What we can do with love: the future of the NHS in public

This is a difficult moment to be writing about the NHS, and especially to be pondering ‘love’ while the headlines are full of stories of harm and loss. Perhaps there is never a right moment: Klein has argued that the history of the NHS is ‘punctuated by crises’ (Klein, 2013). Chronicling decades of panic about the NHS’s imminent demise, Powell (2015) wrote ‘accounts of the death of the NHS have been exaggerated’. Yet, the consequences of a long spell of austerity coupled with the first global pandemic of the service’s history makes this period of crisis particularly unsettling. This morning my radio alarm woke me with a news story about a woman named Koulla Mechanikos, who waited 14 hours for an ambulance to arrive when she broke her hip, and then 26 further hours in the ambulance to be brought into A&E (BBC News Online, 2022). Paton (2022) describes the current moment as a ‘toxic cocktail’: ‘Austerity, the pandemic, Brexit, and barely sorted social care.’ All this is to say, that for many of those working within or trying to use healthcare services in the UK, assertions of public love are likely to feel either irrelevant or, as others have argued (Arnold-Forster and Gainty, 2021), actively unhelpful.

And yet even as the material realities of healthcare feel pressing, I return to the importance of understanding ‘the specific manner in which, at a given moment and in a specified society, the individual interaction between the doctor and the sick person is articulated upon the collective intervention with respect to illness in general’ (Foucault, 2014). The NHS model makes that individual interaction between patient and healthcare system particularly public in nature. Investigating the affective formation of the NHS can be a route into the indistinct but pervasive elements of public discourse about healthcare in the UK, including some of the meta-narratives – gratitude, pride, exceptionalism – that perplex observers who are better versed in questions of comparative healthcare performance. Public discourse in the UK rarely emphasises the sheer value for money (or ‘parsimony’ (Berwick, 2008)) which is, in comparative terms, probably the most exceptional thing about the NHS (Papanicolas et al, 2019). Public attitudes to the NHS can be influential because of, and not despite, their fuzziness: ‘a form of collectively held unconscious ideal which enacts meaning in codified rather than explicit ways, highlighting some ideas and obfuscating others’ (Hunter, 2016, p 163).
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The starting point of exploring public love for the NHS runs the risk of yielding a saccharine picture. Other key analyses of public discourse around the NHS focus on unpicking the consequences of a series of government policies and political campaigns: the Health and Social Care Act 2012; the co-optation of claims about the NHS in the campaign to leave the EU; the introduction of an inequitable NHS ‘migrant surcharge’ for non-citizens already subject to general taxation; and the more aggressive policing of fees incurred by non-residents for healthcare (Hunter, 2016; Fitzgerald et al, 2020). Grounded in these empirical realities of the contemporary NHS, a residual commitment to the NHS as progressive and solidaristic can seem naïve. However, rooting this book’s analysis in public practices, rather than in policy, complicates such a resolutely critical stance. Public efforts to care for and contest the future of the NHS are often grounded in lofty ideals about solidarity, which seem still to hold remarkable power (Béland and Lecours, 2005; Prainsack and Buyx, 2017). More to the point, this chapter wants to argue that their persistence offers a potential route to a better, and fairer healthcare system. The time, energy and creativity that members of the public devote to the practices described in this book are significant. Beyond ‘weepy sentiment’ (Fitzgerald et al, 2020), ‘nationalistic folktales’ (Cowan, 2021) or ‘irrational emotional pull’ (Gorsky, 2008), I want to argue for these practices as an asset for improving health, not blindly loving a flawed system. In this chapter I recap the four practices of care and contestation discussed earlier in the book and explicate the way in which public love for the NHS is affective and cultural, but also political and material. I then go on to unpick two apparently dysfunctional consequences of the NHS’s current public role: the NHS as a ‘national identity’, and (in public spending terms) the NHS ‘on a pedestal’. Finally, I propose why an analysis of the ways we love the NHS might be a useful one, and offer a tentatively hopeful account of what else we might do with that love.

Practices of care and contestation

In this book I have offered an account of public love for the NHS since 2010 that weaves together ‘the complex and rich meanings which the NHS holds for British publics: as family myth, personal life-saver, community supporter, or source of national identity’ (Crane, 2022). The empirical content of the chapters centred on social practices: regularised patterns of interaction with the NHS which, while ‘reinforced by visible symbols and ritual representations’ (Barnes, 1993, p 215), are not external and unchanging but built and rebuilt in the everyday through people’s actions. We learn how and when to be a patient (or a volunteer, campaigner or fundraiser) from those around us and then as we perform these roles, we
strengthen these norms and thus shape the behaviour of those around us. Their effects can therefore intensify over time: even becoming ‘interaction rituals, which generate a collective emotional energy that serves to imbue symbols with deepened cultural meanings’ (Rossner and Meher, 2014). This book’s assertion is that these practices collectively enact love for the NHS. That is, people often understand their ‘appropriate’ service use, fundraising, volunteering and campaigning as motivated by the ideal of the NHS, even when the experience reveals the NHS’s disappointing or ‘failing’ aspects.

In Chapter 2, I used the concept of epistemic infrastructure to review the public opinion data that is the bedrock of policy and media debates about public views on the NHS. I demonstrated that these debates are overwhelmingly oriented to the more limited frame of ‘satisfaction’ with the NHS, with relatively little traction to understand more solidaristic or affective visions of the healthcare system. I additionally noted the way that sample sizes here limit what can robustly be concluded about variation in views across population groups, especially ethnic minority populations. I explored the community of organisations through which these simplifications (of both population and of phenomenon of interest) regularly make the front pages of national newspapers. Finally, drawing on critical takes on the public opinion industry creating ‘opinioned’ people (Osborne and Rose, 1999), I argued that the existence and substantial coverage of these data do not merely report but shape Britain’s sense of itself as an ‘opinioned’ (Osborne and Rose, 1999) country that ‘loves’ its healthcare system.

Chapter 3 turned to an example with lengthy roots that has experienced a remarkable resurgence since the beginning of the COVID-19 pandemic: charitable fundraising for the NHS. The possibilities of charitable donations in the NHS have always existed, with somewhat fuzzy restrictions about their uses supplementing, and not replacing statutory spend by providing enhanced patient and staff amenities, as well as some medical equipment. However, the prevalence and scale of these efforts were suddenly and dramatically expanded by NHS Charities Together’s Urgent COVID-19 Appeal. Presenting an analysis of the text content of 945 fundraising pages created by members of the public, I showed the extent to which these were oriented to gratitude towards staff as ‘NHS heroes’, but also how they mobilised broader narratives of national pride and solidarity in ‘our NHS’. Building on the reach and ease of creating appeals on the GoFundMe and JustGiving platforms (Kenworthy, 2021), this appeal generated a new mode of mass participation in loving the NHS during an exceptional moment of health emergency (Stewart et al, 2022).

Chapter 4 explored another facet of charitable activity in the NHS which has received a lot of policy attention, but commensurately less academic research; members of the public volunteering within NHS organisations.
I explore experiences of volunteering in hospitals, demonstrating how, especially in smaller community hospitals which are deeply embedded in their communities (Davidson et al, 2019), volunteering is often based on long-term relationships. Volunteers described it as relatively informal and changing over time, negotiated between the interests and skills of potential volunteers and the openness of management to their contributions. While motivations are complex to unpick, I argued that doing ‘a good thing’, and also the pleasures of social connection, dominate volunteers’ descriptions of why they give their time to the NHS. I also compared these examples with a flurry of national ‘branded’ NHS volunteering schemes that launched before and during the early pandemic outpouring of affection for the NHS, and reflected on the ways in which these quasi-militaristic calls for service might reflect a new era of NHS volunteering.

Chapter 5 considered examples of public campaigning in and about the NHS, including local campaigns to save or protect hospitals threatened with closure, and two left-wing national campaigns: Keep our NHS Public and Save our NHS. Comparing these local and national mobilisations – which are also linked to each other – sheds light on different frames of what needs protecting in the NHS. Specifically, local campaigns orient to what is special about their specific institutions of care, while national campaigns link examples of patient experience much more tightly to the founding principles of the NHS: especially to universal access to healthcare, free at the point of use. This analysis emphasises the preservationist character of these campaigns, particularly when compared to the more radical and change-oriented campaigning Crane has identified as the advent of national NHS campaigning in the 1980s (Crane, 2019, 2022). This suggests that contemporary campaigning, while still centring progressive aspects of Britain’s healthcare system, focuses more explicitly on nostalgia for an NHS that is perceived to have been degraded (Cowan, 2021), than proposing specific reforms. This shift in emphasis risks making it more difficult to identify problems and things about healthcare in the UK that should change, especially longstanding issues that are not only a consequence of straitened funding (Arnold-Forster and Gainty, 2021; Cowan, 2021).

Chapter 6 shifts towards the terrain of medical sociology, by considering the ways in which affection for the NHS shape embodied experiences of healthcare in the UK. This builds on an analysis of patient feedback on experiences of emergency medicine in the UK that were submitted to the Care Opinion website in 2019 and in 2021, in which the authors made reference to ‘the’ NHS or ‘our’ NHS. These are, of course, a self-selected sample of experiences, but especially given the consumeristic origins of Care Opinion as an information tool for the quasi-market era of the English NHS, the overall positivity of stories is striking. Significant numbers of patients use Care Opinion simply to thank their care-givers, often adding
gratitude to ‘the NHS’ alongside identifying specific health professionals who are perceived as having gone ‘above and beyond’. I identify the way in which negative experiences recounted are softened, blamed on individuals or presented as constructive, and the effort to which authors go to present themselves as a legitimate narrator and patient. I argue that these features are not only a consequence of medical hierarchies – the desire to perform a legitimate ‘sick role’ – but are imbued with the particular characteristics of NHS care. This, I suggest, entails that one’s own claims on the system, and the system’s response, are understood as qualified entitlements, in relation to the ability of the system to meet all the claims made upon it. Thus the persistent and consistent references within these narratives to the NHS as ‘under pressure’: whether pressure of budget cuts or of the century’s first pandemic, using the NHS is understood as making demands on a finite system.

Towards a multi-dimensional understanding of love for the NHS

This book resists the temptation to offer a singular and definitive answer to the question of how Britain loves the NHS. I offer instead an analysis of a series of practices, as lenses through which to understand this multi-dimensional relationship.

Practices of this kind aren’t intrinsically good or bad. They need to be assessed in context and with a view to both their immediate consequences and their broader impact on the healthcare system. Recent analyses have emphasised the way that public valorisation of the NHS has shaped a context for regressive political campaigns, which play on the symbolic value of the NHS in UK society (Hunter, 2016; Fitzgerald et al, 2020). This book builds on these insights to explore the way in which public practices of love are also acts of agency: asserting that the practices of care and contestation that contribute to Britain’s love for the NHS need to be understood as affective and cultural, but also as material and political. This argument resonates with recent calls from social policy theorists for better acknowledgement of public roles as ‘doers’ and ‘judges’, as well as ‘receivers’, within welfare states (Bonvin and Laruffa, 2022).

This book’s empirical chapters underline the affective significance of the NHS in UK society: ‘The ways in which emotion works through culture as the connective tissue of institutional life’ (Hunter, 2016). This book centres a broadly-conceived vision of love, and its societal (re)enactment, rather than satisfaction (the meeting of consumeristic standards of quality). This better explains how deeply held attachments to the NHS seem to be, and the role that ideas of the NHS play in moments of crisis (Day et al, 2022) and celebration (Thomson, 2022). And yet engaging seriously with affect also forces us to move beyond simply noting that fact. While consumeristic satisfaction is grounded in satisfaction with one’s own, or perhaps one’s loved one’s care, the practices described in this book often attributed love
for the NHS to a, possibly naïve hope that everyone ‘we share this country with’ will be taken care of. This is the pride that is referenced repeatedly in patient narratives, in campaign texts and fundraising appeals. It is part, in Hunter’s analysis of discourse around the NHS, of a ‘more complicated multicultural national fantasy which … protects against a related set of (post)colonial anxieties … which deepen in the context of austerity politics and dwindling financial resources’ (Hunter, 2016).

These practices described contribute to the currently intensified cultural role of the NHS in society. Many of the chapters depict campaigns seeking to enrol broader publics into the NHS: whether recruiting volunteers, opposing reforms, soliciting donations or requesting feedback on patient experience. These build a sense of ‘the NHS’ not as organisation but as a collective national project. In his analysis of the mundane practices through which ‘the state’ has effects, Painter depicts

the intensification of the symbolic presence of the state across all kinds of social practices and relations. Again, this does not mean that real institutions are not involved; courts, police, schools, councils and so on all exist. But whether their activities constitute statisation depends on the nature of the practices in which they are engaged, not on the categorization of any particular institution as a part of the state or not. Thus, statisation can occur through practices undertaken by nominally non-state organizations, such as private businesses. (Painter, 2006, p 758)

Thus an intensified cultural role for the NHS – as experienced in the omnipresence of NHS branding since the COVID-19 pandemic – can be built on appeals and campaigns from non-NHS organisations. Not only NHS charities, but private companies donating to them, the Daily Mail newspaper and, of course, the profit-making companies who delivered ‘NHS Test and Trace’ as part of the country’s COVID response under NHS branding (Mahase, 2021) contribute to the intensification. Members of the public who respond positively to these campaigns are further embedded into the affective formation of the contemporary NHS. These practices generate new opportunities for ‘supporting the NHS’ to become an available and appealing social, and perhaps even national, identity.

The analysis offered in this book also suggests that publics hold, and enact, their views on the NHS more strategically and politically than much literature allows. Enacting love for the NHS into practices and statements has created a context where it is at least surprising, and in some corners actively taboo, to criticise the NHS (Hunter, 2016; Arnold-Forster and Gainty, 2021). This can give NHS love a culturally hegemonic character. However this book showcases practices of both care and contestation, not merely uncritical celebration (Crane, 2022). Commitment to what the NHS is perceived to
stand for, and not simply blind or mistaken loyalty, I would suggest, explains
the somewhat hyperbolic 77 per cent of people in England polled in 2017
who agreed with the statement that ‘the NHS is crucial to British society
and we must do everything we can to maintain it’ (Ipsos MORI for the
King’s Fund, 2017). The enthusiasm with which people enrol in practices
of support for the NHS, and the reluctance to name unacceptable instances
of care demonstrated in Chapter 6, are political, as well as blindly affective
acts. Significantly, they come in a context of near continual crisis – actual and
perceived (Duncan, 1998; Powell, 2015). Even in periods where it was more
robustly funded and satisfaction was high, the NHS has never not been seen as
a problem to be solved. As a national health system it is a visible and explicit
site for contestation, in which competing visions of society are played out.

However the NHS is additionally a set of institutions in which bodies
and minds are treated, cups of tea are handed out, and in which people
are born and die. The approach taken in this book re-emphasises these
material dimensions of the NHS as institution. Hunter’s conceptualisation
of the affective formation of the NHS acknowledges its material
existence, but in its focus on political discourse, neglects the particular
embodied encounters that ground the daily ‘technical, bureaucratic and
professional’ (Hunter, 2016) realities of healthcare systems. This book
accentuates medical material realities both in the descriptions of service use
in Chapter 6, but also in people’s descriptions of service use within the
broader range of public acts of support for it. I reassert the significance of
these material encounters, which are often downplayed in health system
analyses. In his ode to NHS care, Many Different Kinds of Love, Rosen
describes readers’ surprise at the ‘very basic and visceral’ descriptions in
the book: ‘That’s where you get to sometimes: just you, in your body,
with your body’ (Rosen, 2021, p 301). Medical encounters need not be
romanticised for us to acknowledge their significance. The King’s Fund
estimates that in 2020 in England alone, on an average day 1 million
people had a GP appointment and nearly 45,000 would attend an A&E
department (The King’s Fund, 2022). These can be converted into ‘units
of activity’, tracked and plotted onto graphs for evaluative dissection.
But they can also be understood as moments in people’s lives which are
unusually likely to matter ‘existentially’ (Freeman, 2008): ‘For the typical
physician, my illness is a routine incident in his rounds, while for me it’s
the crisis of my life’ (Broyard, 1992, p 43).

These near universal experiences of the intensely significant and intimate
nature of healthcare – identifying a problem, seeking help from healthcare
professionals, receiving care – are in the UK NHS rendered particularly
public (Sturdy, 2002). We can see this in the increasing prevalence of
campaigns to ask people to make more healthy lifestyle choices, and
to use services more ‘appropriately’. But, as every chapter of this book
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demonstrates, it is also a connection made by members of the public when they ‘defend’ the NHS. The analysis of Chapter 6 suggests a possibly counter-intuitive role for increased media coverage of NHS failures, as patients gratefully attribute positive experiences of care to ‘the NHS’ and search for someone else to blame for experienced failures.

Better recognising the affective, cultural, material and political dimensions of how Britain loves the NHS also illuminates the multidimensional nature of people in society: as ‘receivers’ with vulnerabilities; as ‘doers’ with meaningful contributions to make; and as ‘judges’, with aspirations and a right to voice (Bonvin and Laruffa, 2022).

What love does

The practices explored in this book are thus prompted by, and also generate, particular forms of public affection in the NHS. In this section I consider two sets of political consequences of the current configuration of how Britain loves the NHS. One is the manner in which the NHS increasingly stands in as a proxy for a substantive national identity. The second is a perception that the NHS is, politically, on a pedestal when it comes to public sector funding, driving the rolling back of broader social protection and other forms of public investment.

As discussed earlier, during the height of the COVID-19 pandemic, effusive expressions of gratitude for the NHS were front and centre: signs stuck in windows, clapping on doorsteps, and raising money for NHS charities (and talking about doing so on social media). Sociologist Gary Younge’s astute writing in newspaper columns during the COVID-19 pandemic repeatedly called attention to the apparent emptiness of these celebrations of the NHS and carers: these activities were, he stated, a ‘meme in pursuit of a meaning’ (Younge, 2020). Remarkably, Nye Bevan identified this risk 70 years earlier when he wrote that social institutions (such as the NHS): ‘Are what they do, not necessarily what we say they do. It is the verb that matters, not the noun. If this is not understood, we become symbol worshippers’ (Bevan, 2010).

Ironically, Bevan’s quote-worthy rhetoric is often incorporated into symbolic celebrations of the NHS. One can buy tea towels with significant Bevan quotes: I was given one last Christmas. Witness: ‘A free Health Service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst’ (Bevan, 2010). Both Hansen (2022) and Meer (2022) note the strong resemblance between contemporary valorisation of the NHS, and the tenor of Bevan’s early speeches on the topic. The narratives of British exceptionalism that Bevan (2010) featured are, we can now recognise, predicated on Britain’s role as a violent coloniser and a ruthless extractor of wealth from other populations around the world (Sanghera, 2021; Bhambra, 2022a; Hansen, 2022). Bhambra demonstrates that this is
not only a question of the national stories we tell about ourselves: the NHS was financed and staffed through the extractive work of empire (Bhambra, 2022a; Millar, 2022). The seduction of soaring rhetoric about the NHS remains. Sixty years later, behold American healthcare improvement guru Don Berwick in a conference speech: ‘Cynics beware, I am romantic about the National Health Service; I love it. All I need to do to rediscover the romance is to look at health care in my own country. The NHS is one of the astounding human endeavours of modern times’ (Berwick, 2008). The healthcare system’s residual grounding in solidaristic goals (Prainsack and Buyx, 2017) gives it an apparent simplicity as a rallying cry. As a symbolic national ‘achievement’, the NHS thus offers a meeting point for a far broader coalition of people than more obviously complicated national institutions like the monarchy or the military.

Valorisation of the NHS is also rooted in what Younge depicts as the evasiveness of notions of British identity: ‘British identity has no lodestar; it is grounded in no principle; put bluntly it has no point beyond its own self-assertion’ (Younge, 2022). There are, as Younge acknowledges, differences in national sentiment across the UK, with the imagined communities of Scotland, Wales and Northern Ireland often defined against a notion of Britishness. For the rest of the UK population, its overwhelming majority, the substance of English national identity is more complex. It is intriguing that, in this context, the NHS branding of volunteering programmes (as discussed in Chapter 4) and the concerned policing of the NHS brand identity (as described in Chapter 1) are particularly features of the context in England, and less apparent in the smaller devolved healthcare systems. Henderson and Jones (2021, p 4) argue that English national identity ‘combines a sense that England has been “forgotten” and unfairly submerged, with the belief that Britain, self-evidently, is or should be, should be, “the greatest nation on earth”’. The NHS as national achievement can stand in here, for ‘greatness’, but also just for something to unite around. In her study of the social roles of happiness, Ahmed proposes: ‘We might have a social bond if the same objects make us happy. I am suggesting here that happiness itself can become the shared object’ (Ahmed, 2010, p 56). This might explain the way in which loving the NHS (or thanking or celebrating it) can become connective, while increasingly detached from the material realities of healthcare delivery.

It is in this context that the ‘weepy sentiment’ (Fitzgerald et al, 2020) of love for the NHS looks particularly suspicious: a sop for the masses to distract from their plight. The NHS can be imagined as one of the ‘system of ditches to protect capitalism and hegemonic groups’ (Filc, 2014, p 170). However a Gramscian notion of cultural hegemony around the NHS is not entirely convincing. First, the material realities of healthcare delivery continue to intrude into people’s lives, not as symbols but as bloody, or scary, or debilitating moments in our lives. Second, the power bases of the
NHS, the hegemonic groups, are multiple and disunited. While policy actors certainly imagine and seek particular roles for the population at particular times, the practices described in this book are also active ways for members of the public to contest and enact possible NHS futures (Fortier, 2016). The notion of the NHS from church to garage (Klein, 2013) was always, of course, something of a caricature, and it was focused on the population as policy audience, not as actors. Centring public love for the NHS, through practices of both care and of contestation, means that neither church nor garage feels apt. The remarkable contemporary ascendance of discourses about ‘our NHS’ denotes something less sacred than a church; yet still more collectivist and affectively significant than a garage. The research in this book suggests that the NHS is often seen as a fragile, crisis-prone yet shared achievement, which we all have a part to play in protecting. All four practices explored in this book have in common an orientation as active stakeholders in, and not mere customers nor congregation of, the NHS.

A second macro-level political consequence of perceived public love for the NHS relates to public spending. During her 2022 Conservative party leadership campaign, Liz Truss argued that the NHS must face the same budget cuts she planned to make across the gamut of state spending. On 20 August, The Guardian’s frontpage headline was ‘NHS “cannot be put on a pedestal” – Truss’ (Mason, 2022). This claim, based on a thinktank pamphlet Truss co-authored in 2009 before entering Parliament, was frontline news because, while it became commonplace under the Conservative government to claim to ‘protect’ NHS spending from broader cuts, this explicit use of the pedestal metaphor went further. It invokes the idea that Britain’s glorification of its health service, rather than an evidence-based decision, has prompted its relative protection from broader austerity government. In a Spectator article to promote the pamphlet, Truss is quoted as stating:

We have identified £30 bn cuts across the ‘big five’; defence, health, work & pensions, communities and education. … No department can be a no go area. This means the NHS, accounting for a sixth of government expenditure, cannot be put on a pedestal. Doctors’ pay which has risen inexorably needs to be restrained. Superfluous bodies such as Strategic Health Authorities, and health campaigns exhorting the public to stop ‘vegging out’, should be abandoned. (Quoted in Mason, 2022)

While Truss’s suggestion of where healthcare funding has gone is dubious, the NHS has indeed been spared some of the most swingeing funding cuts that have been made to the welfare state since the 2010s. Having received significant funding increases during the New Labour era, the NHS has experienced what is referred to as ‘funding restraint’ since 2010 (Edwards,
2022a). While not enough, say many commentators, to support an ageing and growing population, this is less disastrous than in related areas such as social care services (mostly funded by local government) or working age benefits. It is true that broader public spending has been more savagely cut than NHS budgets, especially spending on social protection (Farnsworth, 2021) and local government budgets (Gray and Barford, 2018).

The NHS is not only cushioned from the worst of funding cuts by perceived public support for it, but this support is often powerfully intertwined with other protective factors. The counterfactuals of healthcare (what if there was no NHS) feel more immediate and visible than policy areas whose benefits are more diffuse and long term. Internationally, Jensen emphasises the ‘special importance ascribed to health care in modern-day societies, where other physical risks have been mainly eliminated; in a very real sense, the risk of poor health is universal and therefore provides a strong political motive for public health care provision’ (Jensen, 2008, p 160). Public spending on healthcare can, as discussed earlier, be the ‘acceptable face’ of public spending because much (although not all) need for healthcare is less stigmatised than need for, for example, social security benefits (Wendt et al, 2010; Carpenter, 2012). While the British Social Attitudes Survey consistently puts levels of public support for services (that is, healthcare and education), above public support for benefits, support for spending on healthcare in particular increased during the pandemic (de Vries et al, 2020). As discussed earlier in this book, the deceptive appearance of unity and simplicity of ‘the NHS’ as a brand can be a particularly powerful symbol.

Another cushioning effect is that healthcare and state governance are often particularly intertwined: hence Moran’s (1999) concept of the ‘healthcare state’. Health professionals, particularly doctors, have both an unusual proximity to the state (which often governs their professional registration), and through those processes of professional registration, a ‘natural basis of organisation’ (Carpenter, 2012, p 298). Even if medical autonomy has been squeezed (Harrison and Ahmad, 2000), health professional associations remain powerful actors in UK health politics, and health professionals have both official governmental roles (such as Chief Medical Officers) and significant cultural capital (Greer, 2004). Professional power is thus often buoyed by its status among the broader public, and this status was further boosted by the focus on ‘NHS heroes’ during the COVID-19 pandemic (Cox, 2020).

None of this is to suggest that the NHS is in an enviable position within the welfare state. The current crisis shows how unhelpful this cushioning can be. The relative protection of the NHS is short-sighted, as well as politically cynical, because of a series of upstream causes of ill-health. Our understanding of healthcare has moved far from the curative model on which the NHS was built (Darlington-Pollock, 2022; Greener, 2022). As other kinds of social support fail, people turn up at the NHS’s door with more
intractable problems. The health consequences of cutbacks on education budgets turn up at the door of Child and Adolescent Mental Health Services. The health consequences of a punitive, suspicious benefits system turn up in GP waiting rooms. And, as any semblance of a social care system crumbles, hospitals fill with people who cannot go home without care services, and ambulances queue at the front door, unable to discharge patients needing care. Economists often argue that the NHS needs increases in funding year-on-year just to stand still (Charlesworth and Bloor, 2018). They are right, but if the other preventative planks of wellbeing in society are removed, there is no proportionate increase in NHS funding that can bridge the gap. In their efforts to find solutions healthcare professionals will often, as they are trained to do, medicalise the issues. They might even ‘prescribe’ social solutions to the issues people present with, drawing on local ecosystems of voluntary organisations (Tierney et al, 2020). But the NHS cannot solve these problems while other parts of the welfare state are broken, and, of course, it is manifestly unable to prevent them from occurring in the first place.

What (else) we can do with love

While for Arnold-Forster and Gainty (2021) public love for the NHS is to be abandoned as an obstacle to reform, on balance I disagree. This might well be because my research locates me mostly in the public realm, rather than in clinical spaces where inequalities in care are more starkly evident (Cowan, 2020). However it is mostly because, with a background in the discipline of social policy, I have residual faith in the potential of a solidaristic upsurge of affect around the NHS (Titmuss, 2004; Prainsack and Buyx, 2017). These sorts of not-strictly rational, deeply felt sentiments are what sustain public services (Bambra et al, 2021; Cooper and Burchardt, 2022). They are only intrinsically problematic if we assume that healthcare is a consumer industry like any other, rather than a complex system of interrelated vulnerabilities and capabilities which the broader public is part of, in myriad and complex ways (Cribb, 2018). That the NHS fails sometimes, and that the population famously ‘loves’ it, doesn’t mean that there is a causal link in either direction between the two. Nigel Edwards, Chief Executive of the Nuffield Trust, recently wrote an essay ‘myth-busting’ the idea that public affection prevents necessary reforms of the NHS (Edwards, 2022b). Indeed, he argued that the NHS had been too frequently reformed, but that the problem has been that these are poorly-planned, national and top-down reorganisations in an effort to win party political points.

Much recent concern about Britain’s love for the NHS relates to the discomforts of how it has been co-opted into a narrow nationalism in the run up to and aftermath of Brexit. Stanley (2022) describes how the project of ‘austerity’ since 2008 has included a renationalising of the NHS, as access to
care for non-UK citizens was made more difficult and costly due to overseas patient charging and the Migrant Health Surcharge. However, and inspired by Cowan’s call to find ‘better ways to put this care, love, and energy to use’ (Cowan, 2020, p 214), I want to consider how we might make collective affection for the NHS more generative. The practices of care and contestation explored in this book cohere comfortably with Cribb’s call for a shift from ‘an assumed model of “top-down” service delivery towards a more diffuse and democratic model’ (Cribb, 2018, p 153). Imagining a future for the NHS which neither ignores nor becomes complacent to its current failings, but seeks to learn from them, seems not only worthwhile but vital. After all, every society needs a way to meet the healthcare needs of its population. My suggestion is that we take seriously that public affection for the NHS is predicated on its offer of universality: 88 per cent of those in 2021 polling claim to agree with this ‘founding principle’ (The Health Foundation and Ipsos, 2022a). I want to posit the possibility that we can have a mature, open conversation about what it would take to make that meaningful. One set of possibilities here relates to reimagining public roles in the NHS, and another linked one is to challenge Britain’s professed emotional commitment to universal care for all to build a more constructive public conversation about the broader welfare state.

Despite decades of effort towards ‘public and patient involvement’, the story of the NHS remains overwhelmingly a power battle between government and clinical bodies (Klein, 2013; Newbigging, 2016). The last decade of the expansion of the rhetoric of ‘our NHS’ has not been significantly accompanied by changes to enable collective, rather than individualistic, empowerment in healthcare in any of the constituent parts of the NHS (Newbigging, 2016). However, there is cause for hope. The empirical chapters of this book support existing evidence that there is public appetite to play more active roles in the NHS than passive consumer (Newman and Clarke, 2009). Calls for more dialogic approaches to improvement and decision-making (Cribb, 2018) have potential to generate many more opportunities for debate and engagement. At organisational level, new possibilities are already being carved out. Formal roles of patient leadership with people with significant experience of using health services are increasingly seen as mainstream, if not yet widely operationalised (Gilbert, 2019). Integration of health and social care services has prompted more connections with local government, so that elected representatives should have greater oversight of services (Reed et al, 2021). The thinktank New Local’s vision of a Community-powered NHS also offers new ideas, based on more meaningful localism and participation in the NHS, each of which deserve more attention (Lent, Pollard and Studdert, 2022).

On the other hand, after a decade in which the NHS ‘brand’ has become increasingly prominent, it might also be time for more national-level dialogue
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about the future of the NHS within the UK’s constituent parts. In 2012, NHS England created a remarkably ambitious experiment in systemic deliberation, which, while it currently (NHS England, 2022b) appears to have floundered back into the realms of ‘committee work’ (Stewart, 2016), did at least for a while acknowledge the possibility of recognising collective citizen voice as a priority (Dean, Boswell and Smith, 2019). Recent efforts to develop meaningful proposals for reform of social security (Commission on Social Security, 2022) and of social care (Social Care Future, 2022) with lived experience at its centre, might inspire a resurgence of what often feels a staid, entrenched debate about the future of the NHS. Building on public expressions of love and gratitude for the NHS to identify shared priorities seems to have great potential for a refreshed public debate about the NHS, as the rather brief report from the King’s Fund’s small commissioned discussion groups suggested (Ewbank et al, 2018). That challenges the assumption that public demand for more, better and more expensive medicine is limitless, as does the evidence in this book of a ‘stakeholder’ orientation to services from at least some of the population. Recent initiatives in Scotland towards Realistic Medicine and Wales towards Prudent Medicine both showed a path towards a more parsimonious future which nonetheless prioritised equity of access (Bradley et al, 2014; NHS Scotland, 2015). These agendas were, though, clinically led with minimal attention to broader engagement: as so often, the NHS waits to ‘sell’ its vision to the public after decisions are made (Greer et al, 2021). But each could have been, and perhaps still could be, a meaningful opportunity to start from population perspectives and build a sustainable NHS, especially while paying better attention to the experiences of under-represented groups including ethnic minorities and immigrants. In this, the devolved nations with their vastly smaller populations surely have an easier task on their hands. These solutions are all, it should be noted, collective ones in which the population are partners. This pragmatically recognises the way in which we have come to understand that health and wellbeing are located not in hospitals but in people’s daily lives. It is also a normative one, which acknowledges that democratic solutions to public problems are rooted in our interdependence (Cribb, 2018).

Beyond just realising the vision of ‘our NHS’, we can consider building on this public affection as a starting point for a much broader defence of the welfare state. Cooper and Burchardt’s recent analysis of the British Social Attitudes Survey suggests that claims about the polarisation of attitudes to welfare, and the internalisation of discourses of austerity (Farnsworth, 2021), might have been overstated. They suggest that, in the aftermath of the pandemic, there is a moment of ‘significant attitudinal capital’ in which more progressive policies might be enacted (Cooper and Burchardt, 2022). There may be lessons in the rhetorical power the NHS seems to have on popular imaginations (Crane and Hand, 2022), and potential to expand it to broader
ways that the welfare state cares for the population. Our understanding of healthcare’s role in the welfare state has transformed dramatically since the creation of the NHS. In his reassessment of Beveridge’s Five Giants, Greener (2022) proposes that ‘preventable mortality’, and not ‘disease’ should be the welfare state’s target (see also Darlington-Pollock, 2022). Medical models of social problems tend to pursue expensive solutions through innovation and technology, because healthcare systems have relatively little realistic prospect of preventing problems at source. Indeed preventative care often descends into well-meaning but, in the long term, ineffective efforts at health promotion (Katikireddi et al, 2013). Reducing preventable mortality is overwhelmingly about broader structural changes to society (Pickett and Wilkinson, 2015; Bambra et al, 2021). Can we imagine a world where ‘our JobCentre’, ‘our schools’ and ‘our social housing’ are revered in a similar way to ‘our NHS’ as safety nets with societal benefits?

Conclusion

This book has reviewed the way that public support for the NHS is conceptualised and measured in UK debates, and proposed an alternative way forward that better illuminates the multiple ways that people in the UK encounter and value our sprawling healthcare system. I have argued that the epistemic infrastructures of quantitative data which structure our understanding of public love for the NHS struggle to capture the complexity of relationships involved. The baldness with which media reports proclaim the data reported in Chapter 2, and the relative lack of interest in how views about the NHS might be patterned in the population, are both obstacles to a better understanding of the NHS ‘in public’. I offer this book as the beginning of a more curious and wide-ranging research agenda in this area, rather than as a done-and-dusted answer. The practices covered here are not a complete list of practices which might illuminate the relationship between population and healthcare system, but examples to illustrate the possibilities of this approach.

One of the most obvious candidates for further research is an exploration of how NHS staff, across the spectrum of roles, practise care and contestation for the NHS in their work. For example, (how) do those recently vaunted as ‘NHS heroes’ understand their working conditions and the ‘above and beyond’ work they do (see Chapter 6) as service to the NHS? In a context of industrial action (Issa and Butt, 2022) and staff activism (Pushkar and Tomkow, 2021), there is much more to understand about how being employed by the UK’s biggest employer constitutes a particular positionality. Writing in the British Medical Journal, General Practitioner Margaret McCartney wrote of ‘doctors and the serial devastation the UK’s National Health Service (NHS) wrecks upon them’ (McCartney, 2022). Six years
earlier, her book on ‘keeping the promise of the NHS’ began ‘I am furious, sad, and scared for the NHS’ (McCartney, 2016). Working for the NHS is part of UK health professional identity, yet it is routine now to hear tales of NHS doctors uprooting their lives to make international moves for better remuneration and conditions in countries including Canada and Australia (Brennan et al, 2021). How, if at all, does commitment to the NHS feature in the sacrifices involved in staying, or in decisions to leave? And how are issues of overwork and underpay managed by those people and occupational groups who lack the possibility of international mobility?

Future research in this area also needs to be more purposively focused on particular population groups. I’m mindful, as I write and think about these issues, that the story of how ‘Britain’ feels about anything is one that only limited sections of its population (let alone the broader global population whose living conditions are structured by the former British empire), have been given space to narrate (Meer, 2022). Especially given the increasing co-optation of the NHS into particular visions of nationalism, it is especially pressing to understand whether and how diverse communities see the NHS not (only) as patients but as members of UK society. For example, many of the practices explored in this book are highly gendered, as well as being located within structures of social class, ‘race’ and migration status. The empirical studies reported in this book rely on convenience sampling in case study locations, and the overwhelming majority of my interviewees are white British, leaving multiple gaps in perspective. There is evidence that people who have migrated to the UK from other health systems are often less impressed by ‘our wonderful NHS’ than people raised in Britain proclaim ourselves to be (Madden et al, 2017; Bradby et al, 2020). Belatedly, important work is happening to understand and address experiences of racial discrimination in the NHS, and we know that experience of the NHS is sharply patterned by ethnicity (Black Equity Organisation and Clearview Research, 2022; NHS Race and Health Observatory, 2022). Experiences of healthcare systems are also different across other facets of identity: for example Lesbian, Gay, Bisexual and Transgender populations (Pearce, 2018; Young et al, 2019). Future research should prioritise better understanding how members of marginalised groups feel about ‘the NHS’, and how the increasing ‘nationalisation’ of the service (Cowan, 2021; Stanley, 2022) might be experienced from different subject positions.

There are thus multiple potential avenues to continue expanding and improving knowledge of public feelings about the NHS. This book is a beginning, rooted in the dissonance of watching symbolic statements of gratitude and love for the NHS proliferate, amid a broader feeling of crisis in 2021 and 2022. It really did feel, for a while, like ‘thankyou NHS’ was everywhere I went. In summer 2021, I took my kids to Legoland for a post-lockdown treat and took photos of them standing awkwardly in front of the
‘thankyou NHS’ exhibit in Miniland. At Christmas, my partner brought home a ‘love NHS’ advent calendar, with small pictures of the fundraiser Captain Tom Moore and rainbows all over it, with part of the purchase price being donated to NHS charities. I stepped off a train in Kings Cross railway station on my way to a London meeting, and the train pulling away from the next platform had ‘thank you NHS’ flashing on the digital screen instead of its destination. When I took my child for a hospital appointment, the ground outside the hospital had been emblazoned with a vast Thankyou NHS slogan, coloured in rainbow stripes. The data sources gathered in this book are testament to the intensification of Britain’s love for the NHS that I experienced in this period. The NHS has a remarkable and, as Crane and Hand (2022) have shown, novel cultural role in the UK as we move into the aftermath of the COVID pandemic. This book is, I hope, the beginning of a better understanding of that role, in the hope that we might use it to fashion a better, and fairer, ‘healthcare state’ (Moran, 1999) for the future.