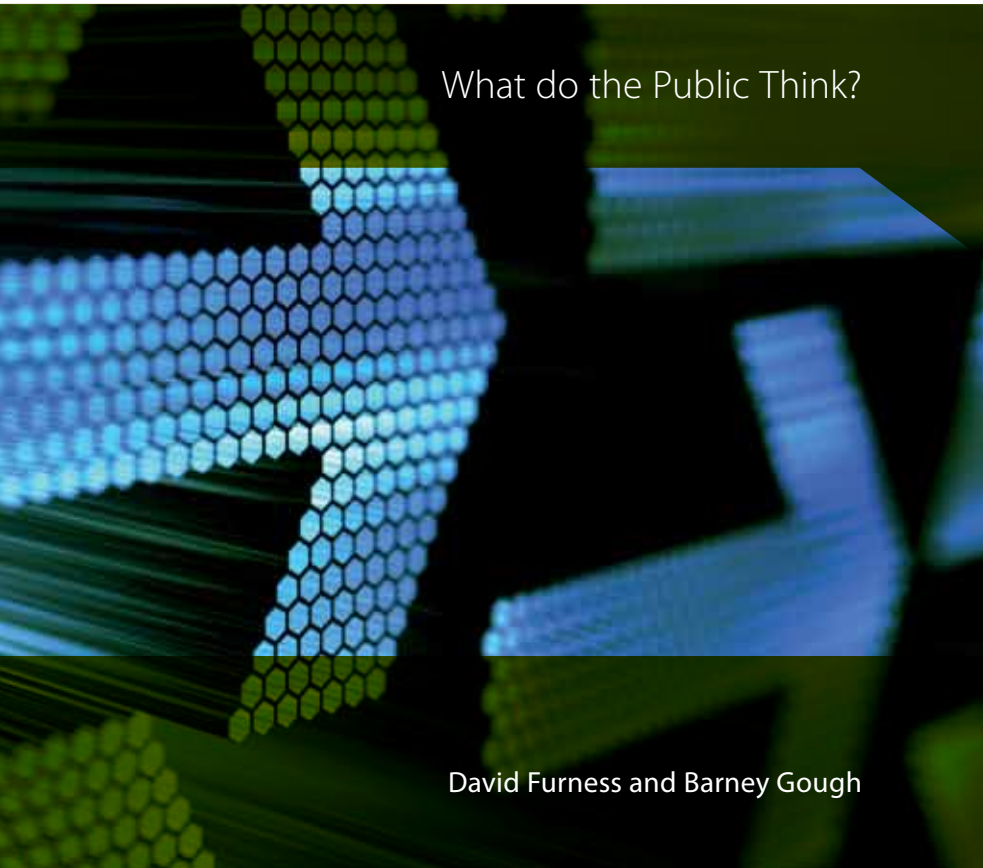
SMF Health Project

LOCAL CONTROL AND LOCAL VARIATION IN THE NHS

What do the Public Think?



David Furness and Barney Gough

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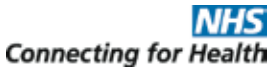
Kindly supported by



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DISCLAIMER

While this report draws on material supplied by Ipsos MORI the views expressed below are solely those of the authors.

INTRODUCTION

The SMF Health Project has examined many aspects of the future of health services in this country. At the heart of our research has been the future of commissioning – how Primary Care Trusts (PCTs) are likely to develop given current policy trends, and the risks and opportunities this presents. The move towards greater PCT autonomy embodied in the World Class Commissioning Framework offers a range of fresh possibilities for the NHS to design services that are specifically targeted at local needs, with new and innovative providers emerging in response to the different needs identified by commissioners. But there are fears that greater local spending and decision-making power will undermine the national character of the NHS. This is a particularly trenchant criticism in the context of public concern about "postcode lotteries" in the NHS. However, while postcode lotteries are a common feature of the public debate on health, they are relatively poorly understood. With Ipsos MORI, we examined public views about variation in the NHS, and explored whether trade-offs could be made over local variation and local control. Will people respond more positively to variation in services if they feel they have control over the decisions that are made in their area? What accountability mechanisms should be introduced to make sure that local health services meet the public's expectations?

These questions have been made even more urgent by the dramatic downturn in the economy. There are fears that there will be real-terms cuts in public service budgets – a huge challenge for health services at a time when every country in the developed world has seen health costs rise year on year for several decades. We do not yet know what the downturn will mean for the NHS. However, now is the time to explore the options available for making the tough decisions that we face.

Presented below are the results of the polling and discussion groups used to examine these questions, and spell out some policy

implications for the long-term future of the health service. These insights will be at the heart of the forthcoming final report of the SMF Health Project.

METHODOLOGY

We worked with Ipsos MORI to develop opinion poll questions to explore what people think about the NHS. These were focused on three distinct areas – local variation, public involvement and the future funding of healthcare.

1. LOCAL VARIATION

It is clear that people are exercised by the idea that treatments might not be available in every area. Headlines like those below resonate with the general public because there is a strong sense that treatments should not be dependent on where one lives:

> "Postcode lottery for cancer wonder drug"[1]
> "Patients denied life-saving drug even after health watchdog approval"[2]

However, these headlines do not necessarily indicate that people think that new treatments should be introduced only if their availability can be guaranteed in every area. Nor do they reveal how people view the substantial variation in healthcare between areas that is not subject to the same level of media scrutiny as access to new and expensive medicines tends to be. A King's Fund analysis of variation in spending between PCTs found significant differences that cannot be explained by differences in need. For example, Islington PCT (adjusting for need) spends £332 per head of population on mental health compared with £114 per head by

1 D. Wilkes, "Postcode lottery for cancer wonder drug", *Daily Mail*, 10 April 2006.

2 "Patients Denied Life-Saving Drug Even After Health Watchdog Approval", *Daily Mail*, 9 January 2008.

East Riding of Yorkshire PCT, and the proportion spent on mental health ranges from 8.7% to 25% of PCT budgets.[3] What does the public think about the pros and cons of deeply embedded local variation in a supposedly national health service? This is a particularly important topic given the general trend of health policy.

The NHS operating framework for 2008/9 shows that national targets still form an important part of healthcare policy. It describes a set of "key non-negotiable national NHS targets"[4] for local PCTs. These include access targets such as the 18-week maximum waiting time as well as those aimed at specific diseases, such as the extension of the NHS bowel cancer screening programme. This would seem to be in line with the goal set out by Aneurin Bevan in 1948 that the NHS should "universalise the best"[5] – creating a truly national health service. But recent NHS reform has seen unprecedented devolution of money and authority to PCTs at a local level. The vision set out in the World Class Commissioning Framework aims for a "new NHS – locally driven". It describes how commissioning will be "developed, articulated and owned by the local NHS, with a strong mandate from local people and other partners".[6] In practice this will mean ever more variation between different areas.

While PCTs are charged with designing a range of services around the needs of local people, it is not at all clear that this fundamental shift in the nature of the NHS has been fully understood by the public. Nor is it clear how national standards and targets will evolve in response to the increasing power of local commissioners who have been told to "look outwards not upwards"[7] – in other words becoming accountable

3 J. Appleby and S. Gregory, *Local Variations in Priorities: An Update* (London: King's Fund, 2008).

4 Department of Health, *NHS Operating Framework 2008–2009* (London: HMSO, 2008).

5 Aneurin Bevan, quoted in R. Klein, *The New Politics of the NHS: From Creation to Reinvention* (London: Radcliffe, 2006), 19.

6 "World Class Commissioning: Vision":www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956.

7 Ibid.

not to central government but to local people. This tension between national standards and increasing levels of local variation is at the heart of the debate about the future of healthcare in the UK.

2. PUBLIC INVOLVEMENT

It is sometimes argued that the public should have a much more direct involvement in the design and running of health services. This debate goes back to the founding of the NHS, when Herbert Morrison supported local government control of healthcare only to be overruled by Aneurin Bevan's preference for a single national hospital service.[8] Since the inception of the NHS, providers of healthcare have generally been more accountable to central government than to local people, in large part because of the national funding mechanisms of the health service. There have been a number of systematic attempts to involve people in the design and running of health services, and in recent years there have been steps taken to make providers more accountable to patients. A good example of this is the elected membership of Foundation Trust boards. However, since the introduction of a purchaser–provider split, with PCTs holding budgets and commissioning services, it is clear that accountability mechanisms are not necessarily adequate to make sure that the views of local people are properly represented. Community Health Councils no longer exist, and it is not clear that Local Involvement Networks (LINKS) are having much impact in affecting decisions at a local level.

It is in this context that some have advocated a radical overhaul of accountability in the NHS to bridge the gap between commissioners and local people. The Liberal Democrats have advocated the introduction of locally elected health boards as a way of establishing real local control.[9] The Picker Institute has argued that the democratisation of PCTs is inevitable as the significance

8 C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2008).

9 *Empowerment Fairness and Quality in Healthcare* (London: Liberal Democrats, 2008).

of PCT budgets and commissioning duties becomes more widely understood.[10] But accountability for decision-making and local involvement in those decisions does not necessarily equate to democratic control. Democratic mechanisms do not necessarily result in a true reflection of the views of local people, and there are practical constraints too – do people actually want to get involved in decisions about healthcare?

We wanted to explore whether the public is in fact interested in being involved in decision-making at a local level, and whether there is a relationship between greater local involvement and greater local variation – would people accept difference between areas if they felt fully involved in decisions about where to put resources? It is important not only to consider the intrinsic opportunities and threats of greater local involvement in healthcare, but also to understand how this fits with the wider context of NHS reform. As discussed above, the drift of health policy is towards ever greater variation between areas, with ever greater control exercised by local PCTs. Is it possible to make sure that decisions leading to greater variation have legitimacy through involvement mechanisms that do not necessarily add up to the kind of democratic control proposed by the Liberal Democrats?

3. FUNDING HEALTH SERVICES INTO THE FUTURE

In conjunction with the questions exploring variation and the extent to which people wish to be involved in decision-making, we also asked about how the health service should raise money in the future. While some of the more extreme claims about cost increases in healthcare seem far-fetched,[11] two things are clear. First, that the general trend of health spending is upward and, second, that the public finances are in a perilous state. To set decisions about future financing for healthcare in context, Derek Wanless's 2002 report for HM Treasury on

10 *Accountability – Public Views and What to Do About Them: Submission to the Local Government Association Health Commission* (Oxford: Picker Institute Europe, 2008).

11 For example, Professor Karol Sikora's prediction of a £50bn UK market for cancer drugs.

the future of healthcare suggested that even in the most optimistic of scenarios, health services would require average real-terms increases in spending of 4.4% up to 2012/13 if we want to see continued improvement. His least optimistic scenario suggested that spending would need to rise by 5.6% per annum.[12] And even before the current economic crisis, many experts had predicted that demand for, and the costs of, health services would rise at a greater rate than our ability to pay for them through taxation. One authoritative report, an analysis conducted by NERA and Frontier Economics, suggested that the NHS will face a funding gap of £11 billion by 2015 if current (up to 2010) levels of annual spending increases are maintained.[13]

In the current economic climate, and with the poor prognosis for the public finances over the next decade, it is inconceivable that the NHS will enjoy funding increases of 4.4–5.6% per annum over the coming years. We are left, then, with options for the medium-term future of the NHS that are not politically attractive:

- a decline in the standard of NHS care;
- significant increases in taxation;
- significantly increased private payments for healthcare;
- a radical reassessment of what the NHS will and will not provide;
- heavy real-terms cuts in other department budgets to protect health spending.

At this stage it is not possible to say which of these options, either alone or in combination, will be required to maintain the publicly funded health system in the future. What is clear is that government needs to engage more with the public to acknowledge the difficult choices that lie ahead, and to understand how their views about

12 D. Wanless, *Securing Our Future Health: Taking a Long Term View* (London: HM Treasury, 2002), 75.

13 E. Bramley-Harker et al., *Mind the Gap: Sustaining Improvements in the NHS Beyond 2008* (London: Bupa, 2006).

financing fit with their views about service development in general. There are few clear-cut answers to the challenge created by a time of scarcity in public resources. And, given the important place of the NHS in British society, we need more than ever to maintain public support for a system that enshrines significant values of universal access to healthcare regardless of income. These are questions of politics, not just of policy. Furthermore, the challenges of local variation and local involvement outlined above are not irrelevant to questions of funding. Ultimately, we are asking people how they would prefer decisions to be made about the future of health services. Given that the economic downturn is likely to preclude significant funding increases for healthcare for many years to come, there is an urgent need to address these questions.

OPINION POLLING AND DISCUSSION GROUPS

To investigate the three areas described above, we conducted an omnibus survey questioning 998 English adults.[14] The results are explained below. The intention of this initial survey was to elicit "top of mind" responses – the instinctive reaction of individuals when questioned about their views. Using these results, we then developed a series of discussion groups to explore in greater depth the findings from the opinion poll and to understand better what informs the views people hold, what those views mean in practical terms for the NHS and what the implications are for policymakers. The results of these discussion groups are presented below.

This research is neither exhaustive nor definitive. The questions we asked do not address every aspect of the debates we hope to illuminate. However, these results provide some useful insights for the future design of health services, particularly in the context of the changing demand-side pressures that have already been elucidated

14 Ipsos MORI omnibus telephone survey, November 2008. Base: 998 English adults (18+)

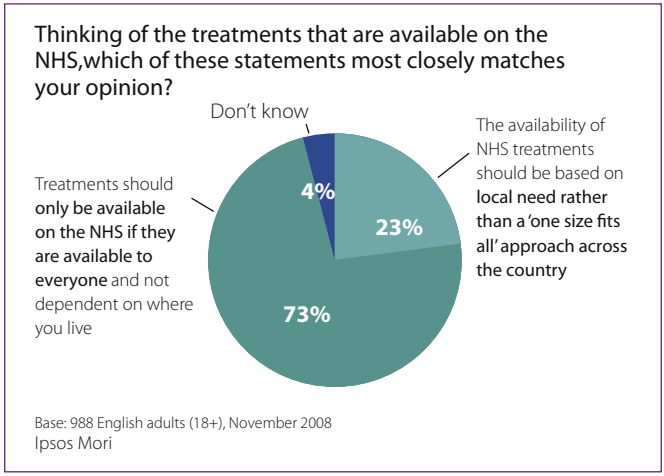
by previous SMF Health Project publications.[15] Notably, the opinion poll data provides a keen sense of how the public approaches the questions that we have defined as crucial for the future of health services. The information gleaned from our discussion groups shows how further debate might enable public opinion to develop, allowing government and health service commissioners to make decisions that both accord with the need to make tough choices and carry support from the public.

THE RESULTS – OPINION POLLING

Local variation in the NHS

Perhaps unsurprisingly, polling uncovered a clear majority of people in favour of nationally available treatments.

Figure 1: Most people want standard treatment available across the country



Beneath the headline figure were some intriguing results. For example, it emerged that 32% of black and minority ethnic (BME)

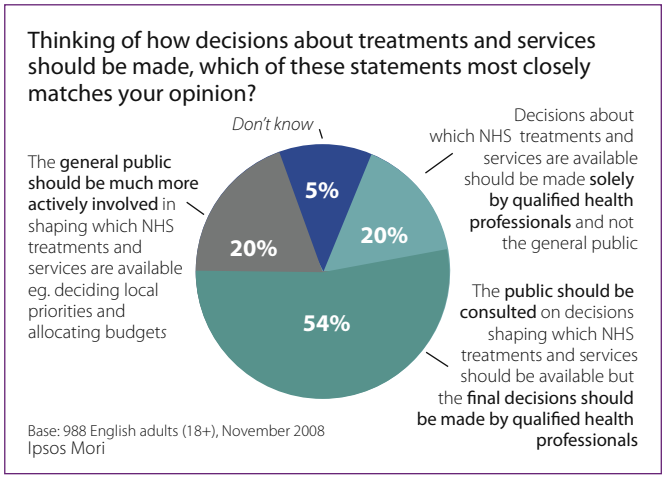
15 D. Furness et al., *SMF Health Project Background Papers* (London: Social Market Foundation, 2008).

respondents are in favour of more locally tailored services compared to 23% of people overall. However, the sample here was not large enough to confidently attribute different values to this group.

Public involvement

There was a clear majority in favour of involving the public in decisions about health services. Only 20% of people do not think that the public should be involved at all in decision-making; most people argued for consultation, with the final decision to be made by health professionals. A further 20% were keen to see much more active involvement for the general public in shaping which NHS treatments and services are available.

Figure 2: The public want to have a say

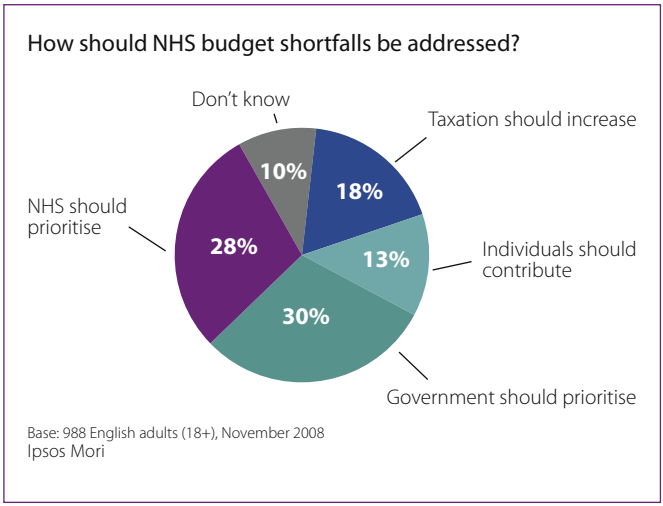


Of course, one of the key challenges here is to understand what people mean by "involvement", and whether it is possible to translate the desire for involvement into structures that will improve health services. There are many potential models for public involvement in health services, but what do people actually want?

Funding into the future

We asked people how any potential shortfall in health budgets should be made up. This does not reflect an ideological agenda for changing the system of funding, but is a pragmatic view based on the clear evidence that health budgets in the next decade will be severely squeezed in comparison to the years of plenty that the NHS has recently enjoyed.

Figure 3: No real consensus about how to address shortfall



We asked respondents about four options for supplementing the NHS budget, including increasing taxes and introducing private payments. We also attempted to distinguish between priority-setting to save money led by government and that led by the NHS. This was intended to demonstrate which group the public expects to take the lead on decision-making about NHS priorities. There has been a lot of focus on the perceived benefits of an "independent" NHS, but our poll shows that many people believe that the government has an important role to play. This distinction is explored in greater detail later in this report.

Unsurprisingly, there is little support for an increase in taxation, and even less for individuals to contribute more to the costs of their healthcare. However, the even split between support for government-led priority-setting and that led by the NHS is a real insight into how we should approach the challenges of the future. As well as looking further into the distinction between government and the NHS, what people mean when they refer to "priority setting" is explored below.

QUALITATIVE WORK – DISCUSSION GROUPS

The polling results above elicit headline findings, and give quantitative results for the key questions. However, the bulk of this research has been qualitative – seeking to understand why people think as they do. To that end, we worked with Ipsos MORI to design a series of discussion groups to explore further the insights generated from the quantitative work.

Discussion groups are designed to take a group of people and work with them through a variety of exercises that reveal the thought processes behind different attitudes and values. Participants might be distinguished by age, locality or socio-economic background to help understand differences between the groups.

A key aim of this research was to understand in greater depth divergent views about variation in care. The tension between national and local control and the consequent variation in services is at the heart of the political debate in healthcare, and is a key part of the SMF Health Project's wider research into the future of the NHS. Consequently, it was judged that the discussion groups would provide more insight if they were focused on different attitudes to this key question about local variation in care. As such, we recruited focus group attendees based on their responses to questions about local control and national standards as well as their socio-economic status.

Four discussion groups were conducted. Two of these groups were made up of people who strongly agreed that NHS treatments should be based on local needs. The other two groups were made up of people who strongly agreed that treatments should only be provided if they were available across the whole country. As well as this attitudinal split, groups also comprised people of different age and socio-economic status. This enabled an exploration of any possible links between attitudes to local variation in health services and other factors.

Group One: Older (45+), low social grades (C2–E), local need preferred
Group Two: Younger (25–35), high social grades (A–C1), local need preferred
Group Three: Older (45+), high social grades (A–C1), national standards preferred
Group Four: Younger (25–35), low social grades (C2–E), national standards preferred

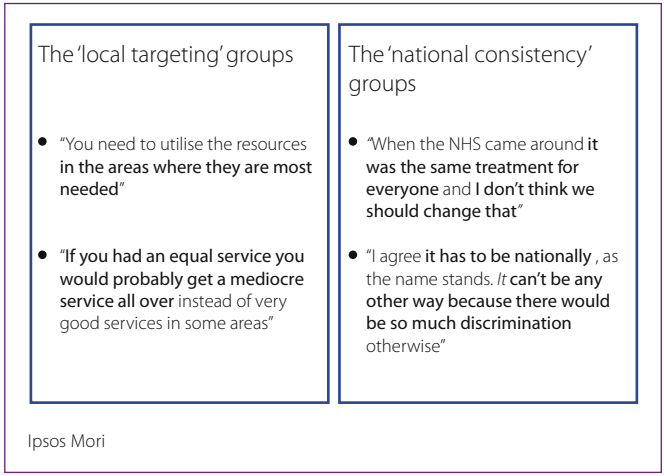
The discussion groups were moderated by experts from Ipsos MORI. Quotations below are representative of the views expressed in the groups.

Why do people hold the opinions they do?

We started by asking people to explain why they hold particular views about the importance of local or national priorities.

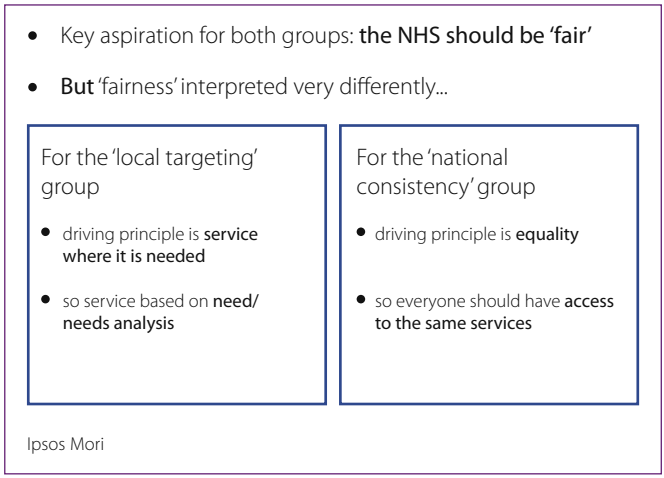
At first sight, these appear to be very disparate sets of views. However, this does not necessarily mean that there are radically different values between the groups. On digging deeper, both justified their views on the basis of fairness. However, fairness means different things to different people.

Figure 4: We asked both groups to explain their views



These responses demonstrate the two very distinct approaches to the principle that the NHS should be fair.

Figure 5: We then asked them to explain why this was important

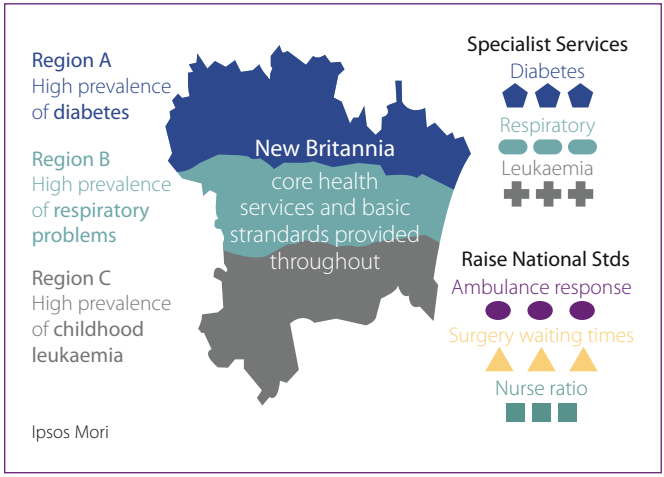


Applying fairness in practice

But what does this mean in practice? The groups were taken through an exercise designed to draw out a process of decision-making that they would consider fair. Participants were asked to put themselves in the place of an NHS funding committee in the fictional country of "New Britannia".

In New Britannia there is a core range of health services delivered to a good standard that is available to everyone. However, there are different health needs in different areas of the country, with diabetes, respiratory disease and childhood leukaemia particular problems in particular areas. The groups were then offered a range of possible service improvements, with the caveat that it is not possible to afford all of them. These ranged from investing in reducing surgery waiting times to increasing the resources available for specialist diabetes services. Some possible

Figure 6: You are the NHS funding committee

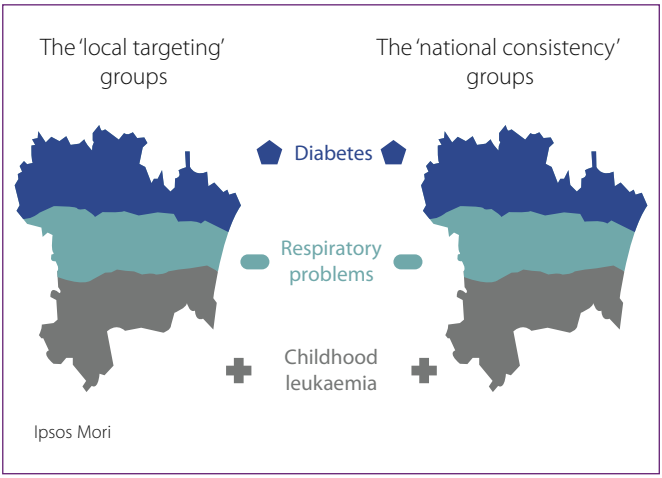


improvements would have a national impact, while others would be targeted at particular health issues. Participants worked together

to decide where resources should be targeted, by placing symbols on a map. The aim of this exercise was to find out whether different groups would choose to raise national standards or would target areas of particular need.

All four groups prioritised investment in specialist services aimed at specific health issues in particular areas before they looked to invest in raising national standards of care.

Figure 7: So how did the groups distribute the spending?



This indicates that, in practice, everyone supports the idea that resources should be specially targeted where the need is greatest. But the environment created by the groups could be described as a "postcode lottery", with more money spent on particular treatments in some areas than others. We asked the groups to consider the impact of the decisions they had chosen to make. Their reactions were particularly interesting.

The groups who had initially favoured local priorities were happy with the decision they had made. They were comfortable with the situation they had created, and could rationalise their

decision by explaining that services were where they were needed most.

In contrast to this, the two groups made up of people who had initially favoured national decision-making were unhappy with the situation they themselves had chosen to create. A sample of their reactions is set out below.

Figure 8: When we pointed out they'd created a 'postcode lottery'

The '**national consistency**' groups were split

- some thought they'd made a **mistake**
  - wanted to change their answer
- some resolved this by distinguishing between **more** and **better** services
  - **more** services where needed fits with their definition of fair (equity)
  - **better** services does not

"If we actually thought that there were going to be specialists in this area, **drugs only available in this area, then we would have voted completely different... we thought we were just putting more people there. If you had mentioned only these people will get the better drugs, we would have thought differently.**"

Ipsos Mori

The quotation highlighted in figure 8 is taken from one of the national standards groups. Interestingly, although it was made clear at the beginning of the task that specialist services would involve *improved* services, the national standard group had not taken this on board and justified their decision post hoc by saying that they thought they were offering *more* services, but not *better* services. Clearly, these categories are not mutually exclusive. In many senses, more services are better services – extra resources in one area mean that people in other areas do not have access to the same levels of care. It seems to be that some participants in the national standards groups felt that a fair distribution of resources was one in which every person has access to exactly the same services.

This is not the case in the NHS – hospitals are not evenly spread throughout the country, for example. But there was still a sense from these groups that the NHS should supply the same services per head, without regard to areas of particular need. This sentiment was expressed despite the fact that all groups elected to devote specialist resources to areas of need rather than acting to raise national standards.

What does this tell us?

The quantitative work showed that there is a large majority (approximately 3:1) in favour of national consistency rather than local targeting in healthcare. However, it is clear that both sets of groups based their answers on ideas of fairness. But, just as the theoretical literature on equality in healthcare contains myriad different definitions, so fairness means different things to different people.

Ideas about what is fair are not necessarily well developed or expressed coherently. This is not surprising, and is probably reflective of the fact that most people do not spend their time thinking about the fair use of resources in public services. But they do have an instinctive reaction about what is fair and what is not.

Broadly, all groups were concerned that people have access to healthcare services when they need them. For some, that meant that services should be allocated according to need, while for others it meant that services should be the same across the country. It is probable that this actually reflects the same underlying value – that treatment should be available wherever you are. However some groups had considered the implication that this means that very different services will be available in different areas. Other groups believed that fair access requires the same services across the country – something that is clearly not the case in the NHS.

But there was also an instinctive acceptance by all concerned of the need for equity and efficiency trade-offs. The exercise designed to

test their attitudes to variation started with the premise that only some service improvements are affordable – we cannot provide everything to everyone all the time. Some groups were more accepting of this trade-off than others groups who saw the local variation this implies as a challenge to the values they assume are at the heart of health provision – that services should be the same everywhere.

However, even people who argue for national consistency (in other words, the same services for everyone across the country) will, when given the opportunity, allocate services based on need. We believe that this has important implications for policymakers, as public fears of a "postcode lottery" are more subtle than might first appear. What can policymakers do in response to this insight? We know from our groups that some people who have a strong belief in national standards will choose what seems to them a "postcode lottery" if the rationale behind variation is properly explained. This indicates that opposition to variation might be overcome with a better process of explanation and engagement with the public.

We were also interested to see whether greater local involvement in resource-allocation decisions would make it more likely that local variation in services would be accepted, or even valued.

LOCAL INVOLVEMENT IN HEALTHCARE DECISION-MAKING

As noted above, there is a clear majority of people in favour of some form of public involvement in decision-making in the health service – only 20% felt that decisions should be made by professionals alone.

This is in line with the direction of policy in healthcare, which attaches ever more importance to engaging with local populations in designing health services.[16] But what sort of people want to be involved with health services, and to what extent?

16 For example, the Department of Health's World Class Commissioning Framework

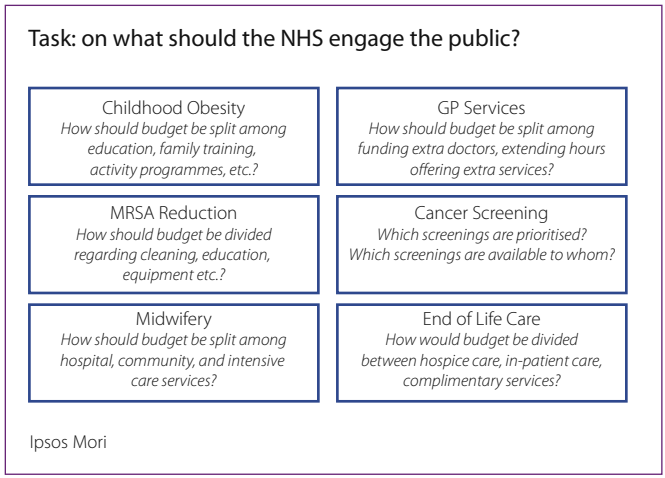
The discussion groups revealed some surprising views:

- the national standards groups were excited by the prospect of local involvement;
- the local needs groups saw it as a last resort.

This could be taken as evidence that locally determined services of the type favoured by local needs groups do not necessitate public involvement. And different values are reflected here. The national standards groups were keen to make sure that health services reflect people's priorities, whereas the local needs groups preferred health services that were objectively designed around an analysis of need.

Significantly, very few of the participants in any of the groups wanted to be involved themselves. People would prefer the NHS and the government to "get it right" without them. To explore these views further, the groups were taken through another exercise, asking in what service areas engagement is particularly important.

Figure 9: Where *do* the public want to be involved?



Where do people want to have their say?

We asked each group to select two service areas, out of a choice of the six set out in Figure 9, where they thought it would be most important for people to have a say. Figure 10 shows how different groups expressed their preferences.

Figure 10

	Local need/ older	Local need/ younger	National stds/ older	National stds/ younger
Child obesity				
MRSA				
Midwifery				
GP services				
Cancer screening				
End of life				

Ipsos Mori

The moderators discussed with the groups the rationale for their decisions, and identified the criteria listed below:

Where people feel the public should be involved:

- where an issue affects a lot of people a lot of the time (GP services);
- if there is a feeling that it's an area where the NHS is currently getting it wrong (MRSA);
- where people feel they have a better idea of what is needed than service providers (GP access);
- where a solution requires public buy-in to be successful (tackling childhood obesity).

Where people feel the public does not need to be involved:

- where the NHS is currently getting it right (based on good personal experience or word of mouth testimony);
- where decisions should be objectively made and clinically based (such as cancer screening).

This might not be a set of criteria that most health managers would be happy to apply to decision-making in their area. But it reflects a general feeling from the groups that people think it is most important to be consulted when things are not going well. However, they are unwilling to devote much time to being consulted – a typical comment from one participant was: "Oh God no, it's too much work."

Other concerns about public involvement

As identified at the start, all groups prioritise fairness in their approach to the NHS, although this feeling is expressed differently. Because of this, all groups were concerned that greater public involvement in decision-making could lead to greater unfairness in the NHS.

Figure 11: Groups also cautioned against self-selecting public involvement

- Many participants were **cautious against the subjectivity** that public involvement could bring
  "If the public was involved it would be total chaos"
  (Older, local needs group)
- Engagement with the public **should be random** and not fall victim to members of the public with a **vested interest**
  "People think about their own situations, people are selfish"
  (Older, national standards group)
- **Hence, unless well managed, people concerned that public involvement will jeopardise fairness** - however it is defined

Ipsos Mori

This broadly reflects the wider concern of policymakers that aiming to increase levels of public involvement in healthcare runs the risk of the unwarranted influence of interest groups that could lead to distortion in the fair allocation of resources.

Information not involvement

The discussion groups broadly reflected the view that availability of information about why decisions are made is more important than public involvement in the decisions themselves.

Figure 12: Information and transparency are more important than involvement per se

- Information, clarity and transparency counteract cynicism

  "If you don't feel involved in something, it's like somebody's making every decision on your behalf. It feels like a military state" (Older, local needs group)

- All of the people we spoke to found it easier to accept tough decisions if they were privy to the rationale behind them

- Without information, there is a tendency for scepticism about the basis for such decisions

  "If they said why they were doing it, for whatever reason, then people would generally understand" (Younger, local needs group)

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This is a useful insight for policymakers. The views expressed in the discussion groups may well be more measured than public reaction to local service reconfigurations (notably hospital closures), but they do indicate that a middle ground needs to be found between expecting the public to play an active role in allocating healthcare resources and ignoring their involvement entirely. It is important that the public is kept well informed about any reconfiguration decisions, and the reasons for such a decision

are carefully explained. This is still a significant communications challenge, as it is not straightforward for government or healthcare commissioners to capture the attention of local people when decisions are made. However, it is important that rigorous attempts are made to explain the rationale for unpopular decisions rather than simply seeking to mitigate the impact of a negative public response.

MEETING SHORTFALLS IN HEALTH BUDGETS

It is clear that the public finances have entered a period of crisis. The IMF has estimated that the recession in the UK will be perhaps the worst in the developed world, with a drop in GDP of 4.1% over 2009, and a continued shrinkage in 2010.[17] As well as this severe recession, levels of public debt have increased substantially, and this will severely hamper the government's ability to invest in public services. The 2009 Budget confirmed that public spending will rise by only 0.1% annually in the period 2011–14, and such is the scale of the current crisis that similar levels of austerity should be expected in the years beyond 2014.

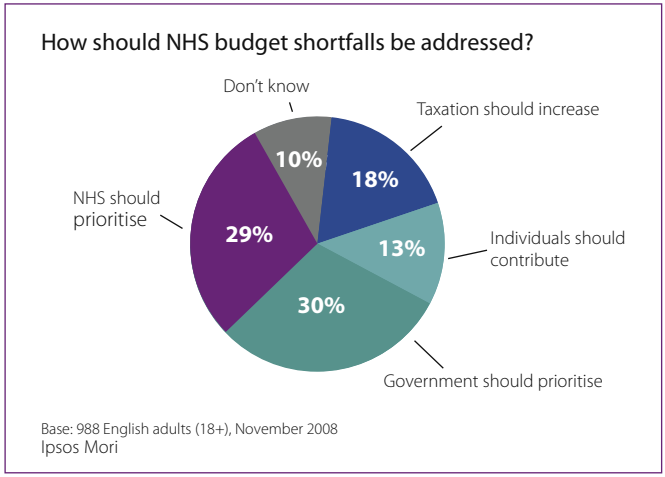
In short, there is no prospect of the type of spending increases that the NHS has enjoyed in recent years. In this context, it is right to engage with the public to understand how decisions should be made about funding health services. This may involve introducing some unpalatable policy options. If the NHS is not to severely decline in quality, the essential choices are:

- pay more in tax;
- raise more money from other sources;
- spend existing budgets more effectively and efficiently.

17 H.Stewart, "Budget 2009: IMF Contradicts Darling's Claim That Growth is Around the Corner", *Guardian*, 22 April 2009

Our quantitative work shows that a majority of people would, unsurprisingly, rather not see tax increases or the introduction of patient charges into the NHS. Roughly two-thirds of those questioned would rather see existing budgets spent more effectively, with decisions made either by the government or by the NHS.

Figure 13: The survey findings



While there is a clear consensus in favour of some form of prioritisation, it is less clear what this means in practice. Our qualitative work was therefore devoted to exploring what people understand by priority-setting in healthcare, and what significance they attribute to who leads prioritisation.

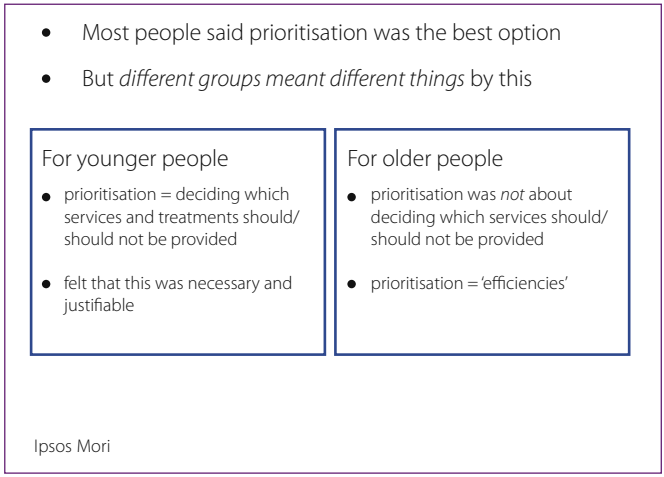
What is prioritisation?

There were very different views between the groups about the implications of prioritising spending on healthcare. These differences were largely related to age, rather than to the national/local attitudinal split explored above.

For younger people, prioritisation relates to tough choices, about what services should or should not be provided. But older

people preferred to view prioritisation as efficiency savings that allow the current levels of service to be maintained: these two views of priority-setting cannot be reconciled – people have divergent understandings of what the phrase means. This has significant implications for communication strategies to inform people about service reconfigurations that will be necessary to save money in the future. The public cannot be assumed to have the same views about service reconfigurations. Some groups may well even welcome closures if it can be shown that this reflects a rational approach to resource allocation. Others may be more inclined to accept the downgrading of certain services in order to raise efficiency – getting more for the same money. This is a subtle but important distinction.

Figure 14: Views on 'prioritisation'



What do people mean by efficiencies?

Older people had strongly developed ideas about where savings could be made, largely centred on not wasting NHS resources on things that they viewed as trivial. Central to this is the idea that it is everyone's duty to use the health service responsibly – not wasting

NHS time on minor matters, or misusing services by failing to turn up for appointments.

Figure 15: What did older people mean by "efficiencies"?

- **Not wasting NHS resources on things they see as trivial**
- See a social and collective responsibility to maintain the NHS - public responsibility as well
  - charging for GP appointments and minor/ affordable treatments
  - This will discourage people using the NHS except where really needed
- Hence, while they rejected language of "prioritisation", they **effectively did prioritise expensive, live-saving treatments**
  - *"If they start charging for the minor stuff, they can put the money towards the big stuff"* Group 1
  - "I'm just thinking, anything that's minor you pay for, but anyone with on-going serious problems like cancer, it's funded" Group 1
- But **prioritisation was on a different basis** from what might be expected
  - not "what's most effective?" but "what's most important?"

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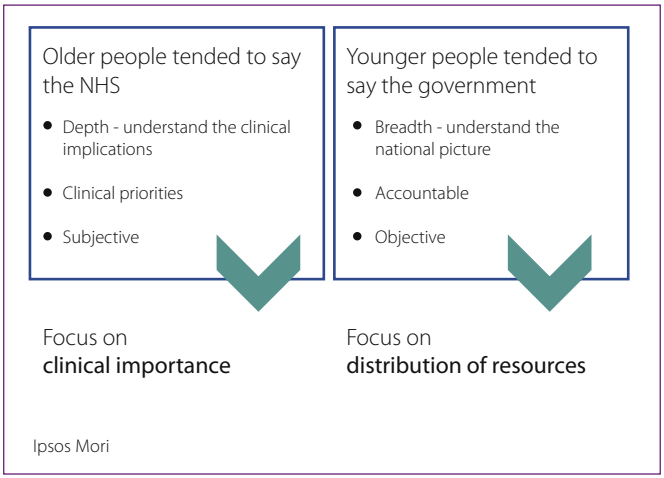
Interestingly, older people were willing to consider patient charging as a mechanism to avoid inappropriate use, and to maintain the NHS for treating serious conditions. This fits with another broad distinction between younger and older people – the extent to which decisions are clinically based or determined by a calculation of the most efficient use of resources. Figure 16 explores some of the underlying values that informed whether participants thought that priorities should be set by government or by the NHS.

This might mean that we can develop efficiency savings that are acceptable to different groups – closures of some ineffective services coupled with incentives to avoid unnecessary treatment, for example. In a resource-constrained environment, it will be necessary to make savings that are congruent with the values of service users. This distinction between a preference for savings based on encouraging responsible usage and those based on

cancelling services means that different groups will require different information to legitimise the tough choices made by local health commissioners.

Figure 16: Who should make the priority decisions: government or NHS?



Government or NHS, clinical- or resource-driven efficiency savings?

We have found that public views about priority-setting in the NHS are varied and reflect different values. There are important implications for policymakers, notably in challenging the assumption that an "independent" NHS would be more acceptable to the public than one in which politicians continue to play a key role.

- The public can accept that healthcare resources are scarce, and that difficult decisions must be made. This contrasts with the political rhetoric on all sides that continues to promote the idea of the NHS as a free, virtually unlimited service.

- The public is not in favour of decision-making left wholly in the hands of the NHS. This runs counter to the position of the BMA and other medical organisations which have strongly argued against what they term "political dabbling" in the NHS.[18]
- Government and local healthcare commissioners may be able to build on the public view that the NHS is a precious resource that should be used responsibly to introduce certain charges, or discourage certain healthcare-seeking behaviours that jeopardise the ability of health services to perform their most important functions – dealing with serious and ongoing disease. This becomes an ever more important priority as public sector funding is cut in the years to come.

CONCLUSIONS

What can we learn from this exploration of public views about the NHS? It is clear that there are both age-related and attitudinal differences in views about variation, involvement and possible NHS funding options.

Age-related differences

Figure 17 illustrates some of the views about the future expressed by our younger and older groups.

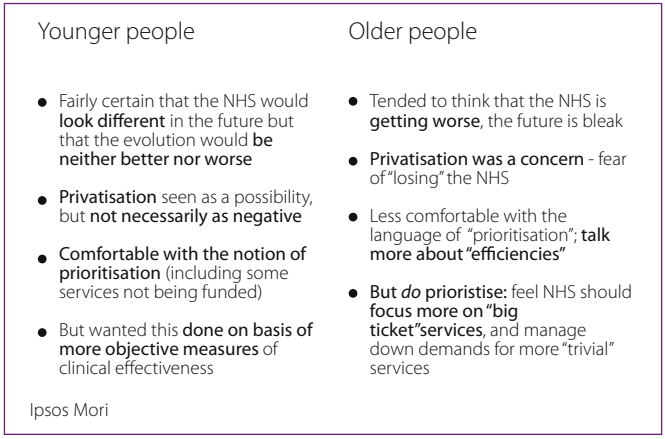
It is important that the public's views inform the political debate about the future of healthcare in a time of recession.

- Politicians should be open and honest about the likely impact of the current recession on the long-term finances of the NHS. People are more willing to accept change if they feel that decisions made are fair, and honestly presented.

18 BMJ, *An independent NHS*, 12 May 2006: www.bmj.com/cgi/content/full/334/7601/0

- Government should explore further the possibility of introducing some limited NHS charges to reduce demand if it can be shown that this will not have a negative impact on the health of the population or challenge the principle of equal access for equal need.

Figure 17: There is an age effect in people's view on the future on the NHS



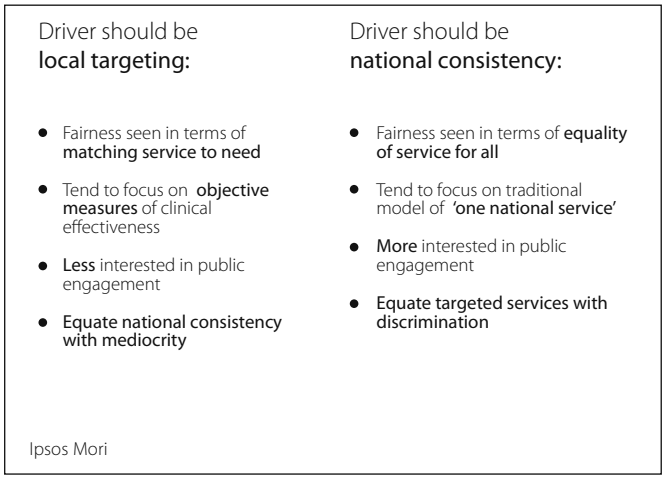
Differences in attitudes towards local variation

This research also identified the core values that inform attitudes about local variation and national standards in the NHS.

In considering the different attitudes outlined above, it is important to remember that the groups in both categories, when given an exercise in allocating health resources, created what many people would describe as a "postcode lottery" – a situation in which better specialist health services are available in areas of particular need. This implies that the conventional view that the public will not accept local variation in healthcare (reflected in media uproar about access to certain treatments) actually conceals a more nuanced view about the necessary trade-offs between equity and efficiency.

- Health policymakers should challenge the commonly held view that the NHS is fair because "everybody gets the same thing" and promote the idea that fairness means that resources are directed towards health needs as efficiently as possible, with resulting variation between areas.

Figure 18: There is a difference in attitude towards variation in the NHS



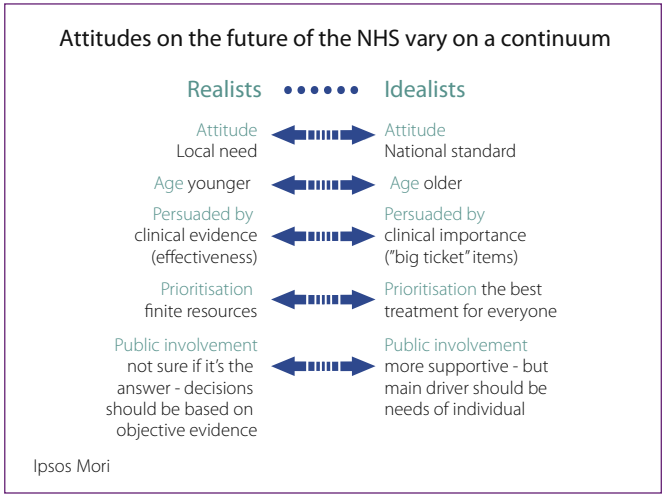
From idealism to realism

Ipsos MORI has represented the views expressed in our discussion groups on a continuum from "realistic" to "idealistic". The ideals of the NHS are valuable ones – healthcare according to need, not the ability to pay. But cost pressures threaten the future of public services. One way of increasing efficiency in healthcare is to accept that national uniformity is far less important than services that genuinely meet the needs of local people. We need to move in political and policy terms from the "idealist" to the "realist" end of this continuum.

What have we learnt?

The research described above has sought to explore what the public thinks about geographical variation in health services, public involvement in resource-allocation decisions and future funding of the NHS. Although there is still a consensus in favour of a nationally based NHS, this analysis shows that, in fact, the public supports locally tailored services, and that the key to allaying people's concerns about service change is transparency in decision-making and a guiding principle of fairness. As we move into a time of severe financial constraints, and further along the road to a truly local NHS, these insights will prove helpful as a guide for policymakers. These results will also inform the final recommendations of the forthcoming SMF Health Project.

Figure 19: So what does this all mean?



Should the NHS be based on local need or national standards?

- All responses were driven by a notion of fairness, but this principle is interpreted differently.
- Around 75% of people say they prefer national standards, yet nearly everyone proposes local variation when considering how resources should be allocated.
- Concern over "postcode lotteries" is more subtle than it first appears, and does not mean that people want the NHS to be the same all over the country.

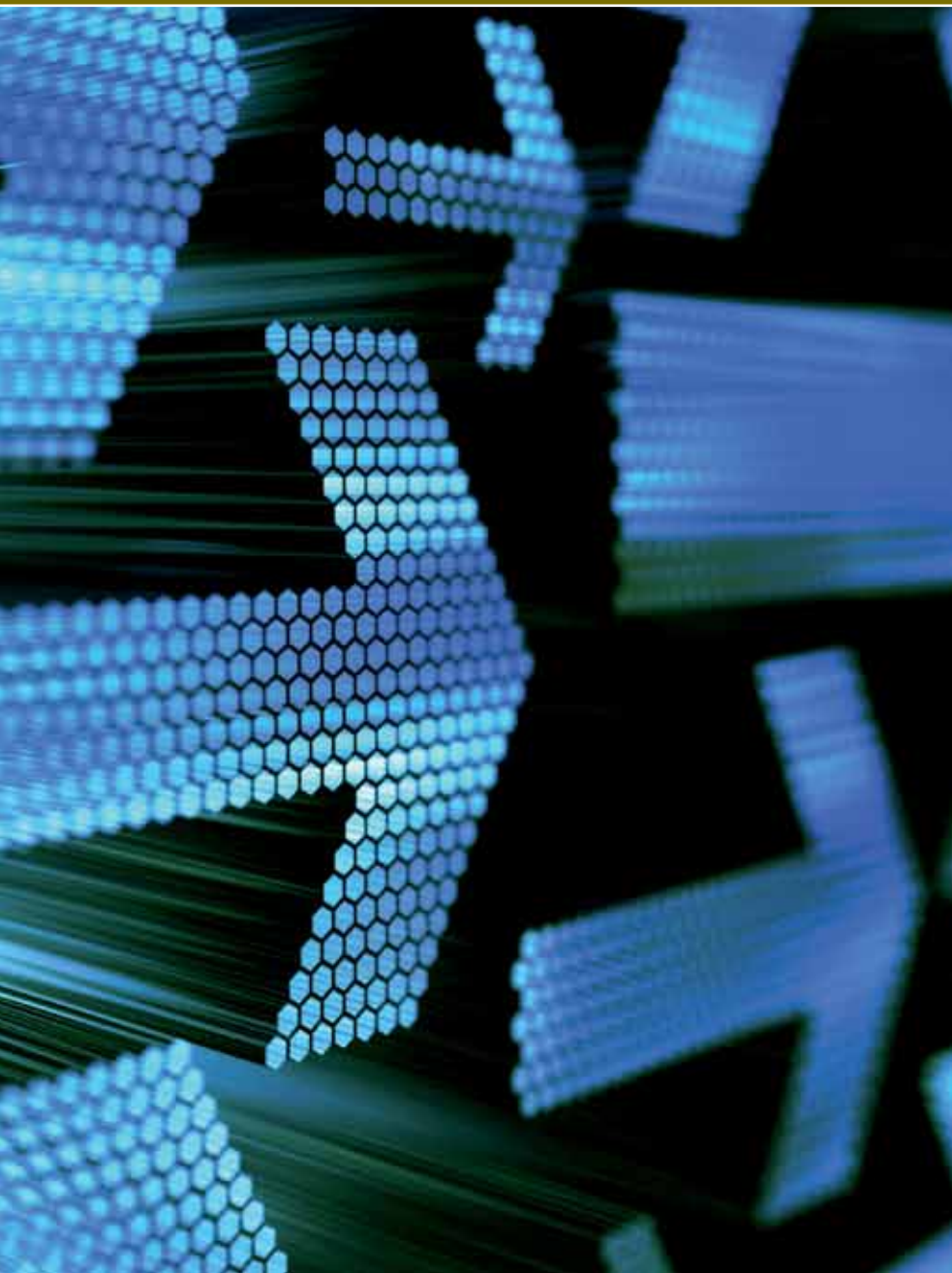
Does the public want to be more involved in decision-making?

- Greater involvement is popular in principle, but is difficult to achieve in practice.
- The public does not want to be consulted on everything – the focus should be on services that affect large numbers of people or require general public buy-in to be successful.
- If there is objective clinical evidence about where to allocate resources, then the public is happy not to be involved, but wants to be kept informed.
- There is concern that greater public involvement leads to greater subjectivity and the unfair dominance of vested interests.

How do people want to deal with potential shortfalls in health budgets?

- Most people favour "prioritisation", but mean different things by this.

- For some, it's about a clinical assessment of where money can best be spent.
- For others, it's about focusing more on expensive medical treatment and less on common or less serious conditions.
- There may be some public appetite to introduce charges for less serious conditions, or to discourage people from seeking unnecessary treatment.



The move towards greater local autonomy in the NHS offers new possibilities for services that are specifically targeted at local needs. Locally varied services will be necessary to make the health service more effective and efficient in the years ahead. But there are fears that greater local spending and decision-making power will undermine the national character of the NHS, amid public concern about 'postcode lotteries'. This study presents the findings of a piece of original research carried out in conjunction with Ipsos MORI examining public views about variation in the NHS. Will people respond more positively to variation in services if they feel they have control over the decisions that are made in their area? What accountability mechanisms should be introduced to make sure that the health service meets public expectations? And who should take the lead in making tough decisions about possible service cutbacks?

These questions have been made even more urgent by the dramatic downturn in the economy. Real-terms cuts in public service budgets are now unavoidable and will present a huge challenge for health services at a time when health costs are rising. This study shows that while people say they are in favour of a nationally based NHS, in practice the public supports locally tailored services. The key to allaying people's concerns about changes to local services is making sure that decisions are transparent and fair.

This report is part of the ongoing SMF Health Project.

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