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ORIGINAL ARTICLE

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Health systems in the COVID-19 crises: Comparative patterns of NHS satisfaction and preferences for public health action in Scotland and England

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Abstract

It is often claimed Scotland is more social democratic in outlook compared to England, if this is the case then we might expect to find differences in public attitudes towards health and social justice, reflecting the growing health policy divergence between the two nations. Comparative attitudes towards healthcare in Scotland and England are worthy of close scrutiny here, given the different reform trajectories, with the running of the Scottish NHS based on professionalism and the English NHS structure built on market-based principles. The Scottish Government also implemented stricter lockdown restrictions compared to the UK Government in England. However, the extent to which the policy responses to the pandemic reflect different attitudes towards collective public health action in the two countries remains under-researched. In this article, public attitudes towards health in Scotland are compared with those in England. The comparative analysis relies primarily on survey data from the International Social Survey Programme (ISSP) module on health and healthcare. This survey was fielded in Scotland and England in the autumn of 2021, during the COVID-19 pandemic. Overall, Scotland is more solidaristic or 'social democratic' than England on key issues relating to public

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health action and social justice. The findings reveal some commonalities between the nations, confidence in the NHS during the pandemic, and a willingness to improve the health service via higher taxes for example, but also important differences in attitudes and preferences for state action exist that help set the scene for greater policy divergence in the UK.

KEYWORDS
comparative social policy, COVID-19, health policy, public opinion

1 | INTRODUCTION

Although people still talk of the 'British' National Health Service (NHS), the publicly funded health systems found in the four nations of the United Kingdom of Great Britain and Northern Island are strikingly different. Until relatively recently at least, the differences observed in the UK's national health services have tended to be regarded as a consequence of history and geography (Stewart, 2003, 2004). Today, however, there is growing recognition and interest in the influence of politics on diverging health systems.

In the UK, devolution has given the Parliaments and Assemblies of Scotland, Wales and Northern Ireland many powers to make laws and deliver public services like health. The organisation of health services in each of UK's four nations is driven increasingly by political considerations, with autonomous decision-making structures governing NHS England, NHSScotland, NHS Wales and HSC Northern Ireland. The extent to which the differences we now observe in policy reflect a divergence between the core social and political values found in the four nations is important for understanding how difference is produced and why it matters.

The comparative focus in this article is between health systems in Scotland and England, justified since Scotland has adopted a social democratic perspective on health, democracy and state action that contests the liberal vision of society and the policy positions developed by the Westminster Parliament. Does that mean public attitudes and preferences on issues to do with health, state action and social justice are different in Scotland compared to attitudes found in England, and if so, to what extent? Empirically, the article draws on recent waves of nationally representative public opinion data recently made available for both Scotland and England, taken from the International Social Survey Programme's (ISSP) health and healthcare module. Before describing the study methods and results and discussing their implications, we consider the scholarship that discusses social attitudes and social reform, with a particular focus on the changing policy context in Scotland.

2 | PUBLIC ATTITUDES AND SOCIAL REFORM

In comparative policy research, the study of public opinion helps us to understand the legitimacy of health and social welfare policy, and the role of contextual factors, both as contexts influencing attitudes and as factors in policy feedback loops (see recent reviews by Ferragina & Deeming, 2022; van Oorschot et al., 2022). If Scotland is more social democratic than liberal, compared to England, then we might expect to find significant discernible differences according to welfare regime theory in public attitudes on important issues to do with health and social justice (Deeming, 2018; Ferragina & Deeming, 2023; Wendt et al., 2009, 2010).

Under devolution, the Scottish Government has been learning from the Nordic countries and has adopted a more social democratic approach to health and social policy, fashioned by social investment and inclusive growth

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policies, stronger safety nets and a more progressive taxation regime compared to England (Deeming, 2019; Keating, 2017). There is a strong and growing emphasis on citizenship rights in health and social care services. The internal market in healthcare (introduced before devolution) was dismantled in Scotland in 2004 (with the abolition of NHS Trusts), but remains intact in England (Greer, 2004; Stewart, 2004). Free NHS eye and dental checks were introduced in 2006, while prescription charges were abolished in 2011, whereas none of these steps has been taken in England.[1] Investing in health and the healthcare sector is an inherent part of the social investment approach (Goijaerts et al., 2023; Schwander, 2019). A sustainable welfare state requires a healthy well-educated workforce for example, while social investment welfare states promote greater social wellbeing (Deeming & Hayes, 2012; Hemerijck et al., 2023).

Personal care is also free at the point of need in Scotland, whereas it is means-tested in England. Mental health service users in Scotland benefit from enhanced rights (Mental Health [Scotland] Act of 2015), while there is an emphasis on the human right to social security in legislation (Social Security [Scotland] Act 2018). Targets to reduce poverty were abolished in England while the policy commitment was reiterated in Scotland. The Child Poverty (Scotland) Act of 2017 set new legal targets to reduce child poverty in Scotland by 2030. Free tuition for university education is another example of solidaristic social policy (Graduate Endowment Abolition [Scotland] Act 2008). Such policy differences might reflect or engender greater public support for a social democratic vision of society in Scotland. Certainly, taxation has become more progressive in Scotland, under the Scotland Act of 2016. Higher earners in Scotland now pay higher taxes and lower earners pay lower taxes compared to high and low earners in England (Deeming, 2019).

Social democratic thinking also underpins the theory and practice of public health intervention in Scotland, resulting in some striking differences between the two countries in respect to public health policy and responses to COVID-19. Responsibility for public health is a devolved matter and the Sottish Government has introduced a range of new public health laws (ahead of England) over the past two decades. Flagship public health policies include, for example, the smoking ban in public spaces from March 2006 (Smoking, Health and Social Care [Scotland] Act 2005) and the introduction of minimum unit pricing from May 2018 to help reduce deaths attributable to alcohol (Alcohol [Minimum Price per Unit] [Scotland] Order 2018). While a Soft Drinks Industry Levy (SDIL), also known as the 'sugar tax', is designed to help reduce childhood obesity (Soft Drinks Industry Levy Regulations 2018). These initiatives, it is argued, reflect a more consensual and consultative approach to policymaking compared to the UK model of government, more 'bottom up', less 'top-down' (Cairney, 2023).

Devolution also played a role in shaping how Scotland responded to the COVID-19 pandemic (Coronavirus [Scotland] Act 2020). Scotland was the most stringent (strict) of the UK nations in its application of lockdown measures. Restrictions on commercial activity and social mixing, together with a requirement to wear a facemask, tended to be tightened more quickly and eased more slowly than in England. More interventionist social democratic policies to protect public health in the pandemic can be contrasted with values that are liberal and policy designs that pursue more minimal intervention to promote individual freedoms and choice, economic activity and growth, as Walby (2021: 24) observes:

> Social democratic visions and practices underpin the theory and practice of 'public health' interventions into COVID as well as other health issues. Social democracy is the model of society that informs the public health project, in which 'if one is sick, we are all potentially sick' and in which the risks and costs associated with sickness are shared by the whole society, not only the individual who is sick.

The comparative differences in public health policy and the responses to the pandemic may reflect, at least to a degree, different public attitudes and preferences between the two countries, on the merits of collective action and associated trade-offs with individual freedom and personal responsibility. Public preferences and pandemic responses are under-researched at present, particularly from a comparative perspective (Greer et al., 2020; Engler et al., 2021).[2]

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Meanwhile, the Scottish National Party (SNP) has increasingly represented Scotland as a progressive social democratic nation with a more inclusive Nordic-style welfare state.[3] Do people living in Scotland with a more universal welfare state see a stronger connection between health and social justice and their own interest compared to people living in England (Kumlin, 2004; Rothstein, 1998). If divergence reflects core differences in electoral politics and institutional contexts between the two nations, then we would expect to find discernible differences in public attitudes in the ISSP health and healthcare data. With Scotland being more social democratic. The extent to which Scottish voters are more left-wing compared to voters in England is an open question.

3 | METHOD AND DATA

The data employed here for the comparative analysis of attitudes to health and healthcare in Scotland and England comes from the International Social Survey Programme (ISSP Research Group, 2024). ISSP is a cross-national survey collaboration programme that began in 1984. Currently, 45 countries are members. Scotland became a member for the first time in 2019, paving the way for reliable new comparative research on Scottish social attitudes for the first time.[4]

ISSP provide country-level datasets, based on nationally representative sample surveys. Here we use the Scottish and British ISSP health survey data collected in the autumn of 2021, during the pandemic. The British data is restricted to England only, for the comparative analysis of Scottish and English attitudes. The total sample count is 2130 completed interviews, 1144 respondents from Scotland and 986 respondents from England.

The ISSP data used in the analyses has a multi-level structure. The individual at one level is nested within the country at the other level. Multiple regression procedures for small-N country estimations are therefore employed (see Esping-Andersen, 2007). The findings section provides descriptive analyses of the country-level results with conventional tests of statistical significance, logistic analysis for binary categorical outcomes and linear regression analysis when the dependent variable is continuous. In the regression analyses, there are control variables measuring individual characteristics that are likely to affect the outcome but they are less theoretically relevant in the present context. They are age, gender, education and income. Fixed-effects models therefore include a set of dummy variables for age, gender, education and income as well as country.

Descriptive statistics are contained in the appendix (Table A1). More than half of the sample is female (56.2%) and less than half are male (43.8%). Just over half of the sample are aged 18–59 (54.0%) and just under half are aged 60 and over (46.0%). For about half the sample the highest educational qualification obtained is degree level (49.2%), 41.5% report educational attainment below degree and 9.3% have no formal qualifications. Weekly household income is grouped into four groups, income quartiles. The bottom 25% includes income of £1000 or less per week, and the top 25% includes income more than £2500 per week.

The dependent variables in the analyses relate to key health and healthcare policy and service issues, and support for governmental action on health and social justice concerns. The ISSP survey module uses Likert-scale attitudinal questions. Respondents were asked whether they would tend to agree or disagree with the following statements:

- People suffer from severe health problems because they are poor
- People should have access to publicly funded healthcare even if they do not hold citizenship
- People should have access to publicly funded healthcare even if they behave in ways that damage their health
- People use healthcare services more than necessary
- The healthcare system is inefficient
- The government should provide only limited healthcare services.

The last three statements here tap support for core NHS principles, concerning support for universal and comprehensive healthcare services. Respondents were also asked whether it is:

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- Fair or unfair that people with higher incomes can afford better healthcare than people with lower incomes
- Easier or harder to get access to healthcare for rich people than for poor people
- Easier or harder to get access to healthcare for women than for men
- Easier or harder to get access to healthcare for old people than for young people
- Easier or harder to get access to healthcare for people who do not hold British citizenship.

Whether they are:

- Satisfied or dissatisfied with the healthcare system, along with how much confidence they have in the health service
- Likely to get or not get the best treatment available if they become seriously ill
- Willing or unwilling to pay higher taxes to improve the level of healthcare for all.

The survey also asked respondents to provide the reason if they did not get the medical treatment they needed in past 12 months:

- Long waiting lists
- Could not pay for medical treatment
- Could not take the time off work.

Fundamental questions about the relationship of individuals to society came to the fore in the pandemic. The ISSP survey therefore obtains views on whether government should or should not have the right to take action in a severe epidemic:

- Shut down businesses and places of work
- Close schools and kindergartens
- Demand that people stay at home
- Require people to wear facemasks.

Finally, the survey also asked respondents whether the way the COVID-19 pandemic was handled increased or decreased confidence in government.

Some of the ISSP survey module questions are specifically pandemic-related, many are not, they are about attitudes and experiences of health and healthcare in general. That said, the survey module was fielded during the global public health emergency, affecting health service delivery across the UK and elsewhere and so the responses are pandemic-related. The next section presents the findings, organised under three headings: comparative attitudes and preferences for health and social justice; comparative attitudes and preferences on the provision of healthcare; comparative attitudes and preferences for actions in a public health emergency.

3.1 | Comparative attitudes and preferences for health and social justice

Poverty is both a major cause and a consequence of poor health, and it is a barrier to accessing healthcare when needed (Marmot et al., 2020). In a country with a social democratic outlook, we might expect more people to be concerned about health and social justice, and to recognise the damaging effect that poverty has on health. Certainly, the right to health has been a central feature of public health policy initiatives in Scotland (Public Health Scotland, 2021).

To assess the appreciation of the link between poverty and health, respondents were asked if people suffer from severe health problems because they are poor. Table 1 presents the comparative findings, structured by respondents living in Scotland and those living in England. People in Scotland are significantly more likely to say that people suffer

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TABLE 1 People suffer from severe health problems because they are poor.

	Scotland%	England%
Strongly agree	15.8	9.3
Agree	47.5	42.9
Neither agree nor disagree	21.3	28.6
Disagree	12.4	15.0
Strongly disagree	2.1	3.0
Can't choose	0.9	1.1
	Exp (B)	
Agree[a]	1.54***	(comparator)
Missing	7	2
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Strongly agree/agree.
Source: ISSP Research Group (2024).

from severe health problems because they are poor. In total, 63.3% agree with this statement, compared with 52.2% in England—a difference of 11.1% points. Responses in Scotland are more emphatic, with 15.8% of Scottish respondents agreeing strongly with this statement, compared with 9.3% of English respondents. As such, living in Scotland significantly increases the relative odds of claiming poverty is responsible for health problems by 50%, compared to living in England after controlling for age, gender, education and income.

As noted earlier, the social democratic ideal of universal access to healthcare based on need rather than ability to pay is the hallmark of the British NHS. If Scotland is more social democratic than England, we might expect to find people in Scotland are more likely than their counterparts in England to feel that it is unfair for better-off people to obtain better public services like healthcare. Conversely, we might expect to find more people in England to say it is fair for rich people to be able to purchase better healthcare. Put simply, if public opinion in Scotland is more social democratic than England in its outlook, more people should say buying better healthcare is unfair.

To measure attitudes on this issue, the survey asked respondents if it is fair or unfair that people with higher incomes can afford better healthcare than people with lower incomes. Significantly more people living in Scotland say it is either 'very unfair' or 'somewhat unfair' that people with higher incomes can afford better healthcare (Table 2). Overall, 62.8% of people living in Scotland compared to 55.8% living in England feel it is unfair that rich people can afford better healthcare—a 7.0% point difference. The difference in attitudes between the two countries is significant with the sociodemographic controls in place.

Is the greater concern for equity also accompanied by a more generous interpretation of 'universalism' in Scotland? Throughout Britain, the NHS operates on a residence-based principle—healthcare is available free at the point of use for everyone considered 'ordinarily resident', irrespective of citizenship. However, the potentially negative impact of immigration on the legitimacy of and support for the welfare state has been noted internationally (Burgoon & Rooduijn, 2021; Garand et al., 2017). Those who are concerned about immigration are more likely to question whether immigrants should have the same social rights and access to public services, such as healthcare, as those who hold citizenship of a country. As public opinion in Scotland is often thought to be more favourable towards immigration, perhaps that view is less common in the survey data compared to public opinion in England. Meanwhile, it is sometimes suggested that people's access to the NHS should be circumscribed if they engage in behaviours that damage their health (Pillutia et al., 2018). Are people less likely to feel that way In Scotland, where poorer health outcomes associated with smoking, alcohol and obesity are more prevalent?

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TABLE 2 Fair or unfair people with higher incomes can afford better healthcare.

	Scotland%	England%
Very fair	4.9	5.9
Somewhat fair	11.6	14.3
Neither fair nor unfair	18.9	22.6
Somewhat unfair	27.4	25.4
Very unfair	35.4	29.9
Can't choose	1.8	1.8
	Exp (B)	
Unfair[a]	1.40***	(comparator)
Missing	2	3
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Very unfair/somewhat unfair.
Source: ISSP Research Group (2024).

To ascertain views and preferences on these matters, the ISSP survey asked respondents whether people should have access to publicly funded healthcare if they do not hold citizenship. It also asked respondents whether people should have access to publicly funded healthcare if they behave in ways that damage their health. The responses given by people living in Scotland and England to the citizenship question are presented in Table 3. While most agree non-citizens should not have access to publicly funded healthcare, we also observe more people in Scotland than in England claim non-citizens should have access to publicly funded healthcare, and the difference here is significant controlling for other factors. Most also agree those who behave in ways that damage their health should not have access to publicly funded healthcare (Table 4). However, significantly more people in Scotland (than in England) believe those who engage in behaviours that damage their health should still have access to publicly funded healthcare: 40.1% of people in Scotland claim this compared to 34.5% in England.

Meanwhile, if people in Scotland and England regard a universal healthcare system that addresses need as an essential element of a just society, then we might expect survey respondents to reject propositions that challenge that point of view (Deeming, 2018; Wendt et al., 2009, 2010). This is now considered in relation to the following issues: rationing or limiting the menu of healthcare services; overuse of healthcare services; and inefficiencies in the health system. The first issue speaks to principles of universality directly. The other two reflect criticisms that are sometimes made of a publicly funded health service that is free at the point of use, that it is relatively insulated from the market mechanism that helps to promote efficiency (Le Grand, 2007).[5]

The great majority of people living in Scotland and England do not think government should only provide limited healthcare services, nor do they believe healthcare services are used more than necessary. On the issue of inefficiency in the health service however, the public appears more divided in both countries (Table A2 in the Appendix). Combining the individual responses from the three questions creates a composite measure of public support for universal and comprehensive public healthcare in both countries: a high score here indicates strong support for core NHS principles. Overall, we find public support for core NHS principles is significantly stronger in Scotland compared to England, with the statistical controls in place.

Given the greater concern about health inequalities in Scotland, and the greater concern for equity, are people living in Scotland willing to pay higher taxes to fund improvements in the health service compared to people living in England? We are able to gauge views on this issue since the ISSP survey asked respondent's about their willingness to pay higher taxes to improve the health service for everyone.

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TABLE 3 People should have access to publicly funded healthcare even if they do not hold British citizenship.

	Scotland%	England%
Strongly agree	10.4	7.3
Agree	24.5	21.8
Neither agree nor disagree	14.4	16.2
Disagree	29.6	30.1
Strongly disagree	18.8	22.6
Can't choose	2.3	1.9
	Exp (B)	
Agree[a]	1.44***	(comparator)
Missing	1	0
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Strongly agree/agree.
Source: ISSP Research Group (2024).

TABLE 4 People should have access to publicly funded healthcare even if they behave in ways that damage their health.

	Scotland%	England%
Strongly agree	7.5	6.2
Agree	32.6	28.2
Neither agree nor disagree	25.6	25.8
Disagree	23.6	29.2
Strongly disagree	8.5	9.3
Can't choose	2.3	1.2
	Exp (B)	
Agree[a]	1.32**	(comparator)
Missing	9	9
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Strongly agree/agree.
Source: ISSP Research Group (2024).

As Table 5 shows, most people in Scotland and England are in favour of higher taxes to improve the health service during the pandemic. More people in Scotland are in favour of higher taxes compared to people in England, and fewer people living in Scotland object to higher taxes compared to people living in England. In Scotland, 59.8% of the population say they would be 'very' or 'fairly' willing to pay higher taxes to improve the health service compared to 55.0% in England; while 22.2% in Scotland and 24.7% in England say they would either be 'fairly' or 'very' unwilling to pay higher taxes for health service improvements.

In summary, support for additional spending via higher taxes points towards an appetite for greater investment in the NHS, at a time when NHS waiting lists are predicted to keep rising until the summer of 2024. More people living in Scotland (where tax rates for most earners are already higher than in England) are in favour of higher taxes to fund a better health service. At the same time, more people in England are unwilling to pay higher taxes for health service improvements compared to people in Scotland. The differences in views here are statistically significant after

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TABLE 5 Willing or unwilling to pay higher taxes to improve the level of healthcare for all.

	Scotland%	England%
Very willing	17.0	15.6
Fairly willing	42.9	39.4
Neither willing nor unwilling	15.6	18.0
Fairly unwilling	13.9	15.1
Very unwilling	8.3	9.6
Can't choose	2.4	2.3
	Exp (B)	
Willing[a]	1.24*	(comparator)
Missing	1	0
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Very/fairly willing.
Source: ISSP Research Group (2024).

controlling for all of the other variables in the model. For the most part then, people in Scotland are somewhat more social democratic in their attitudes towards health and social justice, compared with people in England. There is greater concern about the impact of poverty on health and a stronger commitment to a universal service based on need and not on ability to pay. Does this mean however, that people in Scotland have more confidence in the health service? We consider the provision of healthcare next.

3.2 | Comparative attitudes and preferences for healthcare provision

Although people in Scotland have a somewhat greater commitment to a universal and equitable healthcare system, this does not necessarily mean that they are more likely to think that the NHS is successful at delivering on these principles in practice. As noted earlier, ensuring everyone can access healthcare services on an equal basis has been a key priority for the NHS since its foundation. Equally, the United Nations Sustainable Development Goals (SDG) declaration emphasises the importance of Universal Health Coverage (UHC) and equitable access to quality health (UN, 2015).[6] Does the NHS in Scotland and does the NHS in England manage to uphold the founding principles, or is it failing to meet public expectations? In order to assess how the NHS is working in practice in both countries, we look at views on the funding and provision of healthcare services, and we examine a range of access and equity-related issues that service users may face.

In order to assess issues to do with equity and access, respondents were asked whether it is easier or harder to get access to healthcare for rich people than for poor people; for women than for men; for old people than for young people; for British citizens compared to those who do not hold British citizenship. The comparative distribution of responses to the first of these questions is shown in Table 6. People in England (compared to Scotland) are more likely to believe it is easier for rich people to get access to the health service than poor people. The difference in views is statistically significant after controlling for the sociodemographic variables in the model. About half (46.7%) of people in England believe it is 'much easier' for rich people than for poorer people to get access to healthcare. In contrast, only about a third (34.4%) of those in Scotland express this view—a difference of 12.3% points. As such, living in England significantly increases the relative odds of claiming it is easier for the rich by 50%, compared to living in Scotland.

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TABLE 6 Easier or harder for rich people to access healthcare than for poor people.

	Scotland%	England%
Much easier	34.4	46.7
Some-what easier	32.5	29.1
About the same	26.4	17.2
Some-what harder	2.8	4.0
Much harder	2.0	1.6
Can't choose	1.8	1.4
		Exp (B)
Easier[a]	(comparator)	1.51***
Missing	4	3
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Much/some-what easier.
Source: ISSP Research Group (2024).

Meanwhile, nearly a third (29.3%) of respondents in England who say it is easier for rich people to get access to healthcare also claim that this is fair. While in Scotland however, we find the equivalent proportion is one-in-five (19.9%). In other words, people in Scotland are more likely to think that rich people and poor people can access the health service equally well—and they are more likely to find it unacceptable when they feel that this is not the case.

At the same time however, people in Scotland and England share broadly similar views on other key indicators relating to equity of access, whether defined by age, gender or citizenship. Creating a composite measure from the individual responses, we find there is little overall difference in perceptions of access to NHS care at the country-level (see Table A3, Appendix). The vast majority of people in both countries think that access to healthcare is about the same for women and men; 91.9% in Scotland and 92.7% in England say this. The majority of women in Scotland (89.3%) and England (89.7%) also claim access to healthcare is about the same for men and women; about one-in-ten in Scotland (10.7%) and England (10.3%) say it is harder for women.

According to the survey, just over half of people in Scotland (54.6%) and in England (56.9%) say access is the about same for older adults and younger adults. In both countries, we find the proportion who think it is easier for older people to gain access to healthcare is counterbalanced by the proportion who think it is harder. Most people aged 60 and above claim that access to healthcare is about the same for old and young alike in both countries. In Scotland, 58.2% of people aged 60 or over say this, and 60.8% of those aged 60 or over in England. Few aged 60 or over, think it is harder for older people to access healthcare, just 7.8% in Scotland and 5.9% in England say this. At the same time, around a third of people in Scotland (29.9%) and England (32.5%) think that it is easier for British citizens to secure access to the health service compared to those who do not hold British citizenship. While just under half of people in Scotland (44.1%) and England (43.6%) claim access is about the same for citizens and non-citizens alike (see Table A3, Appendix).

We now turn to important aspects of public confidence in the health system in the two countries. Respondents were asked whether they would get the best treatment if they were seriously ill. Here we find people in Scotland are significantly more confident than people in England that they would receive the best treatment available (Table 7). Specifically, 68.0% of people living in Scotland say either it is 'certain' or 'likely' they would receive the best treatment available. The comparable figure for people in England is 59.0%–9% points lower than Scotland.

According to the international survey, more people in England (compared to Scotland) did not get the medical treatment needed in past 12 months. The country-level difference here is significant controlling for other factors in the model (Table A4, Appendix). In both countries, the length of the waiting list was cited as the main barrier to

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TABLE 7 Likely to receive or not receive the best treatment available if seriously ill.

	Scotland%	England%
It's certain I would get the best treatment	17.7	13.4
It's likely I would get the best treatment	50.3	45.6
Equal chance	20.2	27.0
It's likely I would not get the best treatment	8.1	9.3
It's certain I would not get the best treatment	1.3	1.9
Can't choose	2.5	2.6
	Exp (B)	
Best treatment[a]	1.45***	(comparator)
Missing	3	2
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Certain/likely.
Source: ISSP Research Group (2024).

getting treatment. Around a fifth of respondents in Scotland (20.5%) and a quarter in England (24.0%) said waiting times were an issue, indicating the extent of the problem on both sides of the Anglo-Scottish border. Pressures on waiting times that existed in both Scotland and England before COVID-19 were exacerbated during the pandemic, accelerating a decline in levels of NHS satisfaction expressed in both countries, shown in Figure 1, which shows trends in satisfaction in both countries from the 1980s, based on data from Scottish and British social surveys.

While the NHS offers a comprehensive service, it is also the case that people living in England face user charges and means-testing for some services, including prescriptions, eye and dental checks, and adult personal care services. In contrast, charges for these services have been abolished in Scotland. As might be anticipated therefore, more people surveyed in England (7.3%) say they could not afford to pay for medical treatment compared to people survey in Scotland (5.1%). These estimates imply, according to current population estimates, that approximately 3.2 million people in England and over 220,000 people in Scotland did not get the medical treatment they needed in 2021 because it was unaffordable.[7]

Importantly, the NHS pledges to provide services at a time that is convenient for patients, but access appears to be an issue for many people in work according to the survey. In Scotland, 6.5% of respondents and 8.3% in England claim they did not get the medical treatment they needed because they could not take the time off work (Table A4). Evenings, weekends and public holidays are generally 'out-of-hours' for many health services in both Scotland and England.

Historically, we find higher NHS satisfaction levels in Scotland compared to England, taken from the Scottish and British social surveys (Figure 1). According to the ISSP survey, using a different measure,[8] the great majority of people in Scotland (71.9%) and England (68.8%) are at least 'fairly satisfied' with the health service in the pandemic, and at least four-fifths appear to have at least 'some confidence' in the healthcare system (shown in Table 8). The strength of feeling is greater in Scotland compared to England. Twice as many people in Scotland (6.0%) than in England (2.7%) say they are 'completely satisfied' with the NHS. There is a relationship between perceptions of health system performance during the pandemic—in terms of confidence and satisfaction—and willingness to pay higher taxes to improve the health service (similar findings are also reported in the German context, Busemeyer, 2023). Half of those people in Scotland (52.6%) and England (47.2%) who have confidence in the NHS are also willing to pay higher taxes to improve it. Even some people who express dissatisfaction support higher taxes to improve the health service, more than one-in-ten in both countries (12.3% in Scotland and 14.0% in England).

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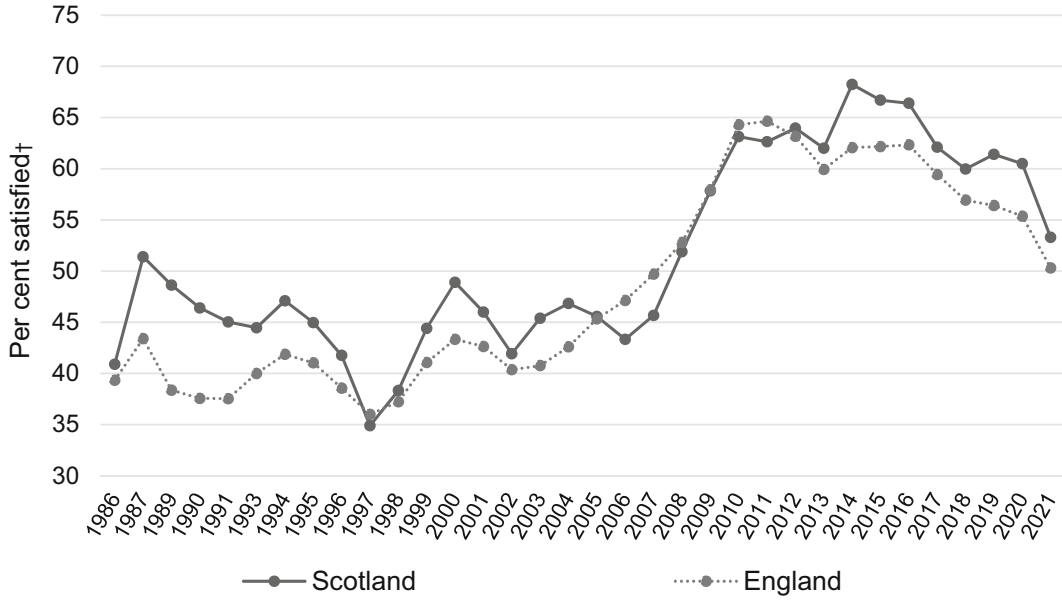

FIGURE 1 NHS satisfaction levels in Scotland and England.
†Very/quite satisfied, 1988–2021, 3-year moving average.
Source: British and Scottish Social Attitudes (NatCen Social Research, 2023; ScotCen Social Research, 2019).

3.3 | Comparative attitudes for actions in a public health emergency

The ISSP survey tapped public attitudes towards public health policy and lockdowns at times of severe epidemics. Certainly, the issue of how to protect public health in a pandemic will have been salient in the minds of those answering the survey. The ISSP health module was fielded in Scotland and England towards the end of November 2021, at this time the Omicron variant was spreading rapidly in the UK. Prime Minister, Boris Johnson, announced on December, 8, 2021 a move to tighter 'Plan B' measures in England, while in Scotland (where somewhat tighter restrictions were already in place), the First Minister, Nicola Sturgeon, urged people to stay at home as much as possible.

As discussed in the introductory section, lockdown measures in Scotland were more stringent compared to England, but to what extent, if at all, did the public in Scotland support a stricter lockdown compared to the public in England? Survey respondents were asked if the government should or should not have the right in severe epidemics to shut down places of employment, close schools, mandate people to stay at home and wear face coverings in public spaces.

The survey data reveals more people in Scotland (51.7%) than in England (46.7%) believe government 'definitely should have the right' to shut down businesses and places of employment in an epidemic (Table A5, Appendix). Similarly, more people in Scotland say government, 'definitely should have the right' to close schools in severe epidemics—49.2% said this in Scotland compared with 43.5% in England. At the same time, slightly more people in Scotland (53.8%) than in England (50.7%) believe that government 'definitely should have the right' to demand that people stay at home in an epidemic. We also find more people in Scotland say government 'definitely should have the right' to require people to wear facemasks—70.0% support this in Scotland compared with 64.8% in England.

Next, for this set of questions a derived composite score was created for all respondents in Scotland and England. The composite score index relates to the level of support for government restrictions. A high positive score identifies somebody who believes that government should have the right to act and a low score identifies somebody

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TABLE 8 Confidence and satisfaction with the health service.

	Scotland %	England %
Satisfaction		
Completely satisfied	6.0	2.7
Very satisfied	24.2	24.0
Fairly satisfied	41.6	42.1
Neither satisfied nor dissatisfied	9.2	9.9
Fairly dissatisfied	11.6	14.2
Very dissatisfied	4.3	4.4
Completely dissatisfied	2.5	1.7
Can't choose	0.4	0.9
Confidence		
Complete confidence	5.2	4.0
A great deal of confidence	33.8	32.2
Some confidence	43.9	46.5
Very little confidence	13.8	14.0
No confidence at all	3.1	2.9
Can't choose	0.3	0.5
	B	
Confident and satisfied with NHS[a]	0.18*	(comparator)
Missing	*2*	*1*
Count	*2288*	*1972*

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Composite measure combining the two questions/variables.
Source: ISSP Research Group (2024).

who believes government should not have the right to take action. The results of a regression analysis on the index of government restrictions confirm that people in Scotland are significantly more likely to believe that government has the right to act compared to people in England (Table A5).

Clearly then, there is significantly greater support among people in Scotland than in England for restrictions to protect public health. Given the Scottish government did impose tougher restrictions than those that were put in place in England, does this mean that people in Scotland had more confidence in the government's handling of the pandemic? Trust and confidence in government are clearly very important for the capacity of a society to organise and mobilise an effective collective response to an epidemic or a pandemic like COVID-19 (Bargain & Aminjonov, 2020; Covid-19 National Preparedness Collaborators, 2022).

To examine this issue, ISSP respondents were asked if the handling of the COVID-19 pandemic had increased or decreased their confidence in government. According to the survey, significantly more people in Scotland (compared with England) claim their confidence in government had increased due to the handling of the pandemic. Overall, just under half (41.2%) of people living in Scotland report their confidence increased (either 'a lot' or 'a little', Table 9). In contrast, only one-in-five (20.0%) in England said their confidence in government had increased. Three-in-five (57.9%) people in England said their confidence in government had decreased compared to a third (35.3%) of people in Scotland. Other things being equal, the odds of someone in Scotland saying confidence in government increased due to the handling of the pandemic are three times greater than someone in England.

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TABLE 9 Confidence in government due to the handling of the COVID-19 pandemic.

	Scotland%	England%
Increased it a lot	16.4	4.8
Increased it a little	24.8	15.2
Neither increased it nor	21.9	21.2
Decreased it a little	15.0	18.6
Decreased it a lot	20.2	39.3
Can't choose	1.7	0.9
	Exp (B)	
Increased[a]	2.93***	(comparator)
Missing	7	8
Count	1144	986

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]A lot/a little.
Source: ISSP Research Group (2024).

Furthermore, responses to the question about confidence in government are found to be related, at least in part, to partisanship in both countries. Supporters of the SNP in Scotland, for example, were more likely to report increased confidence in government than those who identify with one of the opposition parties in the Scottish Parliament. In Scotland, about two-thirds (62.8%) of SNP supporters say that their confidence had increased compared to a quarter (27.0%) of Scottish Labour supporters and a fifth (21.2%) of Scottish Conservative supporters. While in England, people who identify with the Conservatives were more likely to say that their confidence had increased than were those who identify with the opposition Labour Party. But even here only about a third (36.0) of Conservative Party identifiers report their confidence in government had increased due to the handling of the pandemic; this compares to about one-in-ten (8.5%) Labour Party supporters. Clearly, party loyalty helps to explain increased confidence in government but only to a degree, and more in the Scottish context than the English context.

We find the proportion of SNP identifiers in Scotland who say that their confidence had increased was much higher than the equivalent proportion for Conservative identifiers in England. Therefore, the different pattern of responses is not simply a reflection of the different pattern of political party support in the two countries. Moreover, nearly two-thirds (64.0%) of Conservative Party supporters in England report their confidence in government had actually decreased, alongside the vast majority (91.5%) of English Labour supporters.

For the most part, it seems as though the more restrictive approach to the handling of the pandemic that was adopted in Scotland increased confidence in the Scottish Government, a finding that is entirely consistent with the evidence above that people in Scotland are more supportive of enforcing restrictions in an epidemic. The same cannot necessarily be said of views of the UK Government's handling of the pandemic in England (see also Fancourt et al., 2020).

4 | DISCUSSION AND CONCLUSIONS

This article contributes to our understanding of attitudes and preferences for health and social justice in Scotland and England, a timely endeavour given the growing divergence in health systems and public health policy between the two countries.

Under devolution, Scotland has been developing a more social democratic model of healthcare and public health intervention compared to England. Universalist and solidaristic policy pillars are increasingly evident in Scotland. Do Scottish and English attitudes actually differ on key matters of health, state action and social justice however, and to what extent? Puzzling on these issues provided the context and motivation for this study.

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TABLE 10 Comparative findings summary, showing significant differences at the country-level.

	Scotland (compared to England)	England (compared to Scotland)
People suffer from severe health problems because they are poor	+++	
Unfair people with higher incomes can afford better healthcare	+++	
Support for NHS principles (derived composite measure)	+	
Easier for rich people to access healthcare than for poor people		+++
People should have access to the NHS even if they behave in ways that damage their health	++	
People should have access to the NHS even if they do not hold British citizenship	+++	
Harder for vulnerable groups to access healthcare (derived composite measure)	NS	
Did not receive medical treatment needed in past 12 months (derived composite measure)		++
Receive the best treatment if seriously ill	+++	
Confident and satisfied with NHS (derived composite measure)	+	
Willing to pay higher taxes to improve the NHS	+	
Government has the right to take action to protect public health (derived composite measure)	+	
Confidence in government increased due to the handling of the COVID-19 pandemic	+++	

Note: +significant at the 10% level; ++significant at the 5% level; +++significant at the 1% level; NS = non-significant.

Overall, we find people in Scotland are more supportive of the NHS and action on health and social justice compared to people in England. Key findings are summarised in Table 10. People living in Scotland are more concerned about health inequalities compared to people living in England. There is greater concern about the impact of poverty and inequality on health and a stronger commitment to NHS principles based on need rather than ability to pay or any other criteria such as citizenship or rationing based on risk behaviours. People in Scotland are less likely to think access to NHS services should be restricted if people behave in ways that damage their health or if they do not hold British citizenship, compared to people in England. People in Scotland are also less likely to think that richer people can access healthcare more easily and they are more likely to think that it is unfair if they do.

Confidence and satisfaction with the performance of the NHS in the pandemic is high in both countries, but higher in Scotland. People living in Scotland are also more confident that they would receive the best treatment if they became seriously ill. In some respects, the NHS is regarded as being no more or no less equitable in Scotland than in England. The two nations have similar healthcare systems, so we might not expect attitudes to vary significantly here. When it comes to equality of access, a key principle of the NHS, there appears to be little difference between the two health systems, based on age or gender. In other respects however, access to NHS care is a health inequality issue according to the survey data, particularly for non-citizens. While many report problems accessing care in a timely way due to long waiting times or due to user charges, which is more of an issue in England.

More people in Scotland believe government has the right to take action to protect public health. Given this, and given the fact that the Scottish Government implemented stricter lockdown restrictions, it is entirely consistent to find public confidence in government is significantly greater in Scotland due to the handling of the pandemic. The odds of someone in Scotland saying confidence in government increased due to the handling of the pandemic are three times greater than someone in England. Increased confidence in government can be explained by partisanship

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but only to a degree, it does not fully account for it in either country. Two-thirds of Conservative Party supporters in England, for example, report their confidence in government had decreased due to the handling of the pandemic. The ISSP survey does not allow for a direct comparison of public opinion here before, or indeed after the COVID-19 crises, since the first wave of the health survey in 2011 did not include either Scotland or any question relating to epidemics (ISSP Research Group, 2015).

According to the international survey, Scotland is essentially more solidaristic or 'social democratic' than England on key issues relating to health and social justice. At the same time, the extent of these differences should not be overly exaggerated. The English NHS remains essentially 'social democratic' in character, as Seaton (2023) observes. In England, we still find support for public healthcare and confidence in the NHS as an institution. The vast majority of people in England support a comprehensive public health service, while about half of the population think it is unfair if rich people buy better healthcare. When it comes to healthcare, English attitudes are also 'social democratic' to a degree, which in part helps to explain why the NHS survived Thatcher's efforts to reform and privatise important aspects of healthcare in the 1980s (Pierson, 1994).

With the NHS continuing to face significant challenges, the analysis also indicates a certain willingness to pay for additional spending to improve the health service via higher taxes in both countries. Support for higher taxes is greater in Scotland where most earners are already paying higher taxes compared to England. More people object to higher taxes in England where most earners pay lower taxes. At the individual-level, support for additional spending on healthcare is conditioned by confidence and satisfaction with the service, but still we find one-in-ten people in Scotland and England are willing to pay higher taxes to improve the health service.

The findings reveal some commonalities between the nations but also important differences in attitudes and preferences that help set the scene for greater policy divergence in the UK. Doubtless, the handling of the pandemic, strengthening the right to health and social welfare, and tackling deep-rooted health and social inequality are all likely to feature in Scottish policy debates as the country moves further away from policy positions developed by the Parliament in Westminster.

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DATA AVAILABILITY STATEMENT

All ISSP collected data and documentation is available free of charge, www.issp.org. Material from the British and Scottish Social Attitudes Surveys has been made available by the UK Data Service, www.data-archive.ac.uk (where this project on attitudes to welfare is registered: 73549).

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ENDNOTES

[1] User charges were introduced in an effort to contain costs, dental and ophthalmic charges in 1951 and prescription charges in 1952 (NHS Amendment Act 1949).

[2] In practice, restrictions in many Nordic countries—Iceland, Sweden and Finland—were relatively mild during the pandemic. Swedes were free to conduct their life as usual with the exception of a ban on large gatherings of more than 50 people.

[3] The SNP is a Scottish nationalist centre left social democratic political party in Scotland that was formed in 1934, https://www.snp.org/about/. In power since 2007, it has sought to make Scotland an independent social democratic state within the European Union.

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[4] The first round of the ISSP health module was conducted in 2011. Scotland did not feature as a separate country. Scottish responses formed part of the sample for Great Britain as a whole (ISSP Research Group, 2015). The country unit and survey responses are coded 'Great Britain' and cannot be disaggregated for Scotland and England; that is not possible. Further information is available on the ISSP website: www.issp.org.

[5] This is the rationale for the introduction of a quasi-market health system in England (Le Grand, 2007), while others claim this represents a move to privatise the English NHS (Pollock, 2006).

[6] Universal healthcare systems are vital for promoting global public health security, a global priority objective of the World Health Organisation (WHO, 2021), the global health agency of the UN. The inclusion of UHC in the SDGs (Target 3.8) is rooted in the right to health.

[7] Figures calculated based on population estimates produced by the ONS (2021).

[8] The satisfaction question fielded on ISSP differs to that fielded on the British and Scottish surveys, any direct comparisons should be treated with caution. The ISSP response scale includes different categories, that is, 'completely', 'very' and 'fairly' satisfied or dissatisfied, compared to 'very' and 'quite' satisfied or dissatisfied on the British and Scottish surveys.

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APPENDIX A

TABLE A1 Descriptive statistics.

	Count	%	Valid%
Gender			
Female	1194	56.1	56.2
Male	932	43.8	43.8
Missing	4	0.2	-
Total	2130	100	100
Age			
18–29	134	6.3	6.3
30–39	240	11.3	11.3
40–49	331	15.5	15.6
50–59	444	20.8	20.9
60–69	504	23.7	23.7
70+	475	22.3	22.3
Missing	2	0.1	-
Total	2130	100	100
Highest educational qualification			
Degree or equivalent	1045	49.1	49.2
Below degree	882	41.4	41.5
No qualification	198	9.3	9.3
Missing	5	0.2	-
Total	2130	100	100
Household income groups			
£1000 or less	504	23.7	25.0
£1001 to £1500	426	20.0	21.1
£1501 to £2500	551	25.9	27.3
More than £2500	535	25.1	26.5
Missing	114	5.4	-
Total	2130	100	100
Political party identification			
Conservative	472	22.2	22.4
Labour	371	17.4	17.6
Scottish National Party	411	19.3	19.5
Other	236	11.1	11.2
None	617	29.0	29.3
Missing	23	1.1	-
Total	2130	100	100
Country			
Scotland	1144	53.7	53.7
England	986	46.3	46.3

(Continues)

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TABLE A1 (Continued)

	Count	%	Valid%
Missing	0	0	-
Total	2130	100	100

Source: ISSP Research Group (2024).

TABLE A2 Support for universal and comprehensive healthcare services.

	Scotland%	England%
The government should provide only limited healthcare services		
Strongly agree	1.8	1.1
Agree	5.6	9.3
Neither agree nor disagree	8.0	10.6
Disagree	36.7	37.3
Strongly disagree	46.9	40.6
Can't choose	1.1	1.0
People use healthcare services more than necessary		
Strongly agree	11.2	13.3
Agree	38.0	37.8
Neither agree nor disagree	27.6	28.7
Disagree	17.3	16.2
Strongly disagree	2.7	2.3
Can't choose	3.1	1.6
The healthcare system is inefficient		
Strongly agree	8.2	7.9
Agree	28.8	33.7
Neither agree nor disagree	24.9	23.5
Disagree	28.2	27.0
Strongly disagree	8.4	7.0
Can't choose	1.4	0.9
	B	
Support for NHS principles[a]	0.21*	(comparator)
Missing	23	15
Count	3432	2958

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Composite measure combining the three questions/variables.
Source: ISSP Research Group (2024).

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TABLE A3 Equity of access to healthcare services.

	Scotland %	England %
Easier or harder for women to access healthcare compared to men		
Much easier	1.1	1.3
Some-what easier	6.8	5.0
About the same	78.4	81.1
Some-what harder	6.1	5.8
Much harder	1.6	1.1
Can't choose	6.0	5.6
Easier or harder for old people to access healthcare compered to young people		
Much easier	3.7	3.8
Some-what easier	15.1	14.7
About the same	54.6	56.9
Some-what harder	15.7	15.0
Much harder	6.3	6.0
Can't choose	4.6	3.7
Easier or harder for citizens to access healthcare compared to non-citizenship		
Much easier	9.8	9.3
Some-what easier	20.1	23.2
About the same	44.1	43.6
Some-what harder	10.7	9.5
Much harder	3.3	3.7
Can't choose	12.0	10.8
	B	
Harder for vulnerable groups to access healthcare[a]	0.05	(comparator)
Missing	*25*	*14*
Count	*3432*	*2958*

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Composite measure combining the three questions/variables.
Source: ISSP Research Group (2024).

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TABLE A4 Reasons for not getting medical treatment needed in the past 12 months.

	Scotland%	England%
Due to long waiting lists		
Yes	20.5	24.0
No	47.8	43.7
Did not need treatment	31.8	32.2
Could not afford to pay		
Yes	5.1	7.3
No	64.6	61.8
Did not need treatment	30.3	30.9
Could not take the time off work		
Yes	6.5	8.3
No	62.4	60.4
Did not need treatment	31.1	31.2
		B
Did not get medical treatment[a]	(comparator)	0.78**
Missing	10	8
Count	3432	2958

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Composite measure combining the three questions/variables.
Source: ISSP Research Group (2024).

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TABLE A5 Government right to take action to protect public health in severe epidemics.

	Scotland%	England%
Shut down businesses and places of work		
Definitely should have the right	51.7	46.7
Probably should have the right	30.9	35.2
Probably should not have the right	8.2	9.1
Definitely should not have the right	5.5	5.2
Can't choose	3.8	3.9
Shut down schools		
Definitely should have the right	49.2	43.5
Probably should have the right	34.4	38.2
Probably should not have the right	5.4	9.3
Definitely should not have the right	6.9	6.4
Can't choose	4.0	2.6
Demand that people stay at home		
Definitely should have the right	53.8	50.7
Probably should have the right	30.2	33.6
Probably should not have the right	6.9	7.5
Definitely should not have the right	6.5	6.0
Can't choose	2.6	2.2
Require people to wear facemasks		
Definitely should have the right	70.0	64.8
Probably should have the right	20.5	22.5
Probably should not have the right	4.0	5.7
Definitely should not have the right	4.5	5.5
Can't choose	1.1	1.5
	B	
Government right to public health action[a]	0.32*	(comparator)
Missing	18	25
Count	3432	2958

Note: Significance levels: * = 10%; ** = 5%; *** = 1%.
[a]Composite measure combining the four questions/variables.
Source: ISSP Research Group (2024).

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