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Between dissatisfaction and support: justificatory repertoires in public feedback on emergency healthcare in the United Kingdom National Health Service

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ABSTRACT

Quantitative studies of public opinion on healthcare often distinguish between support for the system and satisfaction with its services. The relationship between these two dimensions can appear contradictory: in UK surveys strong support for the NHS co-exists with rising dissatisfaction with care quality. We investigate this apparent contradiction through a novel analysis of 169 critical reviews of emergency care visits in the UK submitted to the Care Opinion platform between 2015 and 2023. While reviews all describe instances of poor care, we identify the 'justificatory repertoires' through which reviewers express continued support for the NHS. We argue this reveals how societal attitudes towards public healthcare provision are in a recursive relationship with actual experiences of healthcare, and that the articulation of those experiences is deeply shaped by awareness of the broader political context. Analysis of patient narratives reveals complex relationships between solidarity and dissatisfaction in public opinion, and insights into policy feedback loops between healthcare provision, institutional design and public attitudes toward healthcare.

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KEYWORDS healthcare; policy feedback; public opinion; United Kingdom

Introduction

Healthcare is a high profile and, in many European states, popular area of public spending (Schwander, 2019). It is additionally 'among the most personal' of policy issues (Hacker, 2004b, p. 724). In this article, we explore

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what this means for efforts to understand public attitudes to healthcare provision, in the context of the UK's universal National Health Service between 2015 and 2023. Public attitudes are significant in public policy because of feedback loops: by creating and governing institutions, policymakers shape population attitudes (Immergut & Schneider, 2020), and policymakers then attend to these population attitudes when making decisions about future policy (Béland *et al*., 2022). Inspired by the growth of scholarship on policy feedback loops around healthcare policy in the USA (Campbell, 2024; Jacobs & Mettler, 2018; Michener, 2019a; Sances, 2024), we explore public attitudes to the UK's longstanding, if beleaguered, NHS during a period when the healthcare service has been widely discussed as being in 'decline'.

Attitudes towards healthcare involve both evaluative (self-interested) consideration of one's own healthcare provision, and normative preferences around the societal safety net for health risks. Reflecting this duality, comparative studies of public opinion in healthcare commonly distinguish between 'support for state responsibility' for a healthcare system and personal 'satisfaction' with one's own care (received and expected) within that system (Missinne *et al*., 2013; Wendt *et al*., 2010). Scholarship on these dimensions has been described as 'disarticulated' and contradictory, amid calls for more consistent longitudinal survey measures to disentangle their inter-relationships (Burlacu & Roescu, 2021). Reflecting this trend, recent large-scale surveys in the UK have found an apparently paradoxical relationship; that reported commitment to the NHS as a system has remained stubbornly high even as reported satisfaction with healthcare received has plummeted (Jefferies *et al*., 2024).

Both policy feedback scholarship on 'mass feedback effects', and public opinion research have tended to emphasise quantitative, rather than qualitative, data (Béland *et al*., 2022; Jacobs & Mettler, 2018; Soss & Schram, 2007). This approach has been especially valuable for expanding generalisable understanding of cross-national patterns of public opinion. However, as well as concerns about survey data availability, public opinion scholars have expressed concerns about how effectively survey measures capture the underlying phenomena of attitudes to healthcare (Ainsaar & Nahkur, 2019). There remain complex, and sometimes counter-intuitive relationships, between different variables (Missinne *et al*., 2013). Quantitative approaches struggle with complex attitudinal configurations which evade binary (happy/not happy) or ordinal (between very satisfied and very dissatisfied) measures. In this paper, inspired by Campbell's (2012, p. 347) suggestion that the policy feedback literature should 'revisit the methods of the older sociological paradigm, with its in-depth work and focus on uncovering the subjective perceptions and knowledge of individuals[?][?], we explore how reported experiences of using a healthcare system are bound up with broader attitudes towards it. This adds an important dimension to

contemporary scholarship on healthcare policy feedback loops, offering a deeper understanding of the recursive, at times paradoxical, relationship between personal experiences of healthcare systems, politically-informed attitudes to healthcare policies, and the wider healthcare policy landscape within which they are embedded.

We take a qualitative single-system perspective, drawing on patients' described experiences of healthcare to explore wider attitudes to the healthcare system and to shed light on the apparent paradox implied by recent British Social Attitudes Survey results (Jefferies *et al*., 2024). Our approach makes use of 'passive' qualitative data, analysing feedback that patients and their family members have submitted to an online health and care reviewing platform called Care Opinion. We leverage critical experiential accounts of service use in emergency departments to propose a more complex account of how (dis)satisfaction with healthcare received can co-exist with loyal support of the healthcare system in which it was received. We analyse 169 critical narratives of emergency care visits that explicitly mention 'the NHS', submitted by patients and their family members to Care Opinion in 2015, 2017, 2019, 2021 and 2023. The experiences analysed contained harrowing accounts of poor care and the language used to describe these experiences was stark and emotive: 'heartbroken', 'devastating', 'traumatised', 'horrific', 'agony', and 'appalling'. Notably, however, none of these accounts rejected 'the NHS' wholesale. Instead, reviewers used what we identify as 'justificatory repertoires' to articulate support for the NHS *through* their critiques, whilst identifying unacceptable failures in the care received. We unpack these narrative strategies in-depth, asking what they can tell us about the British public's relationship with the NHS, where deep affection is articulated, not in spite of, but alongside dissatisfaction and disappointment.

Background: the NHS, online feedback and the UK emergency care context

The United Kingdom is an example of a National Health Service-type system with universal access to healthcare, free-at-the-point-of-use. The British public's strong affection for the NHS is often seen as internationally distinctive, with political rhetoric frequently stressing 'love' for the NHS (Stewart, 2023). However, the gap between survey measures of support for state responsibility, and of satisfaction with healthcare is high and growing. Quantitative measures of public attitudes to healthcare currently suggest resilient societal commitment to what are described as the 'founding principles' of the National Health Service (NHS) (universal, free-at-the-point-of-use, and primarily funded through taxes), alongside sharply declining satisfaction with 'how services run nowadays' (Jefferies *et al*., 2024; Morris *et al*., 2023). This apparent paradox has attracted a range of commentary and analysis, much of which

tends towards assuming the irrationality of population support for a system in which they are receiving inadequate care (Arnold-Forster & Gainty, 2021; Cowan, 2020). Through a qualitative analysis of critical feedback stories submitted to a health and care reviewing platform, we explore this apparent paradox, where public support for the NHS seems resilient to even sharp declines in satisfaction. In our analysis we ask: how do people invoke and refer to the National Health Service as a system, within descriptions of problematic healthcare experiences?

Our focus is online patient feedback about emergency care. Emergency departments are, by definition, spaces dominated by stressful and anxious processes. Described by the Chief Executive of NHS England as the 'front door of the NHS' (NHS England, 2023), urgent and emergency care is particularly politicised in the UK, and tales of long waits regularly make front page news. Accident and Emergency (A&E) waiting times – measured as the time a person spends in A&E before they are admitted, transferred or discharged – are often seen as a 'barometer' of broader system performance (The King's Fund, 2022), and frequently referenced in news reports and political debate. In the UK, the relationship between an individual's decision to seek emergency care and the broader system has been amplified by political anxieties about waiting times and sometimes spurious fears about *misuse* of emergency routes. There are regular calls for the public to restrict or reduce their use of emergency services as part of being a 'responsible' citizen, including in large banners outside emergency departments. Indeed, the pervasive onus on using emergency services 'responsibly' has been shown to shape the functioning of emergency departments, with people's ability to present themselves as 'legitimate patients' influencing access to services and the type of care they receive (Hillman, 2014). This is despite a lack of evidence that inappropriate attendance has been a significant driver of emergency department waiting times (Sansum, 2023).

Online patient feedback is a particular subset of experiential data that includes comments, ratings, and reviews, provided by service users in different formats over digital platforms, which is submitted to the healthcare service provider whilst also being publicly available to a wider audience online (Dudhwala *et al*., 2017). While healthcare practitioners and others working within the NHS have expressed concern about the rise of online healthcare feedback (Atherton *et al*., 2019; Montgomery *et al*., 2022), most shared in the UK is in fact positive (van Velthoven *et al*., 2018), or at least mediated with positive comments, highlighting good practice and expressing gratitude to staff (Mazanderani *et al*., 2021; Stewart, 2023). Research has found that, in the context of the NHS, people provide feedback as a means of improving healthcare services, not only in terms of their own care, but also for other patients, healthcare staff and a more nebulous idea of 'the NHS' as a valued public healthcare service (Mazanderani *et al*.,

2021). They not only position themselves as service users, with the rights and vulnerabilities implied therein, but also as citizens with responsibilities for, and a commitment to, 'the NHS'. Thus, online feedback about experiences of healthcare can be a valuable discursive resource for exploring people's attitudes towards the broader healthcare system.

In this paper, we analyse online feedback provided through Care Opinion, an online platform where members of the public can submit 'stories' of up to 1000 words, linking them to the different provider organisations they interacted with during their care. As a non-profit-making Community Interest Company, Care Opinion's business model is to sell subscriptions to health and social care organisations who can make use of the patient stories (Care Opinion, 2022). While Care Opinion therefore shares some similarities with private digital platforms, often seen as commodifying patient experience (Lupton, 2014), this is a non-profit-making platform which, through these contractual arrangements with NHS organisations, has become interwoven with the NHS, especially within Scotland and Northern Ireland (Care Opinion, 2022). Here, we build on the growing body of social scientific scholarship on patient feedback within health systems, to ask whether we might also use qualitative data about healthcare experiences to understand people's attitudes to healthcare *systems* at a policy level. In previously published work, Stewart (2023) analysed Care Opinion stories to explore the relationship between people's personal experiences of care and their wider commitments to the NHS, emphasising the overwhelmingly positive narratives submitted to the platform. In this paper, responding to the growing evidence from surveys of increased dissatisfaction with NHS care, we expand the time series of the corpus, and focus only on critical stories where a significant problem with care is identified.

Materials and methods

Our corpus of 'stories' posted on Care Opinion are responses to a free text box that asks simply 'what happened? how did it feel?' Feedback is lightly moderated to remove commercial postings, spam, offensive or discriminatory language, and to remove specific healthcare staff names, and prevent legal repercussions for Care Opinion and the story-author (Berry *et al*., 2022; Ziewitz, 2017). The decision to submit a Care Opinion review is voluntary on the part of the service user. Patients are, however often, encouraged to provide feedback by subscriber organisations within the NHS, for example via posters and leaflets in waiting areas. Care Opinion does not collect reliable demographic data about stories, but we can assume that this optional feedback will be subject to some biases. Although collected and moderated by an independent third party (Care Opinion), the feedback is directed at the healthcare provider, who gets to see and respond to it, but as the feedback is posted anonymously and is publicly accessible it has a wide range of potential audiences.

As well as limiting our search to stories concerned with emergency medicine, we wanted to capture reviews that did not simply describe an experience of care (whether negative or positive), but which specifically discussed the 'NHS' or 'National Health Service' within the narrative. We applied text searching for any stories with 'NHS' or 'National Health Service' in the body of the story. Table 1 shows the proportion of stories that met this criteria in each of the years we chose to analyse: 2015, 2017, 2019, 2021, and 2023. We chose to analyse every second year to keep the corpus small enough for the detailed qualitative analysis we wanted to undertake, while also covering as long a time span as possible since the platform was created, but also covering years during and beyond the COVID-19 pandemic, when emergency attendance levels plummeted.

We additionally refined our corpus by concentrating only on the most critical stories published. Care Opinion moderators assign a criticality rating to each story shared, from 0 (not critical) to 5 (severely critical) on the basis of reported emotional or physical harm to the patient (Berry *et al*., 2022). Highly critical stories are likely not to be submitted on Care Opinion (Berry *et al*., 2022): indeed, between 2015 and 2023 only one 'level 5' story was submitted to Care Opinion out of a total of 6,545 stories about emergency medicine. Table 2 shows the relative proportions of criticality level across the time period. The relatively small number of critical stories likely relates to anonymous feedback not being legally 'actionable', and so formal complaints processes might be preferred in cases of serious harm (Locock *et al*., 2020; Speed *et al*., 2016). In previously published work, Stewart (2023) analysed a smaller corpus of stories across all criticality levels, finding that uncritical stories make up the majority, tend to be short (two or three sentences) and often primarily concerned with thanking individual staff members or 'the NHS' as a wider entity. To specifically explore the apparent paradox of stories which describe very poor care coupled with expressions of systemic support, here we focus on the stories graded with a criticality level of 3 or 4. Thus, we use criticality scores as part of our sampling process to aid us in selecting stories that contained at least one negative experience as expressed by the story-author. It cannot be considered an objective measure of either the overall criticality of the story or the underlying experience.

Author 1 extracted the stories from Care Opinion and cleaned the dataset manually (for example, excluding stories where the word 'NHS' occurred only within the title of the local hospital; removing duplicates). Informed by grounded theory approaches for analysing qualitative data (Charmaz, 2006),

Table 1. Numbers of emergency medicine stories submitted to Care Opinion in 2015, 2017, 2019, 2021, and 2023.

	2015	2017	2019	2021	2023
All emergency medicine stories submitted to Care Opinion	158	321	1068	1840	3158
All emergency medicine stories discussing 'NHS' or 'National Health Service' submitted to Care Opinion	108	142	196	185	528

Table 2. Criticality of corpus of Care Opinion emergency medicine stories discussing 'NHS'.

	2015		2017		2019		2021		2023	
Criticality level	All emergency medicine stories	All emergency medicine stories discussing 'NHS'	All emergency medicine stories	All emergency medicine stories discussing 'NHS'	All emergency medicine stories	All emergency medicine stories discussing 'NHS'	All emergency medicine stories	All emergency medicine stories discussing 'NHS'	All emergency medicine stories	All emergency medicine stories discussing 'NHS'
0 (no critical comment)	87	77	215	103	702	141	986	116	2107	364
1 (minimally critical)	19	8	17	5	79	20	247	12	170	17
2 (mildly critical)	34	12	46	16	169	23	265	23	376	53
3 (moderately critical)	16	9	38	17	104	10	241	30	338	85
4 (strongly critical)	1	2	5	1	14	2	30	4	45	9
5 (severely critical)	0	0	0	0	0	0	0	0	0	0
Total	158	108	321	142	1068	196	1769	185	3036	528

all authors read all the stories independently with close attention to discursive elements. We met to discuss, and identified prevalent discursive features and themes noted across the corpus. Based on these discussions, author 2 developed an initial thematic coding frame (Ziebland & McPherson, 2006). This included: descriptions of 'what went wrong' – what feedback authors perceived as 'poor' care; descriptions of 'what went well' – what feedback authors perceived as 'good' care; all references to 'the NHS'; expressions of gratitude and thanks; references to NHS staff; themselves or a family member working for the NHS; pressures faced by the NHS; justifications for service use; emotional descriptions around being 'let down' and 'disappointed'. We discussed these codes, and each of us further analysed a subset of the coding reports in more depth. The material was rich, and there were many potential avenues we could have explored. In what follows, we focus on themes that addressed our core goal of interrogating the interrelationship between dissatisfaction with care received and articulations of support for the healthcare system. These were: descriptions of poor care; pressures faced by the NHS; articulations of support for and recognition of staff; legitimation of service use.

Our commitment to qualitative analysis, rather than (for example) using text mining approaches, requires considerable reflexivity. Engaging with patient stories can be an affecting and difficult process (Berry *et al*., 2022). The stories we analysed contained emotional accounts of healthcare going badly, and sometimes fatally, wrong. The authors rely upon the same healthcare system in which these distressing experiences occurred. We therefore have an affective, and not only an analytic, response to the sense of health insecurity described. Consent for reuse of stories for research is built into the platform (Munro, 2015), and the first author received confirmation from the University of Strathclyde School of Social Work and Social Policy that ethical approval was not required to undertake this analysis. The more engaged work of not just reading, but re-reading and coding stories as a researcher can nonetheless feel intrusive. During analysis and discussion, we returned often to Shapiro's (2011) call to balance critical inquiry with 'narrative humility' when dealing with the stories patients choose to tell. Our role is not to judge or assess the accuracy of the stories we analysed, nor do we edit the spelling or syntax authors use. We take stories at face value and use them as a resource for exploring how people speak about the NHS, without making any claims about their underlying experiences or the performance of services described.

Results

Describing failures of care in context

The stories we analysed described numerous accounts of poor care, many of which centred on important non-medical aspects of healthcare; albeit often with medical consequences. This included long waiting times, a failure to

meet basic bodily needs such as access to food, water and sanitary care, poor communication to patients and their families as well as between healthcare professionals and services, inadequate pain management, rudeness, discrimination, and lack of empathy.

Waiting was, perhaps unsurprisingly, a major preoccupation given documented performance issues. This included waiting for ambulances to arrive as well as waiting for triage within the hospital:

> What shocks my carer and myself is that I was dumped in A & E for a whole night, dissociating on and off and feeling increasingly depressed and anxious. (2017)

> Elderly mother in law suffers fall at home and in lots of pain. Called Ambulance for assistance. Advised of a waiting time of 3 hours Ambulance arrived 7 hours later. (2019)

> Making very ill children wait for 10 hours in an extremely uncomfortable, unhygienic A & E waiting room is just not good enough. (2023)

> I was told that even tho I could barely breathe I had to wait 9 and a half hours to be seen. (2023)

While length of time waiting was often quantified (as above) and highlighted as an issue in itself, the comfort and dignity of waiting was frequently raised. This included issues with meeting patients' needs, such as pain medication, the availability of seats and beds, temperature and ventilation, safety, privacy, hygiene, food and water, access to appropriate toilet facilities. These concerns were raised both in relation to the waiting period, where they were often particularly heightened, and once admitted. For example:

> I felt isolated and the staff couldn't get away quick enough. There was only one person who I felt had time for me. Upon entering the room it was dirty and there was an empty bag of sodium chloride hanging behind me that was obviously from the previous patient as there blood was backed up into it. (2021)

> Unfortunately not only was there no water cooler to hand, the vending machine was faulty, having retained my £2 coin and refusing to take any more coinage and then barring me from reclaiming my 2 pound. I tried to remedy this through the receptionist who merely shrugged her shoulders with bored indifference and informing me that the vending machine was often like this and there was nothing they could do. A not my problem guv attitude given an alibi by third party absentee outsourcing. (2021)

> Hospitals are supposed to be a place of safety and all I know is that I did not feel safe. (2023)

Concerns about communication, empathy and interaction with staff were frequently raised: a sense of being ignored or not listened to featured heavily in many of the narratives. This could also involve feeling dismissed, not taken

seriously or spoken to rudely by healthcare professionals, an experience that could leave people feeling upset and even traumatised for a considerable period:

> I was accessed in less than an hour and saw a Dr about an hour later. I repeatedly told him (and his senior) that I only experienced the pain when I walked – pulling my knee about while I sat DID NOT reproduce the effect or pain. I told them I had fallen twice in three days (I'm 62). They listened but did not seem to hear what I was saying. (2015)

> I didn't feel listened to at all as part of that visit and felt really upset even after I left. I feel I was treated quite badly given I was clearly just a concerned mother who had an obviously poorly baby on her hands. (2017)

> 4 hours she was left in the waiting room frightened and in pain along with other vulnerable people, the manner from members of staff was atrocious, one person who was in pain was told x-ray results abruptly and in front of everyone … Someone asked how long was the waiting time and a nurse shouted a dismissive comment back about how they had some very poorly people there, which my mum stated to me that it made her feel as if she shouldn't be there and was wasting their time. (2021)

> Even now, days later, I am still in terrible pain, exhausted, and tearful when I think of that experience. Everyone has bad days and sometimes we say and do things we don't mean. But to have a patient leave your department visibly upset after being left lying in pain, had their reasons for being in a bed questioned, and then being spoken to with, what felt like, disdain, is beyond explanation. (2023)

As evidenced above, the language used to describe these experiences included repeated references to being 'let down', disappointed, saddened, and angry. While we are cautious about emphasising trends over time based on our qualitative data set, there did appear to be shifts in tone across the different years which may reflect reducing overall satisfaction levels over the period 2015-2023. For example, there were minimal references to 'disgust', 'disgusting', or 'disgusted' in the 2015, 2017, 2019 or 2021 data (once in 2017 and once in 2021), whilst there were six such references in 2023. When embedded within stories, strong emotions (sadness, disgust, shame, anger) were often associated with a sense of disillusionment and disappointment in the NHS as well as the bare facts of the care failures described:

> Blood was taken & as his kidney & liver appeared to be ok they discharged him after 4 hours. I picked him up and was very disappointed and angry that he was treated so badly, he deserved respect & understanding from those treating him. (2017)

> I believe the NHS is broken and the care patients get sometimes is totally below basic human need. I have seen the stress and upset this causes nurses and how

> hard they work. I have been encouraging, grateful and have always tried to build the nurses up with my words. For that nurse in charge to speak to me and behave how they did was disgusting and threatening, in my view. I feel that to leave us in a relatives room with no communication is disgusting. (2023)

The quotations throughout this section show the strength of people's feelings. But it also shows how the feedback writers expressed a belief in the NHS as a social and political project and felt extremely 'let down' by their actual care experiences. In the subsequent sections we will show that, despite these highly critical accounts, many of the authors stressed they were not 'complaining' about the NHS, echoing research on people's self-reported reasons for providing online feedback (Mazanderani *et al*., 2021). Furthermore, not a single story mentioned the NHS to reject the model. Rather, the stories we analysed suggest a more complex relationship with 'the NHS'. Alongside expressions of discontent, story-authors explicitly recognise the extreme pressures the NHS is facing, articulate support for staff and recognise good care, and present themselves and their family members as legitimate users of the service. We explore each of these narrative features, common across the accounts we analysed, in more depth below.

The NHS in 'crisis': acknowledging pressures and problems

The stories contained frequent references to the NHS being under 'pressure', a prevalent theme within media coverage of the NHS in the UK (Greener & Powell, 2024). This recognition of the challenges faced by the NHS was consistent across the corpus. However, the language used to express it changed. In 2015 and 2017, the term 'crisis' was repeatedly used, but by 2019 it was replaced by 'pressures'. This change in language may reflect the wider political framing and associated rhetoric at the time, or it might indicate a move towards what was initially deemed a time specific 'crisis' being seen as a more generalised problem. Either way, references to a 'crisis' and 'pressures', whilst often left implicit, seem to primarily refer to finances and funding (being 'underfunded' or suffering from 'under investment' as some expressed it) and being 'understaffed', with staff seen as overworked and under-appreciated. Evocative words, such as 'crumbling', 'failing', 'broken', were used to describe a situation where services and staff were simply not able to match public demand (and need) for them:

> I feel annoyed and let down by the service at present. Understanding the pinch on public sector jobs being in such a job myself; I feel let down by the NHS in delivery of service. (2017)

> It seems that GPs [general practitioners] can't cope with patients and send them to hospital, who also can't cope. Very clear to me that the NHS is falling apart and can't continue this way, both for patients and staff in all settings. (2023)

The 'blame' or responsibility for these pressures were usually attributed to the government, politicians or hospital management, and there was an overarching sense that the NHS and those working within it were not supported appropriately:

> I am well aware of the pressures on the NHS, and especially on mental health services where government money has not really been forthcoming and where beds are now scarcer than ever. (2017)

> Not complaining – I feel sorry for the staff. In my opinion, they are forgotten – people don't appreciate what they actually actually do. (2019)

> Shame on management and governments for failing to address these obvious shortcomings. (2021)

> Very much aware it is a higher problem that needs rectified and I will be contacting my MP. However, this does not help a family who are concerned about their mother!! (2023)

> The NHS is struggling and I believe the big bosses are to blame … Staff are overworked. (2023)

While an acknowledgement of these pressures provided important background context for authors' negative experiences of NHS care, they were not framed as an acceptable excuse. References to the NHS being under 'pressure' often prefaced assertions that this was 'not an excuse' for problems experienced:

> I understand the pressure and challenges NHS staff are under but I'm not a neurotic time waster and expect to be treated with respect and understanding. (2015)

> I know the NHS is in crisis but to treat my son the way they did was wrong on every level and should be addressed. (2017)

> We all know the pressures the NHS is under but I do find her situation quite alarming. (2019)

> I understand our NHS is under pressure but these staff are not part of the COVID teams. To not provide even the basics in terms of care and support is disgusting practice. There is no excuse. (2021)

> We all know the pressure the NHS is under but this doesn't give employees the right to be abrupt and rude, a little more respect less of the eye-rolling would be appreciated. (2021)

> We know NHS is under pressure but it's no excuse for sub standard care. My father's story is just one of many similar but unnecessary examples of poor care. (2023)

> I know the NHS is under pressure and they do a fantastic job under pressure, but I felt there was zero communication between staff and no basic nursing care in this ward. (2023)

This repetitive acknowledgement, followed closely by 'but' was a remarkably consistent feature of multiple stories.

An important element of the authors' refusal to accept wider pressures on NHS services and staff as an excuse for poor care, was that a significant number of them worked for the NHS or had close family members who did. Thus, references to the author or a family member working for or having worked for the NHS, was used both to express solidarity with healthcare workers and to legitimise criticism of them from a position of epistemic and ethical authority.

> I also work in the NHS myself and understand the problems. But this is very poor service indeed. (2017)

> I feel very sad to have to write this as someone who works in the NHS myself and know how difficult it can be. However after a recent visit to the A&E department at [hospital name]I feel compelled to express my disappointment in the service that was given to my partner. (2021)

> I have no illusion over what is happening with the current pandemic and the toll it's taking on the staff, I have a full family of nurses some of them work within nhs [county name] which makes this even more difficult for me to write. Nurses are my life. But as a patient I should not at any point feel like a pariah, a second class citizen as a burden, and I did. (2021)

An emphasis on the pressures faced by the NHS alongside a refusal to accept it as an excuse for poor care results in an intriguing situation where 'pressure' is acknowledged as justificatory context, but the authors explicitly reject it as a sufficient excuse.

Support for staff and recognition of 'good' care

While the accounts we analysed were categorised as 'critical', and as such necessarily focused on at least one negative care experience, they also contained numerous positive examples. Positive experiences could refer to a particular unit, ward, department or team that cared for the patient at some stage, or specific members of staff encountered. Many of these positive anecdotes focused on healthcare practitioners being kind or understanding, responding to basic needs, and communicating clearly. In some cases, what might seem like a relatively minor event, such as a nurse bringing a glass of water, was spoken of with intense gratitude and appreciation. Thus, helpful staff were recognised, thanked, and held up of as exemplars of what NHS care could and should be:

> The nurses name is [Jean] (wish id found out your surname) thank you so much. You explained things to me, made me feel calm and contacted the Dr to come and speak to myself and my mum. I've forgotten the doctors name? I think it was [John} and I would like to thank you both for your care and consideration and taking the time to explain things. (2017)

> Porters came to assist mum to receiving ward. Absolutely amazing guys, made my mum laugh and feel at ease as did my daughter and I after a very emotional and worrying afternoon. Nurse on receiving ward kind and compassionate. (2017)

> The paramedics that came to my aid were fantastic and a huge credit to the NHS. If it wasn't for them keeping me laughing and their fantastic people skills I think I would have been an emotional wreck. (2017)

> I would like to re-iterate that I'm not complaining about the majority of staff as the nurses who look after me have been absolutely amazing. (2019)

> The nurses were so kind to our family and we will always be grateful to them for their help. They really are angels on earth. (2023)

Expressions of gratitude and thanks often came toward the beginning or end of stories, framing criticisms of poor care. As a result of this juxtaposition, stories can be read as both criticisms of poor care *and* expressions of support for the NHS. They show how poor care was not inevitable, and that the NHS could and did offer excellent care. This complex interweaving of 'good' and 'bad', 'gratitude' and 'critique', is succinctly illustrated in the quotations below:

> I would also like to say the ladies who looked after me in A&E seemed as confused as I was but, regardless, were absolutely lovely, very professional and caring and a credit to the NHS and the hospital. (2015)

> Before I detail my concerns I must also state that throughout the past year I have experienced an incredible standard of care from the vast majority of the healthcare professionals I have come into contact with on my numerous journeys to and from hospital. Almost all of these people have treated me with huge amounts of empathy, kindness and delivered exemplary care with my comfort and dignity maintained as much as possible. I will always be grateful for this. (2021)

> I have had (too) many experiences with the NHS over the last few years, including during covid, and they have always been positive experiences. I have great admiration for the NHS and for every level of staff who do a high pressure job every day. The majority of the staff I came across were lovely, kind and helpful. The auxiliary that came with me to CT, and the 2 nurses that carried out the CT and helped me move when I was in excruciating pain, were amazing. (2023)

Story authors were at pains to stress they were not blaming or complaining about staff in general, and that they supported the NHS and those that worked within it. As outlined in the previous section, issues such as underfunding and understaffing, lack of resources and the unavailability of treatments, long waiting lists and waiting times, and inappropriate or inefficient management, were highlighted as the key underlying problem or issue:

> Im not criticising the staff my heart goes out to them they are doing the best with limited resources. One nurse whos care goes beyond what was expected told me they could not wait to get out of the NHS. (2017)

> Half of the population don't realise how hard our doctors, nurses, receptionists, paramedics, cleaning, catering staff in the NHS work – it's a tough job. I want to thank them – they get no recognition. (2019)

> I would like to re-iterate that I'm not complaining about the majority of staff as the nurses who look after me have been absolutely amazing. It's the overall fact that I'm left in pain and nothing is done about it. (2021)

> I am mostly so very passionate and positive about our NHS and the wonderful job that all staff do which we are extremely grateful for. On this occasion I am left feeling disappointed. (2023)

Support for staff was often expressed in general and even abstract terms, as can be seen in the reference to the 'majority of staff' above, but individual staff members were sometimes highlighted. In a few cases, NHS staff members were referred to as 'heroes' or 'angels', but interestingly this discursive trope was only evident from 2019 onwards. In addition, some authors explicitly questioned wider discourses that lionised NHS staff as 'angels' or 'superheroes'.

Legitimising service use

Story authors made a concerted effort to present their service use as legitimate. As Soss (2000) has identified, such efforts both assume and perpetuate assumptions about the existence of an imagined *illegitimate* service user. Authors presented themselves as limiting their use of emergency services as a personal moral commitment, for example: 'I take painkillers not run to A & E' (2019); 'I rarely, if ever use the NHS, and am aware of the strain they are under' (2023). There was a strong moral undertone to these statements, with authors both implicitly and explicitly positioning themselves as 'good' citizen-service users who only turned to emergency services in extreme circumstances:

> I felt the hospital didn't think we should be there – but we had been advised to go there by the GP. We are not the kind of people who are serial abusers of the medical system which I appreciate is a major problem in the NHS. (2015)

> I was following NHS advice that is often shared in the media about not attending A + E unless an emergency. I completely understand the pressures on the service but I find this quite a stressful experience when I knew that I needed to be treated quickly. (2023)

However, alongside references to the wider social and political injunction to 'protect' the NHS, authors also drew attention to the fact they had *a right* to use these services when in serious need:

> I find it so very sad that now – when I really needed the system to work for my own benefit – the whole experience has shown the system to be so very lacking and leaving me so much out of pocket despite my having made the requisite contributions all of my working life.. (2015)

> I'm 70, have paid taxes for 50 + years and have not been much of a drain on these services. (2023)

> Totally disgusted that an old woman who has paid into the NHS all her life was left on a trolley for 18 hours. She never slept this whole time and had none of her medication which she needs daily. I do know the hospital are under-staffed and the staff under-paid. I think they deserve more but then so does everyone that has paid into the NHS for over 40 years. (2023)

As illustrated above, the right to healthcare was sometimes expressed in terms of being a tax-paying citizen, a theme that was particularly prevalent with older authors and people posting on behalf of older family members. As statements asserting the writer's medical responsibility assume an imagined 'other' who uses services irresponsibly, these references to dutiful tax-paying assume an 'other' who has not paid taxes for an extended period. While never made explicit within the corpus, this may relate to discourses and policies around migrant entitlements and welfare state 'scroungers' which have been increasingly deployed by governments in recent years (Medien, 2023; Okoroji *et al*., 2021).

Discussion

In this paper we have explored how people in the UK invoke the NHS as a healthcare system within the context of their descriptions of problematic healthcare experiences. Across our corpus of critical stories, all contained at least one instance of things going wrong, and most described multiple facets of poor care. Following classical theories of policy feedback (Ingram & Schneider, 1993), one would expect these individuals to express criticism of the NHS in their own self-interest. Burlacu and Roescu (2021) argue that the logical relationship would be people expressing low satisfaction with healthcare preferring to move responsibility for healthcare from the state to private providers, assuming that private healthcare will provide a better quality of care. However, and in keeping with broader quantitative findings which show that the British public's support for the basic model of the NHS is resilient to dissatisfaction with its operation (Jefferies *et al*., 2024), story authors in this corpus still continued to express support for the NHS. This supports the suggestion of Wendt *et al*. that satisfaction with healthcare is not a straightforward cause-and-effect phenomenon but is deeply conditioned by 'a broader prospective and retrospective sense of health security' (Wendt *et al*., 2011). Our analysis extends this argument to consider the affective experience of a sense of health security being eroded by unacceptable experiences of healthcare.

A key contribution of this paper is that this did not take the form of blindly loyal support *in spite of* poor care. Rather, the stories shared three distinctive, yet interrelated, narrative features, which enabled the authors to express

support for the NHS *through* their descriptions of failures. The first narrative feature was a widespread recognition of the pressures the NHS, and emergency care in particular, faced, providing an important *justificatory context* for why the NHS had failed to deliver appropriate care. Recognition of the pressures faced by healthcare services and staff shifted the responsibility (and blame) for unacceptable care away from 'the NHS' as a valued social good, to systemic problems with how it was funded and managed. Second, the critical accounts we analysed contained empathy, gratitude, praise, and support for NHS staff. Through highlighting good experiences alongside bad – what can be thought of as *mitigatory juxtapositions* – stories that were primarily negative in content, could still articulate support for healthcare services and staff. Third, within the context of poor care, the stories emphasised explanations for why the author or their family member had ended up using emergency services. This *legitimising of service use* provides insights into how authors viewed the social contract between the British public and the NHS, and the 'othering' techniques of differentiating themselves from less legitimate users. Descriptions of poor care experiences mediated with the above three narrative features resulted in a 'yes, but … ' structure that allowed authors to vigorously critique the care received whilst simultaneously expressing commitment to the institution ('the NHS') through which it was provided. When viewed in this way, these narrative features show that the apparent paradox of ongoing loyalty to the 'the NHS' alongside dissatisfaction with actual care experiences may not, in fact, be a paradox at all. Instead, in unpacking how patients and their family members find ways to simultaneously express support for a healthcare system and raise concerns about poor care, this paper shows how evaluative dissatisfaction with and normative support for national healthcare services are often entangled, rather than opposed.

The stories analysed in this article can be considered 'unfitting' or 'wild' data (Montgomery *et al*., 2020), in that it neither lends itself to quantification for comparative purposes, nor focuses neatly on problems to be resolved at an organisational level. Public attitudes to healthcare services have often been measured for instrumental purposes, including international comparisons, and longitudinal measurement of individual health system performance. Policy scholars have noted that citizen's experiences with services are rarely straightforward outcomes of a single policy decision or even reform, but are rather experiences of what Mettler (2016) calls a 'policyscape'. In the UK, the NHS's founding principles have been subject to decades of policy layering, conversion and drift (Hacker, 2004b). Accordingly, we do not seek to attribute the attitudes expressed in patient feedback to a single reform, but recognise how people's descriptions of healthcare experiences intertwine the symbolic and interpretive role of the NHS, with the resources it proffers. Our analysis sought to understand the way that

experiential narratives incorporate and articulate system context. While they exhibit the complex interconnections of satisfaction and solidaristic attitudes one might predict from quantitative assessments of public attitudes to the NHS in the UK, they also expand our understanding of how these two attitudinal dimensions co-exist.

Our key concern in this paper is not to identify trends over time, but as described earlier, the time period of this study coincides with a significant reduction in public satisfaction with the NHS, and with recorded reductions in key 'quality' indicators for emergency care in the NHS (Quality Watch, 2024). As a public resource, the experience of using emergency care in the UK has likely declined in quality during the period of this dataset. However, a key contribution of theories of policy feedback has been to draw attention not only to the resource component of public policies, but also their interpretive features (Béland *et al*., 2022; Pierson, 1993; SoRelle & Michener, 2022; Soss & Schram, 2007). In contrast to its material performance in meeting quality standards, the visibility of the NHS has been exceptionally high. The time period includes 2015's highly-publicised financial budget shortfall in the NHS (Greener & Powell, 2024), the Brexit referendum campaign (in which the NHS played an unexpectedly salient role (Stanley, 2022)), very public mobilisations of the NHS's 'birthdays' to build public support (Bivins & Thomson, 2023), and the COVID-19 pandemic, in which 'protect the NHS' was emblazoned on the lectern from which the Prime Minister addressed the nation. This article demonstrates some of the resilience of the interpretive associations of the NHS as a 'proximate-visible' (Soss & Schram, 2007) policyscape, even amidst experiences of a diminished quality of resource.

Conclusion

In the UK, the NHS as a statist healthcare system is an example of what Hacker describes as 'popular and change-resistant policies' (Hacker, 2004a). The NHS is, to use policy feedback terminology, both highly visible and highly proximal to the lives of the majority of people living in the UK (Soss & Schram, 2007). Policy feedback theory directs our attention not only to the 'resource' effects of a policy (in the case of healthcare, access to care and its perceived quality) but also to its 'interpretive' effects in the case of healthcare, how its distribution and quality change 'the ways that people view and understand themselves, others, and the political world' (SoRelle & Michener, 2022). This paper demonstrates the value of sociological analysis of narrative data in understanding public attitudes to healthcare systems. In the specific case of the UK's NHS, we argue that narratives of service use make sense of attitudinal patterns that have been seen as paradoxical in other literature. Specifically, our focus on critical narratives of problematic service user experience allows us to understand how people continue to express loyalty and

support for an institution (the NHS) while describing harrowing and sometimes dangerous experiences of care. Authors of these stories are far from deluded or blind to the failures of healthcare they have received: there is no evidence of a 'Pollyanna-ish 'everything's fine' public persona' (Arnold-Forster & Gainty, 2021, p. 59). Awareness of (and sometimes anger about) failures is nonetheless expressed alongside a political commitment to the solidaristic basis of the UK's healthcare system. Where Likert scales force people to choose, the free text nature of Care Opinion as a platform for sharing experiences allows people to express both/and views, offering distinctive perspectives on complex attitudes and their internal tensions.

While this paper argues for the value of analysing free-text patient experience data within the broader landscape of public attitudes scholarship, we see this as an important contribution to, rather than replacement for, the robust measurement of attitudes which has shaped this field. Given the findings of policy feedback research into universal services (Jordan, 2013; Soss, 2000), there would be particular value in understanding whether this distinctive attitudinal pattern occurs in other countries with a National Health Service-type system. This corpus, and our analysis of it, have limitations which are important to acknowledge. A key one is that the selection of stories for analysis is not representative of the way people review their care on Care Opinion, in that we have focused on critical stories and excluded the majority, which tend to express straightforward gratitude for care received (Stewart, 2023). Nor is our corpus representative of all emergency care experiences: Care Opinion is a distinct modality of expressing experiences, and we know little about who chooses to share their experience in this way. Particularly, this corpus gives us relatively little robust sense of the demographic spread of authors beyond what can be interpellated from the handful of stories which describe experiences of racism. As in many other areas of attitudinal research, not least the British Social Attitudes Survey itself (Morris *et al*., 2023), there is a pressing need for purposively sampled work to enhance our knowledge of attitudes and experiences of marginalised and minoritised groups (Kopec, 2024; Michener, 2019b).

The specific added value of this paper is twofold. Firstly, we illuminate some of the mechanisms through which solidaristic system loyalty might permeate experience of system under-performance within a policy feedback loop. We identify a series of justificatory repertoires which recur within the narratives of experience: framing failures of care within explanatory features of the broader system context; an affective atmosphere of sadness and disappointment based on deeply held commitment to the endurance of a health system; and fellow feeling with employees of the health system, including based on one's own or one's loved ones' prior employment. Secondly, we add to well-established discussion of a 'healthcare discrepancy' within welfare state attitudes, wherein population attitudes to healthcare in a

number of predominantly liberal welfare state types more closely resemble a social democratic attitudinal pattern (Bambra, 2005). The dominant explanation for this has been an institutional one: based on the theories of path dependency and institutionally-generated norms (Immergut & Schneider, 2020). Our sociological analysis of healthcare experiences enhances this explanation with an appreciation of healthcare's distinctive affective role (Carpenter, 2012). A focus on emergency medicine – a field in which use of services is perhaps uniquely likely to be coloured by uncertainty, fear and pain – highlights how the visceral need for a medical safety net heightens the affective pull of this branch of the welfare state, even when one's own care has been unsatisfactory. This paper explains some of the narrative strategies by which people sustain their commitment to a struggling healthcare system. In the context of sustained and troubling failures of emergency healthcare in the UK, what it cannot predict is when, if ever, dissatisfaction with healthcare will 'break' public commitment to the founding principles of a statist healthcare system.

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No potential conflict of interest was reported by the author(s).

Data availability statement

This study is an analysis of existing data which is freely available from the Care Opinion website (www.careopinion.org.uk).

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