Britainthinks

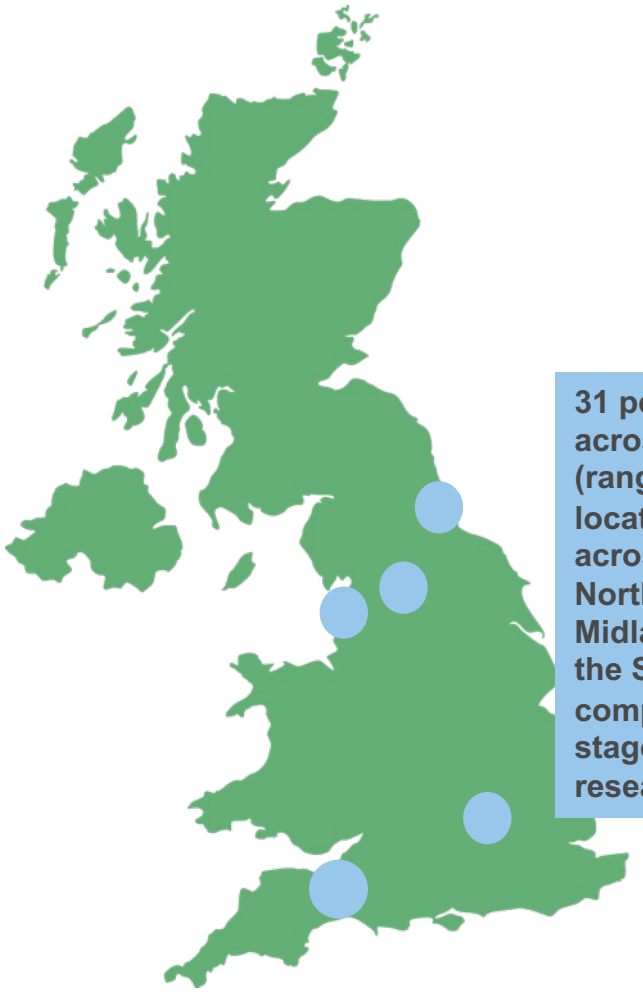
Insight & Strategy

Age UK | What do citizens expect from the NHS and social care?

November 2022

1. Introduction: why we need to talk to the public about the future of health and social care

We brought together a diverse sample of 31 people from across England to explore expectations of the NHS



31 people from across England (range of locations across the North, the Midlands and the South). 27 completed all stages of the research.

Participants took part in several stages of research

Online community	2-hour online workshop	Online community	2-hour online workshop	Online community	3.5-hour online workshop

We recruited a mix of…

- Age, gender, ethnicity, socioeconomic group and urban/rural living
- Digital literacy
- Health, including those with physical disabilities, long-term health conditions and mental health conditions
- Caring responsibilities
- Receiving care, both formally and informally

With participants located in…

- 6 x Pendle
- 6 x Blackpool
- 7 x London
- 6 x Middlesbrough
- 6 x Somerset

Fieldwork conducted in April 2022

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Presenting evidence from those working in the system was a crucial part of the dialogue process

We are grateful to the following people for sharing their perspectives and expertise during the dialogue:

- Ruthe Isden, Age UK
- Tom Gentry, Age UK
- Dr. Eileen Burns, NHS England
- Adam Gordon, British Geriatric Society
- Sally Warren, The King's Fund
- Daniel Mortimer, NHS Employers
- Jamie Anderson, Age UK Wirral
- Dr Martin Marshall, RCGP
- Dr. Adrian Hayter, NHS England
- Eve Riley, Richmond Group
- Chit Selvarajah, Independent Age
- Ruth Thorlby, The Health Foundation
- Charlotte Augst, National Voice
- Nadra Ahmed, National Care Association

What we heard: key findings

1. **Spontaneously, the public expect that the health and care systems will step in and support people who need help, when they need it**. In an ideal world, this support is based on strong relationships with professionals, particularly **GPs who are seen as central to care.**

2. **Expectations of the system are largely based on personal experience and there is low understanding of the full spectrum of patient needs.** This means the public think that the fairest distribution of resources in the system is one where everyone is treated equally.

3. Over the course of the dialogue, **participant expectations of the health and care system changed as they grappled with the impact of the challenges facing the system.** Information that was influential in changing views included hearing about the high bar of eligibility for support (i.e. that some care that was thought to be universal is not); the challenges for people with multiple long-term conditions; and the realities of the workforce crisis.

4. **The public gave less weight to other systemic challenges** e.g. health inequalities, growing demand due to an ageing population, and the efficiency of the NHS. **Evidence about these was often challenged or explained away** where it didn't align with their experiences or preconceptions of the NHS and social care.

5. **By the end of the dialogue, the public had shifted their expectations of the health and care systems and there was support for a new social contract.** They agreed that people with complex needs should be prioritised (rather than looking for universality) and felt that the GP could be less central to everyone's care.

2. What are the initial expectations and perceptions of care?

What are the initial expectations and perceptions of care?

1. There is a mismatch between the public's expectations of the availability of care and reality.

2. The public believe that the fairest distribution of resources in the system is one where everyone receives and is treated equally.

3. GPs are still seen as central to care and there are unmet expectations about levels of access.

4. The NHS is seen as underfunded, but also inefficient and wasteful.

1. There is a mismatch between the public's expectations of the availability of care and reality

- Whilst challenges in relation to access are very top-of-mind, there remains an assumption that for those with complex needs, there is a low bar to be eligible for support. Participants believe that **systems and services will step in and be there to support people with complex needs**, to enable them to live a good life.

- There is very low awareness of rationing / means testing within the system.

"When you've got complicated medical needs, continuity in medical care is very important. [He should be seeing the same GP'"

- Participant, Somerset

"Straight away he should be getting disability living allowance which enable him to get taxis [to his appointments]."

- Participant, Blackpool

2. The fairest distribution of resources in the system is one where everyone receives and is treated equally

Spontaneously, there is **little awareness of what living with complex needs means** for people's lives and requirements of health and care systems.

There is little to no understanding of population health inequalities in outcome and access e.g. based on location, ethnicity.

"Health is something everyone has a right to regardless of who they are. Everyone should get the same opportunities, for example 'we have all these options, and you can go for any of them'. I know some things are super expensive but in most cases I don't think people should be shut out."

- Participant, Blackpool

2. The fairest distribution of resources in the system is one where everyone receives and is treated equally

Low understanding of the full spectrum of needs leads to two assumptions:

1. **That everyone faces similar challenges with the health and care system. And the fairest thing to do would be to treat everyone equally.**

2. **People with complex needs will receive *extra* support, compared to healthier people. Few see an issue with this, provided healthier people still receive a good standard of care**

There aren't calls for the system to prioritise people, as they don't think it's fair, or even necessary.

3. There is an entrenched idea that the GP should be central to care and unmet expectations about levels of access

GPs are expected to…

Be available whenever patients need to see them.

Have strong relationships with their patients. People want to know their GP and want their GP to know them.

Prescribe medication. Often the default outcome of an appointment vs. preventative or self-care advice.

Signpost to wider health and care support as necessary.

3. There is an entrenched idea that the GP should be central to care and unmet expectations about levels of access

There remains a strong perception that **the 'best' and most effective care is provided by doctors**, rather than other healthcare professionals, and that this care is led, from the patient perspective by GPs.

This means **the public can be reluctant to accept care from other professionals**, as it falls short of their expectations.

"At one point we were talking to who we thought was a doctor and it was a nurse. I know sometimes the nurses are ok but the doctor's gone through all these years of medical training. Doctors are supposed to know more."

- Participant, Pendle

4. The NHS is seen as underfunded, but also inefficient and wasteful

There is widespread agreement that the NHS (and to a lesser degree social care) needs to be better funded.

"Essentially more funding is required to fix the root cause of poor healthcare and not short-term fixes such as digital data sharing."

- Participant, London

4. The NHS is seen as underfunded, but also inefficient and wasteful

But there's a perception that the NHS does not always use its funding well and so 'more money' on its own isn't going to address all the challenges facing the system.

X There are too many managers

X Patients 'abuse' the system

X The system is inefficient, complicated and not joined-up

"Management of the NHS has created this mess… True and effective management simplifies systems so they work more efficiently. The management in the NHS has one aim, to overcomplicate the system."

- Participant, Pendle

"There's a doctors surgery in the same building as a pharmacy in my village and it's like its left arm doesn't know what its right arm is doing. The doctor won't know something, then the pharmacist won't know something. You get bounced around and in a real state."

- Participant, Somerset

3. Changing expectations: how did learning more about the system influence views?

Throughout the course of the dialogue we shared information with participants on the challenges of facing the health and care systems, possible solutions, and the trade-offs that could be made.

The information that did most to change views was usually rooted in individual experiences

The full spectrum of patient needs

"I'd be happy to have a shorter appointment or to wait longer. To be honest, I haven't needed to see my GP in years – I don't need it as much as other people do."

- Participant, Blackpool

High eligibility for support

"It seems a shame that someone would not be eligible to access support based on not meeting certain criteria, when it seems like if he had help at an earlier stage he would not need as much support later on. That would alleviate the pressure on the services."

- Participant, Somerset

The realities of the workforce crisis

"After listening to the GP, I think I have gained a better understanding. I may have lacked full thought about the difficulties with being able to see a GP whenever for whatever. […] I didn't realise they would be so busy; my basic assumption would have been something along lines of, [GPs] physically seeing patients all day without consideration of the more back-end stuff."

- Participant, Blackpool

These points help people think beyond their own personal experiences with the health and care systems (where they see challenges centering around access and inefficiencies) to think about other experiences and challenges across the system.

In contrast, information about heath inequalities did not impact views

People **experience the health service through individual interactions, and rarely think about it a system level**.

So, while they can grasp the concept of a discriminatory incident, they find it harder to engage with the concept of a discriminatory system.

"I just don't believe in this statement. How can a different ethnicity be more prone to a problem just by their ethnicity. We are all human?"

– Participant, East Lancashire

The public see **individual choices as the main driver for health** outcomes.

So, the idea that outcomes are powerfully shaped by environmental factors is less top of mind and difficult to accept. In this context, there is a tendency to default to individualistic explanations to account for inequality in the system.

"I'm confused by the reasons for this. Maybe a lack of communication or confidence in addressing health problems within ethnic minority communities?"

- Participant, Middlesbrough

Regional inequalities are a more compelling reason for change but the public think about this issue through the postcode lottery lens

What experts meant by regional inequality:	Different social and economic conditions in different parts of the country result in different outcomes.	Therefore, allocating more resources to where there's greater need can achieve more equal outcomes.

As before, the influence of social determinants of health are not understood nor recognised amongst the public:

What the public understand by regional inequality	Some areas of the country have access to greater resources, creating a postcode lottery which in turn leads to different outcomes.	Therefore, allocating resources more evenly across the country should achieve more equal outcomes.

Arguments about the relative efficiency of the NHS do not convince, even when presented with evidence

Information shared:

"Some people suggest that reducing waste in the NHS will free up money. However, most of the evidence suggest the NHS is fairly efficient compared to other countries: We spend less on drugs and medicines; and the average length of stay in hospital is shorter. And we hear a lot about the number of managers in the NHS. But actually only around 4% of the NHS workforce are in a managerial role."

"I don't believe that it's the amount of money. It's just how to not waste money. Give one person 10 quid and they'll get a meal for four people and another person will come back with some magic beans. There are further efficiencies that can be made – what about all the people who don't turn up to their appointments for a start?"

– Participant, Pendle

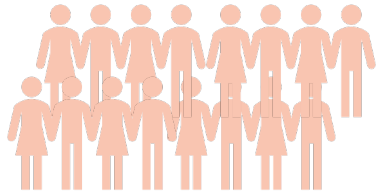
Whilst it's accepted there is an ageing population, there is resistance to framing this as a challenge for the system

This is due to a lack of engagement at two levels:

At an individual level, people do not think of themselves as old. As such they don't see the need to plan for declining capability.

"I saw on my notes at the doctor that they said I was a 'frail old woman'. I was fuming. I know I'm 72, but I'm not frail."

– Participant, Blackpool



At the system level, there is little engagement with the consequences of ageing on the system and pushback against being seen as 'a burden'.

"Elderly people have funded this system their entire lives and now we're a burden?! … The Government has had 60 – 80 years to prepare for this!"

– Participant, Somerset

How did views change?

Where did the public move to?

1. The public understood that there is a high bar to eligible for support due to pressures on the system, meaning people who need care are often going without. **This made them think a degree of prioritisation – rather than equality – is necessary**.

2. They recognised that **certain people have higher needs** than them. This reinforced their perception that **people with complex needs should be prioritised** over others e.g. for relationship-based care.

3. They understood the full extent of pressures facing GPs, leading to a view that **GPs should be less central to everyone's care** and instead hold **strong relationships with those with complex needs**. Others should feel **content seeing nurses and pharmacists.**

4. Perceptions of the NHS as inefficient and wasteful remain. Whilst the public agree the system should be better funded – and were open to how this could happen – there was also agreement it should use its funding 'better'.

1. A degree of prioritisation within the system is necessary

The surprise that some people – who the public see as being in need – are not receiving the care they need is jarring and leads to calls for prioritisation.

"NHS services are not there to manage quality of life. The pressure on [other] services mean that he will be screened out both financially and medically; hence he may fall through the cracks."

- Participant, Blackpool

"It seems a shame that someone [with complex needs] would not be eligible to access support based on not meeting certain criteria, when it seems like if he had help at an earlier stage he would not need as much support later on. That would alleviate the pressure on the services."

- Participant, Somerset

2. People with complex needs should be prioritised over others

The health and care systems are under pressure and cannot deliver 'ideal' care to everyone.

People with complex needs face additional challenges and would benefit more from relationship-based care.

People with complex needs currently might be ineligible for certain support, worsening their quality of life.

Addressing other forms of inequalities (e.g. regional inequalities) would not work in practice.

"I'd be happy to have a shorter appointment or to wait longer. To be honest, I haven't needed to see my GP in years – I don't need it as much as other people do."

- Participant, Blackpool

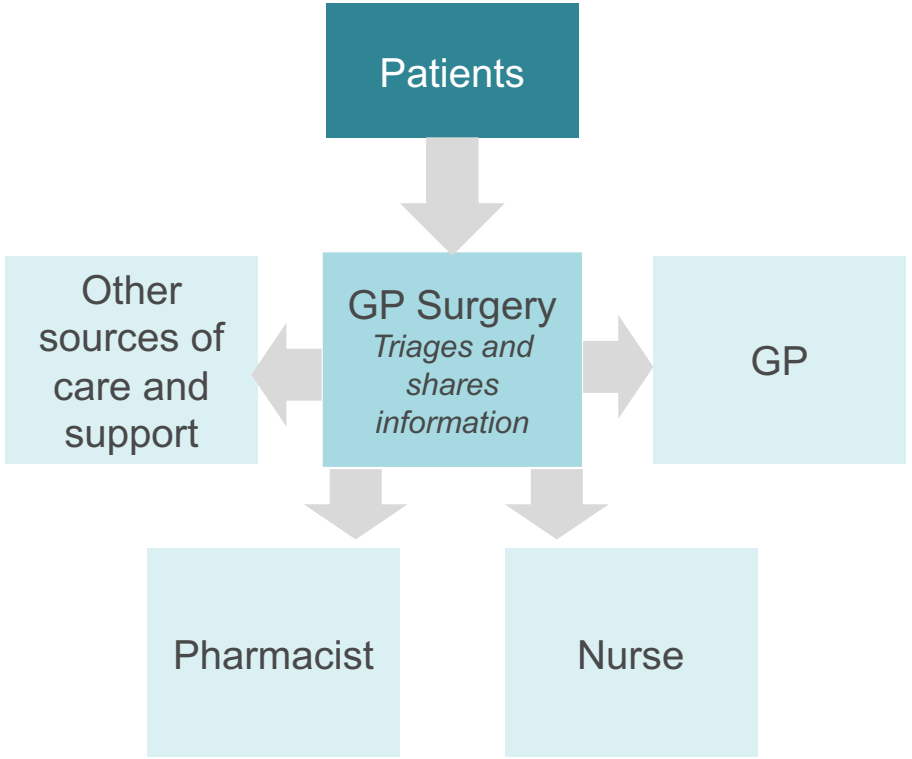
3. The GP should be less central to everyone's care

Reflecting on the experiences of others, participants saw that some patients would benefit more from a stronger relationship with their GP compared to others.

Those without complex needs could have a relationship with a GP surgery, which includes other professionals who could see more straightforward cases.

"People having varying levels of need for care and it doesn't make sense for everyone to have to go to the same person for everything. People with more complex issues/long term illness would benefit from building a relationship with their GP for example whereas me, who just requires some hay fever medication could just get that from a pharmacist without the need to bug a GP."

- Participant, Middlesbrough



4. So what does this mean?

Amongst our informed participants, there is support for a new social contract between the public and the NHS and social care systems

"If you've got a complex health situation, it's better to see the same person because they know you, so should be able to deal with you more quickly, and it instils a sense of trust in you as an individual… If you're coming in for a one off, then it's fine to see anyone qualified."

- Participant, Somerset

However, without access to the same information, the wider public are less likely to support change

65%

agree that people with complex needs should be prioritised by the NHS.

But support drops when the public are confronted with specific trade-offs, without taking part in a deliberative experience:

59% agree if it means they have to see a nurse, or other healthcare professional instead of a doctor

50% agree if that means they have to receive more care remotely

49% agree if it means they have to wait longer

Q7. Thinking about this way of reducing pressure on the NHS, to what extent do you agree or disagree with the following statements? Base: All respondents with fewer than 2 health conditions (n=1726)

So how do you overcome this challenge?

Understand the starting point

The public have limited bandwidth and there is a risk that communicating the cumulative impact of the challenges could tip people into fatalism.

Any messaging must therefore:

1) **Strike a balance between realism and despair**
2) **Be specific, focused and disciplined**

92%

of the general public say the cost of living is concerning

UK inflation forecast to hit 18.6% early next year

Cost of living: Over a third cut back on essentials

*"Definitely what worries me the most is the talk around the cost of living is going up - you can see with petrol costs and electricity and obviously **this is really worrying for me**."*

Root arguments in the information that we know has an impact

This information is well known and tends to have a limited impact:

- ✗ The NHS is underfunded
- ✗ There is a shortage of doctors and nurses
- ✗ NHS workers haven't received a pay rise

Instead, share information about:

- ✓ The full spectrum of patient need
- ✓ The high bar to be eligible for support (and the consequences of this)
- ✓ The realities of the workforce crisis, including daily pressures rather than pay
- ✓ The impact on people, rather than systems

Be confident that there are publicly acceptable solutions to some of the challenges facing the system

Prioritisation within the system is accepted. Similar to the triage process in A&E, the public will trust the process more if:

It is **based on individual need and circumstance,** rather than population inequality.

They **see healthcare professionals assessing and assigning people** to appropriate segments. There may be **less trust in the 'system'** doing this allocation.

The **transition between segments is proactive and routinely assessed.**

Anastasia Knox
aknox@britainthinks.com

Allie Jennings
ajennings@britainthinks.com

Thank you

T: +44 (0)20 7845 5880

www.britainthinks.com

BritainThinks
West Wing
Somerset House
London
WC2R 1LA
United Kingdom