BMJ
1840-1990

LONDON, SATURDAY 14 APRIL 1990

Health service finances

Most health authorities are worse off this year than last or the one before

> The hardest hit authorities include West Lambeth, which is considering an £8 million package of cuts... Newcastle upon Tyne Health Authority is considering a series of ward closures to meet a £1·1 million deficit and Riverside Health Authority is planning emergency cuts of £6·8 million.
>
> *Daily Telegraph* 27 February

> There have been a number of recent reports in the press that health authorities are in financial trouble. Various allegations have been made that underfunding of the Health Service has led to cuts in patients services... I do not accept claims that the NHS is underfunded... Health authorities have to operate within the budgets allocated to them as does any other well run organisation.
>
> Kenneth Clarke, Secretary of State for Health

Mr Kenneth Clarke's letter to conservative backbench MPs, as he implies in his opening paragraph, was meant as a rebuke to reports such as that in the *Daily Telegraph*, which if not exactly alleging underfunding at least suggested that bad management might not be the only explanation for financial difficulties experienced by health authorities towards the end of the year.

Mr Clarke certainly seems to have a problem with health service funding. A letter to backbench MPs is not the action of a secretary of state who is comfortable in the knowledge that he has got it right. Reeling out rhetorical statistics on NHS funding (as in the press release on 3 April) to your political opponents and other sceptics is one thing, but to members of your own party? Are people right to see the health services as beset (yet again) by financial difficulties, struggling to make it to the end of the financial year? And if so, are health service managers really profligate financial incompetents unable to control their clinicians, who continue to insist on treating more patients without a backward glance at their authority's cash limit?

The picture that is now emerging of the financial year just ended (1989-90) is one of a substantial number of health authorities overspent with many more just scraping by. In March the BBC's Social Affairs Unit carried out a telephone survey of 214 health authorities and boards throughout Britain—98% of all authorities. Some 91 stated that they would be overspent by the end of the year. A month before, another survey, this time by BBC Radio, found that over a third of health authorities thought that they would exceed their cash limits by the end of March. A written survey by the National Association of Health Authorities (see p 964) of 144 health authorities (a 68% sample) found that over 83% of health authorities thought that 1989-90 would turn out to be a difficult or very difficult year financially.[1] This survey was carried out in mid-March and covered England, Wales, and Northern Ireland. All three surveys found that the four Thames regions have had a particularly difficult year.

So did 1989-90 start off badly? The Hospital and Community Health Service began the year with a cash increase over 1988-9 of between 8% and 9%. Health authorities' cash releasing cost improvement programmes were estimated to produce around £150m, and the initial tranche of money to help implement the reforms of the white paper *Working for Patients* added a further £85m. All told, financial resources looked to be about 9% to 10% higher than the previous year. On top of this, sale of surplus land and buildings would (according to the Department of Health's estimate) raise about £290m—contributing over 30% to health authorities' capital budgets.

Where has all the money gone? A survey by NAHA last October, confirmed by a similar financial survey by the Health Care Financial Management Association, showed that the vast bulk of health authorities' extra cash was disappearing into higher wage costs and other inflation.[2,3] But the health authorities did not only have to cope with current pressures: the cumulative effects of underfunding have inevitably taken their toll on financial flexibility. For example in 1989-90 for the sixth year in succession the Review Body awards were not funded in full. That is, the gap between the national inflation allowance contained in districts' cash limits and the actual cost of inflation was not made good. By the end of 1989-90 Review Body pay award underfunding was running at a cumulative total of about £160m.

In the face of cumulative underfunding the only option open to health authorities is cumulative saving. But recycling larger and larger proportions of their budgets becomes harder and harder. NAHA's most recent survey found that six out of 10 health authorities think that they will have difficulties with their savings programmes this year, for example. Most health authorities in 1989-90 were left with little or no real addition to their budgets while at the same time facing continuing pressure to develop and expand services to meet increasing health needs.

The current year, 1990-1, is the last of the prereformation era of the NHS—and by all accounts it will prove to be one of the most financially difficult. Despite securing over 40% of the total increase in public spending for 1990-1, nine out of 10 health authorities say that this year will be difficult or very difficult financially.[1] A quarter state that they will be making service reductions, and nearly six out of 10 reckon that they will be worse off than they were in 1987-8—the year when over £100m was provided to rescue health authorities from financial difficulties (BBC social affairs unit, personal communication). Over a third of health authorities say that they will not be able to devote any money to service developments, and the total amount of money set aside for developments in 1990-1 (£111m) is half that spent in 1989-90.[1]

The problem for Kenneth Clarke over health service funding is that no matter how he looks around there is no winning solution. Overspent health authorities are a political embarrassment, raising allegations of underfunding (and counter allegations of poor financial management). But equally if health authorities stay within budget the price of doing so is inevitably cuts in services, reductions in developments, fewer patients treated, longer waiting lists, and an increasing proportion of health needs left unmet. Though there may be no neat solution to the problem of health service funding, the right to set budgets carries with it the equal responsibility for the ensuing consequences.

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1 National Association of Health Authorities. *Spring financial survey: prospects for health authorities in 1990/91*. Birmingham: NAHA, 1990.
2 National Association of Health Authorities. *Health service costs: autumn survey of the financial position of district health authorities 1989*. Birmingham: NAHA, 1989.
3 Chartered Institute of Public Finance and Accountancy. *Health service trends: the CIPFA database*. 2nd ed. London: CIPFA, 1989.

Minitracheotomy

A new, simple technique for treating patients with retention of sputum

Promotion of coughing is important in treating patients with retention of sputum. It needs to be combined with adequate rehydration, humidification of the airways, physiotherapy, and postural drainage. Various manoeuvres have been tried to encourage coughing, the simplest being to use pharyngeal suction, often through a nasopharyngeal airway; this can be effective—if unpleasant. Techniques also described include intratracheal placement of suction catheters, the instillation of saline through the cricothyroid membrane, intermittent endotracheal intubation, and bronchoscopy. These represent an increasingly aggressive continuum of intervention, likely to need repetition. When they fail the last resort is tracheostomy.

A recent innovation in these circumstances is minitracheotomy, in which a vertical slab incision is made in the cricothyroid membrane under local anaesthesia, allowing placement of a 4 mm cannula. This provides ready access for repeated suction and delivery of oxygen.[1-3] It has the attraction of being a simple procedure in experienced hands, it is comfortable for the patient, and he or she retains speech and the ability to eat. It needs sensible monitoring by nurses—for if the suction port is left open secretions will spill on to the chest and oxygen tensions may fall owing to redirected ventilation.[4]

Matthews and Hopkinson described 24 patients (15 who had had thoracotomy and nine medical patients) in whom retention of sputum was a major problem, and in 19 emergency treatment was needed for respiratory distress.[1] Ten of these had been treated with intermittent intubation or bronchoscopy. Percutaneous insertion of a minitracheotomy tube was successful in 23, while in the one remaining patient insertion was undertaken under direct vision as the cricothyroid membrane was calcified. Cannulation lasted between one and 10 days in most patients, but in two patients treatment continued for 33 and 45 days. Two patients required a change of tube. In only one case was the minitracheotomy considered unsatisfactory. Removing the cannula was uneventful and all wounds had healed, without any sequel, in six days.

Pederson *et al* independently assessed the role of minitracheotomy in 15 patients with retention of sputum postoperatively.[3] Thirteen were successfully treated, while the other two deteriorated and required ventilation—but both had minitracheotomy tubes reinserted after extubation. One patient had bleeding, which was controlled by external pressure for 15 minutes, and one developed subcutaneous and mediastinal emphysema related to violent coughing. The duration of the cannulation ranged from four to 38 days, and the wound had healed in all patients within three days of removal of the tube.

The prime indication for minitracheotomy is to remove chest secretions, but it has also been used in the treatment of respiratory failure with a high frequency jet ventilator,[5] in obstructive sleep apnoea,[6] and to manage retention of sputum in the older child (a paediatric version is not available),[7] and it has been described as a preliminary step (as an alternative to tracheostomy) in the management of an obstructed airway before laryngectomy.[8]

Nevertheless, some caution is needed. There have been complications at the time of insertion, and it is very important that the patient is correctly positioned as for a tracheostomy to ensure that the anatomical structures are well displayed and readily palpable. The operator stands at the head of the patient, who may find this disconcerting. A confused, possibly hypoxic patient may not easily tolerate lying flat or still for the procedure. The initial version of the minitracheotomy device lacked a flange, so that the cannula could be inhaled.[9,10] Misplacement into the mediastinum in mistake for the trachea has been reported[11]; displacement from the larynx during high frequency ventilation has led to emphysema and respiratory distress.[12,13] Surgical emphysema has also occurred in unventilated patients, perhaps owing to a combination of the incision being made larger than the size of the cannula and a coughing bout.[3,14] Intraoesophageal placement has also been reported.[15,16]

At the time of insertion there is always some venous bleeding from the stab site, but this resolves with pressure. Severe bleeding may occur and require surgical intervention.[3,14,17] A recent example of life threatening bleeding occurred in a patient who was taking anticoagulants and who had a subglottic polyp.[18] Individual case reports have not given any indication of the frequency of complications, which tend to be reported only if dramatic. Many of the practical complications reflect technical problems at the time