COMMENTARY

NHS expenditure: turning figures into facts

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All the submissions to the Royal Commission on the National Health Service, whether from professional organisations or trade unions, are agreed on one point. This is that financial dry rot is eating away at the fabric of the NHS. Ministerial speeches about cuts in public expenditure seem to be reflected in the daily diet of newspaper headlines about closed wards, unfilled posts, and condemned buildings preserved by lack of funds.

But is this sense of crisis exaggerated or perhaps even self-generated? Does it reflect the sagging morale of professionals, hit by tax and incomes policies, rather than the state of the NHS? These questions are prompted by the Government's annual Public Expenditure White Paper,[1] which sets out both past spending patterns and future plans. For the White Paper figures suggest that, while the rate of increase in NHS spending has indeed fallen, and is planned to fall still further, the Service has done extremely well during the 'seventies taken as a whole.

In 1971-2 current spending on health services was £4216 million. In 1979-80 it is planned to be £5195 million. This is a rise of 23% and it is an increase, it must be emphasised, in real terms. The White Paper figures are presented in constant price terms. And, while such figures present some problems of interpretation, it does mean that, as the White Paper puts it, they "measure the amounts of goods purchased by the public sector and thus provide an indication of the volumes of services supplied." So the increase in expenditure, expressed in this way, provides an indication also of the extent to which the health services have expanded in size. They reflect the increase in the number of staff employed, goods and services purchased.

Deceleration of growth rate

But, and this perhaps explains the current sense of grievance, the growth rate is not being equally distributed over the period. There has been a rapid deceleration. In the first half of the 'seventies current spending on the hospital and community services (which account for over three-quarters of the total budget and which tend to be more sensitive to policy decisions than the GP services) rose by over 4% a year. In the financial year that is just ending, the equivalent figure is 2·7%—though this is still an estimate, subject to revision—and the projected figures for 1977-8 and 1978-9 are 0·9% and 0·7%, respectively. Moreover, even this modest growth rate has been made possible only by cutting the planned investment in new hospitals, the one area of NHS expenditure where there has been a reduction in the amount of money spent as distinct from cuts in the projected rate of increase.

The difficulty comes in trying to make sense of such figures. For it would not be surprising if these were to confirm those actually working in the NHS—and struggling with the day-to-day consequences of budgetary stringency—in the belief that it is possible to prove anything with statistics. In trying to assess them there are, indeed, two quite different sets of questions, where the answers may point in opposite directions.

The first set of questions hinges on the issue of whether the NHS is, in some sense or other, getting a "fair share of national resources." In other words, is the rationing system operated by the Government, and reflected in the relative priority given to different programmes in the Public Expenditure White Paper producing financial justice? Here the answer would appear to be that the NHS is getting a high degree of relative priority. At a time when standards of living in Britain, as measured by consumption, have actually been cut, the NHS has continued to be allocated a rising share of national resources.

Similarly, though the growth rate for the rest of this decade may seem derisory, this must be seen in the context of the overall decision to cut public expenditure as a whole. (Both decisions, however, may well be changed, in one direction or another, in the coming years in the light of economic circumstances.) Furthermore, some programmes—notably education—will have their spending levels actually cut, as distinct from having their growth rate reduced.

This last point illustrates the difficulty of deciding whether priorities are "fair" or not. On the face of it a comparison of spending plans for health and education would suggest that the Government has given an appropriate degree of priority to the former. Yet a slow growth rate for a service where demands are growing (because of the rise in the number of elderly in the population) may represent a lower priority than a marginal cut in expenditure for a service where the demands are falling fast (because of the fall in the number of children being born).

The allocation of resources can therefore be sensibly discussed only within the framework of some explicit assumptions about what the various services are supposed to be doing. A discussion of priorities among the many competing claims on public resources requires some indication—however rough and ready—of the extent to which the money will be used to bridge the gap between what a service is actually doing and what it is meant to be achieving: a gap which may well be measured in terms both of quality of service and of scope of provision.

Precisely because of the lack of such indicators it is even more difficult to answer the second set of questions about the allocation of resources to the NHS: whether these are "adequate." It could well be, after all, that—given Britain's current economic state—the NHS is getting *more* than its fair share of resources, while still getting very much *less* than an adequate amount of money as measured by the gap between what the Service is providing and what it should be doing. And, to the extent that this is true, it may be futile to kick against the system of raising revenue for the NHS, when the problem of underfinancing may largely reflect the fact that Britain is now the poor relation of the Western economic community.

All this would suggest that the Public Expenditure White Paper figures should be treated agnostically. They are more useful as an indication of where the Government is putting the nation's money than as a measure of what that money is doing for the services concerned.

Overtime and prescription charges

In the case of the NHS there are some additional problems in trying to make sense of the spending figures. The introduction of cash limits in 1977-8 has meant that increases in NHS costs—over and above increases in the general rate of price inflation—have had to be met out of the allocated budget. This suggests, for instance, that such items as higher overtime payments to junior hospital doctors may have cut the money available for other purposes: a fact which does not appear to be reflected in the White Paper figures. Again, the White Paper figures are *net* of income from charges, and to this extent understate the amount actually spent: thus in 1975-6 the income from charges was nearly £100 million. Nevertheless, it is not apparent from the White Paper whether the decline in income from prescription charges—in real terms, that is, since their levels have not been adjusted to take account of inflation—means that there is proportionately less money available to the NHS or whether the Treasury has provided compensatory funds: a crucial point, given the current debate as to whether more charges could provide a source of extra income for the NHS or whether these would simply give the Treasury an excuse to pay less out of general taxation.

Again, the NHS is not a homogeneous service. It is therefore quite likely that the benefits of rising spending will be distributed unequally, and that some parts of the country and some specialties may be worse off even while overall standards improve. This, indeed, is explicit Government policy, as expounded in both the document on priorities[2] and the philosophy of resource redistribution.[3] The problem of a slow growth rate is not that it necessarily means a general deterioration in the Service, but that improvements will be bought at the cost of either a standstill or even a fall in some areas.

This is self-evident enough in the case of resource allocation. According to the White Paper, the overall growth rate permits an increase of only 0·25% in the best provided regions as against 3% in the most deprived region. But, since the White Paper itself states that an annual rise of 1% is needed merely to keep up with the change in the population structure (though the precise processes of this calculation are far from clear), this means that the "best provided" regions will have to cut some of the existing provision to meet the

demands generated by an ageing population. Additionally, of course, none of these figures make allowance for the financial consequences of building new hospitals with higher standards —and therefore higher costs—than the ones they replaced: as these come into use, the regions and areas concerned have to pay the bill for the overoptimism of the 'sixties.

Moreover, despite the emphasis on joint financing, it does not seem as though the health authorities can expect much help from the personal social services. The growth rate of these, too, is being cut—though the severity of the reduction may in part reflect the Government's belief that, since local authorities always seem to overspend, it is just as well to set the original target too low. Unfortunately for the NHS, the pattern of overspending and underspending is as likely to reflect the predispositions of local councillors as the complementary local needs of the health and personal social services.

All these difficulties and pressures are real. So not surprisingly there appears to be a clash between the subjective sense of cataclysm among those working in the NHS and the objective evidence of the public expenditure figures. But helping further to explain this apparent contradiction is a basic assymetry in the political balance sheet of benefits and losses within the NHS.

For those who stand to lose as a result of redistribution or because they work in a low priority specialty, there is a clear incentive to protest by drawing attention to their problems. More important still, it is easy enough to mobilise local opinion about a closed ward or hospital, even in the case of maternity wards, where more than half the beds may be empty.

The compensating benefits may, however, be less visible and more diffuse. An extra consultant appointed to relieve pressure, more nurses on a geriatric ward, a much-needed piece of equipment, all these may help to raise standards of care without inspiring the sort of passionate commitment prompted by proposed reductions. What is more, in the case of reductions it is the staff already in post—and consequently threatened—who have an incentive to fight change. But, in the case of the growth points, the staff who would fill the new posts —and would therefore benefit from the change —may not form an organised constituency. And much the same is true of patients where those threatened with the loss of existing facilities have much more of an incentive to be vocal than prospective beneficiaries, since the latter may well be a potential rather than an actual, identifiable audience.

Priorities

In turn, this conclusion reinforces an earlier point made in this analysis: the need to be more explicit about what the money going into the NHS is supposed to buy and about the impact of extra resources (or a new pattern of distribution) on priorities expressed as progress towards specified policy aims. Thus the DHSS's priorities paper sets out its policy aims as a variety of "norms" for particular services. But the White Paper does not explain how its spending plans will affect the rate of progress towards achieving those norms, and to what extent any reduction in the planned growth rate may delay the achievement of the aims. Neither does it explain, though this is equally important, whether a lower growth rate should mean a proportionate reduction in all the proposed priorities, or whether the change should be selective.

For example, if the personal social services are to grow more slowly than expected, does this mean that the acute services should get a higher priority (since, clearly, this will make it more difficult to discharge the elderly, who now occupy some 40% of these beds)? Alternatively, does it mean that over-riding priority ought to be given to the geriatric services (since, obviously, there may be more pressure on them as well)? The answers to such questions are far from self-evident. But in trying to answer them, and similar questions, the first need is to translate expenditure figures into terms which mean something to both service providers and users, and to make some progress along the difficult road of identifying who will gain and who will lose and of measuring achievements against identified shortcomings. Unless this can be done, the debate about NHS spending will continue to be an uncomprehending argument between those who use different currencies of discourse.

References

[1] *The Government's Expenditure Plans, vol II*, Cmnd 6721 -II. London, HMSO, 1977.

[2] DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.

[3] DHSS, *Sharing Resources for Health in England: report of the Resource Allocation Working Party*. London, HMSO, 1976.

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TALKING POINT

Priorities for BMA

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If junior doctors continue to opt out of BMA membership the future is bleak. For it is on them that the main burden of responsibility will fall. So as a junior doctor I welcome this opportunity to comment on the exchange of open letters on the BMA between Charles Hastings and Jim Cameron, Chairman of the BMA Council (8 January, p 117; 15 January, p 181; 22 January, p 246; and 12 February, p 458).

On the cheap

Charles Hastings began by saying that "the BMA is suffering a crisis of confidence" and that with a tradition of "doing things on the cheap," because of inadequate income, members receive an inadequate service. But could it be that the income is not necessarily inadequate but that the BMA tries to do too much with it? Certainly, by comparison with our European counterparts, our membership subscription is low, but then so are our salaries. There is a definite limit on the amount a professional man is prepared to pay in multiple annual subscriptions, such as the GMC, a defence body, the RSM, the BMA, and his royal college, not to mention his golf club. Faced with inflation and a salary diminishing in value on which of these should a doctor save money?

I believe the Association was right to decide not to raise the subscription again at present but this means that it is more important to examine priorities. We have always made the mistake of cutting the financial cake into too many slices. Trying to run too broad a range of activities so as to please everyone can result in none of them being done really well. Some people would draw a parallel here with what is happening in the Health Service.

Overburdened secretariat

All the time that I was chairman of the Hospital Junior Staff Committee I was struck by the sheer volume and variety of work done by the BMA secretariat. I believe we have overburdened them and, in particular, expect most of them to do several different jobs at the same time. This means that relatively unimportant work competes with the work of, for example, servicing a standing committee or membership recruitment. The staff have no time for forward planning or getting out and meeting members on their home ground.

In a changing society inevitably the services which doctors expect from the Association will change. In addition, the influence of the State has meant an attack on professional groups, such as doctors, whose very training and work makes them individualists often out of tune within the State orchestra. This means that more emphasis must be placed on protecting doctors' interests against State encroachment.

There are two important aspects of this task. Firstly, negotiation of terms and conditions of service with the Government on which the BMA rightly spends much time and effort. Secondly, advice to individual doctors. Sometimes this can mean vigorous representation of their interests at local level, particularly for those who are under contract. The BMA needs to improve its performance in local counselling, advice, and representation because, at present, it is locally that a doctor's loyalty and appreciation of the Association will be won. This would also have the bonus of improving communications between those working and negotiating at national level and those at the periphery.

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