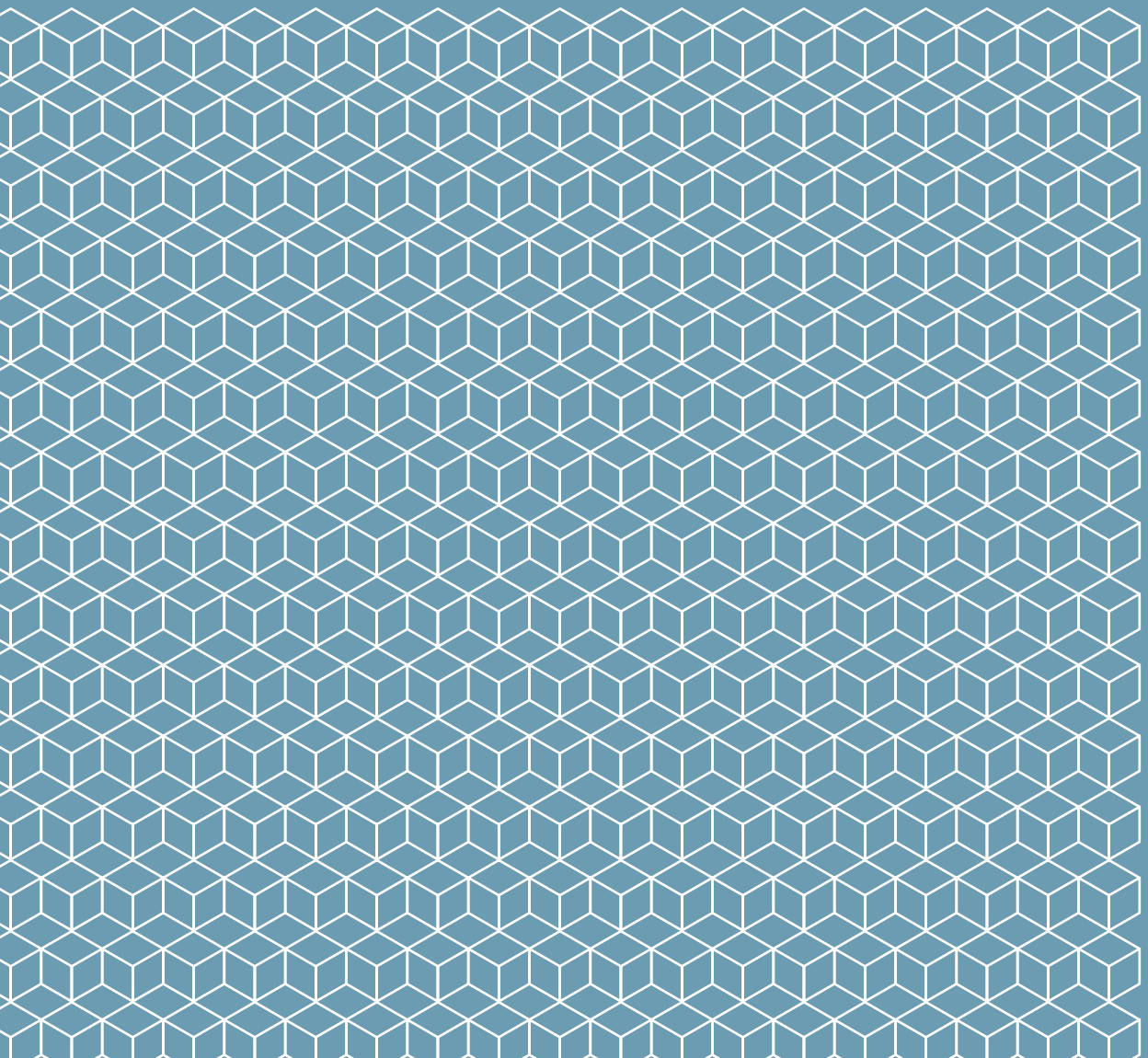
Autonomy ISSN 2515-9852

Automation and Healthcare: an interview with Helen Hester

By Luke Richards



Autonomy

Automation and Healthcare: an interview with Helen Hester

Earlier this year Helen Hester spoke to the writer Luke Richards on the topic of automation in healthcare. Here are some of her thoughts, presented in more or less unedited form.

1. What do you do and what excites you about automation in relation to your job/interests?

I am Associate Professor of Media and Communication at the University of West London. My research interests include feminism, technology, and theories of work (including paid and unpaid care work). My work looks at the potential impact of automation on different demographics, with a particular attention to gender. I'm interested in the emancipatory possibilities of automation – its ability to help us to achieve new things, to do things better, or to mitigate some of the burdens of existing cultures of work. However, I'm also critical about some of the current trajectories of automation, and its potential negative effects on particular constituencies. For the technologization of labour to be beneficial, it must be in the service of people not profit – which is not very likely at the moment! So, my excitement is somewhat tempered.

2. Have you experienced treatment for your health (or someone you know) and been subject to increased automation? How did you reflect on that?

I suffer from chronic lung problems (specifically, from asthma and bronchiectasis), so I am thoroughly acquainted with the NHS! Certainly, I've noticed some changes over the years, though these have often been rooted in the self-administration of technologies rather than in the wholesale automation of processes. Some of these developments – such as being able to avoid long queues by checking myself in on a computer, or being able to request prescriptions and book appointments online – have had a positive impact on my experiences of the GP's surgery. It's quite nice to be able to arrange Pap smear, for example, without the whole waiting room listening in to a discussion about my cervix! There are other developments, though, that I feel less positive about. I am not keen on taking my own blood pressure in a more or less public space, for example; I can't stand the feeling of the tightening cuff, and being able to feel my own pulse makes me excessively squeamish! Being encouraged to do this

in front of onlookers makes me very uneasy. (Fortunately, nobody has ever insisted that I do this, and the lovely healthcare professionals I regularly deal with are happy to take my blood pressure the old fashioned way.)

This move towards a certain amount self-administration in the doctor's surgery is reflective of a much wider trend, of course – one that arguably links contemporary technological developments with a qualitative and quantitative change in personal workloads. Ian Bogost has suggested that technology – far from acting in a labour saving capacity – is in fact generative of ever more tasks and responsibilities. There is a certain amount of unremunerated labour we are now obliged to take on ourselves, which would once have been performed by others – namely, people employed in positions that have been lost to downsizing and cuts. When we take our own blood pressure at the doctors (or issue our own books at the library, or check out our own groceries, or complete our own digital timesheets) we are performing newly individualized tasks, which might once have been undertaken by various paid workers. So, activities that were once within the remit of specialized roles have come to be spread across a wider spectrum of the population, as various services have been dismantled.

Whatever my subjective experience of the technologization of the surgery, the underlying rationale for this is clear – "efficiency savings". Limiting the time spent on face-to-face interactions within healthcare is one key prong of efforts to bridge the funding gap within the NHS. I don't necessarily have a problem with this; indeed, I think telemedicine could be really helpful for people like my parents, who live in a rural area a fair distance from a GP and even further from a hospital. It might also have provided an imperfect, band-aid solution for my grandmother in her later years, when her mobility was restricted, she could no longer drive, and local transport infrastructure was irregular and unreliable. For "specialist" healthcare provision – for example, gender identity clinics – a telemedical option might also broaden access to care for those a long way away from the services they need. Finding a trustworthy, reliable professional with whom one is comfortable is really important in these situations – even if there is a GIC in one's area, there's no guarantee the service on offer will be a good fit. And, of course, not everybody is going to be able to afford to travel up and down the country to get to their preferred provider. Having the option of engaging remotely for some appointments could be a useful step in reducing barriers to access.

That being said, we must remain attentive to some of the ways in which the technologization of healthcare could have a negative impact on patients and service users. Older patients who are not "digital natives" may be wary of a move toward digitally-mediated care, and not everybody has unfettered, private access to a computer or smart phone. (What would the impact of this be on victims of intimate partner violence, for example? What are the implications of moving away from the privacy of the physical space of the doctor's office?) And of course, face to face appointments enable healthcare professionals to pick up on a wider range of interpersonal cues, and perhaps pick up on issues that might otherwise be missed; Caroline Molloy has done some excellent work drawing attention to this kind of thing, and I really recommend her work. So, for all the benefits of telemedicine and technologized healthcare, we must struggle to retain provision of the maximum possible range of services. These developments should be about increasing options rather than increasing obligations.

---

3. Are there any key issues you can see in the future of healthcare automation?

A number of commentators foresee care work proliferating as a result of an aging population and the perceived resistance of much of this kind of work to automation. Others, however, suggest that this kind of labour may be more automatable than we might assume. A 2016 study by Deloitte, for example, suggests that Health and Social Care is amongst the top three sectors in terms of existing jobs at high risk of automation, and points to experimental developments in technologies targeted at the routine, repetitive, and physical aspects of care. I'm of the opinion that we may well see increasing polarization of work within the sector as job profiles in the start to change. We will see "high tech" roles proliferate thanks to the rapid development of technologies for remote monitoring, self-diagnosis, and other forms of telemedicine, resulting in an increase in opportunities for specialist data analytics. We will also require people for "high touch" tasks such as dressing, lifting, and washing – basic care services performed by (often low-paid) care assistants. This division between 'high tech' and 'high touch' will bring with it a marked income and opportunity gap.

Some elements of physical care delivery could potentially be brought within the framework of the gig economy. That is to say, with potentially more competition for "less-skilled" care jobs as workers are displaced from other sectors, and as demographic shifts take hold, there may be opportunities for the 'Uberization' of care – particularly domiciliary care. This may provide benefits to service users, whose caring requirements might vary at different times, who may desire more agency over the care they receive, and who may not wish to navigate the difficulties of employing a personal care assistant directly. However, there are risks associated with this model for the carers themselves, as the least favorable aspects of the gig economy (such as insecurity, forced flexibility, isolated and dispersed workplaces, and low wages) are rolled out to new territories. Indeed, given that many basic care services have historically been performed by a largely feminized and immigrant work force (as well as by unpaid family members), it may be that these unfavorable qualities are not only replicated but amplified. The low wages associated with the 'high touch' end of the sector may be one of the major disincentives to automation. It doesn't make sense to invest in technologizing routine tasks such as guiding, fetching, and lifting if human labour already does this cheaply and effectively.

---

4. Are there any key opportunities for automation in healthcare you're aware of?

One alternative version of the gig arrangement for care discussed above might involve the establishment of publicly owned platforms for care services. Such platforms would help to ensure the effective regulation of app-work involving vulnerable people (DBS checks, qualifications vetting, and so on) and would mean that the NHS or local authorities could avoid relying upon agency workers, who of course tend to be more expensive because of high commission charges. A significant percentage of the money saved might be diverted to the workers themselves, to ensure that they earn a living wage, or used to fund extensive skills training to facilitate greater mobility across the 'high

tech' and 'high touch' ends of the sector. (This is in addition to the positive facets of telemedicine discussed above.) I also wonder what technological advances might offer in terms of autonomous, community led healthcare initiatives – the kind of "self-help" approach associated with the second wave feminist health movement and some contemporary trans* activisms. How can we update the idea of "women's health in women's hands" to incorporate both radical queer perspectives and the new opportunities inherent to suggestive but embryonic advances such as reactionware? What kind of self-directed approaches to health and well-being could these technological developments make possible, and how could these be developed in a safe and equitable way?

Dr. Helen Hester is Associate Professor of Media and Communication at the University of West London. Her research interests include technofeminism, social reproduction, and post-work politics, and she is a member of the international feminist working group Laboria Cuboniks. Her books include Beyond Explicit: Pornography and the Displacement of Sex (SUNY Press, 2014), Xenofeminism (Polity, 2018), and After Work: The Politics of Free Time (Verso, 2019, with Nick Srnicek)

Luke Richards is a freelance writer whose work can be found at: https://medium.com/@myyada

……

Autonomy Research Limited
London
info@autonomy.work
@Autonomy_UK