referral (due to difficulties getting a GP appointment), and the additional cost to patients of travelling to a centralised service.

Scaling up virtual wards

This idea received the least support of all the proposals presented, based on the information available. While some participants speculated that the idea could have some appeal for 'younger generations' and that some patients would appreciate the opportunity to be at home, most found it difficult to identify any benefits. They suggested it might be helpful in certain limited circumstances although struggled to identify any examples of conditions where they thought it would be safe to implement. Some also thought it could potentially be an efficient way to look after patients.

The list of concerns for virtual wards was much longer than the list of benefits. Broadly these fell into the following categories:

- **Concern for patients who are less tech-savvy, especially older patients:** While they thought this could change over time, they were worried that currently an over-reliance on technology to support people at home could exacerbate health inequalities.

- **Cost of set-up and maintenance:** Some participants imagined there would be a high upfront cost of purchasing the necessary equipment to support people at home and were not sure this would be cost-effective. In addition, they anticipated ongoing maintenance costs for the systems and they were worried this funding might not be accounted for. Specifically, they thought that over time areas with higher levels of deprivation might find they had less functioning equipment to support virtual wards.

- **Patient outcomes:** Some participants voiced concerns about the safety and effectiveness of a virtual ward. They wanted more information about the type of condition where it could be appropriate and about what would happen if the monitoring identified a problem. Some suggested that in their opinion the NHS was becoming increasingly risk averse and that this solution might therefore be unpopular with staff who might not want to risk sending people home early.

- **More information about how monitoring would work:** There was a need for more information about how patients in virtual wards would be monitored and who would do this. Participants wanted assurances that the individuals would be qualified, and that it would not be up to the patient to undertake the monitoring. Equally, they wanted to know what measures would be put in place if the technology malfunctioned. Because the patients would need to be monitored, some were also unsure how much resource would be saved by using virtual wards.

- **Suitability of being at home:** Some questioned whether people would have a suitable home environment to recover. For example, whether anyone would be around to help them or whether they would be able to move around the house safely. They were worried that patients could feel abandoned or isolated without direct face-to-face contact from professionals. As such, some thought it could increase the pressure on GPs if people turned to them for support instead.

In conclusion, participants had a number of concerns about the virtual ward model and were unsure how it would work in practice or who it would benefit.

3.6 How participants' views of the balance changed

Towards the end of the session on Day 1, and again first thing on Day 2, participants were given the opportunity to consider whether their opinion had changed as a result of their deliberations. Ultimately, many continued to favour an increased focus on primary and community care than at present, although they acknowledged it was difficult to decide, and some moved further towards keeping the focus on hospital care.

> ***"It [the trade-offs] is staggeringly difficult. You're trying to consider everything, be fair to everyone, but it's impossible. It's far harder than I ever imagined."***
> *(King's Lynn)*

As discussed in section 4.5 above, participants were given six different approaches that could be adopted – three from primary and community care and three from hospital care. Participants judged these on a case-by-case basis and their views were shaped by a number of factors, but whether the

solution was a primary or community care solution, or hospital care solution, did not appear to have much impact.

The main changes which occurred were:

- **Increased emphasis on hospital care:** For some, the discussions crystallised the need to maintain the focus on hospitals for several reasons. Specifically, they wanted to make sure those in 'dire need' are looked after, including those waiting for elective care. Based on anticipated demographic change, some believed increased demand for hospital care would be inevitable, regardless of whether primary and community care investment was effective in reducing need. Others focussed more on the arguments against increasing the focus on primary and community care: namely that they did not believe the investment would happen (because the benefits would take too long to come to fruition so would not get the support of politicians) or that such an approach might be inefficient (especially if it led to an increase in the number of home visits as proposed in the Urgent Community Response service). One group also suggested that by cutting hospital waiting lists, the workload for GPs would be reduced as they would be supporting fewer patients waiting for treatment.

  "It seems that there has always been more money put into the hospitals. I don't see that there is going to be sufficient staffing put in the community and in GPs. Not for many, many years, whereas there is going to be more development of the hospitals. So that's why I've moved my stance."
  (King's Lynn)

- **Continued or strengthened support for community and primary care:** Others doubled down on their commitment to community and primary care. They believed strongly that it would be an investment which would reduce longer term hospital demand (and costs) and therefore was the more prudent investment. Some noted that there could be benefits to bringing more services into the local community that currently have to be accessed at hospital.

  "No life is less important or more important, but my reason for being on this side [community care] is because there's currently a lot more funding on that side."
  (Leeds)

- **Increased recognition of need for short-term solutions too:** Although most were keen to see the NHS take a long-term approach to planning, increasingly they reflected that it was important to reduce waiting lists and improve access now – and that while it was important to invest for the long-term, short-term measures are also required to address current need.

  "I think the 8 million backlog needs to get tackled as a priority. It is only going to go up."
  (London)

In conclusion, there were a number of high level considerations which influenced whether people thought it was more important to prioritise primary and community care, or hospital care. These included the importance of preventing ill health and early intervention, the need for a smooth path from diagnosis to treatment, and the importance of balancing where money is spent so that it is focussed where it can have most impact on the system. When deciding about ideas at a more granular level, participants focussed on questions such as the feasibility and desirability of specific ideas and their likely impact on patients and the health service overall. Ultimately, they wanted investment decisions to be based on

strong evidence, balancing short-term need with longer-term investment to avoid the NHS becoming unsustainable in the long-term.

> ***"The reality is, if there's an extra billion pounds, let's put it in community care, but if we're talking about the current budgets, it's critical care we need to focus on the most."***
> *(King's Lynn)*

4 Funding for the NHS

This chapter of the report begins with a discussion of how participants traded off between improving service levels within the NHS versus increasing the level of funding, followed by a discussion about how additional funding should be raised, if more revenue was going to be raised for the NHS.

Key findings

- When discussing the trade-off between the level of funding for the NHS and the service levels it can deliver, most participants wanted the NHS to deliver better services than at present and therefore said they would be willing to pay additional tax in order to achieve this. They tended towards opting for the higher level of improvements in services (and therefore a higher increase in taxes).
- However, in the context of the cost of living crisis, most participants were very concerned about the impact of increased taxes on individuals and families. They wanted government to do everything it could before resorting to raising taxes (and to minimise any increases).
- In particular, this meant addressing perceived inefficiencies in the NHS, which participants strongly felt should be addressed to free up funding for improving services. This contributed to a hesitance around increasing NHS funding via taxation, with many participants questioning the amount of additional funding needed versus what could be saved. If taxes were to increase, participants would also want to see greater transparency and honesty around NHS budgets, and better long-term planning to maximise the impact of additional investment.
- By the end of the discussion, a small number of participants continued to assert that the NHS should not receive any additional funding via taxation, often as a result of the financial pressures on households at the moment.
- Discussions turned to comparing three different options for raising additional revenues through tax, with a range of views on each option. A tax based on National Insurance with revenue earmarked for the NHS (i.e. a hypothecated tax) and increased VAT were generally preferred to increased income tax. However, participants tended to prefer a mix of the presented approaches as they thought it would spread the burden and mitigate some of the disadvantages of any one tax. Participants also raised other taxes that they thought should be considered, or asserted that additional funding should come from elsewhere in the government budget.
- The main driver behind participants' preferences between the taxes was the cost to individuals and households. They were also concerned about the fairness of the proposed options, though they sometimes had differing views of what constituted ‘fair’. Many participants remained very mistrustful of government and whether additional taxes would be spent as promised.

4.1 The trade-off between the level of funding for the NHS and the service levels it can deliver

The first day of the workshop focused on potential solutions and their trade-offs within the bounds of the current system and its constraints. The second day moved beyond that to explore the trade-off between

service levels the NHS can provide and the level of funding it receives and how additional funding should be raised, as well as whether there is an appetite for more significant changes to the healthcare model in England. After a presentation on the current funding model for the NHS and a brief discussion of some alternative funding models and their pros and cons, participants were presented with different scenarios for how much revenue could be raised for the NHS.

First, the presentation illustrated UK health spending over 2010-2019 alongside other comparable European countries, highlighting a lower spend per person than the average across a comparator group of 14 European countries. It also recapped some of the facts and figures from the first day of deliberation covering issues such as rising demand on healthcare. Participants were then presented with the trade-off between improving NHS services and increasing funding levels, highlighting the main dilemma for deliberation: improvements to services would require increased funding, which would generally mean that individuals have to pay more towards the NHS, most likely through increased taxes.

The presentation then outlined three scenarios for funding levels[9]:

- No additional funding.
- Stabilisation (NHS going back to 2019 levels of service and performance), requiring an additional £51 billion, costing an extra £1,800 tax per average household per year by 2030/31.
- Recovery (services recovering to higher levels of performance than 2019), requiring an additional £61 billion, costing an extra £2,200 tax per average household per year by 2030/31.

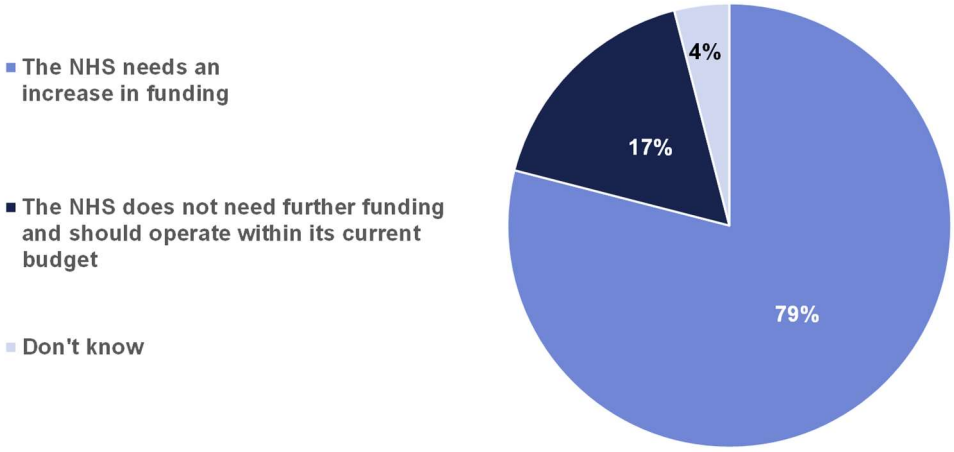
It was noted that there are opportunities for the NHS to spend its funding better, but that the NHS was already ranked highly for efficiency[10] and that the revenue saved from spending the existing budget better would not be sufficient to cover either the stabilisation or recovery scenario. Participants were told that the most likely way of increasing funding would be through taxation (as opposed to increased government borrowing or moving funding from other areas of public spending).

Through a facilitated discussion and using the three scenarios presented, participants discussed **how they felt about the trade-off between improving NHS services and increasing funding levels**, in order to gauge what level of service participants were willing to pay for.

In the Ipsos/Health Foundation surveys with the wider general public, there is widespread agreement that the NHS needs additional funding. Around four in five of the English public (79%) think the NHS needs an increase in funding, while 17% think the NHS does not need further funding and should operate within its current budget.

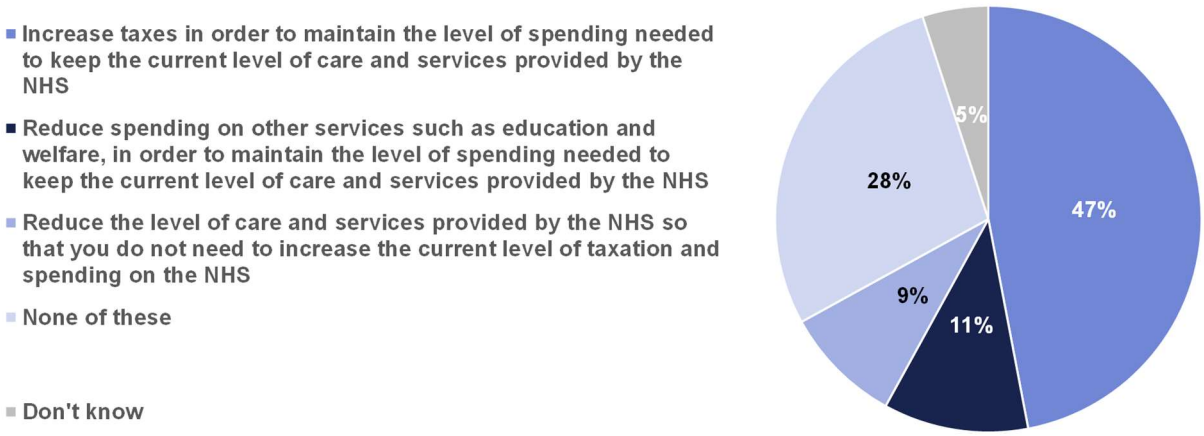
[9] Funding scenarios were based on Health Foundation analysis outlined in the following report: https://www.health.org.uk/publications/health-and-social-care-funding-projections-2021

[10] https://www.commonwealthfund.org/sites/default/files/2021-07/PDF_Schneider_Mirror_Mirror_2021_exhibits.pdf



Q. Which of the following statements best reflects your thinking about funding for the NHS?
Base: All participants in England, adults aged 16+ (1,878), conducted online via Ipsos KnowledgePanel 5-10 May 2023

However, this widespread support does not give consideration to how the increase in funding should be raised. When it is explained that spending on the NHS needs to increase in order to maintain the current level of care and services, the preferred option for the English public is to increase taxes to keep the current level of care and services (47%), rather than reduce spending on other services to move to the NHS (11%) or reduce the level of services provided (9%) – although a further 28% do not like any of these options.



Q. Many experts argue that it is becoming more expensive to fund the NHS because of increasing costs of treatments, an ageing population and several other factors. This means that even in order to maintain the current level of care and services provided for free by the NHS, spending on the NHS would have to increase. With that in mind, which, if any, of the following would you most like to see?
Base: All participants in England, adults aged 16+ (1,774), conducted online via Ipsos KnowledgePanel 23-29 November 2023

However, the proportion of the public saying that taxes should be increased to maintain level of spending needed to keep the current level of care and services provided by the NHS has fallen from November 2022 to November 2023 (from 52% to 47%). Instead, they are marginally more likely to say the level of care and services should be reduced (up from 6% to 9%).

In the deliberative events, most participants' first reaction to the trade-off was a concern that increased taxation would add to existing financial pressures on individuals.

Most participants were very concerned about the wider economic context of the cost of living crisis, which has already impacted on people's ability to pay for essentials such as energy, housing and bills. Even those who expressed willingness to pay extra for the NHS from the beginning of this discussion wanted to declare their worries about this prospect first. This may explain the survey findings, in which the public are now less likely to say taxes should be increased to maintain the level of spending needed to keep the current level of care and services provided by the NHS.

> ***"Everyone is struggling to pay their bills as it is. People can't even afford electricity bills. You can't make them pay more tax."***
> *(London)*

Participants in the deliberative events often wanted to be guaranteed improvements before agreeing to any additional costs – they were primarily concerned about access to services, and wanted to be assured that if they pay more, services will be there when they need them. This was linked to the lack of trust in government decision-making and the volatility of the political system.

> ***"Are services going to be guaranteed? […] Things have to be set in stone, if I'm paying more for something, I want it to be there when I need it."***
> *(Leeds)*

The above was put in the context of the wider government mishandling money (for example on HS2, mentioned in Leeds). Some participants felt that a better distribution of existing government funds was needed to ensure that essential services take priority when the budget is set. However, there was a recognition that many public services are in dire need of additional funds at the moment (such as healthcare, education, housing), and that reallocation of funds would pose a difficult and sensitive challenge.

Perceptions of the NHS as a 'leaky bucket' contributed to the hesitance to increase funding for the NHS.

There was a strong feeling among some participants that in order for the NHS to improve services, some fundamental issues needed to be addressed. Participants mentioned administrative inefficiencies (for example use of fax machines), poor communication leading to more patient visits than necessary, or material waste, such as giving out free crutches that do not need to be returned. They thought that these issues could be addressed without additional funding, and that they should be attended to before the NHS budget is increased. They viewed the NHS as wasteful, and worried that putting additional funding in was like putting more water into a 'leaky bucket' that needed to be repaired.

> ***"I don't think everything can be addressed with money. There are fundamental management issues, more money with the same issues is just chucking money at it."***
> *(Leeds)*

To deal with this, some participants suggested addressing the high turnover of staff which they identified as a key area contributing to extra costs (as well as having implications for the quality of services), increasing accountability of senior management for how the budget is spent, as well as additional transparency around finances.

Most participants leaned towards wanting improved services and therefore that the NHS needs more funding.

On the trade-off, most participants did not view current service levels as acceptable, which led most of them to lean towards wanting to increase funding. There was a general feeling that the quality of care

and access to services need improvement, such as the amount of time one gets at an appointment, or the experience of 'customer service' when accessing the NHS.

> ***"Yesterday we spoke of customer service, if you are paying for that would you expect more time, a lot more for our service, going to the doctors is more about making me feel at ease, valued."***
> *(London)*

Participants reflected on the facts and figures presented on the first day of deliberation, which outlined current and future strains on the NHS such as an ageing population. They often believed that in order for the NHS to continue to be accessible to all (and preferably for access to improve), it will need additional funds. Services such as cancer care and diabetes care were also mentioned as needing improvement, alongside waiting times for a GP appointment and hospital care. Additionally, some participants reflected on the historical government spending on the NHS which was presented on day 1. They pointed out that the evidence showed a stall in funding for more than a decade, which was seen as having led to sub-par service levels now.

> ***"What I took from yesterday was the lack of funding since 2010, the disparity between governments, […] you are trying to catch up now with the lack of resources."***
> *(London)*

However, a few participants strongly opposed this view, unable to move past their initial worries of increased financial burden. They continued to go back to the cost of living crisis and difficulties faced by families and younger generations who would have to be responsible for raising revenue for an ageing population. They found it difficult to accept an additional financial burden on individuals and families without certainty of improvement.

> ***"Yes, the perception is that [the NHS] is in crisis, but have we ever had the perfect NHS? Would this funding, which will cripple some families, actually create that?"***
> *(King's Lynn)*

Those who wanted improved services and therefore increased funding from the beginning of the discussion tended to opt for 'recovery'.

Overall, many participants agreed that the NHS requires additional funds from the beginning of the discussion. They were more likely to opt for the 'recovery' scenario (with higher levels of improvement to services), as they perceived the difference between the two scenarios to be small, making the financial impact on households of both options comparable. They thought that if they have to pay more taxes they might as well do it 'properly', helping the NHS to be the best it can be. However, this claimed willingness to pay more in taxes is clearly dependent on the level of improvements to NHS services that it can deliver.

> ***"I don't think that the 2019 levels are good enough. I'd say that for the £400 more it is absolutely worth it. It just makes sense. It's not that much more for what you get."***
> *(King's Lynn)*

Additionally, aiming for 'recovery' was seen as promoting a long-term approach to planning. These participants believed it was a more forward-thinking scenario, which would benefit society in the long-run. Some were worried that a short-term goal of only stabilising the NHS would lead to its downfall again in the future.

> ***"I would go recovery. We have to think, if we go for stabilisation, where will it be in 5 years? This is where the government and a lot of people make mistakes, there's no forward thinking."***
> *(King's Lynn)*

At the same time, some participants still recognised the importance of mitigating the impact of increased taxation on individuals and families. They proposed that raising the minimum wage could help those on lower incomes to be less affected.

In contrast, for those who were originally hesitant, 'stabilisation' was seen as a more achievable goal and a good first step towards 'recovery'.

Most participants who were initially hesitant began to agree that additional funding was needed as the discussion went on. Ultimately, participants could see that the quality of services was not ideal at the moment, and without increased funding it would likely get worse due to societal changes such as an ageing and growing population. They expressed a preference towards the 'stabilisation' scenario (restoring services to 2019 levels rather than better than 2019 levels) because it would have the lowest financial impact on individuals and households. It was seen as more achievable in the current economic climate, and as a good first step towards improving services. These participants reflected that if 'stabilisation' was achieved, it would increase the public's trust and help to persuade people to go the extra mile towards 'recovery'.

At the same time, 'recovery' was seen as the preferred scenario 'in an ideal world', but reflecting on the current difficulties and financial struggles faced by the population brought these participants back to stabilisation. This tension between what participants wanted to see and what they were willing to pay for was difficult to resolve, as all agreed that improvements are needed.

> ***"Yes, I was shocked* [by the amount of money needed for recovery]*, that was the first impression, but now when I know what's needed it seems maybe not even enough."***
> *(King's Lynn)*

Those who began the discussion on the side of 'stabilisation' tended to move towards 'recovery' as the discussion continued.

Many participants who were initially reluctant to increase NHS funding or preferred the 'stabilisation' scenario were persuaded by the arguments mentioned by advocates of the 'recovery' scenario. The key point that resonated with these participants and changed their opinion was the potential for a greater level of investment to aid long-term planning. As the discussion went on, they echoed the worry mentioned above, that a focus on stabilisation could mean that the UK is back in the same place in 10 years' time. They also drew on their lack of trust in government decision-making, worrying that if stabilisation was the agreed goal, the government would move away from improving the NHS once it was reached instead of continuing with the momentum.

They recognised that improvements might take a long time, which might be felt more by the next generation. Whilst they would have preferred to see and feel improvements themselves, they were happy to contribute so that their children can benefit in the future.

> ***"I came in thinking about me, but now I'm thinking about my kids, they are the ones who will be here in 20, 30 years, even their kids. You won't change anything tomorrow, the damage is done."***
> *(King's Lynn)*

There remained a small number of participants who thought the NHS should not receive any additional funding at all.

These participants remained unwilling to personally pay more in taxes to help raise more funds for the NHS. The key reasons for this were existing financial difficulties and other personal circumstances that took the priority over improving the NHS, such as family.

> ***"I was the stabilisation option, but I think when you actually put the numbers on it… I think the tax increases are too much. When I look at the numbers. I know it's for the future and the national health. But I think that it just affects too many people now."***
> *(Leeds)*

Accountability, transparency and long-term planning would reassure participants that their money is being well-spent.

Even among those willing to increase funding for the NHS to improve services, there were concerns about whether the money would be spent well, and how the NHS and the government would be held accountable for their budget. Throughout the discussion, participants generally expressed a willingness to accept additional tax burden if certain criteria were met, such as:

- Increased transparency about how the money is spent, with an example given of pie charts disseminated by Local Councils breaking down the council tax spend to show residents what their money is spent on.
- Increased accountability of the government or other decision-makers, which would stem from transparency.
- Being able to see and feel the improvements one is paying for.
- Better long-term planning and more stable, carefully planned investment in the future of the NHS (for example, on improving facilities or training staff).

Those that wanted to see improvements to maintain their willingness to pay additional taxes mentioned access as a key issue. They wanted waiting times to go down, and to be able to access healthcare when they needed it, and felt it was a metric of whether the additional funding is helping to address the current issues within the healthcare system.

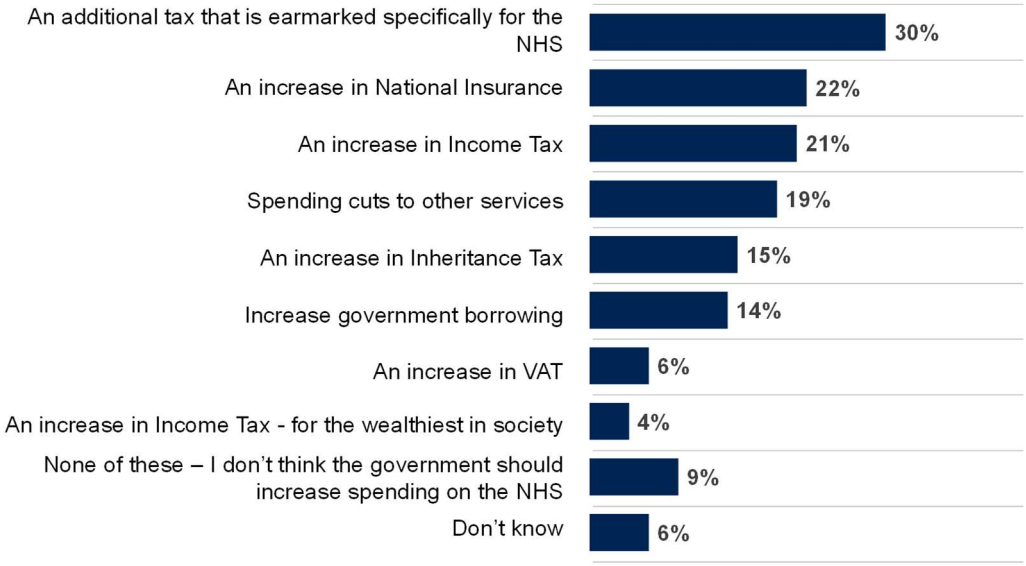
> ***"Things have to be set in stone, if I'm paying more for something, I want it to be there when I need it."***
> *(Leeds)*

Participants often felt that the above commitments would address their hesitance by binding the government and the NHS to transparent goals, measured and reported on in a transparent way. They did not trust governments in general to deliver on their promises without a greater element of built-in accountability.

4.2 The pros and cons of different tax mechanisms for raising revenue for the NHS

Following the above discussion, participants listened to a presentation on three possible ways that revenue for NHS could be raised through taxation. The presentation focused on tax, because it was identified as the most feasible option for future governments to raise revenue.

The Ipsos/Health Foundation surveys show that the wider public are fairly divided about how to fund any increase spending on the NHS, if the government decided to increase spending. The funding mechanism with the most support is an additional tax that is earmarked specifically for the NHS (30%). However, this is some way from a majority, and only slightly smaller proportions favour an increase in National Insurance (22%) or an increase in income tax (21%). The public is also divided across a range of other ways of raising revenue.



Q. If the government decided to further increase spending on the NHS, how do you think this should be funded?
Base: All participants in England, adults aged 16+ (1,878), conducted online via Ipsos KnowledgePanel 5-10 May 2023

Given the range of preferences about how to raise additional funding, the deliberative research offered an opportunity to trade off these different options and understand preferences in more detail, and once a cohort of the public have more information.

The three tax options discussed were income tax, a tax earmarked for the NHS (modelled on the recent Health and Social Care Levy, which was based on National Insurance), and VAT. These were selected due to:

- Their potential for raising large amounts of revenue.
- The precedents for raising revenue via these mechanisms, with data available to illustrate how they might work if implemented[11].

[11] https://ifs.org.uk/publications/securing-future-funding-health-and-social-care-2030s

- Them allowing for discussion of the pros and cons of different ways of raising revenue.

Participants were presented with general overviews of each option, arguments for and against their implementation, and estimated projections of what the increase in these taxes would mean for individuals and households by 2028/29. These costs are summarised in the table below, with full details available in the accompanying appendix. For increases in income tax or introduction of an earmarked tax, the additional costs were provided for different salary levels, while for VAT participants were provided with the impact of an increase on a wider range of items. It was explained to participants that these estimates are subject to uncertainty and were provided only to illustrate the magnitude of the changes needed over the next five years.

Tax option	Stabilisation	Recovery
Income tax	Increase of 5% across all rates, meaning those on a salary of £30k would pay an extra £73 monthly.	Increase of 6.5% across all rates, meaning those on a salary of £30k would pay an extra £94 monthly.
Earmarked tax via National Insurance	Those on a salary of £30k would pay an extra £37 monthly. Employers would match that for each employee.	Those on a salary of £30k would pay an extra £56 monthly. Employers would match that for each employee.
VAT	Increase from 20% to 24%, meaning a price of a new boiler would rise from £2,500 to £2,583.	Increase from 20% to 26%, meaning a price of a new boiler would rise from £2,500 to £2,625.

The question agreed for deliberation was:

How should any additional spending by the NHS be funded?

The remainder of the chapter details views of each type of tax, before summarising how participants prioritise the different options.

4.2.1 Income tax

Although participants had previously often said they wanted to increase funding for the NHS to improve services, when they were presented with projected figures of what the increase to income tax could be, they looked for ways to concentrate the burden on those with higher incomes. Therefore, the advantage of income tax that particularly resonated with participants was its progressive nature – the fact that people pay a percentage of their income, which means that those on lower incomes pay less than those earning more. During that discussion, many participants were circling back to their initial worries from the beginning of the discussion, with those on lower incomes and younger people seen to be struggling already, and wanting the impact on them to be minimised.

Another feature of income tax presented to participants that particularly resonated was that an increase in income tax could be implemented relatively easily, minimising the administrative costs and allowing more funds to go to the NHS.

> ***"Income tax. The more you earn, the more you pay. If you are on a low income, you're not scratching so much as if they automatically stick to X amount [the same percentage] on everything that you buy."***
> *(King's Lynn)*

However, the increased impact of income tax on higher earners was also mentioned as a disadvantage. These participants thought that it 'punished' people for hard work, and were worried that it could discourage people from progressing in their work as they would not see the benefits of it.

> ***"Why should those doctors and surgeons, who are the ones saving people's lives and have gone to university and got a good education, should they really be paying more than those that didn't? Should you be punished for working hard?"***
> *(Leeds)*

Additionally, many participants were conflicted about the fairness of this approach, as it would see working individuals bear the brunt of funding the NHS, placing an unequal burden on working people. This was contrasted with VAT as a solution that would impact everyone, or National Insurance which is paid by both individuals and employers. This concern was mitigated when participants were reminded that income tax is also paid by wealthy pensioners, but the worry about an ageing population and shrinking workforce continued to make participants uncomfortable about increases to income tax in order to raise more revenue for the NHS.

Lastly, in the presentation to participants the projected amount that an individual would have to pay in additional tax was highest for income tax. This discouraged some participants from seeing it as a viable option, as even those who supported the 'recovery' scenario wanted to feel the impact of a tax increase as little as possible.

4.2.2 Earmarked tax paid for via an increase in National Insurance

Generally, participants liked the earmarked tax (a hypothecated tax based on National Insurance and modelled on the Health and Social Care Levy) as an option for raising additional revenue for the NHS, but their distrust in government undermined their confidence in it as a feasible option. The advantage that resonated most with participants was its transparency. The fact that it could appear separately on a payslip could make people feel better about having to pay more tax in the first place, as it would be clear what that extra money is funding. Participants also thought that this transparency could promote more accountability for spending of the NHS budget, which could ultimately help to plug the holes in the 'leaky bucket'. The idea of ringfencing funds to get the NHS to a better place was accepted as a good idea despite its risks of inflexibility.

> ***"This is my favourite one, it's simple, visible, and it's limited. It's just going to the NHS and no one will come in and take it to the military."***
> *(London)*

In the example provided of the earmarked tax being raised via National Insurance contributions, participants were generally in favour of the burden being spread between employers and employees to reduce the impact on the working individual. Participants also agreed that safeguards would need to be put in place to ensure that this tax does not disproportionately affect small businesses, who are already struggling because of the pandemic and increased costs. This was raised particularly strongly in King's Lynn.

> ***"There has to be some kind of threshold where if the turnover of the business is too low then they don't have to pay it. It might be the tipping point to put companies out of business, especially at the moment."***
> *(King's Lynn)*

However, there was a general mistrust of government's decision-making, especially in Leeds, with a few participants mentioning the scrapping of Health and Social Care Levy as an example of short-term thinking and the volatility of decisions. Similarly, many participants questioned whether the funds would indeed be protected, with a few citing that funds raised by the 'sugar tax' (soft drinks industry levy) are now absorbed into the general tax pot, having been initially ringfenced for children's health. They agreed that those worries could only be addressed with transparency and honesty coming from the government, and potentially an independent board or watchdog organisation overseeing how this money is spent.

> ***"The interesting thing about this is that as a society, the impact of the pandemic was huge. And this could be the transparent way of saying, this is how we have to recover. This is what this tax would be like, this is why we're doing it."***
> *(London)*

Another worry about a tax earmarked for the NHS was that it could set a dangerous precedent. A few participants acknowledged that society is facing difficulties on many fronts (for example, climate change), and were worried that with time, each government department would want to introduce their own levy. In addition, as with each of the options for raising revenue, the fairness of who is paying for it was raised. The prospect of basing an earmarked tax on National Insurance, which may not be paid by wealthier pensioners, was questioned by participants of all ages, including older participants who expressed that they would be happy to pay an additional contribution towards the NHS.

4.2.3 VAT

Participants' views and feelings towards increasing VAT in order to raise additional revenue for the NHS were at the extreme ends of the scale, making them difficult to change or mitigate. Those who were in favour of this proposal thought that it introduced personal choice, making it fairer. They believed that people could decide to be more or less impacted by varying their spending, making this option stand out from the others, which they could personally have little control over. Additionally, they believed that it was fair that everyone would pay this tax, including those who are not currently working.

> ***"It feels fairer to me, because raising taxes and it being the people who earn more paying so much more in, with VAT it's your choice of what you buy so it affects everybody. People with less money can make the choice with what they spend it on. It's a choice for everybody, not just forced."***
> *(Leeds)*

On the other hand, those who disagreed described this tax as 'invisible' because it is difficult to know how much an individual is paying in VAT. Out of all arguments against this option, participants were particularly concerned about its disproportionate impact on poorer households, increasing the existing burden of the cost of living on household budgets.

> ***"VAT would be the one that angers people the most. It's almost a sneaky tax. People won't realise how much they're paying, and it'll quickly add up. Also, it'll really hit families when the costs go up."***
> *(King's Lynn)*

The potential for this tax to have a negative impact on the economy also resonated with those who disagreed with this proposal. They were worried that raising VAT may adversely impact the UK economy

in the aftermath of the pandemic and the cost of living crisis. They thought that out of all the options, this one was the most unpredictable in its impact on spending habits.

More participants supported a targeted rise in VAT on items linked to poor health (such as alcohol, tobacco, sugar or fast food) used both as a deterrent and a revenue-raising tool for illnesses linked to these products. However, they recognised that it infringed on the freedom of choice, and that it could not raise all the revenue needed for the NHS, and would therefore have to be introduced alongside another solution.

4.2.4 Other suggestions

During the discussion, some participants wanted to offer alternative ways of raising revenue to those proposed in the presentation. They mentioned:

- Corporation taxes
- Taxes on pharmaceutical companies so that the NHS can share the profit
- Taxes on income from stocks, shares and cryptocurrency

What the alternative suggestions had in common was their lack of impact on the individual taxpayer. It was suggested that the burden on individuals was too high already, and so government should pursue other avenues for raising additional revenue.

> ***"Raising tax is the traditional way of raising money so we need to think outside the box."***
> *(London)*

It was also suggested that before any new taxes were introduced the government should look at its current budget and move funding between departments based on priorities. Even though participants generally accepted that the NHS needed more money, they wanted government to do everything it can to find revenue internally before introducing additional taxes. This included a thorough investigation of current spending, informed by robust evidence.

4.3 Participants' prioritisation of different tax options

At the end of the discussion about each of the three options for raising additional revenue for the NHS, participants were asked to indicate which option they favoured. Many participants identified significant downsides to each of the three options presented to them, which led them to lean towards a combination of some of the proposed approaches. They believed that combining different options would mitigate some of these disadvantages. For example, where participants questioned the fairness of income or earmarked tax being paid only by a group of people (employers, employees, wealthy pensioners), a VAT increase would be paid by everyone, mitigating this to some extent. At the same time, combining income tax or earmarked tax with VAT would allow the VAT increase to be smaller, minimising impact on poorer households whilst still requiring them to contribute.

In terms of selecting a single tax, participants were split between earmarked tax and VAT, with income tax favoured least. Participants' prioritisation of the options was motivated by three key drivers outlined below.

Cost to individuals and households was the main driver of participants' decision-making.

The cost of living crisis was mentioned extensively throughout the whole discussion. Ultimately, even those who agreed that the NHS needs more money and supported the 'recovery' scenario wanted to be impacted as little as possible.

In the information shared with participants, income tax was shown to have the highest cost to individuals. This resulted in income tax being least favoured – the fact that it was progressive did not mitigate participants' need to choose the 'cheapest' option. On the other hand, the fact that for earmarked tax the burden on individual would be lower, as it would be shared with the employer, pulled people in its direction.

> ***"I like the earmarked tax. On the costs – starting on the lower income earners it will cost them less than income tax, and with an additional VAT you'd probably spend more as well."***
> *(Leeds)*

In order to minimise the financial impact on individuals and households, many participants were keen to combine the proposed approaches. They believed that smaller increases in VAT, combined with smaller increases in income tax or an introduction of a smaller, earmarked tax, would make it easier for people to have control over the impact of the increased tax burden.

> ***"Why can't you do all of them? If you take a bit from each, you wouldn't really notice."***
> *(King's Lynn)*

The fairness of who the additional tax burden would fall on had a significant impact on participants' choices.

Participants were concerned with the fairness of the proposed options, but had different narratives of what constitutes fairness. On one hand, some participants thought that everyone should contribute to help the NHS. This often resulted in participants favouring an increase in VAT or a combination of a smaller or more targeted rise in VAT (for example, on items linked to poor health) together with either an increase in income tax or an earmarked tax. Ultimately, these participants thought it would be better if the burden was spread (either across society or between employers and employees), with those who can afford it such as working people or employers bearing the brunt of an additional tax.

> ***"I think it should be a mix. I don't think it's fair income tax falls on employees only. If employees are contributing towards the company and making a decent profit it should be split."***
> *(London)*

On the other hand, when it came to pensioners, there were two opposing views. Some thought that it would be fair for them to contribute as they tend to use NHS services more. However, others pointed out that pensioners would often have been paying National Insurance and taxes their whole lives, and so deserved to access healthcare without additional burden.

Lastly, there was concern over the fairness of increased costs to businesses. This worry moved some participants away from earmarked tax, which was proposed as a raise in National Insurance paid by both employers and employees.

> ***"I'm leaning towards the income tax. It's because the self-employed and the small businesses, the earmarked tax will impact them a lot. Income tax is based on your earnings, what you earn. And whilst I love the transparency of earmarked tax, it would have a big negative impact."***
> *(Leeds)*

Ultimately, participants disagreed on which tax was the fairest option, and their view on what was fair had a significant impact on their preference.

Lack of trust in government decision-making played a role in participants' prioritisation.

There was a general feeling of distrust in government, with many participants hesitant to believe that the government would keep their promise of giving additional funds to the NHS. This pushed some participants towards the earmarked tax, as there was a clearer line between the additional revenue and where it would be spent. However, participants remained mistrustful.

> ***"I think that having it on your payslip, showing exactly where it goes might help people understand what it is, where it is going, and why it is important."***
> *(King's Lynn)*

To mitigate their general worries about paying additional taxes to raise revenue for the NHS, many participants wanted to see a long-term plan that is accessible and easy to read, with accountability built in.

> ***"This is the government's opportunity to be open and transparent. This is what we did in the pandemic – this is the cost of it – and this is how we want to deal with it."***
> *(London)*

5 The NHS model and alternatives

This chapter of the report presents an analysis of participant views of the current NHS model, set against some alternatives. It details participants' preferred model, alongside the reasons underpinning their views of each model, before finally drawing out the key features participants would want from any healthcare system in the UK.

Key findings

- Participants discussed the current NHS model alongside some alternatives: the current model with additional charges, social health insurance and private health insurance.
- Overall, participants preferred the current NHS model over any alternatives. They strongly believed in its founding principles, in that it is available to everyone and free at the point of use. They considered the model to be largely fair and were supportive of taxation as the funding mechanism. However, some participants were concerned about the longevity of the current model given the challenges the NHS is facing, and many were critical of the lack of independence of healthcare from politics in the UK.
- The idea of the current model with additional charges made many participants uneasy and it was the least popular alternative presented. It felt like a move away from the NHS's founding principles, and participants were concerned about the impact on inequality. If inequality was addressed in a system of charges, for example via exemptions, comparatively little revenue would be raised so they questioned how useful this would be. Participants often thought it would work better if charges were aimed at 'abuse' of the health service such as missing appointments, more to change how people use NHS services than to generate any significant revenue.
- Participants were more divided about a social health insurance model. They were worried about how they would choose between policies, the risk of not being covered for something they need, about it being the beginning of privatisation, the impact of potential involvement of profit-making companies on patient care, and the cost to individuals. However, greater political independence was seen as a key advantage to this model.
- A system of private health insurance was very unpopular, due to concerns about the involvement of profit-making companies and the inequalities they have heard about in the United States. The main benefit of this model was seen to be greater political independence.
- The key desired features of any healthcare system in the UK were: equality and fairness; minimal cost to individuals; minimal political influence; minimal involvement of profit-making organisations; minimal administrative costs; and minimal abuse of the system.

Early on the second day of the workshops, a presentation was given to participants on the NHS's current model. The presentation explained the founding principles and how funding for the NHS is raised at present, along with the strengths and drawbacks of the current NHS model. Brief explanations of the two

main alternatives to a tax-based system were provided, private health insurance and social health insurance, again with a summary of the strengths and drawbacks of these models. Participants had an initial discussion about their views of the current NHS model.

Following intervening discussions on funding for the NHS under the current model (as reported in Chapter 5), the workshops returned to the NHS model. Participants were provided with additional information on two alternative models that had recently been proposed as policy options the government should consider:

- The current model with additional charges for specific services such as to see a GP or visit an A&E department.
- A social health insurance model.

The information presented to participants on these alternative models included: an overview of how the model could work; a summary of the likely trade-offs involved; examples of where the approaches have been applied elsewhere; further details on the arguments for and against; and personas of fictional characters who illustrate the trade-offs.

The question presented for deliberation was: **Do alternative models hold promise for the future of the NHS, and how do these compare to the current NHS model?** Participants discussed each of these alternatives, before finally voting on the three models (current model, current model with additional charges, social health insurance) to demonstrate their preferences.

5.1 Participants' preferences among the potential models for the NHS

Having discussed the alternative models in detail, participants were asked to vote between the following three models for a healthcare system in the UK:

- The current NHS model, free at the point of access, funded primarily via taxation, and with a comprehensive service available to all.
- The current model with additional charges for specific services.
- A social health insurance model.

Participants were given sticky dots and asked to place their dots across the models to express their preferences. They did not have to put a sticker on every model, but could put multiple stickers on a given model if they felt strongly about it.

The current NHS model emerged as the model with most support.

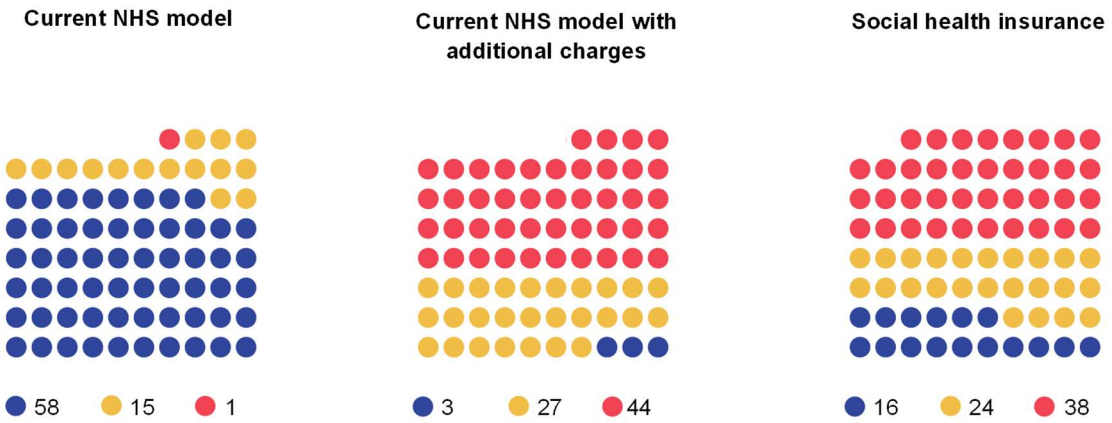
Overall, the current NHS model was most preferred for the UK, with 58 votes, far more than either of the other models. Only one participant selected it as a model that is definitely not the right model in the UK.

In contrast, the current NHS model but with additional charges was the least preferred model, with the fewest saying it is their preferred model (three votes) and the most saying it is definitely not the right model (44 votes) for the UK.

Participants were more divided regarding social health insurance, which garnered 16 votes as the most preferred model. This means that those questioning the current model largely opted for a social health insurance model instead. Equally though, more than twice that number thought that it was definitely not

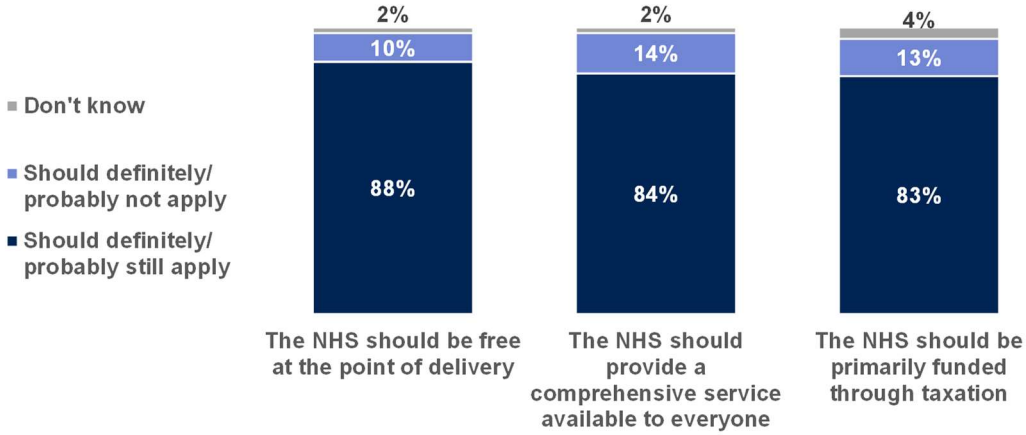
the right model for the UK (38 votes).

- Preferred model for the UK
- Not sure / need more information
- Definitely not the right model for the UK



5.2 Views of the current NHS model

The Ipsos/Health Foundation surveys demonstrate that the wider public in England still strongly subscribe to the NHS model. Nearly all think that the founding principles *should* still apply to NHS services today, including the NHS being free at the point of delivery (88%), providing a comprehensive service available to all (84%) and being funded primarily through taxation (83%). Support for the founding principles has remained fairly steady, although fewer think it should provide a comprehensive service available to everyone in November 2023 than in November 2022 (down from 90% to 84%, though still only 14% think this principle should not apply).

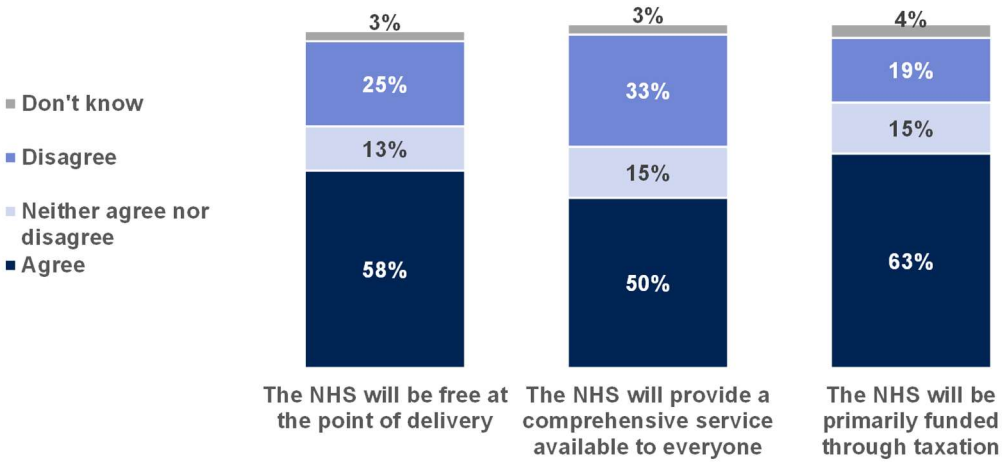


Q. When the NHS was set up, it was based on several core principles. For each of the following principles, please select the extent to which you think the principles should still apply to NHS services today.?
Base: All participants in England, adults aged 16+ (1,774), conducted online via Ipsos KnowledgePanel 23-29 November 2023

Similarly, among the 55% of British citizens living in England who say that the NHS is the thing that makes them most proud to be British (the top item making them proud to be British), the key reasons for

this relate back to the founding principles of the NHS. Just over half (55%) say it makes them proud because it is free or affordable and paid for via taxes, while around one-third (36%) say it is because healthcare is available to everyone.

However, although the wider public think the founding principles *should* still apply to NHS services, there is less confidence that the principles *will* still apply in 5 years' time. This is particularly the case regarding the NHS providing a comprehensive service available to everyone, which half (50%) think will still be the case in 5 years.



Q. And thinking about the NHS in five years' time, to what extent do you agree or disagree with the following statements?
Base: All participants in England, adults aged 16+ (1,774), conducted online via Ipsos KnowledgePanel 23-29 November 2023

In the deliberative research, there was also strong support for the principles underpinning the current NHS model.

Discussions across the workshops reflected this pride in the principles underpinning the NHS model. When they contrasted the NHS with other potential models, they highlighted that the NHS was available to all, regardless of an individual's conditions.

> ***"It's what makes us stand out to the rest of the world, we would all be treated the same, it's worth keeping for everyone, if we have to contribute to make it work I think so."***
> *(London)*

On the whole, this meant that the current NHS model was considered to be fair – though various exceptions were identified where the NHS was not felt to treat everyone fairly and equally.

Concerns about the current NHS model were often about its practicalities rather than its underlying moral principles.

While the current model was strongly supported in principle, questions were raised about its longevity. For example, some participants (particularly in King's Lynn) thought the UK was already moving away from it to some extent (for example, with some patients having private health insurance), while a few thought it was a 'losing game' to keep funding at the necessary levels via tax.

> ***"I think it's a fallacy, I think we've already moved from it. For example, NHS contracts hip replacement to the private sector. And someone pays for it. And thinking back, if you can afford the private insurance, I'm not saying you jump the queue, in effect that's what's happening."***
> *(King's Lynn)*

Aside from practical concerns about how the NHS would be sufficiently funded, many participants thought the funding mechanism for the NHS would generate better health outcomes.

When comparing the NHS with alternative models, a common concern about the alternatives such as private health insurance or social health insurance, was the extent to which the nation's health would be determined by companies generating a profit. There was a widespread, strong feeling that the involvement of profit-making organisations in the health system would lead to poorer outcomes, with a view that these organisations would be driven by making profit rather than improving health outcomes (and limited recognition that a focus on making a profit could also lead to better health outcomes). For example, they suggested that the decision about an individual's treatment may be driven by its cost rather than by what is best for the patient (again with limited understanding that the same could happen within a publicly-funded system).

> ***"I'd rather just give money to the NHS, rather than someone profiteering off it. So that people don't go without healthcare."***
> *(Leeds)*

However, there was a further fundamental concern about the underlying principles of the current NHS model, around the implications of a perceived high level of government involvement in the NHS.

The main disadvantage of the current NHS model that participants raised was the level of political involvement in the NHS, leading to it being treated like a 'political football'. Most participants perceived that this leads to short-term thinking about the NHS and its budgets. They thought alternative systems may limit the extent to which the health system is politicised.

> ***"The French system seems the most reasonable. It takes responsibility away from government completely. We could pay into a fund, to an entity that is (inaudible) and overseeing and managing the NHS, and distributing the funds, non-political. That really is what the French system is.***
> *(King's Lynn)*

However, while they thought alternative systems may enable greater independence of healthcare from government, there were also many suggestions for how this could be achieved within the current model (please see Chapter 7 for more information).

5.3 Views of alternative potential models for the NHS

5.3.1 The current model with additional charges

Overall, participants were negative about the prospect of introducing additional charges, partly due to concerns about the impact of charges on people's health, and health inequalities.

Many participants worried that the cost of the additional charges would lead some people to delay seeking healthcare, for example by not making a GP appointment when they need it. They thought this could lead to adverse outcomes such as later diagnosis of conditions, people trying to diagnose their own conditions and getting it wrong, and less preventative care, all of which could lead to people having worse health. Dentistry was often used as an example of this, with people foregoing dental care due to its cost. A few also noted that this could lead to additional health issues (and costs) later as a result, for individuals and therefore for the NHS as a whole.

> ***"I don't think it's a good idea, because you're going to end up with people that are going to die. They're worried about the money and the cost."***
> *(King's Lynn)*

Although some participants said they personally would be happy with paying additional charges in this way, there was a common concern that some individuals would not be able to pay and therefore would not seek healthcare when they need it, which could lead to worse health impacts for specific groups within the population. This included people on lower incomes (due to charges being less affordable), men (seen as being less likely to access health services when needed anyway), and older people or people with long-term conditions requiring more frequent appointments (due to the amount that they need to use health services). This led participants to be concerned about the impact of additional charges on health inequalities.

> ***"It's creating divides. You create this divide where the rich can get all the healthcare you need but when you're poor you're just unhealthy because you can't afford it."***
> *(Leeds)*

Participants were therefore broadly supportive of the need for exemptions from additional charges. Some thought it would be sensible to reflect the current exemptions from prescription charges, and a range of groups were identified for exemptions that overlapped with those exempted from prescription charges. This included children, pensioners (or, for some, pensioners on lower incomes only), people on benefits, and people who have a disability or chronic condition. A cap on the total amount an individual would pay per year was also thought to be fair, to limit the costs for any one individual. This view on exemptions was not universal, however, with a few participants who did not think it was fair for people who could afford it to effectively be paying to cover the costs for people unable to.

These concerns were exacerbated by practical considerations about how much additional revenue these charges would raise, and how it would be implemented.

With the need for exemptions broadly accepted, many participants then questioned the purpose of introducing additional charges, pointing to the limited amounts of revenue that would be raised once the majority of the population would not be required to pay. When combined with consideration of the costs of implementation, and the presumed ongoing cost of administering a system of charges, participants commonly thought there was a limited financial advantage to introducing additional charges.

> ***"Personally I think this is completely pointless. I'd be happy to pay if that's going to work, the evidence is showing that it doesn't though. It won't change the need. The majority of people will be exempt, as from a prescription point of view. So actually is it going to make a dent?"***
> *(Leeds)*

This was exacerbated by pragmatic questions about how a system of charging would work in practice. Issues that were raised included:

- How people would know if their condition was life-threatening when deciding whether or not to go to A&E, and therefore the potential for someone to avoid going to A&E due to the charge without realising their condition is life-threatening.

- What would happen if someone had a broken leg and needed to go to A&E but did not have a GP referral, so that in a system where charges do not apply if the patient has a referral, in this example the patient would have to pay the charge.

- Whether these issues might cause strain elsewhere in the system (such as if demand on NHS111 might increase so people can get a referral because they do not want to pay for an A&E visit – in a system where charges do not apply if the patient has a referral).
- How it might feel for staff to implement it.
- What would happen if a patient was dissatisfied with their care after they had been charged for an appointment.

A few participants also suggested they would expect a better quality of care if they were directly paying for it, linked to a discussion about whether those paying the additional charges would receive a 'better' service than those exempted from paying.

However, many of the groups identified the potential to prevent 'abuse' of the NHS as a key benefit of additional charges.

While making people think twice about using health services meant that some participants worried about the impact on people's health, they could also see an advantage to this. They thought it might help to prevent 'abuse' of the NHS, for example with people missing appointments or using health services when they do not really need to. Some participants went so far as to suggest the advantage of introducing charges might be around changing patients' behaviour when using services, rather than raising revenue. This meant that the concept of charging for *missed* appointments was popular among many participants, who remained keen to reduce wastage across the NHS. While the discussions on charging for missed appointments were not detailed, with limited additional information fed in about the pros and cons of the approach, it instinctively appealed to participants as a way of improving how people use the NHS.

> ***"I also think the missed appointments is a dreadful waste on the NHS. People should be penalised for it."***
> *(London)*

As well as this, a few participants thought that charges might encourage people to live healthier lifestyles to avoid needing to pay for healthcare.

Ultimately though, the move away from the NHS's founding principles – a system where healthcare services are free at the point of use – made many participants feel uneasy.

At its heart, introducing additional charges (other than charges for missed appointments) felt like a move away from the NHS model and its founding principles, and this made many participants uncomfortable. For example, they thought it meant the NHS would move away from being free at the point of use and available to all, and would lead to inequalities in access, potentially with a two-tiered system that was felt to be inconsistent with the NHS values to which many were attached.

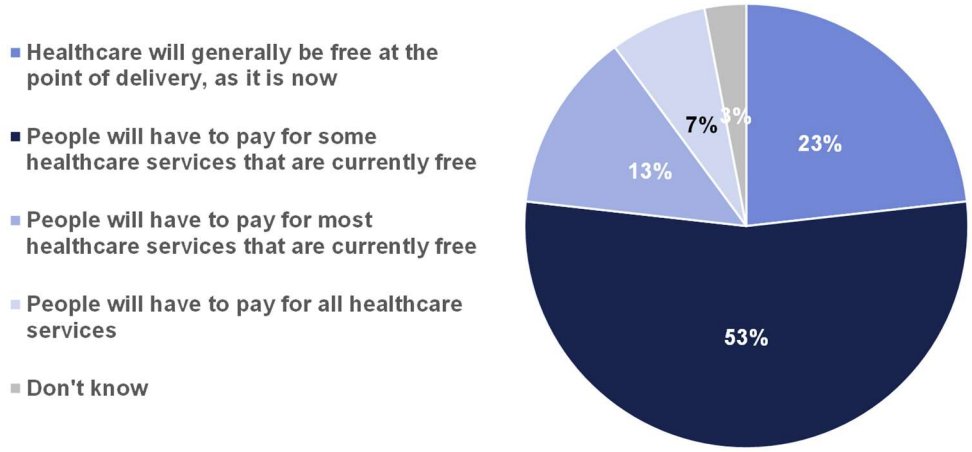
> ***"Services should be free for all. It's just not the NHS anymore."***
> *(King's Lynn)*

This added to a reticence towards introducing further charges for NHS services.

However, surveys of the wider public show they anticipate having to pay additional charges in the future.

Only around one-quarter of the wider public in England (23%) think that healthcare will generally be free at the point of delivery in 10 years' time, as it is now. In contrast, around half (53%) think people will have

to pay for some services that are currently free, 13% that people will have to pay for most, and 7% for all services.



Q. Which of the following statements best describes what you think healthcare will be like in the UK in 10 years' time?
Base: All participants in England, adults aged 16+ (1,878), conducted online via Ipsos KnowledgePanel 5-10 May 2023

This suggests that while the public are generally not supportive of this model, they think it will have to be imposed anyway in the future, speaking to their concerns about the sustainability of the current NHS model (even though it is their preferred approach).

5.3.2 Social Health Insurance

Participants were divided about the social health insurance model.

Some participants were negative about a social health insurance system, while others questioned how far it differs to the current NHS model (particularly under social insurance models that allow less choice). However, some participants were positive towards it as an alternative.

Regardless of their view of the system, for many participants it was important that if such a system was introduced, there would be reductions in tax, and that all of the population would have access to health services.

As they discussed the social health insurance model, there were clear areas that would need to be addressed if the system was to be implemented. Many participants asserted that, if they were expected to pay health insurance premiums, they would need to see taxes reduce accordingly. However, some were sceptical about whether that would happen in practice.

> ***"If social insurance is increased then tax should be reduced. Then you have to pay again. It doesn't seem fair."***
> *(London)*

In addition, as for the current system that provides a comprehensive service available to all, participants were careful to clarify that everyone would still need to be able to receive healthcare under a social health insurance model. They noted the importance of ensuring those who cannot afford a policy are covered, and mitigating against inequalities in access and quality of health services, and a potential two-tier system.

> ***"My main concern is inclusivity and those who can/can't afford it, this seems to mitigate it."***
> *(King's Lynn)*

Participants were often uneasy about the concept of choosing between different insurers and insurance policies.

When presenting participants with the details of different social health insurance systems, they were told that there were different models. For example, in the French model there is very limited choice of which insurer to use, while in the Netherlands there are many options for people to select from. Participants were shown images of a website from the Netherlands that people can use to choose an insurance policy. In this context, many participants were not comfortable with the concept of choosing between insurers and insurance policies.

> ***"I'm not a fan of all of the choice. It can be confusing. If you do a compare site for car insurance, holiday insurance, vets, it's quite confusing. You're never really sure if you've got the right level of cover for what you need."***
> *(King's Lynn)*

Concerns included the complexity of comparing insurance policies and how confusing it might be, which led them to question whether they would choose the policy that was best for them. Another common concern was what would happen if someone purchased a policy, but then something unexpected happened that they are not covered for, or if the 'small print' meant they were not covered.

> ***"From an aspect of understanding home insurance and car insurance, people don't understand it, so do we understand the nitty gritty and impact of the policy, until it comes to the crucial moment when we need the policy, do we know what we're covered for?"***
> *(Leeds)*

As a result, a few participants asserted that the public would need to be educated in order to be able to make these choices – while others thought it was a choice that people should not be expected to make, and that clinicians were better placed to make decisions about healthcare. Some concluded that they did not think an insurance model was right for healthcare in particular, making the comparison with other types of insurance such as car insurance or travel insurance to explain that. To them, they felt that 'health' should be treated differently. Some also noted that if the UK did move towards a social health insurance system, the French model would be preferred in order to limit the choices people have to make. These participants tended to see the French model as being closer to the NHS model.

> ***"And with the Dutch system, how do you choose which option to go for? We're not medically trained, do you look at reviews?"***
> *(King's Lynn)*

These views were not universal, however, with a few participants identifying potential advantages to higher levels of choice between insurers and insurance policies. This included potentially reducing prices through competition, being able to choose policies offering a better service, and being able to choose only a base level of cover for those who are healthy.

There were concerns about privatisation, profit-making and the costs to individuals under a social health insurance system.

Against a general perception that the NHS is currently being privatised, many participants were mistrustful that introducing such a model would ultimately lead to further privatisation. They did not trust that the changes would stop with a social health insurance system.

> ***"I think in theory it's good if it was like the French system and employers are putting money. But in practice it would be a back door to the American system. Those companies would lobby government and it would become more on private insurers getting a foothold."***
> *(London)*

As well as this, some participants were worried that the insurance premiums would cost more than they currently pay for the NHS via tax, and so the cost to the individual would be higher, or indeed 'spiral' over time. Finally, a few participants asserted that they would be more negative about a social health insurance model if the insurers were profit-making, invoking concerns that profit-making insurers would not have the right motivations.

There were differing views of the potential impact of a social health insurance model on employers and employment.

There were two key concerns that resonated with participants regarding employers and employment. Firstly, some participants worried about the impact of companies needing to pay towards their employees' social health insurance, both financially (particularly for small businesses) and the possible outcome of lower job creation or people being less willing to move jobs. Secondly, some thought that people may be influenced not to work if they need to pay more as a result.

> ***"I think going back to what we were saying earlier, about competitiveness in work, this could fall into the same pattern of if you are unemployed, but you get cover anyway, it's almost like you don't have that incentive to work? And it's probably going to increase cost for those who are in employment tax-wise. So does it make the work market less dynamic because of that and because people might be hesitant to move?"***
> *(London)*

Having said this, a couple of groups thought that the system might bring benefits to employers, if it could reduce employee sickness.

The key advantage that resonated with participants about a social health insurance model was greater independence of the health system from government.

Taking responsibility for health away from politicians was the most commonly identified advantage to social health insurance models, and this benefit was strong enough for some to lead them to favour the model. This view sat alongside a general tendency across groups to be mistrustful of government and politicians. Although there was also mistrust towards insurers, particularly when profit-making, there was a hope that a health system with increased independence might mean a consistent budget that enables better long-term planning.

> ***"The only tiny advantage I can see that it is independent from government control. It doesn't change with an election nor whatever."***
> *(King's Lynn)*

This positive view about independence from government was not held by all participants, with some questioning who would make the decisions if not the government, and others saying this alternative would be 'scary' or could lead to increasing costs.

5.3.3 Private Health Insurance

A healthcare system predominantly via private health insurance was considered by participants in less detail, with less information provided about what this might look like in practice (since it was not

considered likely that the UK would move from the current NHS model to a private health insurance model).

Participants tended to quickly dismiss a model based on private health insurance, with the main concern being a mistrust of profit-making companies.

The predominant concern about private health insurance was ideologically based, with widespread and deep misgivings about entrusting healthcare to companies that need to generate profit. They thought this could lead to consequences such as insurers cherry picking who they do and do not insure, greater costs for people who are unhealthy, and decisions about treatment and care that are based on cost rather than what is best for the patient.

> ***"The other thing is, insurance companies, you can't trust them. Their job is to get away with paying as little as possible. So you could have cover, suddenly be faced with a cancer diagnosis and they will look at every single aspect of your life and scrutinise it."***
> *(King's Lynn)*

However, again, a small number of participants raised potential advantages of the involvement of private, profit-making companies, such as increasing efficiency.

Some participants made comparisons with what they had heard about healthcare in the United States, in particular regarding inequalities.

The main system that participants were familiar with using this model was the United States, and they drew comparisons between the US model and the current NHS model, favouring the latter around equality and fairness in particular. For example, they were concerned about people in private health insurance systems who were unable to get insurance and the extent to which they could still access healthcare, as well as the inequalities baked in from different people being able to afford differing levels of cover.

> ***"My first thought is what happens to those that fall through the gaps? Look at America, people can't afford their healthcare."***
> *(Leeds)*

Few consistent benefits of private health insurance were identified, with political independence chief among these.

Given the stark differences between the NHS model and a model based on private health insurance, participants identified very few benefits of a private health insurance model. The main benefit mentioned by a few participants was that there would be independence from the political system. Having said that, there remained little enthusiasm for a system run by profit-making companies.

> ***"I think it's beneficial to have it taken away from the government but when you bring private companies then there will be corruption, because they will be trying to make a profit."***
> *(London)*

5.4 Key desired features of a health system in the UK

Drawing together findings from across the discussions on the current NHS model, and potential alternative models for healthcare in the UK, the following are participants' key desirable features of a health system in the UK:

- **Equality and fairness**: It was important to most participants that everyone can access healthcare regardless of how wealthy they are, and how much they need to use health services. The quality of the services available would ideally also be as equal as possible.

- **Minimal cost for individuals**: While participants generally said they were willing to pay additional in tax for a better level of service from the NHS, they still wanted this cost to be as low as possible in the context of the cost of living crisis**.**

- **Minimal political influence:** Political influence was seen as limiting long-term planning for the future of the health service in the UK, so greater independence from politics and government would bring about benefits.

- **Minimal involvement of profit-making organisations**: Participants often assumed this would lead to decisions about healthcare that are not in individuals' best interests and often assumed it would lead to higher costs.

- **Minimal administration costs**: Participants were generally less positive about systems that would have greater administration costs, wanting to keep as much revenue for directly caring for patients as possible.

- **Minimal abuse of a public system**: While participants wanted the NHS to be available to all, they also often worried about patients 'misusing' the NHS, using up resources unnecessarily, and wanted to minimise this within any system in the UK to retain revenue for where it is needed.

6 Confidence that governments are planning well for the NHS's future

This chapter of the report explores what would build participants' confidence in long-term planning for the NHS. It begins by looking at spontaneous views about what hinders and builds their confidence that emerged throughout the weekends' discussions and were then developed through a group discussion. It then moves on to present the results of a deliberation between four different approaches to building confidence that were suggested to participants.

Key findings

- From the outset of discussions, participants significantly lacked confidence in long-term planning for the NHS, and this strengthened throughout the weekend.
- Perceived declines in the quality of and access to NHS services were seen as evidence of poor long-term planning, attributed to inadequate funding and mismanagement of budgets that many participants thought had led to outcomes such as insufficient staffing and poor infrastructure.
- Participants generally thought these outcomes resulted from poor planning. They often linked this to politics – they were deeply sceptical about the political intentions of governments (for example around privatisation of NHS services), questioned whether decision-making is evidence-based, and recognised that electoral cycles could lead to a short-term view.
- Instead, participants identified that their confidence in long-term planning for the NHS would be built by long-term planning, independence of the NHS from government, greater transparency and honesty, along with more consistency in decision-makers who would also ideally have hands-on experience of the NHS.
- Four approaches that may boost confidence in long-term planning were presented to participants for consideration. Participants were particularly positive about the NHS having greater independence from government control. This was seen as an effective way of enabling more long-term planning by reducing the impact of electoral cycles on healthcare policy.
- More long-term planning via an independent commission for the NHS was also widely supported as a means to provide stability and enable strategic decision-making. However, participants recognised that this may face some practical challenges, such as adaptability to unforeseen changes and the influence of political and financial uncertainties.

6.1 Deliberation question

Alongside discussions that happened spontaneously over the weekend about participants' confidence in planning for the future of the NHS, the research aimed to present a range of options for deliberation, to understand what approaches would best build their confidence.

The question agreed for deliberation was:

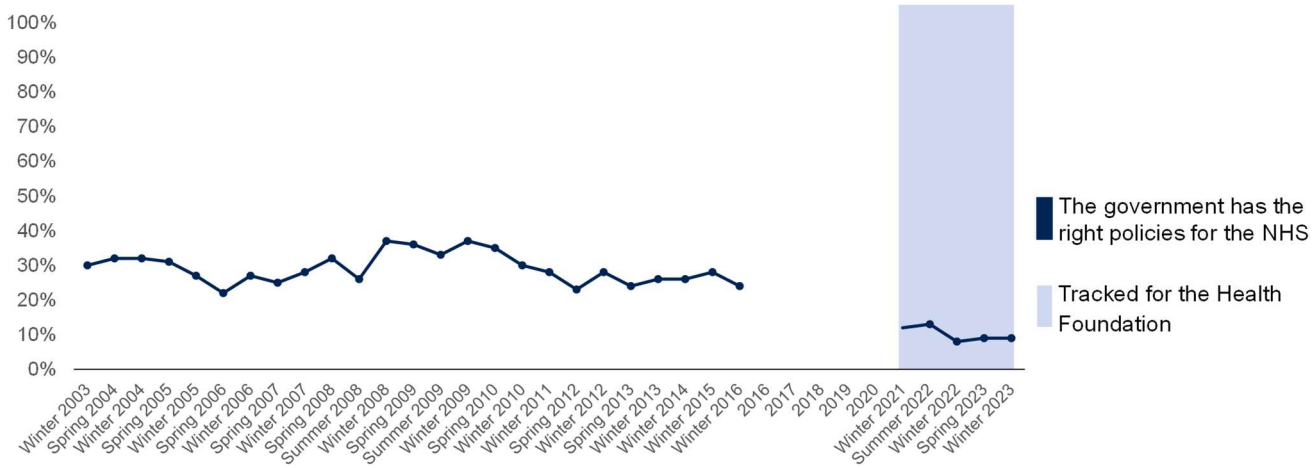
What are some approaches that a government could take to build public confidence in plans for the NHS's future?

In an initial discussion, participants made their own suggestions around what builds or hinders their confidence, drawing on their deliberations over the weekend. To aid these discussions, a representative from the Health Foundation then delivered a presentation outlining four potential approaches a government could take to inspire public confidence in plans for the NHS's future.

In this part of these conversations, participants were directed to consider governments in general, including those that may be formed in the future, and not specifically the current government. The findings are intended to highlight what *any* government could do to build confidence in plans for the NHS's future.

6.2 Spontaneous views on what hindered participants' confidence that governments are planning well for the NHS's future

The Ipsos/Health Foundation surveys suggest that public confidence in NHS planning is currently low. In Among people in England, just 9% agree that the government has the right policies for the NHS. Historically, since the question was first asked in 2003, only a minority have believed the government's policies were right. However, current levels of confidence are particularly low, especially when compared to the relative confidence observed in 2008-2009, when 38% agreed that the government had the right policies (noting a change in methodology between surveys).



*Q. To what extent do you agree or disagree with each of the following statements? The UK government has the right policies for the NHS. Base: *Winter 2003 – Winter 2016: Ipsos MORI/Department of Health Perceptions of the NHS Tracker, Adults aged 16+ in England, face-to-face, c. 1000 per wave* I KP survey, England participants Nov 2021: 1,618 | May 2022: 1,622 | Nov 2022: 1,632 | May 2023: 1,878 | Nov 2023: 1,774* ****Note: Findings from 2016 and before were collected using a different methodology, and so comparisons should be treated with caution. Findings from Winter 2021 – present were collected using the same methodology, and findings are directly comparable. Findings are for England only.***

Taking a longer-term view, three-quarters of the English public (76%) think the NHS is not well prepared to meet the increasing health demands of an ageing population. They also do not think the NHS is well prepared to respond to the impact of climate change (60%) or keep up with new technologies (50%), and are divided about its preparedness to respond to future pandemics (48% think it is well prepared; 45% think it is not). This suggests a potential lack of public confidence in the ability of government and the NHS to undertake long-term planning.

Overall, participants in the deliberative research also lacked confidence that governments had been planning well for the NHS's future, informed by perceptions of a deterioration in NHS services and an NHS in 'crisis'.

From the very beginning of the weekends' discussions, participants expressed a perception that the NHS is undergoing a crisis. They observed a noticeable decline in NHS services in terms of access and quality, with many believing that standards of healthcare have deteriorated from what they once were, whether that was at the NHS's inception in 1948, a decade ago, or even in the more recent pre-pandemic era.

> ***"What hurts my confidence is that things are visibly getting worse than it was years ago. There's more striking, I'm not getting appointments that are crucial, I'm not being able to get my medication, these are things that impact on me."***
> *(Leeds)*

Participants frequently recounted personal experiences such as rescheduled appointments, a discourteous service from staff, and prolonged waits for medical treatment, which contributed to the view that NHS services have deteriorated. They also regularly referenced 'nightmare scenarios' and anecdotes involving acquaintances or stories they had come across in the media, where misdiagnoses or inadequate care had resulted in ongoing health complications or even patients dying.

This perception of a 'crisis' in the NHS prompted most participants to doubt the effectiveness of planning for the NHS's future. They questioned why no measures were being taken to reverse the declining quality, and speculated that standards would be allowed to deteriorate even further in the future.

Participants in the deliberative workshops often highlighted inadequate funding and mismanagement of budgets as a key way in which planning had been poor, which then had wider impacts on standards.

A recurring theme was the adverse effect of inadequate NHS funding over the past decade on service quality. Examples included:

- A lack of strategic investment in staff, covering areas like training and wages, has caused discontent among existing staff. This, they feared, may lead to a departure of the most skilled healthcare professionals, including doctors and nurses. They also felt that this underinvestment hindered the recruitment of new staff to fill existing gaps in the workforce. In their view, these staffing challenges compromised patient care, resulting in longer waiting times and hurried patient care.

  > ***"What hits my confidence in the NHS is the strikes. You worry about being seen by doctors and nurses. Of course, they're entitled to strike and I support them, they deserve a better wage after all, but the rest of us do worry. They know best and they're striking."***
  > *(King's Lynn)*

- A widespread sentiment that NHS infrastructure has suffered from underfunding. They thought this had led to outdated hospital equipment, capacity issues, inadequate computer systems, and problems with building maintenance.

Participants were often deeply sceptical about political influence over the NHS, and this strongly impacted on their confidence in planning for the NHS.

During the discussions, particularly those concerning the NHS's financial status, many participants expressed profound scepticism about political interference in the NHS. This distrust in political motivations played a significant role in shaping their confidence, or lack thereof, in future planning for the NHS.

"When the politicians talk, you just can't believe anything that comes out of their mouths. I've got no trust in anything they say to be honest […] They've had three different health ministers over the past few years. One of them looked like he cared a bit, he was actually working in hospitals as well. It's the political system that's wrong."
(Leeds)

Specific ways in which political involvement in the NHS hindered participants' confidence in long-term planning for the NHS included:

- A common opinion that evidence-based decision-making often took a backseat to political ambitions and ideologies. This was why the health service had, in their view, been so underfunded for the past decade, and why participants felt they couldn't trust the same people to plan for the NHS's future. Linked to this, they perceived that politicians prioritise motivations such as vote-gathering over patient outcomes. As one group put it, they would go for the 'shiny new toy they could show off', over more understated policy that would actually make the biggest difference.

  "Austerity. They decided that health of patients wasn't the priority and they cut back on the infrastructure and now we're reaping the rewards of that. The NHS can't cope with the situation […] how can we trust them?"
  (King's Lynn)

- A perceived short-sightedness in policymaking, was attributed to political ambitions and electoral cycles. This narrow outlook by the political figures in charge of the NHS's funding and direction was seen to lead to erratic policy changes and an inability to devise and adhere to comprehensive, long-term healthcare strategies, which was ultimately harming the NHS.

  "What makes me nervous is, when we come up to elections, manifestos and government promises. They'll have a manifesto, if they get in, they don't follow their manifesto. You've got the shadow secretaries, it doesn't matter what one person says, the other one has to argue. It just seems bonkers. If they could agree a bit more, I would have a bit more faith."
  (King's Lynn)

- Many participants were worried about the political parties, especially the Conservatives, moving the NHS towards privatisation. They felt this could lead to unequal service quality and availability, similar to the US healthcare system. There was a common belief that the government wasn't being fully honest about privatisation plans, as some individuals in government stand to profit from it. This added to the general distrust towards any government's management of the NHS.

  "[What stops confidence in the NHS is] parties with their own political agendas. Some of what the MPs are lobbying for is to do with privatisation, they have done that to many of our services since Thatcher. I don't trust them to run it […] also handing stuff over to their friends."
  (London)

There was an infrequent view that the media narrative emphasises negative elements of the NHS or promotes political agendas.

A small number of participants also raised the perception that the media often acted as a platform for political parties to push their agendas, including pro-privatisation narratives. It was felt that this further diminished public confidence in the NHS as they weren't seeing 'the real picture'. It was felt that the challenges within the healthcare system were being exploited by the right-wing media.

It was felt that the media deliberately fostered a negative perspective of the healthcare system by focusing on the NHS's present shortcomings, such as bed and staff shortages, extended waiting periods, and industrial action. These participants noted that the media's preoccupation with these issues and sensationalist reporting, without a balanced representation of positive developments or successful outcomes, furthered the impression of deteriorating service quality and eroded trust in the NHS.

> ***"I don't know why it wasn't something we were told about in the media. I didn't know about these kinds of things at all. That's why we don't have any trust in the NHS, I don't know about them."***
> *(King's Lynn)*

The narrative cultivated by the media eroded public trust in both the NHS staff and those managing the service, causing them to question the adequacy of the service and the competence of those making future plans.

6.3 Initial views on what would help build confidence in governments' plans for the future of the NHS

Participants at the discussions proposed various measures to rebuild public confidence in the NHS's future planning, advocating for a more strategic and autonomous NHS.

Before receiving detailed information on four specific approaches that may boost confidence, participants spontaneously offered their own suggestions for what would enhance their confidence in governments' future planning for the NHS. Starting with the most commonly discussed, these included:

- **Long-term planning**: Participants consistently – and from the very beginning of the weekends' discussions – expressed the need for long-term planning in the NHS, stating that short-term political considerations should not influence decision-making processes. They felt that decisions around issues such as the ageing population or the development of new hospitals should be made decades in advance in order to be effective, and not just within election cycles.

  > ***"We need more long-term thinking to boost confidence. They are going to think about the next two years. You need someone who is in the direct position, someone being there making these decisions in the long-term. Like a government person appointed to be there for five years."***
  > *(Leeds)*

- **Importance of hands-on experience in healthcare leadership:** Many participants believed that leaders with direct experience in healthcare would be more effective in making decisions for the NHS than the people who often become politicians and ministers who participants thought not have the required knowledge of the NHS.

  > ***"One of the things that would make me feel happier would be if they had people in there that knew the jobs, people who had worked on the floor and knew how it should be run as opposed to businessmen and bankers who understand money, but don't understand what the job entails and what the job needs. I think more hands on."***
  > *(King's Lynn)*

- **Independence from government:** Participants in the discussion continually conveyed a strong desire for the NHS to gain greater independence from governmental control, aiming for a healthcare system that prioritises patient needs and long-term planning over short-term political objectives. They suggested that an autonomous NHS could more effectively focus on stable,

consistent healthcare delivery, and advocated for the establishment of an independent commission or trust to guide the NHS.

"It's not that I don't trust the NHS but they are heavily controlled by the government and I don't have much faith in the government, especially how they handled the Covid situation, it was corrupt. I like [… the] idea of having an independent body to govern things. It's not the NHS that I don't have faith in. Apart from some of the deplorable people that work there, the other people were amazing. It's governed by a body I just don't have faith in."
(London)

- **Consistency and continuity in decision-makers:** A handful of participants in the discussions expressed a strong desire for greater consistency and continuity in the NHS, driven by concerns that frequent policy changes and government turnovers hinder the development and execution of effective, long-term healthcare strategies.

"With ministers changing around all the time. What do they need to change in that role? It's a ridiculous system."
(London)

- **Transparency in funding and spending:** Some participants highlighted the need for clear and direct information regarding the financial management of the NHS. They suggested that publishing comprehensive reports on how funds are allocated and spent would be crucial for public understanding. This transparency was expected to lead to increased trust in how the NHS is managed and confidence in the decisions made for its future.

- **Honesty:** Participants emphasised the importance of honesty from government officials and healthcare leaders when communicating about the NHS. They believed that honest discussions about the challenges faced, the limitations of resources, and the true impact of policies on healthcare services are essential for building public confidence regarding planning. Participants wanted leaders to acknowledge past mistakes and provide clear, factual information about the NHS's direction, avoiding political spin or manipulation of statistics. They stated this approach would foster a more trusting relationship between the public and those managing the healthcare system, leading to greater engagement and cooperation in the future.

"I think more honesty. Even if it's not what we want to hear, tell us what is going on. Tell us the truth so we know what we're dealing with."
(Leeds)

- **Local decision-making:** For a small number of participants, there was an unprompted desire for more localised control to meet specific area needs, particularly in King's Lynn and Leeds. This would build their confidence because those planning services would do so based on their local areas and populations.

- **Independent analysis and advisory bodies:** A handful of participants called for the establishment of an independent entity to advise the NHS. They suggested that such bodies could offer unbiased, expert advice on healthcare strategies, helping make decisions based on best practice and evidence rather than political expediency. The participants saw these bodies as pivotal in breaking the cycle of reactive policymaking and fostering a more strategic, future-oriented NHS.

- **Accountability:** A small number of participants expressed the need for measurable outcomes and performance targets within the NHS. They thought that, by setting clear goals and publicly reporting on progress, the NHS could demonstrate its commitment to improvement and provide a basis for accountability.

6.4 The deliberative discussion

As previously noted, the discussions finished with a deliberative question:

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

To support the discussion, the public were presented with four approaches that any government could take to boost confidence in long-term planning for the NHS. Participants were provided with the overall purpose of each approach, their pros and cons, and real-life examples of how they had been applied within the UK:

1. Incorporating more long-term thinking and planning into decision-making via an independent commission or review.
2. More public engagement to inform decisions.
3. Giving the NHS greater independence from government.
4. Greater devolution of decision-making.

These discussions took place at the end of the weekends, giving participants time to reflect on earlier presentations and integrate all they had learned and discussed. However, this timing limited the opportunity for in-depth discussion on each individual option. Consequently, participants often considered the four options together, comparing them and discussing how they might complement each other.

6.4.1 Preferences between different approaches for building confidence

As the discussions concluded, facilitators encouraged each participant to vote for their preferred approach, as shown in the following table. Generally, participants had little difficulty selecting at least one option, as the proposed strategies resonated with their personal perspectives on how to enhance NHS planning and bolster their confidence in its future. However, in almost all cases, participants struggled to choose one single approach, as they either favoured multiple options or believed these strategies could effectively work together.

Across the three weekends, greater independence of the NHS from government and long-term planning via an independent commission or review were identified as the approaches that would most build their confidence in governments' planning for the future of the NHS.

Workshop	Groups (1-3)		
King's Lynn	Independent commission or review	Independent commission or review/ Devolution	Public engagement
Leeds	Greater independence of the NHS from government	Devolution	Greater independence of the NHS from government
London	Greater independence of the NHS from government	Independent commission or review/ Greater independence of the NHS from government	Greater independence of the NHS from government

The remainder of this chapter presents participants' perspectives of the advantages and drawbacks to each approach.

6.4.2 Giving the NHS greater independence from government

Participants strongly advocated for the NHS's independence from government control.

Even before the presentation, most participants had asserted a preference for the NHS to have greater independence from government influence. When further considering the idea with some additional information about what this might look like (such as giving NHS England even greater independence from government), and some of the potential pros and cons, many participants concluded that greater independence could lead to more stable and consistent long-term planning, less susceptible to the volatility of political cycles.

> ***"You have to make the NHS independent. There are no ifs and buts with that. It's a political football. Yes, we vote in politicians, but they can change their views at any point. So, it has to be independent."***
> *(King's Lynn)*

Some suggested a non-political entity like an independent commission, regulation or trust board to oversee the NHS on an ongoing basis, with the hope that this would provide unbiased planning and potentially improve the quality and equity of healthcare services.

> ***"There needs to be an entity to oversee it all that's non-political. I think the NHS does need greater independence from government."***
> *(King's Lynn)*

The advantages of greater independence that particularly resonated with participants included:

- **Professional leadership:** It was felt that greater independence would better enable their preference for the NHS to be led by people with hands-on healthcare experience.

- **Autonomy in decision-making:** They thought the NHS would be able to make decisions more swiftly and efficiently, without the constraints of political processes or changes in government, leading to better responsiveness to healthcare needs.

- **Focusing on patient care:** With greater control over its operations, many participants thought that the NHS could prioritise patient care and outcomes over political considerations, potentially improving NHS services.

- **Long-term planning:** Participants often thought that independence would facilitate consistent long-term planning, free from the influence of electoral cycles, and allowing the NHS to implement strategies that are not subject to short-term political goals.

  "If we have greater independence, we might have more long-term thinking anyway really. We'd be free from politicians."
  (Leeds)

- **Reduced bureaucracy:** Some participants theorised that less government oversight could result in a reduction of bureaucratic obstacles, enabling a more streamlined healthcare system that can focus on delivering care instead of navigating administrative hurdles.

- **Tailored healthcare:** Some participants expressed the belief that an NHS autonomous from government could potentially decentralise some decision-making processes to the local level. This could result in healthcare services that are better tailored to the specific needs and preferences of diverse regions.

Although there was general endorsement for greater independence, participants also had several apprehensions about the implications.

Participants raised concerns about the extent to which independence was feasible and the potential unintended consequences of greater independence that may need safeguarding against. Though many still favoured greater independence regardless, this was not universal. Concerns included:

- **Accountability:** There were worries that without government oversight, it might become more difficult to ensure the NHS is accountable to the public and that standards of care are maintained across the board.

  "I think it's not a bad idea, the only thing is what are you building? And in 10 years' time are you building a pseudo government that is just as bad? A different body with a different name."
  (London)

- **Continued ties with government due to funding:** Some participants voiced apprehensions that with increased autonomy, the NHS might grapple with uncertainties surrounding its financing. They noted that without privatisation, the NHS's revenue would always be tied to the government, implying perpetual influence and dependence.

  "Ultimately, wouldn't this go back to the government because that's where the money came from? How do you stop that?"
  (King's Lynn)

- **Policy fragmentation:** There was a risk highlighted that an independent NHS could create policies that do not align with other sectors, such as education and/ or social care, which they thought might lead to greater inefficiencies.

- **Postcode lottery**: Some participants expressed concern that if an independent NHS was created at a more local level and policies were not joined up by national organisations, then there was potential for a 'postcode lottery', where the quality and availability of healthcare services could vary by location, which they generally did not want to happen due to wanting equal services.

- **Implementation challenges:** Concerns were raised about the practical challenges of implementing greater independence, including how to maintain funding streams and manage transitions without disrupting service delivery.

  "I'd really like to see more independence. I don't think it's possible though. How would it actually work?"
  (Leeds)

6.4.3 More long-term thinking and planning in decision-making via an independent commission or review

Many participants broadly expressed support for an independent commission or review in order to help the long-term thinking and planning that was so important to them.

As mentioned already, throughout the discussions participants had voiced significant, unprompted support for a move towards more long-term planning. One of the suggestions to them was for a one-off independent commission or review to provide neutral, informed recommendations for a long-term approach. Participants highlighted numerous benefits of adopting this type of approach:

- **Support for independence:** Overall participant support for independence has already been established, and this was also seen as a strength for an independent commission or review, allowing a focus on the long-term needs of the NHS with less susceptibility to short-term political agendas.

- **Expertise in leadership:** The opportunity for such a commission to have expert input was seen as a strength, as it would ensure that decisions are informed by deep knowledge of the system.

- **Consistency and stability:** It was felt that such an approach would offer a more stable and predictable direction for the NHS, including with regards to budgets, which was seen as essential for maintaining the momentum of healthcare improvements over time.

  "We have seen a lot of policy changes, it feels like a lot is suddenly undone and you think, I don't understand how that is possible. That's where the lack of trust comes […]. We need to look at 10 years plus, plan for 2030, and moving to 2035. It needs to be longer than they are in term for [...] then it becomes more than a sticking plaster."
  (London)

- **Strategic decision-making:** A few participants thought a longer-term approach could allow for a more thorough evaluation of healthcare initiatives and their outcomes, which could lead to more effective healthcare delivery. It was hoped that such an approach would encourage policymaking grounded in data analysis and evidence-based strategies.

- **Addressing systemic issues:** Some participants expressed their belief that a long-term approach could help the NHS tackle its multifaceted challenges. They discussed existing issues

such as staff shortages, infrastructure requirements, and the need for service integration. The consensus was that these problems cannot be resolved overnight, but rather necessitate consistent effort and long-term planning.

- **Predicting resource allocation:** With a long-term plan, the NHS could better predict future healthcare demands and budget accordingly, potentially avoiding redundant spending and improving the system's financial health.

- **Transparent operations:** Some participants felt that the commission would operate transparently by publishing its work. This would mean they could hold the government accountable, as well as providing the public with clear information about NHS direction and funding through the report.

Despite these positives, some participants had reservations about how this approach would work in practice, while others identified potential negative consequences.

Even though many participants recognised the benefits of a long-term planning approach via a commission or review, some also offered a pragmatic evaluation of its difficulties, though they were generally still in favour of the approach overall. Examples of challenges to the approach included:

- **Potential for bureaucracy**: There was a perceived risk that creating an additional independent review could introduce more bureaucracy into the healthcare system, potentially slowing down decision-making processes.

- **Potential rigidity:** It was felt by some that long-term plans may lack the flexibility needed to adapt to sudden and unexpected changes, which could make them less effective over time. Examples of this included reacting to unforeseen events, such as pandemics.

- **Complexity in implementation**: Establishing and coordinating a new commission or review process could be complex and might encounter resistance from existing structures and stakeholders.

- **Resource allocation**: The resources required to establish and maintain such a commission, including financial and human capital, might be significant, and some participants questioned if these resources could be better used directly within the NHS.

- **Forecasting difficulties:** Accurately predicting future healthcare needs and trends is fraught with uncertainty, and there is a real risk that predictions may not match reality, leading to ineffective plans or resources allocated ineffectively.

  "We're in the state we're in now because Covid hit, this [The Wanless Review] is a 20-year review from 2002. That would never have predicted what we were going to go through. I'm wondering if it's as beneficial as it would seem. It's costed us a lot of money."
  (Leeds)

- **Political and financial uncertainties:** A long-term plan could be disrupted by other shocks as a result of shifts in government policy or external shocks such as wars or financial crashes, potentially making any long-term planning challenging.

- **Opportunity costs:** One group discussion noted that by focusing on long-term planning, immediate issues might be neglected in favour of the established plans in place, and the system might miss out on short-term opportunities that could yield benefits.

  "Because of the nature of government, we should focus on the short-term and hopefully that will lead into the long-term pretty much taking care of itself. Waiting lists need to come down in the short-term, there is no point planning for five years' time."
  (Leeds)

Very few participants knew about the examples shown in the presentations, the 2019 NHS Long-Term Plan or the 2002 Wanlass Review, which led one group to speculate whether the decline in the standards of care in the NHS since 2012 was indicative that such an approach didn't work. Others believed that the existence of long-term plans indicated that such planning was already integral to the NHS. They suggested that further publicity of these plans could enhance public confidence in the system.

"There is an element of we're all upset with the NHS as the government isn't doing what it is doing, but there is an element of planning in place right now, right? It takes time for things to filter through. Are there actually long-term plans in place, but we don't know about them?"
(King's Lynn)

6.4.4 More public engagement to inform decisions

Participants generally agreed that increased public engagement in NHS decision-making could enhance decisions and representation.

Participants largely concurred that, if done correctly, enhancing public engagement with the NHS could foster a positive impact, potentially bolstering the trust between the community and the healthcare system. They felt that being included in the decision-making process and having their contributions valued would likely increase their confidence in the system's objectives and functions.

Participants also noted the following benefits to increasing public engagement in decision-making:

- **Enhances decisions and representation:** Involving the public in decision-making would provide the NHS with valuable insights into the public's concerns and experiences regarding healthcare services, which would help to ensure healthcare decisions reflect the diverse needs and preferences of the specific communities they serve, whether that be locally or nationally.

  "It would give them [the government] more of an idea about what we say and what we want – it might actually aid their long-term planning."
  (Leeds)

- **Encourages innovation:** Some participants thought that public engagement would allow the NHS to tap into a broader range of experiences and expertise beyond what is available within the healthcare system itself. This can lead to more innovative and effective solutions to healthcare challenges, as a variety of perspectives and ideas are considered and incorporated.

  "More public engagement would be my vote. It can help politicians understand the public needs and encourage them to make the difference. The public sometimes know things the politicians don't."
  (Leeds)

- **Empowers communities:** Some participants thought that public engagement would empower communities by giving individuals the opportunity to contribute to discussions about their healthcare. They also felt that decisions made by the NHS that involve public input are often perceived as more legitimate and fair, particularly when the decisions are difficult or controversial. Public engagement could therefore foster a sense of ownership and responsibility, potentially leading to increased civic participation, a stronger connection to local healthcare services and greater support for new policies and practices.

- **Increases accountability:** Some participants believed such an approach would mean the NHS becomes more accountable for its actions and decisions when the general public is given a role in governance, as the process would become more transparent.

While public engagement in NHS decisions was seen as beneficial, participants had some concerns, which ultimately meant it was less favoured as an approach to improving confidence in planning.

Many participants acknowledged complexities with increasing public engagement in NHS decision-making, questioning its practical application and whether their contributions would genuinely impact decisions made by those in power. Challenges included:

- **Non-obligatory:** Some participants pointed out that the government could merely disregard their recommendations in any engagement process. Individuals remarked that the NHS already enjoyed substantial public support, yet the government continued to underfund it. They struggled to see how additional engagement would shift the status quo, fearing it might merely serve as a 'tick-box exercise' for image enhancement.

  "Look at Covid when they said it'd be evidence led, run by the scientists, but the politicians ignored them in the end and played a game."
  (King's Lynn)

- **Complexity of healthcare decisions:** There was a concern that it might be difficult for the public to understand technical and specialised information, which could lead to misinformed, or oversimplified contributions to the discussion.

- **Issues with representativeness:** It was felt it would be difficult to ensure that the voices heard are truly representative of the entire population. Discussions noted a risk that only the most vocal or engaged individuals participate, which could skew the direction of planning towards their interests rather than the broader needs of all constituencies.

  "As long as you get a mixed section of society representing all different views, poorer, politically savvy, those who use NHS a lot, those who use less."
  (London)

- **Requires significant time and resources**: A common issue raised in the group discussions was that public engagement requires significant time and resources to be done effectively. It was noted that to do so involves a lengthy process to solicit, organise, and incorporate public input into decision-making, which could slow down the implementation of necessary changes.

  "I've been really impressed by going from ourselves and our own experiences, and taking in our broader view, but that has taken time. Would we have that time in these meetings?"
  (King's Lynn)

- **Might lead to conflict:** Some participants thought that public engagement might sometimes lead to conflict or disagreement among stakeholders, which can be difficult to manage and resolve. Navigating diverse opinions and finding a consensus that satisfies all parties can be a complex and contentious process. There was a concern in some groups that it would lead to no real answers, or potentially a watered-down approach that actually didn't benefit anyone.

- **Risk of disillusionment or cynicism:** Finally, a number of the groups raised the issue that if the public is engaged with, but then feels that their input is not genuinely considered or if they do not see the results of their engagement reflected in the outcomes, this could undermine trust in the NHS and erode the perceived value of public participation.

- **Importance of engagement with NHS staff:** Some participants raised the importance of engaging individual employees within the NHS in policy-making, either as an alternative to, or at the very least, alongside public involvement.

> ***"Public engagement is helpful, but if they're not listening to subject experts why would they take notice of what we the public have to say. It's the staff that need a voice."***
> *(Leeds)*

6.4.5 Greater devolution of decision-making

There was some support for greater devolution of decision-making as a potential approach for building confidence in long-term planning for the NHS.

Some individuals were in favour of a devolved NHS structure, as they believed it could lead to healthcare that is more tailored to the specific needs of each area and that local decision-making could be more responsive. This was particularly the case in Leeds and King's Lynn, due to a perception that health services were less well-funded or less maintained than other areas of the country, such as London.

> ***"I like the devolution idea, that each area like Yorkshire, Lancashire are allowed to get control of the money. Cause obviously they will put their money into the areas where they know they need it."***
> *(Leeds)*

Other examples of the potential benefits of a devolved health system that resonated with participants include:

- Fostering innovation through more experimental approaches that could be tested and adopted quickly at a local level.

- Empowering communities and local health professionals by giving them a greater say in how healthcare is delivered, which could increase engagement and satisfaction.

However, many participants expressed concerns about the devolution of decision-making for health services and concluded that it was not their preferred approach to building confidence.

A range of concerns were raised about the concept of devolving healthcare systems to a more local powerbase, which led many participants to become decidedly less enthusiastic about the approach:

- A very common concern among members of the groups was the fear of creating a 'postcode lottery,' where the quality and availability of healthcare services would vary greatly depending on someone's location.

"I would be a bit wary of it turning into a postcode lottery of services. I don't like to hear of people that can't have certain treatments or medicines, because they live three miles this side of the border."
(King's Lynn)

- For some, there was also mention that devolution might just lead to the same politicians and bureaucrats running healthcare, albeit on a local level instead of a national one. They also thought it could create greater bureaucracy and less accountability.

  "Councils are still political […] they still waste a lot of money on rubbish. I already see councils favouring one area over another. So, if you give them more power you will see certain hospitals favoured or whatever. I don't like the types who go into councils."
  (King's Lynn)

- Others were concerned with the idea that devolution would not work when people sometimes have to travel for healthcare anyway, such as having a complex operation at a national hub. They worried that funding would become complex, or they might lose access to some services.

  "I had a problem with my father-in-law who came down for Christmas and needed his eye looking at and they said they can't do it because it costs money and he is a different local health authority. How much more is that going to happen with devolution?"
  (London)

- Discussions also touched upon the idea that devolution could lead to increased local financial burdens and potentially exacerbate existing local disparities. Some participants worried they might end up having to pay more.

  "I think deprived areas have greater health issues. Whereas more affluent areas generally are healthy and will have less of a strain. The gap between the social groups is going to grow more and some areas will end up paying more as a result."
  (London)

- A few participants were concerned that devolving healthcare could lead to increased complexity and potential duplication of services, which might result in inefficiencies and increased costs.

  "Devolution is a very expensive thing to do. Just better organise what's already there."
  (King's Lynn)

- A few participants also raised that the coordination of national health initiatives and responses to pandemics or emergencies could be more complicated with a devolved system.

7 Conclusions

Early discussions confirmed a connection to the NHS model and its founding principles, though participants were worried about the future.

Participants remained strongly bought into the current NHS model throughout the deliberations, a view maintained from the outset through to latter points in the process when further consideration had been given to alternative models for healthcare in the UK. This also aligns with wider public support for the founding principles of the NHS from the Ipsos/Health Foundation surveys. The current model fulfils participants' values through being largely free at the point of use, available to all, and paid for via taxation – leading to broad equality in care (albeit that participants recognised that there are exceptions to this, and with limited initial knowledge of the health inequalities that exist in the UK).

However, participants were fearful about the future of the NHS and the sustainability of the current model. They also embarked on the discussions with a fairly negative view of the NHS at the moment, perceiving there to be poor access to a range of services, declining quality of care and too much inefficiency within the system.

They already had some understanding of the challenges facing the NHS, though they were shocked and angry when given information about the extent of these issues.

Participants had a fairly nuanced view of the challenges facing the NHS before any additional information had been presented to them, built from a combination of their own experiences, what they had heard from others, and what they saw in the media. This included inadequate funding, mismanagement of funding, staffing challenges, and the ageing population – challenges that many thought pre-dated the Covid pandemic, albeit that the pandemic had exacerbated these issues.

The understanding of the challenges also meant that participants often recognised that it would take time to address the NHS's challenges. They also wanted to see change in the NHS. This was about change within the current system rather than more radical transformation – evidence suggests that we are not yet approaching a tipping point at which NHS performance is so poor that the connection to the founding principles is eroded.

However, despite having a fairly nuanced understanding of the challenges facing the NHS, they were often shocked and angry when given information about the extent of these issues. There were also misperceptions about some of the challenges participants thought the NHS is facing, such as views that there are too many managers in the NHS, that too much is spent on healthcare for migrants or tourists to the UK, and that the service is being privatised.

Overall, improving service levels was important to participants even if they had to fund additional NHS funding through increased taxation – but there were some important caveats to this.

One of the reasons for the deliberative research was to be able to share more information with a group of the public and push them to make trade-offs about what they want, more realistically reflecting the constraints that policymakers are grappling with. For example, pushing them beyond a belief that the NHS needs to improve services but without being given any additional funding. When presented with the trade-off between the level of services the NHS is able to offer and the level of funding participants were willing to put into the NHS, many participants wanted the NHS to deliver better services than at present and therefore said they would be willing to pay additional tax in order to achieve this. They tended towards opting for the higher level of improvements in services (and therefore a higher level of tax) – though neither of these views were universal.

However, they very much struggled to accept that, to achieve those higher levels of service, the only option was to increase funding via taxation of individuals, particularly in the midst of a cost of living crisis which loomed large in discussions about increased funding for the NHS and cannot be overlooked. If taxes were ever going to be raised in order to increase funding for the NHS, based on this research there are reassurances that the public would need and specific things they would need to see in return.

There was limited consensus around *how* additional funding for the NHS should be raised.

Participants wanted any tax rises to be fair, but they had different narratives on what constitutes fairness. Their overwhelming concern was the impact of additional taxation on individuals and households in the context of a cost of living crisis. This led the discussions about how additional revenue could be raised to conclude that a combination of different approaches is needed in order to spread the burden. For example: to include businesses as well as individuals (as an earmarked tax raised via National Insurance would); to allow some level of choice over how a tax increase impacts an individual (as participants thought an increase in VAT would, as people have some control over their spending); or by impacting more on higher earners (as income tax would). They also questioned whether additional funding could be raised via other mechanisms such as corporation tax, or moving public spending from other areas such as defence.

There was a strong view that the NHS could, and should, improve how it uses resources through reducing waste and inefficiency and organising resources across the NHS differently, to help address its challenges.

One particular area where reassurances would be needed if funding for the NHS is to be increased, is the way in which the NHS uses its resources, an issue that repeatedly dominated discussions in different ways. This includes how efficiently funding is spent and how resources are organised across the NHS. Participants in the deliberation sometimes began with a view that improving how resources are used in the NHS would be sufficient to bridge the gap to the additional funding that the NHS would need to improve service levels.

Concerns about waste and inefficiency emerged as being particularly important to address. Aside from what they read or heard in the media, participants gave multiple examples of where they personally, or those close to them, had experiences where they thought the NHS could use resources more effectively. Drawing on these experiences, and their views more generally, they gave a wide-ranging set of practical examples where they thought NHS resources could be used more effectively, as well as having potential benefits for patient care and outcomes.

Examples included improved administration, for example so patients do not receive letters about appointments after the appointment date, and actions related to NHS staff, such as improving retention so that experienced clinical staff continue to work in the NHS rather than needing to train up new people. However, they struggled to accept that these ideas would not release sufficient funding to address the issues they identified.

Many participants favoured a rebalancing of the focus towards primary and community care, away from hospital care, partly because they thought it would reduce demand and so be a better use of resources.

Another clear example of where participants often thought resources could be used better was a shift in focus away from hospital care and towards primary and community care. This was partly because participants were particularly experiencing issues with access in primary care at the moment. However, they were also strong advocates for improved prevention, and early diagnosis and treatment, to reduce demand and lead to fewer patients needing hospital treatment. Despite generally wanting a greater focus on primary and community care, they often also asserted the importance of hospital care given that it

impacts on patients with acute needs, and therefore did not advocate for a sole focus on primary and community care.

As part of the same discussion, participants generally had an understanding to some extent that the different parts of the NHS system work alongside each other, and an issue in one part of the NHS can impact elsewhere. They were keen to address the root causes of the challenges facing the NHS, recognising that an issue in one part of the system may be best solved by addressing a challenge in a different part of the system. For example, focusing on better systems to direct patients to the most appropriate service if they do not need A&E rather than putting more resource into A&E to address long waits.

The importance of reducing the pressure on frontline NHS staff, along with improving morale (for example through better working conditions and pay), was a common thread throughout discussions.

Conversations about frontline staff within the NHS were prevalent across discussions. Increasing the number of staff, and reducing the pressure on staff, were often priorities for participants (as is also seen in the Ipsos/Health Foundation surveys of the public). This was seen as central to addressing some of the sources of their dissatisfaction with the NHS, such as poor access and feeling like healthcare professionals were rushed resulting in declining quality of care. They thought that addressing challenges around NHS staff would improve confidence in the NHS and how it is being run, as well as improving patients' experiences and outcomes. The deliberative research suggests that, without evidence of this being addressed, it would be extremely difficult to build confidence in the future of the NHS.

Overall, to secure the future of the NHS, long-term planning was seen as both critical and currently lacking, impeded by political involvement in the NHS of which participants were very mistrustful.

There was a strong feeling that there is insufficient long-term planning for the NHS from the outset of discussions, before any information was presented to participants. Hearing more detail about the exact challenges facing the NHS only exacerbated these worries, while also angering participants due to what they saw as a lack of planning.

Participants often blamed politics for this lack of long-term planning. They were deeply mistrustful of governments and the short-term approaches that they felt electoral cycles encouraged. Greater independence of the NHS from government emerged as the key approach that would build participants' confidence that governments are planning well for the future of the NHS, alongside long-term planning via an independent commission. This was important to many participants, so that the NHS is protected for future generations.

Participants wanted to protect the current NHS model for future generations, rather than considering the alternative models of having additional charges or introducing a system with social health insurance.

A system comprising the current NHS model but with additional charges was largely unpopular among participants. It felt like too much of a move away from the principle of health services being free at the point of use, and many participants worried about the impact of this on health inequalities if some individuals did not access health services as a result of charges. While charging for *missed* appointments were not the focus of the discussion, and the pros and cons of this approach were not presented to participants, the idea was championed by some participants, since it resonated with their sense that some patients 'abuse' the NHS.

Participants were more divided about a social health insurance model, with the idea of purchasing insurance for health worrying to many. For example, they were concerned about how they would select the best policy and what would happen if they had a condition that wasn't covered. In this context, the

concept of choice generally made them feel uneasy, with too much pressure on them to make the ‘right’ choices without having all of the understanding and knowledge they felt they needed. This led some to conclude that, if there were a social health insurance model, they would prefer a model similar to that in France, where there is limited choice across insurers. Participants were also sceptical about the involvement of profit-making companies in health and the impact this would have on patient care, as well as it potentially being the start of greater privatisation. However, a significant positive to this model was greater independence of healthcare from politics, identified as being a major downside to the current NHS model.

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