cc Paul Gray
John Whittingdale

ROMOLA CHRISTOPHERSON

NEW STATESMAN ON NHS

Please see attached article on NHS in the current issue of the New Stateman. The highlighting is mine.

The Secretary of State and his Supporters can have a lot of fun with this in the Commons on January 31.

BERNARD INGHAM
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Waiting in line

What people loathe about the NHS is its impersonality. Jolyon Jenkins looks at the prospects for a post-Fordist health service

On 28 November last year, 18 month old James fell against a park swing, and hurt himself so badly that he found it difficult to walk. His father, Bill, took him to the GP's surgery that evening. The doctor diagnosed "superficial bruising". But 24 hours later, James was no better, so the GP arranged for him to be X-rayed the next day at the Whittington hospital in north London.

The appointment was for 11.30 am, and Bill and James arrived five minutes early. "We waited first of all in one crowded room, then another," Bill recalls. "Eventually we were seen by a paediatrician at 1.20 pm. He decided to take X-rays; they were back an hour later. We had to see the paediatrician again. He diagnosed a fracture in James's leg, and summoned an orthopaedic registrar. We waited some more.

"James was getting hungry, but we couldn't get any food because we were worried about missing the registrar. At 4.00 we were told he was on his way. Half an hour later we bumped into the paediatrician, but it wasn't until 5.15 that an orthopaedic doctor arrived. He decided that James should be put in a toe-to-thigh plaster cast. That was done by 5.45. Then it was back to the X-ray department and then on to the registrar again. We were out of the hospital by 6.30. The whole thing had taken seven hours, and James hadn't eaten since breakfast."

As hospital horror stories go, it's fairly mild—just another brush with the hard-pressed health service. But it's one of the most ignored aspects of health care: how do ordinary people feel about the NHS? There's no evidence that the health service review, despite all the modish talk of "choice" and "consumers", is even asking that basic question.

Opinion polls always show great support for the NHS in principle, but when you look at how users feel about their own treatment a more complex picture emerges. One such survey was published last year by Social and Community Planning Research and the Royal Institute of Public Administration. One of the researchers, Tessa Brooks, summarises some of the findings: "People were increasingly unhappy as they went through the system. They were at their most satisfied using GPs. They were fairly tolerant using Accident and Emergency Services—they understood that waiting times just had to be endured—but they became less satisfied with outpatient departments and inpatient departments. I think that was based on a knowledge that they were block-booked: that there were procedures that were geared not to their needs but to those of the system."

People are amazingly stoical. At GPs' surgeries, of those who were kept waiting more than 45 minutes, only 14 per cent said it had caused them problems. But they are most irritated when they have kept an appointment and the doctor seems to be breaking it. At outpatients' surgeries they resent *their* time being wasted: nearly half agreed that "no one seems to care that patients also *have* busy lives".

Take the case (not part of the survey) of Leonora, a 37-year-old woman who suffers from diabetes and has been going to St James's Hospital in south London since 1980. "I started to notice that when I arrived for an early appointment, at, say nine o'clock, there were already vast numbers of people in the waiting room. Outbreaks of belligerence and aggression were quite common, and nurses were often brought in to deal with complaints. Sometimes people who complained about waiting for three hours were grudgingly moved up the queue—to loud comments from the rest of us.

"It slowly dawned on me that people were seen in the order they arrived, regardless of their appointment times, and that everybody had sussed that out. So I worked out an alternative system of rolling up at 12.45, regardless of my appointment time. Then the system changed two years ago so that people really were seen in appointment order. There was mayhem at first and even more aggro as people got used to the new order, but after that it went very smoothly and now you don't ever need to wait more than

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15 minutes. But it only happened because a doctor wrote and installed his own computerised appointment program with a very fierce recall system if you didn't turn up."

It's hard to believe, in the era of Sir Roy Griffiths, streamlining and consumerism, that such things depend on clued-up individual doctors. But they do. At St Thomas's eye department, it's possible to wait three hours. One patient says, in some fury: "When I suggested they saw patients according to their appointment times, they said this had been under discussion for some time but no decision had been taken. Why it needs a committee to decide something as simple as this I fail to grasp."

What we seem to be seeing is increasing dissatisfaction with a health service that operates, at least in the hospital sector, on "Fordist" principles of mass production. People want efficiency—efficient use of *their* time. They don't automatically want efficient use of *doctors'* time. Nor do they necessarily want "choice". Tessa Brooks comments: "We assumed that people would want more choice in health care, and that was not borne out by the survey. The average person is very happy to abdicate the decision-making process to the doctor: what they want is a sense of being involved, which has to do with being given information and being treated intelligently."

The two objectives don't necessarily conflict. In 1987, the National Audit Office published its findings into how operating theatres were being used. During weekdays, operating theatres were empty for nearly half the time, largely because sessions were cancelled at the last moment. There was very little advance planning about, for example, how many beds would be available for patients coming out of the theatre. This is not only inefficient, but extraordinarily annoying for patients. If there's one thing worse than a production line system, it's a production line system that doesn't work.

The right's answer to this is that market forces should even out mismatches between, say, the number of beds, the number of nurses, and the availability of operating theatres. Hospitals which opt out will be able to spend their money more effectively than district and regional bureaucrats ever could. And if they concentrate on particular sorts of treatment—hip replacements is the normal example—they will become more efficient and provide a better service to the customer.

Well, maybe. In purely medical terms, hospitals that specialise in certain sorts of operation, *do* get better at those operations. In America there are surgeons who deal only with slipped discs, and very good at it they are too. In this country, Peterborough general hospital has a unit that specialises in repairing old people's fractured hips. It has achieved significantly better results than other hospitals. The price, of course, is greater use of the Fordist ethos that everybody dislikes so much. Specialisation may save time and money for *hospitals* but do precisely the reverse for *patients*.

Moving towards a more responsive health service may mean changing the way we think. The Social Services Select Committee last year produced a report on NHS underfunding. Under the heading "Underutilisation and inefficiencies", the report quoted junior hospital staff at NE Thames, who spoke of "inefficient use of medical time as doctors spend increasing amounts of time cancelling admissions, consoling patients and re-arranging admissions." But perhaps this is only inefficient if you think of the NHS as a production line. After all, what's so bad about doctors consoling patients?

There are other fundamental difficulties. The NHS often hides serious conflicts and disagreements about what it's supposed to be doing. Professor Gilbert Smith at Hull University, for example, has studied the way psychogeriatric care is organised. "We found there was a major disjunction between the views of the old people's relatives and those of health professionals. The latter saw it as a medical problem—a disease—to be treated; the relatives wanted the solution to whatever it was they saw as the problems in their lives. That could be their jobs, their partners, their children or their sex relations, which all get disrupted when you've got a crazy old person about. If we could get our home situation right, they said, then we'd be quite capable of looking after granny.

"Everybody sees the issue in terms of the problems *they* have, so for health professionals the issue was whether there were enough places in psychogeriatric hospitals. They would make concessions to other views: for example, they had a relatives' support group to 'support the supporters'. But in practice, the support group attempted to sell the medics' perspective to the relatives." No amount of opting out and free markets is likely to solve that.

In the end, a post-Fordist NHS is likely to come about—whether we want it or not—from changing technology. It may soon no longer be necessary to wait a fortnight for your results to come back from a distant pathology laboratory. A survey last year, funded by the World Health Organisation, reported that: "In the future, many diagnostic kits will probably be offered to the general public. Tests for sexually transmitted diseases and hepatitis may be offered in the next five years. Certain screening tests for cancer could also be marketed in the next ten years. Genetic screening kits are also being developed for home use, especially by US companies, who plan to develop and market tests for common diseases with a genetic basis, such as diabetes."

A recent study by the National Association of Health Authorities adds: "In the longer term, there is no reason why diagnostic kits should not become available for self-use for other purposes, including tests for inherited diseases such as Huntingdon's chorea and Parkinson's disease." In other areas, too, post-Fordist "flexible specialisation" is coming. As the NAHA study says: "Boundaries between medical specialisations are becoming blurred as new techniques are made more widely available. For example, investigation for treatment of gastric ulcer may be undertaken by a physician, surgeon or radiologist using the same techniques. Another example is gall-bladder stones which could be treated by a physician using drugs, a surgeon using open surgery, or by a radiologist using endoscopic techniques under radiological control."

Perhaps some of this can be accommodated in the government's proposals, if GPs are given the freedom to buy new equipment that will give patients the quick results they want.

But on the present showing we're not ready for this brave new world. Technological post-Fordism solves some problems by creating others. Who will pay for those handy across-the-counter pathology tests? We can be sure the government won't want to. When you can test yourself for HIV, who will counsel you if you find you have the virus? When computers are moved out of intensive care units into the home to monitor the health of old people (one of the forecasts of the WHO group) who will monitor the computers? Without deliberate government intervention, health care for the average citizen is on course to get worse rather than better. ●