COMMENTARY

Public opinion and the National Health Service

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With all the criticisms of the National Health Service it is too easy to forget one startling fact. The NHS is probably the most popular institution in Britain. Its staff may, at times, be on the edge of revolt; its finances may be precarious; its facilities may often be threadbare. Yet, whenever the opinion pollsters ask the public about the NHS, something like four out of every five people asked declare themselves to be satisfied.¹ Moreover, this figure has remained remarkably steady over the decades. Overall satisfaction with the NHS does not appear to be eroded by exposures of shortcomings on the media, by lengthening waiting lists, or by talk of impending collapse. The contrast between continued public support for the NHS and increasing cynicism about other national institutions, such as Parliament, is striking.

But there are several problems about interpreting the public opinion survey evidence about the NHS.² Firstly, public support cannot be equated with patient opinion: not everyone has much first-hand experience of the Service. Secondly, general satisfaction may be compatible with specific grievances: the perception of particular shortcomings may be offset by a general sense of gratitude for care received. Hence the interest of the recently published surveys of patient opinions carried out for the Royal Commission on the National Health Service: one a national survey of hospital patients,³ and the other a small-scale study of primary care consumers.⁴ For these were designed to elicit opinions about specific aspects of the services concerned, to probe below the surface of overall satisfaction in line with the results of studies of patient views by Cartwright,⁵ Carstairs,⁷ and Raphael.⁸

High level of satisfaction

In line with all their predecessors, the two surveys confirm a high level of overall satisfaction. For example, of the 788 former inpatients interviewed in the national study, only 7% would not be willing to go back to the same hospital—as against 52% who would positively want to go there. Again, most people thought that the hospital staff were considerate, though paramedical and non-medical staff were rated more favourably than nursing staff. In the case of the primary care patients, a much smaller sample limited to two geographical areas, over four-fifths of those interviewed thought that they could see their doctor as often and easily as they would like and that they had no problems of access to NHS services generally.

Where, then, does the shoe pinch? Surprisingly, in view of the public preoccupation with the lengths of waiting lists, dissatisfaction about access to hospital services is relatively limited. Only a fifth of those interviewed objected to the time

taken to get admitted into hospital or to have their first outpatient appointment. The reason for this may be that—as the survey shows—45% of patients get admitted within a month of being told that this would be necessary, and that only 14% had to wait more than six months. This is still, of course, a high proportion and the survey unfortunately does not classify waiting times by either the nature and severity of the condition or the age of the patient. It could well be that length of waiting time is associated either with low severity or high age: the elderly tend to be the least demanding patients. Similarly, 60% of patients get their outpatient appointments within three weeks of referral by their GP and 17% have to wait for more than six weeks.

Main sources of dissatisfaction

The main sources of dissatisfaction fall into two categories: the organisational routines of hospitals and the personal attitudes of doctors, among other staff. For example, over two-fifths of former inpatients complained that they were woken too early—not surprisingly since the survey shows that it is still all too common to wake up patients before 6 am. There were many grumbles about food (21% dissatisfied), inadequate washing facilities (19%), and noise on the ward (12%). In these respects such surveys clearly show their value in providing crucial information for the management of the NHS. By definition, patients are experts at knowing what it feels like to be a patient and their views thus carry unique authority. And, though some of the complaints may reflect conditions imposed on the NHS by shortages of resources, this is certainly not universally true. Many of them seem to reflect the fact that the patterns of ward life are far too often determined by the needs of the staff rather than by those of the patients. In short, many of the complaints could be met by introducing more sensitive organisational routines—by generalising what are already the best practices.

The other main area of friction—that of personal attitudes—is more difficult because the problems are not amenable to ready-made solutions. Each patient is, clearly, unique to himself or herself, a subject of overriding interest and continual concern. For the staff, however, each patient also has to be treated as a case: he or she belongs to a general category, whose classification will trigger off a series of (more or less) preset responses. Moreover, the patient's subjective anxieties may be totally unrelated to the objective classification of his or her condition, while the allocation of resources (time and care) obviously has to be related to the severity or urgency of that condition. So perhaps not surprisingly the survey of hospital inpatients suggests considerable dissatisfaction—36% of those interviewed thought that they had been treated as “just another case.” But, given the pressures on those working in hospitals, it is probably more important that nearly two-thirds thought that they had been treated as “individuals”—a tribute to the staff concerned.

In turn, this links up with another major finding of the survey. In line with previous findings,⁹ nearly one in three of the former inpatients thought that they had not been given sufficient

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information about how they were progressing. Almost half those who wanted to know more felt that they could not ask their doctors for the required information. Much the same was true of outpatients. And even when the doctors did tell patients, 15% had difficulties in understanding them because of the medical terminology used, while a further 15% had other difficulties (mainly because the doctor was foreign). Similar kinds of criticism were made by a minority of patients interviewed in the primary care survey, which produced such comments as "You just go in and he starts writing and, before you know, you're out." "He almost has the prescription waiting for you in his hand when you get there," and "I never feel he has much time to spare and he seems preoccupied: half-listening." Interestingly, the primary care survey suggests that patients become conditioned by their GPs to limit their demands: that they deliberately ration their calls on the doctor's time either out of a sense of consideration or out of apprehension that they might meet a brusque and critical reception. The deferential patient seems to be more common than the demanding patient.

Communication with patients

The question of communication and relationships between staff and patients is much researched and much discussed. Unfortunately, while it is obviously and self-evidently desirable to have good communications and to encourage sympathetic, helpful manners, it is not at all clear how such a happy state can best be achieved. In particular, it is important to distinguish between two kinds of explanation for the shortcomings in the system: what might be called the cultural and the structural explanations. The cultural explanation puts the emphasis on traditional medical attitudes, which may, of course, in turn rub off on to other health care staff—for instance, the doctor's perception of himself as an authority figure whose efficacy depends largely on maintaining his patient's confidence. This confidence could all too easily be undermined by a practitioner who starts explaining just how problematic the diagnosis is or how uncertain the form of treatment may be. Indeed, it may well be argued that when patients declare themselves to be dissatisfied about the lack of information they are really asking for more reassurance rather than more explanation (which may be unsettling and anxiety creating). In contrast, the structural explanation puts the emphasis on the setting in which doctors—and other staff—work. If there is no direct incentive to spend time on each patient (such as may be offered by a fee-for-service system, where the dissatisfied consumer can turn to a more understanding doctor if he wishes) or if pressures of work on doctors and others are excessive, then inevitably staff will concentrate on providing technically necessary procedures even if this means taking short-cuts in terms of treating patients as individuals who require personal attention as well as technical care.

The two types of explanation—set out in an inevitably oversimplified and caricatured way—are not mutually exclusive. But their policy implications are different. If the explanation for the dissatisfaction confirmed by the two Royal Commission surveys lies in attitudes the search for remedies must lie in trying to change these. If many doctors are not good at communicating with patients something is wrong with medical education. If, on the other hand, the explanation lies in structural factors there are obvious implications for the NHS as a whole. For example, it might be argued that the NHS simply needs more doctors: that the best way of improving communications is to have smaller lists and work loads. Were this argument to be accepted medical manpower planning would have to take account of this factor.

Unfortunately, the two Royal Commission surveys—like previous studies—do not provide enough of the information needed to come to any judgment on this point. On the basis of

their findings it is impossible to relate patients' views to either the level of resources or the way in which these are organised. We do not know what the distinguishing characteristics are of those hospitals or primary care practices which score highly in terms of good communications and patient satisfaction and those which perform less well—characteristics which might reflect either the educational backgrounds and personalities of the doctors or the work environment. Until more information on this is available attempts to improve communications are likely to continue to take the form of hopeful exhortation or psychic massage—remedial training programmes, and the like—rather than attempts to tackle the root cause (whatever it may be).

Generational effect

Two considerations reinforce the case for seeking more certainty as to the causes of poor communications. The first is the generally accepted emphasis on the importance of patient compliance—to which may be added the more recent emphasis on seeing the patient not as a passive recipient of care but as someone who should be actively contributing to the maintenance or restoration of his or her own health. The second is the fact, confirmed by the Royal Commission surveys, that dissatisfaction and criticism are linked to age. It is the younger patients who voice more dissatisfaction, while the elderly are far less likely to complain. This repeated finding is not, of course, unambiguous in its implications. It could simply indicate that increasing satisfaction is the product of the aging process: that people get more passive and less critical as they grow older.

The explanation could also lie in a generational effect. In other words, the finding may show that people who grew up in the pre-NHS era have lower expectations than the next generation: that they are consequently more aware of the improvements brought about by the NHS and less likely to be conscious of its shortcomings. If this is indeed the case and there is a generational effect consumer dissatisfaction with various aspects of the Service—including communications—is likely to increase.

But it should not be assumed that such consumer dissatisfaction with specific aspects of the NHS will also lead to disillusion with the NHS as an institution. The evidence reviewed suggests a different, more subtle conclusion. This is that the public make a more critical assessment of the NHS than many of those critics who urge root-and-branch changes. The combination of general support for the NHS and specific criticisms would seem to indicate that the public make a sort of implicit cost-benefit analysis of the Service and have decided that the costs, in terms of waiting lists and unsatisfactory ward conditions, are less than the benefits of a comprehensive Service of the kind available. In other words, the apparently puzzling contradiction between overall satisfaction and specific grumbles may indicate neither ignorance nor muddle but the drawing of a balance sheet and an acceptance of the limitations imposed on the NHS by Britain's economic circumstances.

References

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