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Deux chevaux, Jaguar—or Ford

The arguments during the election campaign about the National Health Service seem to have raised awareness (both in the public and among doctors) of the complexities of assessing health care systems. Truly the NHS is a curious entity, since different observers (as in the legend of the blind men and the elephant) seem quite genuinely to perceive it as growing or shrinking, efficient or inefficient, and providing a first or third rate service to patients.

Some of these apparent contradictions can be understood by a close examination of the latest edition of the *Compendium of Health Statistics* published by the Office of Health Economics.[1] As a proportion of its gross national product British expenditure on health care (including the NHS, the private sector, and over the counter drugs) has changed hardly at all since 1980, but in cash terms it has risen dramatically from £12 000m in 1980 to £20 000m in 1986. Nevertheless, when measured against a planned growth rate of 2% (the national target set in 1980-1) the hospital and community health services have been underfunded by £1325m between 1981 and 1986.[2]

Scores of further contrasts appear in the compendium. The number of hospitals in Britain fell from 3027 in 1959 to 2341 in 1985. Hospital beds declined from 546 000 to 404 000 in the same period, but the number of nurses for every 1000 beds rose from 348 to 1223 and doctors per 100 000 people from 37 to 77 (the variation in the denominators is characteristic of health statistics). Furthermore, the operation of the Resource Allocation Working Party formula has led to variations within Britain in both growth and decline: the four Thames regions used to contain 27% of the hospital beds in Britain, but by 1985 they contained only 25%.

Out of this bewildering fog of figures some consensus is emerging—right across the political spectrum. The young but flourishing discipline of health economics should take some credit for this, and its leaders are justified in their recent claim that they will have even more to contribute in the next 25 years.[3] Every Western country is trying to reconcile the continuing growth of consumer demands for health care with limitations on state expenditure. The free market cannot operate freely for one clear reason: the individuals most likely to need medical care are those least likely to be able to afford it—the poor and the elderly. In all countries the state is funding an increasing proportion of the care for patients in these categories. (One example close to home is that 82% of NHS drug prescriptions now fall into one or other exempt category.)

The gap on to which attention is now focused, as Sir Brian Thwaites explained last month,[4,5] is between the public's expectations and the resources that are available, and this gap seems certain to grow despite efforts to introduce rationing. The question that doctors should now be addressing is how wide the expectation/disenchantment gap should be—and how it can be narrowed.[5] This week the BMA has joined with the Royal College of Nursing and the Institute of Health Services Management in proposing that expenditure on the NHS should be linked to economic growth so that its funding should rise in line with the nation's wealth (p 1695).[6] Next week the BMA's annual representative meeting will be giving priority to several motions calling for a re-examination of ways of funding the NHS.[7]

Doctors should not be too modest in arguing the case for more state money for health. The economists tell us, rightly, that the countries that spend most on health care are the richest, such as Germany and the United States. Yet in Europe the countries with gross national products closest to ours—Belgium, Austria, The Netherlands, and France—all spend more on health, and The Netherlands and France spend 60% more (around £590 a head as opposed to our £364 in 1985). As Nicholas Timmins pointed out last week in a perceptive article in the *Independent*,[8] a substantial factor in that increased spending is the cost of administration of a health insurance system. Yet surely health care could get a truly bigger slice of the national cake by spreading the sources of income wider so that the government, employers, and citizens all contribute. And to suggest modelling health care on a Dutch pattern does not betray the principles of the NHS; in The Netherlands there is, in effect, a single standard of health care available to the whole population funded by health insurance with no one excluded.

At present Britain has the cheapest (and possibly the most cost effective) health system in Western Europe. Most citizens have no choice on where to go for medical emergencies, chronic illnesses, or high technology treatments: they rely on the NHS. Private practice schemes rarely offer comprehensive care. But in a simple if crude analogy the NHS is priced like the cheapest Citroën car—efficient and reliable but with every possible economy. The private sector offers a few the equivalent of a Jaguar or even a Ferrari. There is nothing in between. Yet in recent years living standards have risen (for those in work), and the opinion polls suggest that many people would like spending on health to rise until it corresponds to, say, a Ford. Is it beyond the ability of politicians and doctors to understand that desire and come up with an answer?

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Correction

Asymptomatic carotid stenosis: spare the knife

We regret that an error occurred in the numbering of the references in this leading article by Peter Sandercock (30 May, p 1368). In the fourth paragraph the reference number after the sentence "The annual risk of ipsilateral ischaemic thromboembolic stroke may be as low as 0·1% per year" should have been [4], not [3].