Public opinion and the NHS

On 29 August 2022, *The Times* published a story headlined ‘Britain falls out of love with the NHS: poll reveals three in five now expect delays’ (Lintern and Wheeler, 2022). The report was of a YouGov poll commissioned by the newspaper to explore public attitudes to the NHS. Notably, none of the reported questions asked about, or even addressed, love at all. Online discussion of this article among commentators leapt from statements of declining satisfaction to the end of the NHS, and the inevitable importation of ‘an American system of private medicine’; truly the spectre which haunts the feast of UK health policy debates (Lorne, 2022). Even responses which were more measured still quickly asserted that falling out of love might prompt people to ‘opt out’ and buy private care, undermining the service. A few months later, in November 2022, thinktank the King’s Fund hosted a conference session of journalists and campaigners entitled ‘Is the public falling out of love with the NHS?’ and published a blog on the topic. Referring back to British Social Attitudes Survey data, the blog concluded ‘the public’s love for the NHS is being severely tested but it is far from being broken’ (Wellings, 2022). Public support for the NHS is often evidenced in this way with reference to a fairly limited set of statistics. There remains a remarkable appetite for discussion and analysis of these data, promoted and contextualised by a handful of well-established health policy thinktanks.

This chapter explores the idea that these data constitute epistemic infrastructures (Bandola-Gill et al, 2022) which structure debates in the UK about public views of the NHS. The concept of epistemic infrastructure highlights how ways of knowing about, and of communicating knowledge on, any given issue can become embedded and entrenched in a context. Epistemic infrastructures are “the entities that make things known” (Bueger, 2015). I review quantitative analyses of public views on the NHS, but also seeks to contextualise these quantified reports of support, both in international comparison, and by investigating the organisations which fund and report such data in the UK. This role is particularly filled by three specialist health thinktanks: the Health Foundation, the King’s Fund, and the Nuffield Trust. I explore the way in which questions often conflate ‘satisfaction’ and ‘solidaristic’ attitudes (Burlacu and Roescu, 2021) and argue that these data tend to close down conversations about the public and the NHS, rather than generate new insights. Drawing on research from scholars in sociology and in Science and Technology Studies (Osborne and
Rose, 1999; Law, 2009; Stone, 2020), I argue that these numbers are also performative. That is the act of measuring and reporting this information about public feelings, is not just descriptive, but purposeful, and has effects over and above a simple reporting of fact.

Public opinion and healthcare: the NHS in comparative perspective

Public opinion is understood as an important element of health system performance internationally (Reibling et al, 2019; Burlacu and Roescu, 2021), but also one that is particularly challenging to robustly quantify. Former KPMG Director Britnell’s influential *In Search of the Perfect Health System* bemoans that in global rankings of performance:

> There is little attention paid to the recipients of health and healthcare – the patients and citizens. This is a serious omission and it is, unfortunately, the case that no universal patient satisfaction or experience scores exist for meaningful global comparisons. I hope this changes and countries collaborate more effectively in the future. (Britnell, 2015, p 2)

The potential of benchmarking (and potentially learning from success) in this area is complicated. First, and in common with many other aspects of health system performance, outcomes emerge from many decisions, both inside and outside the healthcare system, very few of which will be influenced by a desire to aid international comparison (Freeman, 2008; Schneider et al, 2021). Differences between the NHS in England, Northern Ireland, Scotland and Wales are a good example of how difficult comparison becomes when there is no political incentive to enable it by collecting consistent data (Bevan et al, 2014). There are also aspects of patient and citizen views that are particularly difficult to compare, based on their inherent subjectivity, and differences in what those statuses imply in different systems. In the UK, as this book will demonstrate, the population often act as stakeholders in the healthcare system, more than as demanding customers, and this orientation might influence the way we answer questions about healthcare.

When large-scale international comparisons do attempt to measure public views, they tend to conclude that support for the NHS in the UK is higher than support for healthcare systems in many European countries. Especially in the 2000s, satisfaction with the NHS was consistently above the European average (Burlacu and Roescu, 2021). However, it is worth noting that these figures are not quite such an outlier as claims about public affection for the NHS might suggest. Papanicolas et al (2019) compare the UK with nine high income country comparators: Australia, Canada, Denmark, France, Germany, the Netherlands, Sweden, Switzerland and the US. In 2017, 44 per cent of
adult respondents think ‘the healthcare system works well’ in the UK. While close to the average for all high income countries the study compared, this is well below France (54 per cent), Germany (60 per cent) and Switzerland (58 per cent). This reflects a significant fall in this measure between 2010 and 2017. 63 per cent would have agreed with this statement in 2010, at which point the British public would have been the most satisfied with how their health system works within this study (Papanicolas et al, 2019).

Some of this distinctiveness is likely a function of our health system type: national health service-type systems do tend to have higher levels of public support than, for example, social insurance systems. Gevers et al (2000) conclude that ‘support for an all-encompassing health care system is especially high in countries with highly developed national health services’, citing Denmark and Sweden as other examples. What is more striking is that the UK continues to have high levels of public support for a national health service-type system within a broader context of our welfare state. The UK’s relatively ungenerous income maintenance policies tend to place it as a ‘liberal welfare regime’, in which we might expect state provision to be minimal. And yet in the UK the NHS remains a highly state-centric model of healthcare, largely funded through general taxation.

Bambra has explained this as part of what she describes as a ‘healthcare discrepancy’ within scholarship on public attitudes to the welfare state (Bambra, 2005b) in which patterns of attitudes towards healthcare may be distinct from those towards other public provision. The classical welfare state typologies, starting with Esping-Anderson’s (2013) ‘worlds of welfare’, have, Bambra argues, overstated the salience of cash transfers (also known as welfare payments or social security) and neglected the role of service-based provision (including healthcare, education and social care) (Bambra, 2005a; Jensen, 2008). Esping-Anderson’s work takes as its starting point ‘income maintenance’ programmes but generalises from it to all social policy provision, without considering how the experience of service-based provision such as healthcare might shape attitudes towards it. Other examples of this discrepancy identified by Bambra (2005b) are Canada, New Zealand and to a lesser extent, Ireland. The discrepancy is often attributed to the way in which healthcare muddles straightforward notions of redistribution: public attitudes to spending on healthcare might be more positive because ‘in the field of healthcare … redistribution takes place primarily between risk groups, not between social classes’ (Wendt et al, 2010, p 189).

Recently, scholars have also sought to be more specific about what kind of public attitudes are being measured. Reviewing literature on public opinion on healthcare in Europe, Burlacu and Roescu (2021) have proposed that academic research on public opinion and health systems consist of three ‘disarticulated’ literatures. These, they argue, have separately explored three different phenomena. The first is solidarity, which they describe as generalised
normative feelings about the health system. A classic question to measure solidarity is one from the European Social Survey: in 2008 respondents were asked on a 10 point scale how far they think it is the government’s responsibility to ensure adequate healthcare for the population. On this measure, the UK population was in the middle range across Europe, with highest support in Latvia and Lithuania, and the lowest in Switzerland. The second is *satisfaction*, which captures specific views on how well one’s own or one’s family’s needs have been met by services within the health system. A classic question for this phenomenon would be the European Social Survey question ‘please say what you think about the overall state of health services in this country nowadays?’. On this measure, the UK was towards the top of the distribution of European countries until 2012, with a significant drop in 2014 and 2016. The third is *salience*, which refers to how highly the health system features within one’s own political priorities. That is, if a member of the public was asked to rank different areas of public policy as priorities for spending or attention, how would healthcare fare alongside education, defence, criminal justice or social security? The Eurobarometer survey asks people to select the two most important problems facing their country. In 2006, 41.6 per cent of UK respondents selected health. Thereafter this fell until 2012, when (in line with reducing satisfaction as outlined), it began gaining in political salience again.

While closely related, each of these facets of public opinion about health systems is interesting to different audiences. Salience, that is, how much people care about the NHS tells political actors not what substantive policies they should progress in order to get their party elected, but simply how much they need to be seen as ‘pro-NHS’. And yet even satisfaction is a more complex phenomenon than it is often credited with being. As Wendt et al argue: ‘The perceived (subjective) security to receive adequate medical treatment when in need can be considered to be highly relevant for the evaluation of the healthcare system in general’ (2010). Thus satisfaction might not simply be a consumeristic evaluation of a single care experience, but rather a broader, retrospective and prospective sense of health security: ‘Positive experiences with existing arrangements will lead to a favourable evaluation and can, in the long run, be expected to enhance trust not only in individuals (for example, certain healthcare providers) but in the overall institution’ (Wendt et al, 2010). A lack of attention to the multi-faceted nature of public opinion on healthcare thus explains how news headlines can simultaneously report Britain ‘falling out of love’ with the NHS alongside robust support for its founding principles.

**National research on public attitudes to the NHS**

While international comparisons of public attitudes to healthcare fascinate health policy analysts, much discussion in the public realm focuses solely on
data from within the UK. Quantified national accounts of public attitudes to the NHS come from a range of sources including the British Social Attitudes Survey, one-off opinion polling commissioned by thinktanks and newspapers, official NHS patient surveys, and occasional ad hoc projects by thinktanks. These are very different data sources.

One strand of knowledge about population perspectives on the NHS is contained within official NHS patient surveys. These have come and gone over the years and vary in their coverage across the UK (Care Quality Commission, 2022). Additionally they are focused, especially in secondary care settings, on recent patient experience rather than a more general sense of public views. One interesting exception to this, the ‘Friends and Family Test’, asks patients ‘How likely are you to recommend our service to friends and family if they needed similar care or treatment?’. NHS organisations in England have been compelled to collect this data since 2014, despite consistent claims that it imposes a burden on providers without proving very useful (Robert et al, 2018). For the purposes of this chapter, the greater issue is that the Friends and Family Test remains focused on an assessment of a specific recent episode of care within one provider organisation, rather than broader attitudes to the NHS as a healthcare system.

By contrast, the British Social Attitudes Survey and one-off polls include questions on broader perspectives about the NHS as a healthcare system. The British Social Attitudes Survey is a large, annual survey that has run since 1983 (NatCen Social Research, 2022). It is managed by NatCen, a charitable social research organisation. A random probability survey, usually administered with in person interviews not online, the long-term nature of the survey enables it to track attitudes over time with a degree of robustness few other surveys can offer. Significantly, this survey operates across England, Wales and Scotland, excluding Northern Ireland but not, as with most commissioned polls, focusing only on England. Commissioned projects from commercial polling organisations (primarily Ipsos MORI) make up the rest of the data source of thinktank coverage of Britain’s views of the NHS. These are very rarely random probability surveys, instead relying on demographically representative samples drawn from ‘opt-in’ panels of survey respondents (Curtice, 2016). In this section, I will review recent evidence from these different data sources and will also consider the single example identified of these thinktanks using qualitative methods to explore public views of the NHS.

**British Social Attitudes Survey**

The key question asked in the BSAS, which has been part of the survey since 1983, explores levels of satisfaction with the NHS. The question reads ‘All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?’.
As shown in Figure 2.1, in the most recent report, this measure of satisfaction dropped off 17 percentage points between 2020 and 2021, from 53 per cent very or quite satisfied, to 36 per cent very or quite satisfied. This is, the report underlines, a dramatic finding: ‘This fall in satisfaction is exceptional. It is the largest year-on-year fall in satisfaction since the question was first asked in 1983’ (Wellings et al, 2022).

Since 2015 (although not every year), the survey has also sought to explore reasons for these stated levels of satisfaction. Respondents are given a different question depending on their stated level of satisfaction with the NHS. Respondents who are ‘quite’ or ‘very’ satisfied can choose up to three from a list of options. In the 2021 survey, the list is as shown in Figure 2.2.

The report notes that the top three reasons have been consistent since 2015, but with some statistically significant reordering between 2019 and 2021, with the NHS being ‘free at the point of use’ became a more popular reason, while satisfaction with waiting time was less often selected. The question for people who have stated that they are ‘very’ or ‘quite’ dissatisfied (see Figure 2.3) offers a slightly different list of potential reasons for respondents to select three from: for example there is no equivalent answer about the extent to which services are free or paid for at the point of use.

Again the report highlights that the top three reasons have remained unchanged in surveys since 2016, but highlights a change in order, with waiting times for appointments increasing to ‘top’ the list in 2021. The third most popular reason given – dissatisfaction because the government doesn’t spend enough money on the NHS – is particularly intriguing, as it rejects the straightforward evaluation of a consumer (my NHS healthcare was not good enough) in favour of signalling political displeasure (my NHS healthcare was not good enough because the government has not funded it properly). The BSAS data thus suggests a significant decline in satisfaction with the NHS in recent years, and the reasons that people give for their verdict emphasise system features (cost and funding) alongside assessments of specific care received.

It is important to note that reports of BSAS data by the King’s Fund and Nuffield Trust pay careful attention to claims, and make attempts to disaggregate views by population group. The reporting of the data is, at least below headline level, consistently robust and clear. For example, in 2020 the BSAS changed its standard questions in response to the pandemic, and conducted its survey online instead of face-to-face. The Nuffield Trust’s reporting of this change is exemplary: a boxed section explains the changes in detail:

The change in method brings a risk that differences in attitudes between the BSA in 2020 and 2021 and earlier years may be a consequence of the change of methodology. However, the 2021 data has been carefully
Figure 2.1: Public satisfaction with the NHS 1983–2021

Question asked: ‘All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?’

Source: The King’s Fund and Nuffield Trust analysis of NatCen Social Research’s BSA survey data. 2021 sample size 3,112. This question was not asked in 1985, 1988 and 1992; ‘Don’t know’ and Refusal responses are not shown; in 2021 these response categories were selected by 0.5 per cent of respondents. Data has been carefully weighted to minimise differences due to the change in methodology between 2020 and previous years.
Figure 2.2: Reasons for satisfaction with the NHS overall in 2021

Question asked: 'You said you are satisfied with the way in which the National Health Service runs nowadays. Why do you say that? You can choose up to three options.'

- NHS care is free at the point of use: 78%
- The quality of NHS care: 65%
- Good range of services and treatments available on the NHS: 58%
- Attitudes and behaviour of NHS staff: 49%
- Don’t have to wait long for a GP or hospital appointment: 46%
- Money is spent wisely in the NHS: 14%
- How much money the government spends on the NHS: 5%
- Stories in the newspapers, on the radio or on TV: 4%
- Other: 1%
- Government reforms that affect the NHS: 1%

Source: The King's Fund and Nuffield Trust analysis of NatCen Social Research’s BSA survey data. Sample size = 410. This question was asked to respondents who said they were ‘quite’ or ‘very’ satisfied with the way the NHS runs nowadays within the random third of the overall sample selected to answer the health and social care module of questions.
Figure 2.3: Reasons for dissatisfaction with the NHS overall in 2021

Question asked: ‘You said you are dissatisfied with the way in which the National Health Service runs nowadays. Why do you say that? You can choose up to three options.’

- It takes too long to get a GP or hospital appointment: 65%
- Not enough NHS staff: 46%
- The government doesn’t spend enough money on the NHS: 40%
- Money is wasted in the NHS: 39%
- Government reforms that affect the NHS: 26%
- Some services or treatments are not available on the NHS: 22%
- The quality of NHS care: 16%
- Attitudes and behaviour of NHS staff: 13%
- Other: 8%
- Stories in the newspaper, on the radio or on TV: 3%

Source: The King's Fund and Nuffield Trust analysis of NatCen Social Research’s BSA survey data. Sample size = 400. This question was asked to respondents who said they were ‘quite’ or ‘very’ dissatisfied with the way the NHS runs nowadays within the random third of the overall sample selected to answer the health and social care module of questions.
weighted to ensure this risk has been minimised. The methodology section explains further reasons to be confident in making comparisons between years. (Wellings et al, 2022, p 4)

This rather dry technical content, flagging the need for caution in interpreting results, is featured in both the prologue to the webpage and the first sentence of the substantive content.

The academic orientation of the BSAS does stand out when comparing with the broader corpus of reports on public views of the NHS on thinktank websites. While most of the reporting relies on descriptive statistics, British Social Attitudes Survey reports are the only ones which routinely describe statistical significance and transparently discuss the significant limitations of the sample size (in 2021, the NHS questions were answered by 3,112 people). For example, for ethnic groups, the report differentiates satisfaction between people identifying as ‘mixed/other’ (33 per cent very or quite satisfied), ‘white’ (36 per cent), ‘Asian’ (37 per cent) and ‘Black’ (36 per cent). The report explains ‘these are the most granular levels of ethnicity captured in the survey’. Due to the small numbers of ethnic minority respondents in the survey (there were 63 Black respondents in 2021), it isn’t possible to ascertain whether changes in satisfaction between survey are statistically significant for any group except those identifying as white (Wellings et al, 2022, p 9). The BSAS sample size is, as we will see, larger than those routinely used for commissioned polls, as well as more robustly recruited. However its ongoing weakness in exploring ethnic minority perspectives seems increasingly problematic given improved evidence of racism in healthcare (Kar, 2020; Black Equity Organisation and Clearview Research, 2022). People with disabilities are not disaggregated in the report at all. While reports do make some effort to disaggregate the data by age, gender and party political affiliation, the headline reporting, and certainly content that makes it out of the published report and into media coverage, remains focused on a singular public and simple descriptive statistics.

**Commissioned polls**

Beyond reporting the BSAS data, thinktanks and other organisations also commission and conduct additional research on public opinion on the NHS on an ad hoc basis. Rather than the academic standards of the BSAS, polling reports generally state adherence to the Market Research Society standards, designed for political polling (Mortimore and Wells, 2017). Given the priority placed by all the thinktanks on English policy, both because of their London base and due to its much greater size within the UK, commissioned polls also tend to focus only on respondents in England. Reports are largely oriented to influencing Westminster decisions, and often timed to coincide
with elections or changes of government (Ipsos MORI Public Affairs, 2019; Buzelli et al, 2022). Special polls were also commissioned to commemorate the 70th anniversary of the NHS in 2018: all three thinktanks teamed up with the Institute for Fiscal Studies to commission a poll to explore perceptions of the NHS’s future (The Health Foundation, 2018). In 2019 the Health Foundation repeated many of the questions in commissioned polling from Ipsos MORI, with a face-to-face survey of 2000 people (Ipsos MORI Public Affairs, 2019).

On balance, these reports supplement rather than challenge or offer new perspectives to the report based on the BSAS. The questions in commissioned polls are similar to the key BSAS question wording on satisfaction: ‘All in all, how satisfied or dissatisfied would you say you are with the way in which the NHS runs nowadays’. In a series of commissioned polls, respondents are asked instead: ‘I’d like you to think about your own experience and everything you have seen, heard or read recently. Do you think the general standard of care provided by the NHS over the last 12 months has been getting (scale from slightly better to much worse).’ This question is more specifically focused on standard of care, while the BSAS question might reasonably prompt reflection on, for example, broader system issues such as accessibility or equity of care. The prompt to think beyond one’s immediate experiences to ‘everything you have seen, heard or read recently’ is another difference, as well as an explicit focus on whether things are perceived to be getting better or worse. Comparing results with 2017 data, the 2019 report states that fewer respondents describe care having got worse, and additionally that ‘when thinking about the future, the public are slightly less pessimistic than they were in 2017’. Although the key points listed in the report’s executive summary focus only on headline findings for the whole sample of respondents, inside the report it is also noted that

People who have used an NHS service in the last year and people with disabilities are particularly negative about the standard of services over the last year, which is concerning as they may actually have seen declines in standards rather than making assumptions about them (for example, based on media coverage). (Ipsos MORI Public Affairs, 2019, p 6)

Another recurring concern of commissioned polling questions goes beyond people’s satisfaction with the current state of the NHS, and instead probes how respondents feel about its ‘ideal’ or ‘founding principles’. The Health Foundation polling repeatedly investigates support for what they describe as ‘the principles underpinning the NHS’. The question asks respondents, on a scale of 1–10, to express their agreement with the statement ‘The government should support a national health system that is tax funded, free at the point of use, and providing comprehensive care for all citizens.’
Agreement with this statement has risen in the waves of this survey, from 60 per cent in 2015 up to 72 per cent in 2019 (Ipsos MORI Public Affairs, 2019). The report, implying that these principles were highly supported historically, suggests ‘the public feel as strongly connected to the principles underpinning the NHS as ever’. In fact, within the 2017–19 period, the data actually show a notable increase in this measure.

Intriguingly in other Ipsos MORI polling (The Health Foundation and Ipsos, 2022b), this question is disaggregated by principle and the wording altered:

- The NHS should be free at the point of delivery (91 per cent support in 2017, 89 per cent in 2022);
- The NHS should provide a comprehensive service available to everyone (85 per cent support in 2017, 88 per cent in 2022);
- The NHS should be primarily funded through taxation (88 per cent support in 2017, 85 per cent in 2022).

These data are drawn from two different polls with different methods, and so no conclusions can be drawn from the comparative stability of these figures. Ipsos MORI polling for the King’s Fund in 2017 asks respondents which of the following statements best reflects their thinking about the NHS: 77 per cent select ‘the NHS is crucial to British society and we must do everything we can to maintain it’ while 23 per cent select ‘the NHS was a great project but we probably can’t maintain it’. Setting to one side the crudeness of the question, the report’s interpretation is ‘The public is still bought into the ideal of the NHS and are keen to protect it.’ The report suggests that this polling question goes back as far as 2000, including in a former Department of Health-funded ‘perceptions of the NHS tracker’, and the proportions are, as the report states, ‘remarkably stable’, with a low of 73 and a high of 79 per cent (Ipsos MORI for the King’s Fund, 2017).

What is striking about these ad hoc additional polling projects are their strong similarities to the British Social Attitudes Survey questions, with reported findings mirroring the framing of the BSAS. Satisfaction (‘is the NHS providing a good service?’) remains the primary lens through which public perspectives are viewed. They generate findings which are similar enough to BSAS not to offer novel insights, and yet with wording that is different enough to make it difficult to draw conclusions over time. By including additional questions probing ‘the founding principles’ of the NHS – and consistently finding high levels of declared support for these – the polls do, though, shed some light on the solidaristic attitudes of the sample towards healthcare provision. Headline reporting of these polls also remains primarily interested in a headline figure which can represent a singular imagined public, and track its (singular, imagined) satisfaction over time. The executive summary of a tailored report on ‘What the new
Government should know’ (Buzelli et al, 2022) reports only four overarching views attributed to ‘the public’, and makes no reference to how views might vary across the population. While reports of ad hoc polling in the 2010s demonstrate even less focus than the British Social Attitudes Survey reports in disaggregating responses across demographic groups, there is a noticeable shift in 2022. Reports from the Health Foundation’s newest programme make claims about how attitudes vary by ethnicity and region, offering a new, and overdue, focus on diversity in attitudes (The Health Foundation and Ipsos, 2022b).

Occasionally, one-off projects pursue a different approach. One report on public expectations of healthcare shifts into using polling, curiously enough, to show how wrong the public are about the NHS (Duffy, 2021). A report from King’s College London’s Policy Institute and the Health Foundation reports a poll of 2,056 English adults conducted by Savanta ComRes at the height of the 2020 winter lockdown. The conclusion page is titled ‘Perceptions vs reality: what the public get wrong about the state of the NHS and the health of the nation’. Reporting the data, it begins: ‘People in England have an overwhelmingly positive view of the NHS. There is almost universal agreement (84 per cent) that the health service is one of the best in the world, and the public have a hugely favourable opinion of the care that they and their family have access to’ (Duffy, 2021). The report acknowledges that this might have been skewed by the pandemic context, because views of service quality were less positive before the pandemic. It then goes on to identify negative ‘misperceptions’ (‘the average guess is that 52 per cent of people wait at least 18 weeks for hospital treatment, when the reality is 17%’) and positive ‘misperceptions’ (‘The public believe that life expectancy in the UK compares more favourably to other OECD nations than it does in reality’). It isn’t clear from this report what significance is being attributed to the public’s ‘misperceptions’, but it is reminiscent of longstanding arguments that public ‘deficits’ of knowledge justify either educating, or ignoring, their views entirely (Wynne, 2006; Kerr et al, 2007).

Searching the thinktank websites identified only one example of qualitative methods being employed to explore public views on the NHS. The King’s Fund, again working with Ipsos MORI, conducted what they variously describe as ‘deliberative workshops’ or ‘discussion events’ in England in 2018 (Ewbank et al, 2018). These were attended by 75 people recruited to include a range of self-reported use of the NHS, levels of satisfaction, status as a carer and political affiliations. These events focused on perceptions of the NHS in general, of expectations of the NHS, and (somewhat peculiarly, given the extensive evidence that health outcomes are primarily determined neither by healthcare nor individual behaviour (Marmot, 2010)) of the balance of responsibility between governments and individuals for personal health.
While brief and basic, the report still gives a sense of the richness and complexity which could be brought to these conversations when public views are explored on their own terms, rather than measured against pre-existing yardsticks. The section of the report which considers views on the NHS in general, and ‘its role in Britain today’ describes pride in the NHS as ‘part of our heritage’, as a ‘safety net’ and as a ‘fundamental right’. Participants also, though, describe the service as being ‘under pressure’: ‘Despite feeling grateful for and positive about the NHS, some people were more negative about their day-to-day experiences with the service’ (Ewbank et al, 2018). More negative views emphasised waiting times, and concerns about efficiency. In common with polls, the events also explored founding principles, which were summarised as ‘a comprehensive service available to all, free at the point of delivery, and primarily funded through taxation’. These were felt by participants to still be correct, but with some discussion about whether they remain achievable in a changing population (the report specifies participants referencing increasing life expectancy and a perceived increase in immigration as pertinent here). This is in agreement with polling in which 77 per cent of respondents stated ‘the NHS is crucial to British society and we must do everything we can to maintain it’ (King’s Fund, 2017).

Perhaps most interesting, participants were asked to work in age-segregated groups to come up with ‘new deals’ for the NHS and the public, in which they put forward a broad range of proposals including suggesting that the NHS should look for additional sources of funding beyond taxation. No detail is offered in the report for whether limits were placed on the additional sources of funding, or indeed whether this is understood as a threat to the progressive taxation-funded basis of current funding (Ruane, 1997). Despite these intriguing possibilities for a more complex discussion on how publics feel about the NHS, the reporting is, as so often in this genre of policy-relevant output, brief and only lightly contextualised. Insights about public debate about the future of the NHS remain overwhelmingly stuck in a binary dead end: in, or out, of love.

**Polling data as epistemic infrastructure**

This analysis demonstrates both the sheer quantity of these assessments of how Britain feels about the NHS and the relatively narrow parameters through which that relationship is viewed. The overwhelming focus is on satisfaction, with more solidaristic questions channelled through the particular lens of the ‘founding principles’. The bifurcation suggests either confusion, or a lack of interest, in how answers to the questions ‘are you happy with the care you receive from NHS services’ and ‘do you support the NHS as a public service’ are related (Wendt et al, 2010). The inclusion in the British Social Attitudes Survey of whether media stories are a reason for (dis)satisfaction
(Wellings et al, 2022) exemplifies this muddle. People don’t tend to agree that media coverage is one of the top three influences on their feelings about the NHS, but of course media coverage is inexplicably entangled with how we know the NHS. Fortunate people who go months, even years, without personally experiencing the NHS, might not be personally aware of things like growing waiting times. However, the chances of someone in the UK never hearing anyone talking about these issues seems close to none. We encounter the NHS discursively as well as by using services, and for swathes of the population, our knowledge of it is shaped as much by societal discussions as by visits to a hospital.

One way to contextualise quantitative measurement of public attitudes to the NHS is to employ the idea that these data comprise an ‘epistemic infrastructure’ of knowledge about the public and the NHS. Put simply, these surveys and reports structure the ways in which the relationship between healthcare system and population is understood. Utilising the concept to reflect on the Sustainable Development Goals in global governance, Bandola-Gill et al (2022) propose that an epistemic infrastructure consists both of the practical aspects of how knowledge is generated (what they call the ‘materialities of measurement’) and the broader context of people and organisations around the data (the ‘interlinkages’). This approach brings the broader context of this data into view: the ‘materialities of measurement’ consisting of the financing and the practical design and delivery of polls and surveys; the interlinkages between journalists, thinktanks and broader policy communities that fund, commission, report and generate debate about the data. While the concept of epistemic infrastructures has been most often used to trace the international journeys of expert knowledge (Bueger, 2015; Tichenor et al, 2022), it also has significant potential to enhance our understanding at the national level. The advantage of this approach is that it understands the knowledge generated through these activities holistically, embedded into both the way it is generated and the way these data act in the world (as ‘knowledge products’). This section explores each in turn.

The materialities of these measurements – that is, how this approach is built into the construction of a public view of the NHS through particular research methods and questions – revolves centrally around the UK’s health policy thinktanks: the Nuffield Trust, the King’s Fund, and the Health Foundation. Together, they have an established body of work on public opinion and the NHS over several decades. Each year, they provide extensive analysis of the publication of the British Social Attitudes Survey questions on the NHS, speculating about what in the broader policy landscape might have caused a rise or fall in satisfaction. Their role goes beyond reporting these data: in 2011, the Department of Health declined to continue funding the module of the British Social Attitudes Survey on views on the NHS, and the King’s Fund stepped in to do so (Young, 2011). It was later joined by the Nuffield
Trust, and in 2022 the two thinktanks continued to share funding of the question module. These efforts allow the continuation of the key question asked since 1983 – ‘all in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays?’ – and the possibility of adding additional questions. In 2021 they added questions about priorities for the NHS and ‘the extent to which they think the founding principles of the NHS should still apply’ (Wellings et al, 2022). Enabling a consistent question to be asked across decades generates remarkable data, as described earlier in this chapter. However this, and the preoccupation with framing broader discussions about the NHS in terms of ‘founding principles’, also structures and limits what can be known through this survey.

As described, the Health Foundation’s approach instead has mostly involved commissioning its own polling from Ipsos MORI. This included polling for the 2015, 2017 and 2019 General Elections, and for the NHS’s 70th anniversary in 2018: they ‘wanted to conduct further public perceptions research to add to its “library”’ (The Health Foundation, 2018). This research included updating some trend data from previous years, as well as collecting new data on emerging issues. In the wake of the COVID-19 pandemic, the Health Foundation launched a new two-year programme of ‘public perceptions research’ again in partnership with Ipsos MORI. Stating that the pandemic has prompted ‘major shifts in public attitudes towards health, the NHS and social care’, this programme asks: ‘But how might public attitudes continue to change? And what might this mean for policy makers working to plot a course out of the pandemic, learn from the response so far and repair the social and economic damage caused by the virus?’ (The Health Foundation, 2022). This programme brings together multiple polls into what is termed an Expectations Tracker, depicting trends over time. However, as the report states: ‘Please note that methodologies differ and so comparisons are indicative rather than direct”’ (The Health Foundation and Ipsos, 2022b, p 2).

Starting with the most basic level of the materialities of these measurements, the choice of questions asked shapes answers given in a survey. Surveys are expensive undertakings and inevitably directed towards what are perceived to be the most salient issues by those running and funding them (Henderson and Jones, 2021). This is unavoidable: there is no neutral question wording that can tap into our innermost consciousness and extract a quantifiable response like a nurse might a blood sample. High quality surveys are transparent about this, but, especially in commercial polling, question wording is much less transparent. This explains why prominent academics are often critical of commercial opinion polling, especially when results are reported without context in front page news (Jennings and Wlezien, 2018). In the UK we are fortunate to have the long-running and robust British Social Attitudes Survey to rely upon, which, as described, has some
consistent question wording over time. We are additionally fortunate to have thinktanks who transparently report their own role in funding particular questions and who clearly explain when results over time are not directly comparable, because a question has changed. However, answers to survey questions, like all research questions, remain artefacts of measurement, not natural phenomena.

The consistent interest in, and time and money provided for, measuring public attitudes to the NHS gives thinktanks a key role in structuring the debate about those attitudes. This makes understanding the role of thinktanks within UK health policy debates a crucial part of the jigsaw of understanding how Britain loves the NHS. The three main thinktanks, the King’s Fund, the Health Foundation and the Nuffield Trust, are funded by varying sizes of charitable endowments, and supplement this with ‘soft money’ consultancy and grant income (Shaw et al, 2015). This means that the more solidly endowed thinktanks sometimes commission and fund work from the more precarious ones, and that they sometimes work in partnership. As well as these variations within their roles, their strategic foci shift over time with changes in leadership and context: these organisations are not static actors within the health policy landscape.

A handful of thoughtful studies have explored UK’s health policy thinktanks’ peculiar knowledge positions. A focus on research and analysis tasks allows health thinktanks to present their outputs (for example reports, events, press releases) as what Shaw et al describe as ‘a view from nowhere’ (Shaw et al, 2015). The conclusions that they draw are presented as being neutral, when in practice these organisations are enmeshed within complex relationships of dependency with opinion formers and decision-makers (Maybin, 2016). In these, the issues which become deemed as ‘matters of concern’ are iteratively formed: thinktanks may put some issues onto the policy agenda, but they also learn what is already appearing on the agenda and shift their considerable powers of analysis towards those issues in search of influence. These are not malign processes, although they are worthy of scrutiny and transparency (Shaw et al, 2014). Financial independence is not the only marker of neutrality, and thinktanks trade in influence (Stone, 1996). To do this, they must balance ‘keeping distance’ and ‘arranging proximity’ to power (Jezierska and Sörbom, 2021).

In the context of these reflections about the shifting substantive and organisational priorities of UK health thinktanks, it is striking that public opinion on the NHS is such a consistent interest across the Health Foundation, the Nuffield Trust and the King’s Fund over the years. Responding to sustained media and political interest in reporting and debating the topic, these organisations play significant roles in making public opinion on the NHS known. A search of the organisational websites in October 2021 found a significant track record of reports, events, blogs
and briefings on the topic, from all three. The language used to describe these reports varies. While all three discuss public attitudes (presumably due to the foundational role of the BSAS within this epistemic infrastructure): the Nuffield Trust additionally employs public satisfaction, perspectives, thinking and acceptance; the King’s Fund discusses views, opinion and satisfaction; and most expansively, the Health Foundation variously explores mood, perceptions, expectations, thinking, views and support. The choice of language might not be consciously strategic, but the consequences are significant. Osborne and Rose (1999) note the emergence of the idea that what most needed to be measured was ‘opinion’, denoting something considered and informed, and they distinguish it from closely related alternatives like ‘attitudes’. Attitudes, they argue, denote more reflex, deeply held (and even in some cases concealed) perspectives. They identify the way in which quantified representations of ‘mass opinion’ became integral to political and economic functioning, as both politicians and businesses look to understand and act upon them.

Once these data are generated, the nexus of health policy thinktanks and related commentators form an epistemic community (Bandola-Gill et al, 2022) in which the meaning and significance of the results is generated and debated. Scholars have argued that the very idea of public opinion is a phenomenon significantly generated by the industries of market research during the 20th century. For Osborne and Rose, the industry which sprang up around public opinion generated an illusory image of solidity:

Opinion here hardly referred to anything beyond itself; it became, so to speak, something that was thing-like in itself, something that existed in its own right and, with the right technical resources and procedural methods, could be known and measured. In other words, opinion was something that simply emerged as a fact in its own right from the collectivity of people’s individual opinions. (Osborne and Rose, 1999, p 387)

To help trace what they call ‘the creation of public opinion’, they point to other possibilities, or roads not taken, in this emergent science of quantifying what people think. They unpick the standardisation of the innovation of sampling theory in the 1940s, and the increasing acceptance of the notion that this, well-constructed, could stand in for how a whole population feels. John Law makes similar arguments about this, describing it as a ‘romantic notion’ in which society as a collectivity is ‘a more or less coherent whole that both contains and is emergent from the interactions between the individual elements that make it up’ (Law, 2009). This romanticism, he argues ‘assumes that this larger context can be known in a manner that is single, centred, explicit, homogenous, and abstract’ (Law, 2009).
Beyond the creation of an industry of public opinion, Osborne and Rose argue that one of the most significant effects of the institutionalisation of public opinion has been on publics themselves. Opinion polling has, they assert, caused ‘the creation of “opinioned” persons. … If humans themselves are changing, there is no obvious stable point to visualize a “before” and “after” scenario, no static dimension with a fixed scale allowing the measurement of relative success or failure. We are all “opinioned” now’ (Osborne and Rose, 1999). By this account, the idea that, as members of the UK population, we should hold opinions on the NHS becomes a self-fulfilling prophecy. Furthermore, the structures which run surveys and report this data encourage a particular way of thinking about how we might value the NHS, focusing on our (personal) satisfaction with a service and squeezing space for broader debates about how we might value healthcare now and in the future. This is an artefact of an industry that has collected that opinion, in particular ways, and reported it widely.

Conclusion

Data on the public’s opinion of the NHS serves as a seemingly endless catalyst for media discussion and political debate in the UK. UK politics is not alone in according quantitative evidence disproportionate weight within its policy debates; even quantitative specialists often express frustration at the way that a ‘killer graph’ or figure can take on a life of its own (Jerrim and de Vries, 2017). However, this chapter has demonstrated that in the UK our debates about how the public values the NHS have been heavily shaped by a relatively limited set of statistics, promoted and contextualised by a handful of thinktanks then further amplified by media coverage. In weighing and measuring stated attitudes to the NHS, surveys lump together more differentiated experiences into a question of degrees of ‘satisfaction’. The potential for exploring more solidaristic rationales for feelings about the NHS is transposed instead into a debate about adherence to ‘founding principles’, which risks confusing nostalgic and optimistic responses. Furthermore, despite improved efforts to disaggregate perspectives across different population groups, the wider reporting of these data consistently reverts to a series of statements about a singular public view. That such reports are usually based on robust statistics from a well-respected social survey does not mean that they are the final word, or an unarguable truth, when it comes to how the British public feels about the NHS.

Conceptualising these data as epistemic infrastructures asserts that they do not only let us know how the public feels, but structure the possibility for how public views might be known. The data has value, but its dominance in debates about the NHS is limiting. The very commitment to the dataset’s quantitative rigour, and to its comparisons to last year’s data, last government’s
data, data from the periods of largesse or austerity, prevents our grasp of this social phenomenon shifting and improving. The ‘seductions of quantification’ (Merry, 2016) are often described in relation to international comparisons: a field in which health system comparisons are an enduringly fascinating topic (Freeman, 2008; Vindrola-Padros and Whiteford, 2021). However in the case of public opinion data on the NHS, it is the potential for comparisons over time that seems to fascinate and absorb media coverage. Newspapers ponder us falling in and out of love with the NHS with similar focus to the love affairs of minor celebrities, but correlated instead with policy, with spending and with performance measures. The numerical tracking of opinion creates an illusion of ‘order, mobility, stability, combinability and precision. Numbers transform complex issues into readily auditable objects’ (Bandola-Gill et al, 2022). And yet, as this chapter has demonstrated, we cannot escape the instability and incommensurability of language in this area: embedded as it is in question wording, our own articulation of phenomena as ‘opinioned people’ (Osborne and Rose, 1999), and in the epistemic communities that report and debate the phenomenon.

This epistemic infrastructure is more than the ‘attitudinal context’ for policy decisions (Cooper and Burchardt, 2022). They have political value in helping organisations justify or oppose reforms: informing politicians that they must be seen to preserve healthcare spending even as the services that prevent ill-health are crumbling around the NHS. Sometimes, by emphasising the ways in which public respondents’ expressed attitudes are at odds with evidence, they help organisations make a case for paying less attention to public preferences. However this epistemic infrastructure also shapes publics. With reference to the example of Canada, Marmor et al (2010) refute the idea that health systems exist as reflections of foundational societal values: ‘Social and political institutions, once created, develop lives of their own.’ There is as Burlacu and Roescu (2021) note, a ‘two-way relationship between public opinion and health policies’. By exploring the work these polls do in their broader socio-political context, this chapter is also about how we come to know, as a society, our feelings about the NHS. Reflecting on the associated but distinct phenomenon of how a ‘patient’ perspective on any given issue might emerge, Pols (2005) stresses that any particular articulation is ‘not something that is “already there” in the mind of the patient, to be put into words … the patient perspective (or any other perspective) can be seen as being produced in a practical situation marked by specific possibilities and constraints’. She describes the way in which expressing an opinion can be performative, and not merely a linear communication of a pre-existing fact. Pols offers the example, also very familiar in Britain, of expressing an opinion about the weather, in a fashion that is so banal as to be almost nonsensical as communication, but highly functional as a ‘binding’ device. I think we can understand that stating and debating our views about the NHS has similar
functions, generating a (sometimes illusory) sense of shared experience and values, as much as shedding light on the issue of how we feel about whatever we might mean by ‘the NHS’.

The rest of this book explores other possibilities for thinking about public relationships with the NHS more expansively, and in a fashion that better connects up the parts of human experience. This rejects a quest to better pin down and analyse public views from within the ‘all-embracing episteme’ (Law, 2009), of ‘thingified’ public opinion. My approach prioritises understanding politics as what Latour (2005) calls ‘matters of concern’ rather than ‘matters of fact’. For Freeman and de Voß (2015), ‘social ordering is now achieved by seeking to establish valid representations of reality and shared acceptance of the factual conditions of collective action, rather than political representations of a collective will’. This book pursues an alternative, and more ambitious approach. Alongside or as well as trying to refine methods of surveying public opinion on the NHS, we can acknowledge the role these data play within entrenched institutional narratives (Tuohy, 2023) of our healthcare system. Doing so might create space for other routes to understand and act on public love for the NHS.