Final Project Report

The future of the National Health Service:

Results from a Deliberative Poll

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1. Introduction

In June/July 1998, SCPR and Professor James Fishkin of the University of Texas in Austin collaborated with Channel Four Television and the King's Fund to undertake a Deliberative Pollä to mark the fiftieth anniversary of the NHS. At that time, explicit discussion of rationing issues within the National Health Service was largely confined to policy and academic circles and had barely surfaced on the public political agenda (New, 1997). Politicians of all parties were reluctant to admit that it was even an issue at all. The Deliberative Poll offered the opportunity for a representative public airing of this complex issue in a way designed to simplify the arguments without sensationalising or trivialising them. This paper is a preliminary report on the event and some of the results.

2. Deliberative Polling

The Deliberative Poll on health rationing was the fifth Deliberative Poll to have taken place in Britain so far. The technique itself is the brainchild of Professor James Fishkin of the University of Texas in Austin (Fishkin, 1991;1995). However, it was first put into practice in Manchester, Britain in the spring of 1994, when SCPR and Professor Fishkin were funded by Channel 4 Television and the Independent newspaper to develop and implement a Deliberative Poll on crime and punishment. Much of the event was televised and later broadcast in a two hour Channel 4 programme. The unique contribution of the technique to public debate about complex policy issues is that it explores what random samples of the public *would* think and do about an issue if they were given the opportunity to learn, think and deliberate more about it in advance.

When George Gallup first developed public opinion polling, he suggested that it would restore democracy to the nation state. At least figuratively, he argued, citizens could now gather together, make and hear the arguments for and against various policy proposals, and vote them up and down. The mass media were of course already covering political discourse about issues to the public and opinion polls were thus intended to complete the conversation by carrying the public's views back to political leaders. It would, said Gallup, be as if everyone were "in one great room" (Gallup, 1939).

Now, several decades the wiser, we know that opinion polls have not been the boon to democracy that Gallup initially imagined. In addition to a variety of practical problems, the most fundamental flaw about them is that most members of the public do not have sufficiently well-formed or well-informed opinions on most issues to express more than a knee-jerk reaction. In the extreme, opinion poll responses can represent what Converse (1970) famously called *non-attitudes*, representing no more than ill-considered and inconsistent responses to a question that is ill-comprehended or at least of very low salience. Since Converse, more evidence has been gathered to show how little information underlies many opinion poll responses:.

> "It is not just civics book details … that are lacking… Major chunks of information critical to comprehending the stakes and arguments in policy debates are mostly absent. Converse (1975) cites the example of majorities in 1961 in favour of knocking down the then newly constructed Berlin Wall, but not knowing that Berlin was surrounded by Communist East Germany" (Luskin, 1987; see also Schumann and Presser, 1981).

This gap between *actual* public opinion and *well informed* public opinion is what Deliberative Polling is designed to bridge (Luskin, Fishkin, Jowell and Park, 1999, forthcoming). An ordinary opinion poll is designed to show what members of the public think about a set of issues - even though they may have given these issues very little thought at all. In contrast, a Deliberative Poll is designed to show what an informed public *would* think about the issues, if only it were enabled to consider its opinions more carefully on the basis of impartial information. As Fishkin (1991) put it, it is an attempt to provide a glimpse of a hypothetical public, one more engaged with and better informed about politics than citizens in their natural surroundings.

Thus a Deliberative Poll involves various stages. First, a national probability sample is selected and questioned in detail about their attitudes towards a particular issue. Before 1998, five such national Deliberative Polls had taken place - four in Britain and one in the USA. The subjects they covered were diverse - 'crime and punishment', 'British attitudes to Europe', 'the future of the monarchy' and electoral issues (on both sides of the Atlantic). The Deliberative Poll on 'health service priorities' was thus the sixth such event (and the fifth annual one in Britain to be broadcast by Channel 4).

In all cases, the process started as above with a normal household interview followed by a self-completion questionnaire. This is to establish 'benchmark' public opinion as an ordinary poll would measure it, prior to any special information or deliberation. To ensure this, only at the end of the interview are respondents invited to take part in a televised weekend event and offered an honorarium of £50 to do so, plus all expenses, including transportation to and from their homes, hotel accommodation and meals.

The second stage is between the household interview and the weekend event itself. Contact is maintained with the potential participants to ensure they 'keep faith' and make appropriate arrangements to attend the weekend. They are also sent a detailed 'briefing document' about the issue, meticulously and impartially outlining the arguments surrounding it on all sides.

The third stage is the weekend itself in which the participants are 'immersed' in the issue both through focus groups each containing around fifteen randomly-assigned participants, expert plenary sessions during which key specialists representing different standpoints answer questions framed by the focus groups and, finally, political sessions in which prominent party spokespersons have equal time to answer questions from participants.

At the end of the weekend's deliberations all participants once again complete the self-completion questionnaire in order that we can measure the direction, volume and distribution of change in attitudes - the public's considered opinions as opposed to their first reactions.

On one level then, Deliberative Polls are designed to be purely *descriptive* - initially plotting general public opinion and later, after deliberation, representing the views of a hypothetical, well-informed public. But they may also be seen as *predictive* - of how opinions might change if an issue were to become more salient over time. And they even be seen as *prescriptive* - since they show what the public would think if it were better informed and had sufficient opportunity to reflect on the issues.

3. The Deliberative Poll on Health Rationing

The Deliberative Poll on health service priorities was partly funded by The King's Fund and the event itself was funded by Channel 4 Television, who broadcast a linked series of four programmes on it during the weekend of 5-6 July 1998, the 50th anniversary weekend of the founding of the NHS..

Following the usual random household survey and questionnaire, 228 people attended the weekend in Manchester, arriving in time for dinner on the Friday night and leaving shortly after lunch on the Sunday. As usual the bulk of their time was spent deliberating in 15 small groups, to which they were randomly assigned for the duration of the weekend, each group was moderated by a specially trained experienced moderator from SCPR. The remainder of the participants' time was spent in plenary question-and-answer sessions with two panels of prominent policy experts (such as Anglela Coulter, Nick Bosanquet, Julian Le Grand and Alan Williams) and with one panel of politicians (Secretary of State for Health, Frank Dobson MP and shadow spokespersons Ann Widdecome MP and Simon Hughes MP). As usual, participants had previously been sent a carefully balanced briefing document outlining the key issues and the different arguments surrounding them. The contents of the briefing document were then summarised in a short video shown to all participants in a plenary session on arrival.

4. The findings

Summary

The picture of the NHS that emerged from both the original survey and the post-weekend repeat survey is of a greatly-cherished national institution, whose role is perceived to be the universal provision of health care without favour. Substantial majorities before and after deliberation were in favour of increased government spending on the NHS, even if this meant paying higher taxes. Although there was a recognition that some forms of implicit rationing already take place within the NHS, and that these may become more widespread in the future, very little support emerged for the introduction of *explicit* rationing criteria which would effectively govern the allocation of NHS resources. This opposition to rationing remained steadfast despite a widespread recognition that the NHS will not of course be able to cater in practice for all needs long term and that it is bound to face a relative shortage of resources.

The public's resistance to explicit rationing did not take the form of outright opposition to the notion of priority-setting *in principle*, but - as will be seen - to nearly all the actual criteria posited on which rationing might conceivably be based. In other words, although many people recognise that rationing already happens, they nonetheless remain deeply suspicious not only about how it is done now, but also about whether appropriate criteria can actually be drawn up to improve the situation. They fear that decisions on priorities set by government or NHS administrators would be misplaced and that it should perhaps be left as far as possible to individual doctors - currently seen to have too little clout anyway - to make inconsistent treatment decisions unfettered by rules or legislation.

It would be surprising if the experience of taking part in an event such as a Deliberative Poll, with the exposure of participants to detailed information and debate, were not associated with a change in attitudes. Certainly, the first five national Deliberative Polls were all associated with quite substantial changes in public opinion towards the subject of the Poll, resulting in significant net changes but, of course, an even greater amount of gross change (often referred to as 'churn'). In contrast, the Deliberative Poll on health rationing was associated with much less net change. There were, for instance no large swings either in favour of or against rationing per se, or of particular forms of treatment, nor even a large change in the proportion believing that rationing was 'inevitable'. There are two broad factors that might explain this relative lack of change in attitudes. One is that the briefing materials and the event itself failed to get the issues across in sufficient detail to make an impact. Yet there was certainly a measurable increase in participants' knowledge as a result of deliberation and a fair measure of gross change across the sample as a whole. A more plausible explanation therefore is that public attitudes to the NHS are actually more robust than they are towards the other issues covered by Deliberative Polls to date. More analysis is still required to be certain, but our preliminary analyses suggest that the British public is deeply protective of the NHS, and that this protective attitude makes people fearful of proposals that even implicitly threaten the perceived even-handed nature of the institution towards all its potential consumers - regardless of their weaknesses (for instance, smokers) or medical condition (for instance, those requiring expensive treatments). Implicit, and often explicit, during the weekend's deliberations was a strong sense of the 'democratic' nature of the NHS, which - with all its imperfections - was still seen to run on the basis that there were no 'classes' of patient who were automatically given less priority than others. It was almost as if a lottery system of priority-setting was seen to be an advantage rather than a disadvantage.

We have a further opportunity to test this thesis by virtue of a further survey, also to be funded by The King's Fund, as part of SCPR's annual British Social Attutudes series in June 1999. This will be particularly helpful because, in the year since the Deliberative Poll took place, explicit debates about aspects of NHS rationing have taken place and have been covered in both tabloid and broadsheet newspapers as well as on radio and television. In the first instance, considerable attention was paid to the introduction of Viagra in Britain, to the terms of its availability here and the resource considerations in rationing its availability. Indeed, in the debate in response to the Queen's speech in November 1998, Ann Widdicombe MP, Shadow Health Secretary, ironically said she had reason to be grateful to Viagra precisely because it had brought the discussion of health rationing prominently on to the public agenda (Hansard, 26/11/98)! In any event, the long-standing reluctance of politicians on all sides to acknowledge that resource considerations had always necessitated implicit or explicit rationing within the NHS is now at last beginning to dissipate. This makes regular measures of public opinion on these issues more important than in the past.

General views about the National Health Service

We consider first general attitudes towards the National Health Service - in particular, its funding and current performance. As noted, the picture that emerges is of a much-cherished institution,

whose responsibility to provide health care for everyone is strongly defended. Clear majorities were in favour of government spending more upon the NHS, even if this meant paying higher taxes. Notably, the effect of deliberation was to increase rather than reduce these positive and protective attitudes towards the NHS as an institution. For instance, while 58 per cent of respondents felt in advance of deliberation that the NHS was doing 'very well' or satisfactorily in catering for everyone's medical needs, this proportion had risen to 70 per cent by the end of the weekend.

How well would you say the National Health Service nowadays caters for everyone's medical needs?

	Pre-deliberation	Post-deliberation
	%	%
Very well	11	14
Adequately	47	56
Not very well	31	26
Not at all well	7	3
Can't choose	4	2

This association between deliberation and increased faith in the NHS was also apparent when we asked people to respond to the statement "Britain's NHS is the best health service in the world". Before deliberation, 56% agreed with this view, rising to 70% afterwards. Reflecting the public's tendency to be protective of the NHS, there was also an increase in the view that public expectations about the NHS were unreasonably high. Before deliberation, 45% subscribed to the view that "we expect too much of the NHS nowadays". After deliberation, this figure too had gone up - to 51%.

As anticipated from earlier research findings (Judge, Mulligan and New, 1997), we found strong public support for a universal health care system in which government pays for everyone's health care, irrespective of their income. A comfortable majority of 58% took this view before deliberation, but it increased substantially by 17 points to 75% by the end of the event.

Who should pay for health care?

	Pre-deliberation	Post-deliberation
	%	%
Government should pay for everyone's	58	75
Government should pay for health care of those who cannot afford to pay	29	20
Everyone should pay for themselves	2	*
Can't choose	11	3

Moreover, an overwhelming 71 per cent, rising to 76 per cent after the event, supported extra government spending on the NHS - even if this meant higher taxes. Although such a figure may be dismissed as a hypothetical rather than an actual vote for extra taxes, it is only the direction of change that is of interest and relevance in this context. The fact that virtually nobody wants less spending on the NHS, even in return for lower taxes, is impressive indeed.

Spending on the NHS: which should the government choose, if it had to?

	Pre-deliberation	Post-deliberation
	%	%
Spend more, even if higher taxes	71	76
Keep spending about same	22	22
Spend less and reduce taxes	1	-
Can't choose	5	1

Attitudes to rationing

There is widespread public recognition that rationing, in one form or another, already takes place in the NHS and that it will inevitably increase in time. Even so, before deliberating on the issue in some detail, only one in ten people approved it or acknowledged its inevitability. Although information and deliberation caused a substantial overall diminution of outright opposition to rationing *per se* from 84 per cent to 65 per cent, this overall shift was not entirely reflected in an acceptance of particular forms of possible rationing. Indeed, in several cases, deliberation resulted in a fall in support for particular types of possible rationing position.

Attitudes towards rationing

	Pre-deliberation	Post-deliberation
	%	%
With people living longer, the NHS will always have too many demands on it and should cut down or cut out certain types of treatment	10	33
Everybody has a right to health care, so the NHS should never cut down or cut out any types of treatment	84	65
Can't choose	5	2

Despite this robustly-held public view (diminished but still fairly dominant even after deliberation) that rationing must be resisted, there was a widespread acceptance acceptance that some form of rationing was probably inevitable in the future. Only a quarter (24%) were optimistic enough to believe that in the future the NHS will have "enough money and resources to provide everyone with the treatment they need when they need it". Indeed, in response to another question, two-thirds (65%) believed that the NHS would "have to cut down or cut out certain types of treatment". But although in the table above the proportion supporting a pro-rationing position rose after deliberation, the proportions believing it *would* actually happen in the future barely change at all before and after.

In order to assess attitudes to particular forms of rationing, we presented participants with a range of scenarios and options - the responses to which all confirmed that, even before deliberation, high proportions of people believed that rationing on various grounds was already commonplace within the NHS. For example, we asked:

Suppose two equally sick people in the same area go on a waiting list at the same time for the same heart operation. One is a heavy smoker, the other does not smoke. Which one do you think would be likely to get the operation first?

By a large margin (54 per cent to 35 per cent) the sample's view was that the non-smoker would be treated first, rather than a patient's smoking habits having no influence on his or her place in the queue. Similar results were obtained when the scenario switched to that of a 30-year old and a 70-year old. Again around half believed the younger person would get precedence, and around a third that age would not make no difference. Deliberation made little difference to these findings.

We also posited a number of other criteria that might be employed in order to choose between different patients or treatments, and asked first whether the sample believed that the NHS currently used such criteria. These included:

*Giving **lower** priority to expensive treatments so that more money is available to treat a larger number of sick people whose treatment costs less*

*Giving **higher** priority to those whose quality of life will benefit most from treatment than to those whose life is most in danger*

*Giving **higher** priority to preventing illness than to treating the very ill*

*Using seriousness of condition as the **only** basis of choosing between patients*

*Using a person's place on the waiting list for a particular treatment as the **only** basis for choosing between patients*

*Giving **higher** priority to treating people who can't afford private medical insurance*

As the table below shows, all these criteria (barring the last one) are widely believed to be in practice already within the NHS when making choices between individual patients or treatments. Before deliberation, between 55 per cent and 67 per cent of the public believed that five of the six criteria above were used all or some of the time as a basis for making decisions between patients or treatments. Even the sixth criterion above - whether or not the patient had medical insurance - was thought to influence treatment decisions all or some of the time by around two in five people. So, there is a widespread acknowledgement among the public that, on occasions, decisions have to be made within the NHS about which patient or treatment gets priority.

		Pre-deliberation		
		How often is priority given to …		
		Always or most of time	*Some of time*	*Hardly ever or never*
… Lower cost treatments	%	11	55	11
… Quality of life	%	11	48	17
… Preventing illness	%	9	46	24
… Most serious condition	%	24	43	11
… Waiting list position	%	14	51	14
… No private medical insurance	%	9	32	43

The distribution of opinion as to what currently happens within the NHS did change somewhat as a result of deliberation. The most pronounced change was in the proportion of people believing that, at least some of the time, higher priority is given to those whose quality of life would benefit most (rather than to those whose life is most in danger), up 16 points from 59 per cent to 75 per cent. There were also increases in the proportion of people thinking that cost of treatment mattered at least some of the time (up 12 points from 58 per cent to 70 per cent). But another big increase (up 12 points, from 67 per cent to 79 per cent) was in the proportion who believed that the seriousness of one's condition was the **only** basis for choosing between patients - hardly a classic example of what rationing is usually taken to imply. In respect to the other criteria, deliberation appeared to make little difference to people's perceptions of current practice.

But in addition to measuring what people think *does* happen, we measured what people think *ought* to happen. We asked, in respect of all the criteria above whether they should be taken into account when making treatments decisions. As can be seen from the table below, the distribution of opinion (pre-deliberation) is rather different. The public's preference is for priority to be given to 'need' - whether in the sense of medical need (people whose condition is most serious) or economic need (people who have no recourse to private medicine). Ironically in view of the political weight behind 'rationing by waiting list', this criterion for priority-setting generated the highest level of opposition. Similarly, the idea of giving lower priority to lower cost treatments attracted very little public support (a finding supported by answers to another question in which almost seven in ten people endorsed the view that "no medical treatment, no matter what it costs, is too expensive to save a life").

		Pre-deliberation Priority should be given to …		
		Agree	*Neither agree nor disagree*	*Disagree*
… Lower cost treatments	%	25	24	38
… Quality of life	%	34	15	38
… Preventing illness	%	52	16	24
… Most serious condition	%	58	10	22
… Waiting list position	%	38	13	44
… No private medical insurance	%	55	16	26

The relatively high level of 'neither agree nor disagree' responses in the above table is evidence of the difficulty people have with these sorts of choices.

We also asked participants pre- and post-deliberation what they thought *should* happen in the earlier hypothetical cases which pitted a smoking patient against a non-smoking one and a 30-year old against a 70-year old one, waiting for the same operation. While, as noted, 54 per cent had thought the non-smoker *would* get priority and 49 per cent that the 30-year old *would* get priority, the proportions who believed they *should* get priority were 12 points lower in the case of the non-smoker and an impressive 18 points lower in the case of the 30-year old.

But what effect did deliberation have on attitudes towards these specific rationing criteria. In the case of the latter two scenarios, deliberation *depressed* participants' support for rationing even further. For instance, the proportion who felt that a person's smoking habits should be immaterial to their treatment rose by ten points to 57 per cent. As for attitudes towards the desirability of other rationing criteria, they tended to change much less, if at all. Even the somewhat extreme formulation that 'no medical treatment is too expensive to save a life', while dropping its support by around ten points, nonetheless retained agreement from nearly six in ten people after the event.

We have already seen very limited public support for the notion of restricting or giving lower priority to expensive treatments, even when the result would be to allow other treatments to a greater number of people. We asked a further question on this subject, this time specifying three examples of such treatment:

> *Some people say the NHS should cut down on very expensive treatments or services and use the savings to provide less expensive treatments or services for more people. With this aim, how much would you be in favour of or against:*
>
> *the NHS cutting down on … a) heart transplants; … b) long-term nursing care of the elderly; … c) intensive care for very premature babies whose survival is in doubt?*

Surprisingly perhaps, before deliberation fewer than one in six people agreed with cutting down on any of these treatments or services. Ten per cent were in favour of cutting down on heart transplants, 13 per cent of reducing long-term nursing care of the elderly, and 15 per cent of cutting down on intensive care for premature babies. Moreover, deliberation had almost no impact on these figures.

There was, however, rather more ambivalence in respect of other treatments by the NHS.

> *Some people say the NHS should cut down on certain treatments or services that should be provided instead by private medicine or charities. With this aim, how much would you be in favour of or against the NHS cutting down on … a) fertility treatment; … b) hospice care for the terminally ill; … c) cosmetic surgery?*

While still attracting only minority support, rather larger proportions (35 per cent and 44 per cent respectively) are in favour of 'privatising' the provision of fertility treatment and cosmetic surgery. But as far as hospice care is concerned, only 10 per cent were in favour. Once again, deliberation did not have much impact on these views, except in the case of cosmetic surgery. Support for the NHS cutting down on cosmetic surgery went up 13 points to 57 per cent.

Another possible way of increasing the NHS's resources is through the introduction of charges for specific services, such as visiting a GP, home visits by a GP, in-patient hospital meals or using a non-emergency ambulance. As the next table shows, there was overwhelming opposition (80 per cent) to charging people for visits to their GP, or charging for hospital accommodation (76 per cent), and strong opposition (64 per cent) to imposing charges for GP home visits. There is, however, more public support than opposition to the introduction of charges for the use of non-emergency ambulances. Deliberation had little effect on any of these figures.

Charging for services		*Pre-deliberation* *In favour*	*Neither in favour nor against*	*Against*
Visiting your GP	%	11	5	80
Your GP visiting you at home	%	21	11	64
In-patient hospital meals	%	26	15	51
Hospital accommodation	%	10	8	76
Use of non-emergency ambulance	%	43	15	36

Decision-making

Since many people consider rationing of one sort or another to be commonplace within the NHS, it was relatively easy to ask the sample where in the system they thought such decisions were - and should be - made. As the table below shows, the most popular view is that is that these decisions are wholly or mostly in the hands of government and the NHS (or hospital) managers and less so in the hands of hospital doctors and, especially, GPs. The public is seen to have little or no say. But when the figures in the first two columns are summed, there is almost no distinction between the various actors (apart from the public).

We asked specifically how much say various different groups currently have in making decisions about "who to treat, or the order in which they should be treated".

How much say do they have?		Pre-deliberation *All or most of the say*	*Some of the say*	*None of the say*
The government	%	39	43	5
GPs	%	11	69	10
Hospital/NHS managers	%	35	47	4
Hospital doctors	%	28	54	10
The general public	%	2	13	72

When we then asked how much say these different groups *should* have, the results were quite different. Those groups seen as having the most say in the current system - government and hospital/NHS managers - were the least favoured to exercise the influence. Indeed, four in ten thought government should have *no say at all* in these decisions, and a third felt that about hospital/NHS managers. As other studies have found, the most trusted group were doctors. Six in ten wanted hospital doctors to have all or most of the say over who gets treated and four in ten wanted GPs to exercise this dominant role.

How much say should they have?		Pre-deliberation *All or most of the say*	*Some of the say*	*None of the say*
The government	%	8	40	40
GPs	%	38	51	2
Hospital/NHS managers	%	11	42	33
Hospital doctors	%	59	33	-
The general public	%	10	40	35

Once again, these views were barely affected by deliberation.

To assess the public's faith in medical expertise further, we asked people to choose between two conflicting views:

If these sorts of difficult decisions need to be made, which do you think is the better way of making them?

> *There should be publicly available guidelines about who should get priority for health care*
>
> *or*
>
> *Medical experts should be allowed to make these sorts of decisions as they think best*

Once again, the favoured option was for medical experts to work unfettered, with just over half (54%) taking this view. Only one third thought that public guidelines should be available, but this figure did increase (to 42%) after deliberation.

	Pre-deliberation	Post-deliberation
	%	%
Public guidelines	34	42
Medical experts free to decide	54	50
Can't choose	11	4

Participant feedback

The feedback from participants at the weekend was overwhelmingly positive. 94% found the weekend either 'very' or 'quite' interesting. The most valuable sessions were seen to the focus groups, with nearly seven in ten (68%) finding these 'very valuable' in helping them work out their positions on the issues. Five in ten (51%) also found meeting and talking to other participants valuable. Disappointingly, perhaps, only around a third (36%) thought that they had gained much from the expert sessions - whether the ones involving specialists or the ones involving politicians. Indeed, around one in six (16%) regarded these sessions as 'of little or no value'.

5. Conclusion

In only fifty years the NHS has come to occupy a special symbolic place in British national life, alongside much more venerable institutions such as the parliamentary system. As a source of great national pride, no government could afford to diminish or destroy the NHS.

This helps to explain why debates about *health rationing* have for so long been steadfastly avoided by senior politicians on all sides. The very concept of 'rationing' raises the spectre of unwelcome cuts in resources for health care. But, perhaps even worse, it also engenders fears of a different sort of NHS in which people would effectively be categorised into 'deserving' and 'undeserving' groups on the basis of their characteristics or the nature of their condition, rather than on their need for treatment. At the very heart of the NHS's appeal is its perceived egalitarianism, its duty to treat all comers on the basis of medical need alone. Unlike many British institutions, such us the judicial system (Brook and Cape, 1991), the NHS has managed to maintain an enviable image of classlessness, of success in delivering its services without fear or favour.

Naturally, a considerable proportion of the population is aware that resources for health care are limited and that in practice certain priorities are selected. But they are nervous nonetheless about such decisions being pre-determined by politicians or bureaucrats and then being set in stone. They prefer these decisions to be taken by doctors according to medical criteria, even if (or perhaps especially if) it leads to inconsistencies. There is a good deal of public resistance to the notion that certain types of NHS patient or treatment should be *systematically* given priority over others.

The picture that emerged before the event was one of deep public suspicion about rationing both in principle and in practice. Only one in ten people would endorse even the relatively bland statement that, "with people living longer, the NHS will always have too many demands on it and should cut down or cut out certain types of treatment". Instead, more than eight in ten opted for the rather more uncompromising opposing view that "everybody has a right to health care, so the NHS should never cut down or cut out any types of treatment". Such an imbalance of public opinion (of over eight to one in a particular direction) is unusual in public policy debates and may well reflect the absence of serious public debate over this issue in comparison with others.

As in many previous surveys on this subject (see Kneeshaw, 1997), when it came to particular forms of rationing in most cases there was widespread opposition. There were, however, considerable differences between what people wanted and what they thought would happen. For instance, only a quarter (24 per cent) of the sample were optimistic enough to believe that in the future the NHS will have "enough money and resources to provide everyone with the treatment they need when they need it", and two-thirds believed that in the future the NHS would "have to cut down or cut out certain types of treatment". Disapprove as they might, sizeable proportions of the population nonetheless recognise that systematic rationing already takes place within the NHS.

Information and consideration of the issue via the Deliberative Poll led to considerable changes in public perceptions and preferences. In particular, opposition to the principle of rationing

diminished sharply. Whereas before the event the very notion of reducing or removing certain types of treatment from the NHS's repertoire was anathema, this solid principled opposition had dispersed somewhat by the end of the weekend. So, in answer to the question described above, outright resistance to rationing *per se* dropped dramatically from 8:1 against to 2:1 (that is, to 65 per cent against and 33 percent in favour), still a decisive majority against ever "cutting out or cutting down on certain types of treatment", but representing an impressive shift of opinion. On the other hand, opposition to a range of specified candidates for rationing, which started high, generally ended up in either the same position or higher still (the single exception being cosmetic surgery). Faced with explicitly choosing to give priority to certain categories of people or treatment over others, the public - like the politicians and policy-makers before them - could not quite bring themselves to make the difficult choices. Why should they? Their response, as always, was to leave it to doctors to make these decisions in the privacy of their consulting rooms and hospital wards. If that meant sacrificing openness and consistency, so be it.

Since the Deliberative Poll, which took place in July 1998, the debate about the availability of Viagra has brought certain forms of health rationing much more into the open. Explicit references to it have been made in parliament and in the mass media almost as never before. Fortunately, the planned British Social Attitudes survey module on rationing (also supported by the King's Fund), with fieldwork scheduled for the summer of 1999, will give us the opportunity to measure changes in public opinion in the intervening year.

What we know so far is that exposure to the arguments about the issue, *pro* and *con*, and consideration of them, does certainly lead to a shift in people's views. Not surprisingly, however, it does not make their decisions on specific priorities any easier.

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