LETTER FROM WESTMINSTER

Patient power on the march

JOHN WARDEN

Perhaps doctors should beware, but the old idea that the needs of the patient are paramount is now so attractive to politicians that they are in danger of believing that they thought of it first. Listen, for instance, to John Moore, Social Services Secretary, referring last week to the review of the National Health Service:

"Above all we will bear in mind that our paramount concern is and always will be the interest of the individual patient."

The sentiment is commonplace enough today, but it was not always so. The founders of the NHS did not identify the needs of the individual patient as a prime objective above all others. There was much talk about the health of the people, though in the opposite sense of making the individual paramount. The new official history of the NHS (14 May, p 1391) is a fascinating account of the problems and politics of its first decade. But it is clear the paramount preoccupation was with structure and organisation, not the patient as such.

Patient power is a phenomenon of the Thatcher years and the rise of the consumer society. It emerged as an instrument of policy about a year ago when on the eve of the general election I reported that the motto of a third Conservative administration would be "The customer comes first." Mrs Thatcher has no more loyal disciple than Mr Moore.

Is the exaltation of the patient mere lip service? Not quite. Ministers do sometimes practise what they preach. They have recently reduced the minimum catchment area for radiotherapy units from one million population to 650 000. This was specifically to put patient access above clinical convenience.

The Labour party, too, is bowing to consumer power, which is to be a strong theme running through its forthcoming policy reviews. Shadow health minister, Miss Harriet Harman, returned this month from a visit to the United States enthusiastically brandishing a typical questionnaire given to private hospital patients there. It invited them to answer some searching questions: "Did doctors show concern for you as an individual?" "Did nurses introduce themselves to you?" "Did staff members create a positive environment and a feeling of teamwork?" "Were meals served at the right temperature?"

Miss Harman supposed that many NHS managers would be horrified to ask their patients such questions, so she will be suggesting that they adjust to the view from the patient's bed and go for consumer satisfaction. Does it mean that Labour and Conservative health policies are converging in the cause of consumerism? Far from it. The divergence could not be wider. Labour's consumer culture is strictly within the bounds of the NHS. For the Tories consumer choice means being able to put more of their own money into private health care.

No big bang for NHS, promises Moore

That, indeed, is back on Mr Moore's agenda with last week's kite flying about allowing privately insured patients to contract out of the NHS. The Treasury is said to have relaxed its objections to something of the sort being considered. Lest it made Tory MPs more nervous than they are already, the move was offset by Mr Moore's soothing assurance to an "ideas symposium" that there will be no big bang in the NHS and that change will be evolutionary.

Next day the case for more private health provision was again being argued before the social services select committee. Witnesses were concerned to dispel any thought that the NHS and the private sector should compete against each other. Dr Marvin Goldberg of AMI Healthcare did not believe that people wanted the NHS to be substantially reduced. Any major disruption would cause intense political upheaval. The role of private hospitals was to be more caring and sensitive to the patients' needs—"which is really what we are selling," Dr Goldberg said.

Mr Anthony Byrne of the Independent Hospitals Association submitted his National Healthcare Plan for copayment by the NHS and private insurance. People would take out top up insurance for acute surgery in private hospitals, relieving the NHS which would pay half the cost, thereby releasing £1 billion for its own use. He foresaw 20 million people choosing the plan, enabling premiums as low as £5 a week. The argument is again about consumer satisfaction. The plan is basically a means of raising £1.5 billion extra for health care. The advantage claimed is that it allows patients to see the surgeon of their choice at the time of their choice, as Mrs Thatcher does. Opponents argue that for £1.5 billion the NHS could offer patients an equal service.

Meanwhile, the select committee is some way ahead of Mr Moore in its review of the health service and is confident of completing its report by the summer recess. From the signs so far it will be a surprise indeed if the bottom line does not firmly endorse the principle of a tax funded NHS as the best method of providing health care to the satisfaction of patients, taxpayers, and voters, who, after all, are mostly the same people.

Value for money is the main concern of the Commons public accounts committee, and it has found it lacking in the provision of care for the 270 000 elderly and mentally ill or handicapped people of whom the DHSS has oversight. In a report last week the committee focused on the mushroom growth of private residential and nursing homes for the elderly (p 1543). The number of people in such homes increased from 42 000 in 1980 to 90 000 five years later.

About a third of the residents were supported by supplementary benefit at an average cost of £200 a week, amounting in total to more than £500m a year. This growth was not planned and reflected serious deficiencies in the operation of community care as official policy. The committee strongly suspected profiteering and drew attention to a finding that 23% of old people entering residences could have stayed in their own homes with community support services at a cost of half that for residential care. In the fashion of the day, the MPs interpret this as not only a waste of money but a failure to provide services best suited to patients' needs.

To correct it, the committee suggests that there should be an evaluation of the clinical need for residential care before it is financed by supplementary benefit. The DHSS is considering whether such a clinical assessment should be introduced in addition to the means test, which is the only assessment at present. But who will make the clinical assessment? It looks as if doctors may have to give way to social workers in the final analysis of their patients' needs. The Griffiths report on community care, for example, proposed a new duty for the general practitioner to refer such patients to the social services authority, which will then "tell him what action it has decided to take." The General Medical Services Committee, however, opposes such a change, arguing that it should be the responsibility of the social service authority (p 1548).

It is a novel feature of the consumer society if the patients' needs are too important to be left to the doctors.