RAND EUROPE

RESEARCH BRIEF

# Options for funding the NHS and social care in the UK

## How the UK general public would prefer extra funds to be raised


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## Key findings

Increased spending on healthcare and social care can be funded by **taxation, mandatory insurance, voluntary insurance or user charges**.

Internationally, **all options are used** to varying degrees.

In the UK, the National Health Service is **99 per cent tax funded**; although adult social care is **partly tax funded**, almost as much comes from **user charges**.

A discrete choice experiment with over 2,700 members of the UK public showed they **prefer to raise additional funding for adult social care in the same way as for the NHS**:

By progressive taxation

Preferably ring-fenced to be spent only on health or social care

Not by increased user charges or voluntary insurance.

## The policy challenge

We all want to be looked after when we are ill, frail or have difficulty performing the normal activities of daily life. The demand for health and social care is rising in the UK, as it is internationally, and it will continue to do so as the population ages, as expectations grow about the care they should receive, and as technological progress increases what healthcare, in particular, can achieve. The challenge is to find a way to raise the extra funds needed in a way that is acceptable to the general public.

Different countries have developed different care systems, and different tax and insurance systems, and their populations may have different attitudes to what it is acceptable for citizens to have to pay out of their own pockets when they need care. This RAND briefing reflects on the main lessons from research into how the UK general public would prefer additional funds for the National Health Service (NHS) and adult social care to be raised. The details of this Health Foundation-funded research, including all of the findings, are set out in Sussex et al. (2019).[1]

For many years there has been recurring debate about whether taxation should remain the main source of funding of the NHS and whether funding should be ring-fenced using a dedicated NHS tax (hypothecation). There have also been calls to introduce additional payments for certain aspects of NHS care, such as visiting the GP, although this option has been viewed as problematic.[2] Similarly, there has been a long-standing debate about how

1 Sussex, J., P. Burge, H. Lu, J. Exley & S. King. 2019. *Public acceptability of health and social care funding options. Health Foundation Working Paper 4*. London: The Health Foundation.

2 See in particular: Barker Commission. 2014. *A new settlement for health and social care. Interim report.* London: The King's Fund.

the responsibility to pay for social care should be split between public authorities (using tax funds) and the individuals requiring the care (and their families) paying for it out of their own pockets.

Nearly 99 per cent of NHS funding comes from general taxation, and a little more than 1 per cent from user charges, e.g. for dentistry and, in England, prescription medicines. Social care is funded differently from NHS care. Part is tax funded but almost as much is paid for privately by care recipients and their families, and most social care for adults is provided unpaid by family or friends.[3]

Analysis by the Institute for Fiscal Studies and the Health Foundation concluded that 'UK spending on healthcare will have to rise by an average 3.3 per cent a year over the next 15 years just to maintain NHS provision at current levels … Social care funding will need to increase by 3.9 per cent a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities.'[4]

## Funding options

There are five main options for funding NHS and social care:

- General taxation
- Ring-fenced or 'hypothecated' taxation, where the funds raised are promised to be spent only on health or social care
- Mandatory insurance, also known as 'social insurance'
- Voluntary insurance, sometimes referred to as 'private insurance'
- User charges, i.e. paying for care when receiving it.

3 A good description of this is in: Morse, A. 2014. *Adult social care in England: overview. HC 1102, Session 2013–14.* London: National Audit Office.

4 Charlesworth, A., P. Johnson, et al. 2018, *Securing the future: funding health and social care to the 2030s*. London: The Institute for Fiscal Studies.

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**Table 1: Main sources of UK tax revenues 2017/18**

| Tax | £ billion | Per cent of total tax revenues |
|---|---|---|
| Income tax | 180.0 | 27.6% |
| National Insurance contributions | 130.9 | 20.0% |
| Value Added Tax | 125.4 | 19.2% |
| Tobacco duty | 8.8 | 1.3% |
| Alcohol duties | 11.4 | 1.7% |
| All other taxes collected by HMRC | 137.5 | 21.1% |
| Council tax (2017 calendar year) | 31.7 | 4.9% |
| Business Rates (2017 calendar year) | 27.3 | 4.2% |
| *TOTAL* | *653.0* | *100.0%* |

*Sources: HM Revenue & Customs.[5] Office for National Statistics.[6]*

Taxation can be of income, wealth or expenditure (e.g. VAT and taxes on purchases of alcohol, tobacco and petrol). All three types already exist in the UK tax system. Taxation can be progressive or regressive. A progressive tax is where people on higher incomes pay a higher percentage of their income in tax, as with UK income tax. A regressive tax takes a higher percentage of income the lower your income is. VAT and most taxes on expenditures are regressive as people with lower incomes tend to spend a higher proportion of their incomes. Taxes can be raised not only at the national level but also at regional and local levels, e.g. UK local authorities levy council tax, and the Scottish government raises one percentage point of additional income tax beyond the rates set by the UK government.

The UK does not currently have any hypothecated taxes. Taxing expenditure on health-harming goods such as tobacco, alcohol and sugar (so-called 'sin-taxes') have been discussed as a way to boost funding for the NHS, as they also benefit public health by deterring damaging consumption behaviours. However, the potential revenues raised are small relative to the scale of NHS spending. Table 1 summarises the main sources of UK tax revenues.

The UK does not currently use mandatory insurance to fund NHS or social care. People in paid employment (and their employers) or those who are self-employed pay National Insurance, which qualifies them for a state pension and certain other benefits. However, entitlement to NHS care or social care is based on residence and is unrelated to National Insurance contributions. National Insurance contributions are collected by central government and are part of the total tax revenue stream.

About 10–11 per cent of the population in the UK has voluntary health insurance, with £6.2 billion

5 HM Revenue & Customs. 2018. *HMRC tax and NIC receipts. Monthly and annual historical record October 2018.* As of 18 June 2019: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757520/Oct18_Receipts_NS_Bulletin_Final.pdf.

6 Office for National Statistics. 2018. *UK National Accounts, The Blue Book: 2018.* As of 18 June 2019: https://www.ons.gov.uk/economy/grossdomesticproductgdp/compendium/unitedkingdomnationalaccountsthebluebook/2018/publicsectorsupplementarytables.

spent on it in 2016.[7] This is used to supplement what the NHS offers by being able to access non-NHS healthcare. There is currently no voluntary insurance available for adult social care in the UK.

The study team reviewed published analyses of health and social care funding arrangements in high income countries and undertook 30 interviews with experts in nine of those countries to gain additional insights into funding reforms being considered outside the UK.[8] While the high income countries we reviewed differ in the precise ways they fund health and social care, two common threads emerge:

- Most countries fund healthcare mainly from public sources, either taxation or mandatory health insurance or both. The US and South Korea were outliers, but even their public funds covered more than half of healthcare expenditure.
- Compared to healthcare, social care funding relies much more on individuals paying for care privately or receiving unpaid care from family and friends.

From interviews with key international informants, the study team learned that consideration of fundamental reforms to how healthcare is funded is rare, although rather more radical approaches have been considered for funding social care. France, Germany, Japan and South Korea all have experience with some form of mandatory long-term care insurance for some elements of social care.

Political commitment and preferences, which are strongly influenced by an understanding of what is thought to be publicly acceptable, shape whether and what changes in funding are considered in a given country. The history of health and social care funding arrangements inevitably affects public and policymaker perceptions about what is desirable or even possible in that country. Societal values and a country's political, social and economic context are strong forces shaping the options that may be implemented. Consequently, the study team has undertaken a thorough examination of the preferences of the general public in the UK.

## Which ways of funding care are most acceptable to the UK public?

To understand which approaches to raising more money for NHS and social care might be most feasible in the UK requires an understanding of the preferences of the UK public. Surveys are used, from time to time, to ask samples of the UK population about how they think the NHS should be funded. In 2017, the British Social Attitudes (BSA) survey (of a representative sample of adults from England, Scotland and Wales, but none from Northern Ireland) asked, 'If the NHS needed more money, which of the following do you think you would be prepared to accept?' Of the respondents, 26 per cent opted to pay more through existing taxes and another 35 per cent favoured a separate tax that would 'go directly to the NHS'. Thus, 61 per cent chose increased taxes. Only 21 per cent preferred charges to be increased.[9] The question of how to pay for social care in the UK has not (to our knowledge) been explicitly asked in a published survey during the last decade.

However, surveys like the BSA cannot determine what it is about each funding option that makes it more or less desirable to the respondent. The study team's research fills that evidence gap by focusing on the attributes of different ways of raising the funds for NHS and social care respectively. We first explored with members of the public across the UK in five focus groups why they preferred one way of funding to another. Based on what we learned there, we then tested, with a sample of over 2,700 adults, the strength of their preferences between funding approaches with different attributes. We did this via a discrete choice experiment (DCE); the first time (to our

7 Office for National Statistics. 2018. *Statistical Bulletin: UK Health Accounts: 2016*. As of 18 June 2019: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2016#financing-of-healthcare

8 Cylus, J., D. Roland, E. Nolte, J. Corbett, K. Jones, J. Forder & J. Sussex. 2018. *Identifying options for funding the NHS and social care in the UK: international evidence. Health Foundation Working Paper 3*. London: The Health Foundation.

9 Evans, H. 2018. *Does the public see tax rises as the answer to NHS funding pressures?* London: The King's Fund. As of 18 June 2019: https://www.kingsfund.org.uk/publications/does-public-see-tax-rises-answer-nhs-funding-pressures

knowledge) that such a detailed approach has been taken to analysing NHS care or social care funding preferences in the UK.

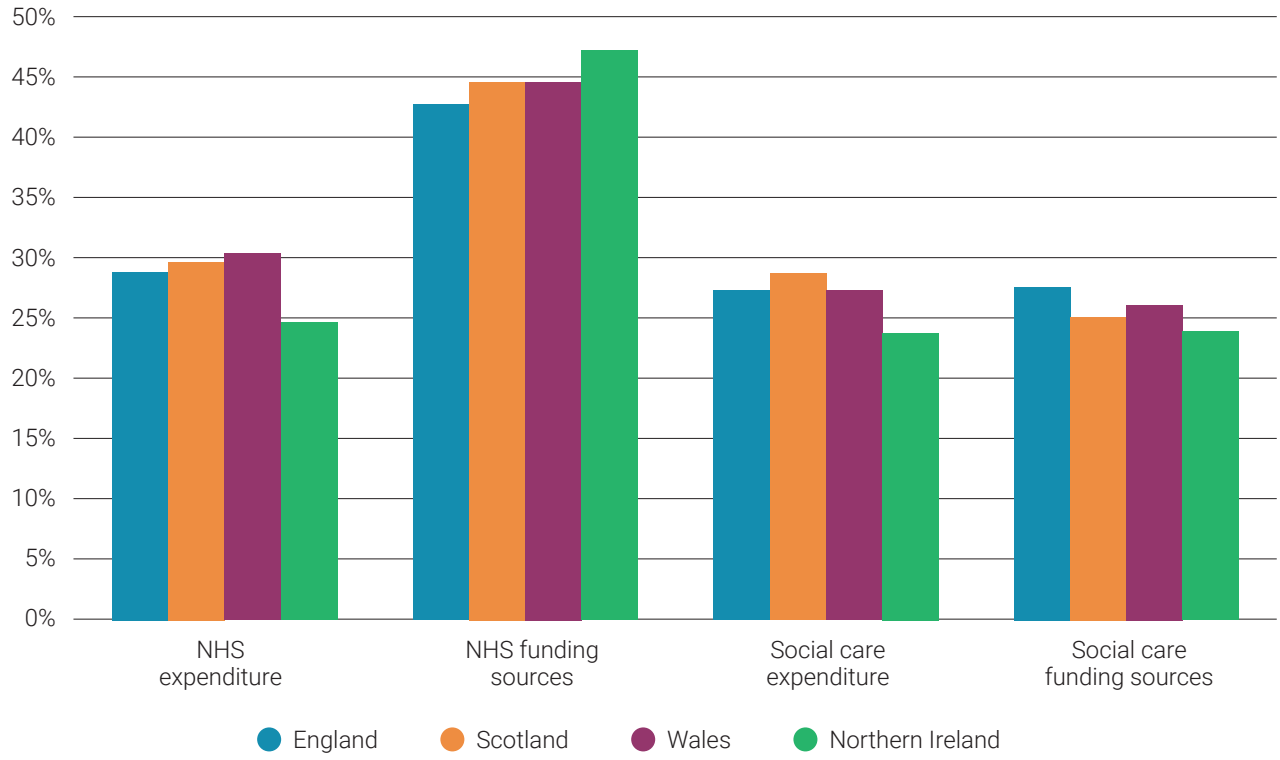
Table 2 lists the attributes, and their 'levels', that we tested in the DCE survey. In the survey we first checked respondents' understanding of current NHS and social care funding arrangements, and the scale of current annual expenditures, with multiple-choice questions. We then asked each respondent to make a series of binary choices such as: would you rather care was funded by a system with the set of attributes A or with the set of attributes B? By asking a large enough sample to make a number of such choices and by offering different people different combinations of choices, it is possible to infer the relative strengths of preferences the population has for the different attributes. To avoid the risk of skewing the findings by the order in which we asked people about NHS and social care respectively, we asked half of the respondents about social care first and then about NHS care, and half of the respondents about NHS care first and social care second. We also asked samples of the population from each of the four countries of the UK to see if views differed between respondents in England, Northern Ireland, Scotland and Wales.

Our first major finding is that the general public has, on average, poor knowledge of the scale of NHS and social care funding. When offered a choice between four levels of annual NHS expenditure in the UK, fewer than 30 per cent selected the correct amount; and when offered four different splits of public/private funding of the NHS, only around 45 per cent correctly identified that the NHS is 99 per cent publicly funded (Figure 1). Knowledge of the level of public funding of social care and how that compares with private funding was poorer still: correct responses from a choice of four options were around 25 per cent, i.e. no better than random (Figure 1). There is clearly scope to increase public understanding of funding levels and sources for both the NHS and, especially, for social care. Having first tested respondents' prior knowledge of NHS and social care expenditure levels and sources of funding, we then presented them with the correct answers before going on to ask them the DCE questions.

**Table 2: Funding attributes and levels for testing in the discrete choice experiment**

| Attribute | Levels | Description |
|---|---|---|
| Universality/collectivism | 0 | Everyone contributes, everyone gets benefit |
| | 1 | Individual decides whether to pay (either through insurance or one-off payments), individual doesn't benefit if hasn't paid |
| Income equity | 0 | What you pay does not depend on your income |
| | 1 | People pay broadly in proportion to their income |
| | 2 | Those on higher incomes pay at higher rates |
| Inter-generational equity | 0 | What you pay does not depend on your age |
| | 1 | Young people pay less, and older people pay more |
| Who controls the fund | 0 | UK national government (not ring-fenced) |
| | 1 | UK national government (ring-fenced for health) |
| | 2 | Regional/devolved government (not ring-fenced) |
| | 3 | Regional/devolved government (ring-fenced for health) |
| | 4 | Local authority (not ring-fenced) |
| | 5 | Local authority (ring-fenced for health) |
| | 6 | NHS body |
| | 7 | Commercial company |
| | 8 | Charitable organisation |

**Figure 1: Proportion of sample that correctly answered questions regarding current funding**




The focus group discussions showed that it was more realistic to concentrate on how *additional* funds would be raised in future to meet the growing demand for NHS and social care expenditure, rather than ask people how NHS and social care should be funded *in total*. A strong and clear finding is that all sections of the public – across age groups, income groups, employment status, health status and the four countries of the UK – would like additional funding for both NHS and social care to be raised in the same way. This contrasts with the current reality in the UK that social care depends heavily on self-funding by individuals, whereas the NHS is 99 per cent funded from general taxation.

The majority view across all age groups, income groups and UK countries is that it is preferable to fund both NHS and social care as a social responsibility so that these services are available for whoever needs them (collectivism). There is a slightly stronger preference for collectivism among people aged 45 or over, and among people in Scotland, relative to other age groups and countries. This preference is in line with current arrangements for funding the NHS. But satisfying this preference in finding additional funds for social care would imply that the additional money should come wholly from taxation or mandatory insurance, rather than the current default situation in the UK where additional social care demands are either being funded privately or not at all.

We find that the UK population has, on average, a clear preference that the amount someone contributes to additional funding of NHS and social care should be at least proportional to income, and a slightly stronger preference that funds should be raised progressively relative to income. This preference holds on average within all age and income subgroups of the population and across all four countries. Even people in the highest income groups support progressivity in funding both NHS care and social care, albeit not quite as strongly as people on lower incomes. The implication is that an increase in income tax would be a relatively popular way of increasing funding for both the NHS and social care, and that increases in regressive taxes like VAT would not.

We find across all age groups a clear preference that, as now, what an individual pays to fund NHS or social care should not depend on their age.

Older age groups have a stronger preference for this non-discrimination, but even the 18–24 age group of respondents on average does not want over-40s to pay more.

Our results show that the public has a strong preference that raising additional funds for both NHS and social care be undertaken by a public body rather than a private company or charity. However, we also find that throughout the UK the public's preference is for the body that receives the additional funding to be constrained to spend all of those funds only on healthcare or social care. This indicates support for some form of hypothecation of taxes to provide additional funding for NHS and social care. This raises practical issues concerned with establishing and maintaining the credibility of the hypothecation promise, but we did not refer to those issues in the survey.[10]

We also found that there is a slight preference, on average, that such ring-fenced raising of funds for both social care and NHS care to be conducted by a devolved government or subnational body, rather than by the UK national government. This is consistent with the current role of local authorities in England, Scotland and Wales in raising some of the funds for social care, and with the existing discretion of the Scottish government to levy income tax at a slightly higher rate than in the rest of the UK. A more detailed consideration of potential local taxation arrangements might therefore be a fruitful area for further investigation.

## Conclusions: what's new?

Thus, we conclude that:

- The UK public supports funding additional NHS spending in future in a way that is consistent with being based on increased, progressive, income tax and not on increased user charges or voluntary insurance.
- There is a further preference for ring-fencing of the additional taxes to only be spent on NHS and social care.
- Additional funds for social care should be raised in the same, collective and progressive way as for the NHS, not by increasing out-of-pocket payments or voluntary insurance.
- These preferences prevail, with varying strength, across all age and socioeconomic groups within the adult population, and across all four UK countries.

Inevitably, even a study of public preferences as detailed as ours (incorporating focus group discussions and a discrete choice experiment) has its limitations. In particular, we must be cautious in extrapolating to the whole UK adult population from the results of our experiment with around 1 in 20,000 of them. However, the great consistency we found in the preferences revealed by the experiment, across all parts of the UK and all age groups and socioeconomic groups, gives confidence that the main results can and should be taken seriously.

10 The pros and cons of hypothecation are discussed in: Cylus, J., D. Roland, E. Nolte, J. Corbett, K. Jones, J. Forder & J. Sussex. 2018. *Identifying options for funding the NHS and social care in the UK: international evidence. Health Foundation Working Paper 3.* London: The Health Foundation.

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