MEDICAL PRACTICE

*Contemporary Themes***Decision making in the National Health Service**

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One of the complaints made by clinicians since reorganisation of the National Health Service is the failure of the administration to make decisions. They contrast this with the comparative ease with which decisions were made before the reorganisation and still are made in private practice. The answer to this is twofold. Firstly, it is much easier to make decisions in private practice, where you can define the type of work you intend doing and can restrict the patients coming to see you on the assumption that somebody else will deal with those you do not wish to see. This ability to choose which patient to treat and which to reject does not apply in countries where private patients form a larger part of the whole than they do here, and where the costs are paid by some insurance body which will lay down complicated rules about who is eligible for treatment. In other words the freedom of the doctor to make decisions even in private practice is conditional on alternative facilities being available for those patients who are rejected.

So the reason why decisions are more difficult in the National Health Service (NHS) than in private practice is because the NHS cannot turn patients away. Secondly, the reason why reorganisation is seen as a particular bogey is because each reorganisation usually has as one of its main aims to increase specific pressures on the clinician. Thus the Lloyd George Act of 1911 establishing the panel¹ meant that any family doctor who accepted panel patients had a continuing obligation to them, an obligation that had not previously existed. The Act which led to the introduction of the NHS in 1948 extended this to the whole family and every citizen of Britain when they need medical treatment.² The 1973 Act extended the service to include the former local health authority services so that the district health authority of today has a responsibility also for preventive medicine.³ The 1982 reorganisation was different in

that it did not extend the responsibilities of the service so much as change and, I believe, improve the organisational structure,⁴ but it is still too early to evaluate this. It is worth noting that the obligations laid on the general dental practitioner are appreciably different from those laid on the general medical practitioner in that the dentists do not have continuing responsibility for a patient who has completed a course of treatment, and therefore they do not suffer from the same sort of pressure. Clearly there are different types of pressure on different clinicians.

I want to consider primarily the way in which decisions are made within and concerning the NHS, starting at Cabinet level, because it is here that the major decisions are made—decisions that are the outcome of discussions with other members of the cabinet in the light of political pressures from the whole population. The sorts of decisions include, for example, the proportion of the gross national product to be spent on the NHS and the proportion likely to be spent on health in the private sector. Figure 1 shows that the proportion of the gross national product

FIG 1—Regression of "per head health expenditure" on "gross national product (GNP) per head" by selected OECD countries in 1977 (£).

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spent on health varies considerably in different countries.⁵ In general, the richer the country the greater the proportion spent on health, so that Italy and the Republic of Ireland, with comparatively small gross national products, spend very small sums on health. Trebling the gross national product up to the level of West Germany or the Netherlands results in a fourfold increase in expenditure a head on health. It would therefore not be unreasonable to expect the United Kingdom government to keep expenditure a head on health roughly along this line, which means that if the gross national product increases then we can expect an increase in the amount of money allocated to the health services, but if it does not do so then it is unlikely that the NHS will receive appreciable additional funds.

Health and wealth

The general assumption made is that as a country increases its wealth so it is able to spend more money on health services as health services are seen as some sort of luxury. On the other hand, it may be argued that those countries that do spend more on health achieve an increase in their gross national product at least in part because of the benefits derived from their increased spending on health.

There are many examples where increased expenditure on health can either increase the contribution made by the individual to society or reduce the cost to society of supporting the individual patient. One example would be a more effective vaccination programme which eliminated the congenital rubella syndrome and thus reduced the cost—financial and emotional—of maintaining a handicapped child. Vaccinating girls aged 11 to 14 will result in substantial financial saving over the next 20 to 30 years by reducing the number of affected children with rubella syndrome who will require to be supported in part by the state. So the benefits of this type of investment may take a generation to reach their maximum.

A second example would be reducing the length of time patients have to wait for hip replacement surgery. We know that suitable patients benefit considerably from hip replacement surgery so that they are more mobile, more likely to return to work if of working age, or, if older, less likely to require admission to a home or hospital since hip replacement surgery for patients with certain specific signs and symptoms is effective in units with high standards. As the technique becomes more widespread the criteria used may be less strict and the results in some centres may be worse than those originally published.

FIG 2—Public expenditure by selected sectors and expressed as a percentage of total public spending in the United Kingdom. The actual figures have been deflated by a general index and hence include relative price effect.

The Office of Health Economics has produced a useful analysis of the economics of this operation.^{6, 8} In 1978 the cost for each case was £1200, making a total cost of £18m for the 15 330 patients operated on in 1978 at 1981 prices. Add to that 2900 knee replacement operations costing a further £3.5m and you have a total cost of £21.5m. The benefits can be divided into those relating to patients under 60 and those aged 60 to 70. In the under 60 group, with criteria for surgery unequivocal radiological changes of arthritis and disabling pain, it can be shown that the cost benefit ratio is 10 to 1. In other words, the loss of earnings and the cost of social security payments to a man or woman who has had to stop work would be 10 times the cost of surgery. The figures for the 60 to 70 years age band are less impressive, 2:1, but these figures do not allow for a reduction in admission to part III homes as a result of increased mobility after successful hip replacement.

It may therefore be argued that any waiting time is undesirable and carries a cost, but that would be true only if all patients on the waiting list fulfil the basic criteria—that is, they must be suffering from pain sufficient to limit mobility and must have clearly demonstrable radiological changes and be a reasonable surgical risk.

Nature of waiting list

Not all patients on the waiting list will qualify and it is noticeable how even with long waiting lists most patients are admitted comparatively quickly, a few patients waiting for prolonged periods, often because they do not really fulfil the basic criteria. In other words, before allocating extra beds or other facilities to reduce a waiting list for admission it is necessary to look very closely at who is actually on the waiting list. The importance of expanding services which have a positive cost benefit needs to be more widely understood and also the fact that a healthier population can be expected to effect improvements in society, which the sick lack the energy to initiate. This phenomenon is seen at one extreme in the Third World, where the bulk of the population is struggling to survive, with little strength left to improve the lot of the community, and improvements there are likely to come from a healthy and well educated élite within the country or from outside experts with similar characteristics.

The money available for the NHS is limited in the first place by the amount of money raised by central taxation and secondly by other government needs. Thus fig 2 compares the expenditure in the public sector in 1950, 1970, and 1980 and shows, for example, that expenditure on the Health Service rose considerably more than that on defence,⁹ to roughly half the cost of social security. The figures for 1983 are defence £16 000m, social services £35 000m, health £14 500m, and education £12 500m. Hence clearly the Cabinet decision to set a cash limit for the National Health Service needs to bear in mind (a) the proportion of the total gross national product that is appropriate to take in tax; (b) some assessment of the size of the private sector providing health; (c) charges for health services; and (d) the other pressures on central government expenditure. It is worth noting that the number of people covered by private medical insurance was 1.5m in 1966, rose to 2.25m by 1976, and to over 4.0m in 1981.¹⁰

If the main task for the Cabinet is to set a cash limit for the NHS for the year we need to consider issues that may endanger the cash limit after it has been set. For example, what would be the response to a wage claim that is so large that it cannot be met within this limit? The alternatives are to resist the claim; to reduce the number of employees in the NHS so that the remainder can be paid more; or to obtain money from elsewhere, perhaps by increased charges (for dentures, prescriptions, etc); or by transfer from other spending departments.

Similarly, the Cabinet's response to increasing expenditure on drugs prescribed by general practitioners to a level above the estimate was to find the money from the regional health

authorities' budget. One of the main tasks of the Secretary of State is to provide cash limits for each of the regional health authorities. Table I shows expenditure throughout the different regions of England and for Wales, Scotland, and Northern Ireland from 1970 to 1980.¹¹ In the early years of the NHS it was customary to allocate money to each region on a historical basis—that is, what it received the year before plus increments for agreed developments—but this effectively meant that regions

Resource Allocation Working Party target.¹⁴ The figure is further complicated by the service increment for teaching and an adjustment for the standard mortality rate.

It will have become clear that the inner London districts are in for a hard time, in part because of the falling population and in part because the Resources Allocation Working Party formula makes no allowances for social deprivation and suggests that they have an unduly large proportion of the

TABLE I—NHS hospital net revenue expenditure (£) per head of population, year ending 31 March, based on mid-year estimates

	1970/1	1971/2	1972/3	1973/4	1974/5	1975/6	1976/7	1977/8	1978/9	1979/80	1980/1	1981/2
United Kingdom	20.16*	23.77*	27.16*	31.29*	43.12	56.09	63.83	71.85	81.07	97.36	125.46	138.46
England†	20.33	23.87	27.28	31.48	41.68	54.20	61.77	69.30	77.97	93.58	120.60	132.76
Northern	16.70	21.00	24.76	28.74	38.41	49.78	55.80	62.31	74.40	88.28	114.35	125.19
Yorkshire	18.09	21.22	23.89	27.67	38.61	49.75	57.34	64.23	71.88	86.98	112.55	124.52
Trent	14.22	16.86	19.34	22.69	32.47	43.05	50.04	57.22	65.75	80.42	104.13	114.48
East Anglia	14.43	17.17	19.67	22.81	35.94	47.08	53.24	60.16	67.99	81.61	105.02	114.99
North west Thames	16.81	19.67	22.79	25.54	51.21	66.25	73.83	83.41	91.16	107.08	139.05	153.47
North east Thames	18.59	21.54	24.57	29.32	51.94	67.12	76.15	84.28	92.57	109.24	142.14	153.97
South east Thames	17.65	20.82	23.91	28.33	47.72	64.18	74.02	82.42	91.84	108.81	138.55	150.04
South west Thames	20.79	24.16	27.45	30.36	48.81	62.08	70.24	77.17	85.84	98.38	131.76	140.91
Wessex	17.91	20.58	23.42	26.64	36.31	46.74	53.43	60.23	67.64	80.55	104.11	114.45
Oxford	15.35	17.85	20.38	23.30	35.66	46.62	52.70	57.63	64.71	77.37	97.67	106.63
South Western	18.14	20.98	23.62	27.48	37.12	48.13	54.76	61.57	69.00	88.81	107.34	125.09
West Midlands	15.51	18.49	21.07	24.46	35.15	46.12	53.08	59.92	68.25	83.75	107.03	117.20
Mersey	18.60	22.14	24.45	26.92	43.15	55.56	62.45	70.52	79.03	95.89	123.59	135.98
North Western	16.87	20.10	23.24	26.90	38.85	50.44	58.35	66.68	76.08	91.21	120.30	134.58
Wales	21.25	25.66	28.87	33.32	42.70	55.09	62.17	70.47	80.40	96.64	124.35	137.14
Scotland‡	23.93	28.88	33.23	37.80	53.20	70.03	77.96	90.02	103.17	123.44	159.80	180.09
Northern Ireland	NA	NA	NA	NA	53.26	67.73	80.97	89.68	100.91	125.00	159.25	175.50§

Figures may not add up to totals because of rounding.

*Figures relate to Great Britain only.

†Figures include boards of governors.

‡Figures include hospital running expenses, specialist services, and ancillary services expenditure.

§Provisional figure.

NA = Not available.

like Trent never caught up with the better off London regions. The next proposal in the 1970s was to allocate resources on the basis of the population served (table I). This was not totally satisfactory, and there were wide differences. In 1970-1 the Trent region spent £14.21 per head of population on hospital services compared with £27.45 in Scotland. Even within the English regions the south west Thames region had a figure of £20.79 a head, 46% more than the Trent region. While those differences have gradually reduced in recent years, this discrepancy between affluent and impoverished regions was present in 1948 and virtually unchanged between 1948 and 1974, and politicians of both parties have taken the view that this discrepancy cannot be justified.

RAWP

The Resource Allocation Working Party set up by the Secretary of State in the mid-70s produced a new formula based on the different rates at which money was spent per head of population. Thus the actual cost of NHS treatment for each male¹² in 1979 was: <1 year £311; 1-4 years £117; 5-15 years £73; 16-24 years £75; 25-44 years £82; 45-65 years £127; 65-74 years £268; and over 75 years £507. The figures for women are similar if diseases related to childbirth are excluded.

There are also, however, important differences in mortality between regions. For example, the Trent region had a much higher mortality at 11.78 compared with the Oxford region, with a figure of 9.70 (fig 3).¹³ There was therefore a further inducement to redistribute funds to those regions that were seen to have the highest death rates on the assumption that improving the Health Service would reduce the death rate. The proposal of the Resource Allocation Working Party was therefore that for each region or district it was necessary to identify the populations in the eight age groups indicated, weigh them according to the known demands that each makes on the National Health Service, add a further figure for women of reproductive age and as a result produce what is known as the

FIG 3—Crude death rates per 1000 population, England and Wales Regional Health Authorities, and Scotland, 1976.

resources available. A further problem, especially for losing districts, is that resources are not increasing at the rate at which medical technology is increasing, nor are they increasing at the same rate as the increasing demand for health care. Too small an amount is spent on capital: the proportion is only 6% of the total cost of the NHS, which has not risen in proportion to the total expenditure on health. Certainly the proportion spent on capital seems far too little to maintain an efficient service. Table II shows how the expenditure on the hospital services has increased from 55% of NHS expenditure in 1950 to 63% in 1980.¹⁶

Table III shows the increase in consultant staff and shows that between 1974 and 1981 general medicine increased by only 2% and general surgery by 1%, whereas paediatrics increased by 35% and radiology by 20%.¹⁷ These are, of course, ap-

that opportunities are now less than with paediatrics or radiology where there has been less difficulty in gaining consultant posts because of the increase in the number available.

Specialties for priority

The regional health authorities' main task is to allocate the cash available to districts fairly bearing in mind the special needs of multidistrict specialties. They must make some sort of evaluation of how to select these specialties for priority. It is difficult enough to identify the populations of various districts, and with the Resource Allocation Working Party's formula to show their cash needs, but that would leave out the problem of districts, notably teaching districts, where there are regional

TABLE II—National Health Service gross expenditure—proportion spent on each service (%) United Kingdom

	Hospital services	Pharmaceutical services	General medical services	General dental services	General ophthalmic services	Community health services*	Other†	Total
1950	54.9	8.4	10.1	9.9	5.2	7.8	3.7	100.0
1951	55.7	9.7	9.5	7.8	2.8	8.5	6.0	100.0
1952	55.7	9.7	15.8	5.9	2.1	8.7	2.1	100.0
1953	55.5	9.5	10.8	5.5	2.2	8.8	7.7	100.0
1954	56.7	9.4	10.6	5.9	2.5	8.7	6.2	100.0
1955	57.2	9.5	10.2	6.3	2.5	8.9	5.4	100.0
1956	57.4	9.8	9.9	6.3	2.3	8.9	5.4	100.0
1957	56.8	9.7	9.7	6.4	2.2	8.8	6.4	100.0
1958	57.5	10.0	9.8	6.5	2.1	8.9	5.2	100.0
1959	57.1	10.2	9.2	6.5	2.1	9.1	5.8	100.0
1960	57.2	10.1	10.0	6.3	2.0	9.1	5.3	100.0
1961	57.0	9.8	9.6	6.2	1.8	9.3	6.3	100.0
1962	59.0	9.7	8.5	6.0	1.7	9.8	5.3	100.0
1963	60.1	10.1	8.3	5.7	1.6	10.0	4.2	100.0
1964	60.3	10.2	7.9	5.5	1.7	10.0	4.4	100.0
1965	60.4	11.1	7.8	5.1	1.6	10.3	3.7	100.0
1966	60.8	11.2	7.5	5.2	1.5	10.2	3.6	100.0
1967	61.3	10.9	8.1	5.1	1.5	10.7	2.4	100.0
1968	60.9	10.4	8.0	4.9	1.4	10.5	3.9	100.0
1969‡	64.3	10.6	8.1	5.0	1.5	7.9	2.6	100.0
1970	65.2	10.2	8.7	5.0	1.4	7.1	2.4	100.0
1971	66.6	10.0	8.3	5.0	1.3	7.1	1.7	100.0
1972	67.2	9.9	8.1	4.6	1.2	6.9	2.1	100.0
1973	67.4	9.6	7.5	4.5	1.1	7.0	2.9	100.0
1974§	66.6	8.6	6.5	4.3	1.0	5.7	7.3	100.0
1975	63.4	8.6	6.2	4.1	1.2	6.4	9.9	100.0
1976	61.7	9.1	6.2	3.9	1.2	6.1	11.8	100.0
1977	61.5	10.0	6.1	3.7	1.2	6.2	11.3	100.0
1978	61.1	10.4	6.0	3.6	1.1	6.1	11.7	100.0
1979	62.6	10.1	6.3	3.9	1.0	6.3	9.7	100.0
1980	62.7	9.4	6.2	3.9	0.9	6.2	10.7	100.0

Figures may not add up to totals because of rounding.

*Figures before 1974 refer to former local health authority services.

†Includes headquarters administration (regional health authorities, area health authorities, health boards, and boards of governors), central administration, ambulance services, mass radiography services, etc, and centrally financed items such as laboratory, vaccine, and research and development costs, etc, not falling within the finance of any one service. Figures from 1974 onwards are not strictly comparable with earlier years.

‡Change in definition of NHS. Certain local health authority services transferred from NHS to social services.

§Reorganisation of NHS. Administration of certain NHS community health services transferred from local authorities to new area health authorities. School health services formerly administered by the Department of Education and Science also transferred to the NHS.

||Estimated.

TABLE III—No of consultants and senior hospital medical officers with allowance in England

	1974	1981	% Change
Anaesthetics	1361	1598	+ 17.4
Mental illness	933	1045	+ 12.0
Pathology	1232	1423	+ 15.5
General medicine	980	998	+ 1.8
General surgery	888	895	+ 0.8
Radiology	668	804	+ 20.4
Traumatic and orthopaedic surgery	559	629	+ 12.5
Obstetrics and gynaecology	628	674	+ 7.3
Paediatrics	370	498	+ 34.6
All	10623	12397	+ 16.7

preciable changes affecting the use of resources, and decisions of this sort can only be made centrally in the Department of Health and Social Security (DHSS). They will affect the prospects of registrars and other trainees in the specialties concerned. So that, for example, it is not surprising that the senior registrars in general medicine or general surgery have great difficulty in gaining consultant posts because the number of senior registrars tends to be related to the needs of past years, and the relative decline in consultant posts available means

specialties that should properly receive additional money by "top slicing"—in other words, money being allocated to regional specialties before applying the Resource Allocation Working Party's formula. One criterion would be the effectiveness of the treatment. The uptake of any new technique is an S shaped curve where initially a few patients are treated by a new research technique. If that appears to be successful the numbers increase conspicuously and more specialists become familiar with the technique—and then there is a hump followed by a decline; the hump is the backlog of patients suitable for the technique, the decline falling to a plateau reflecting the incidence of new patients. It is important to recognise this, because as the technique becomes acceptable the need will be increasing year by year and will appear to justify greater resources than will eventually be required.

There is much evidence, notably from the excellent monograph describing the results from the University of Alabama in Birmingham, USA,¹⁸ of the social and economic impacts of coronary artery disease. The conclusions, with which most would agree, are that surgery is indicated for disease of the left main coronary artery and also if the lumens of two or more other coronary arteries are occluded a certain percentage and if there are in addition severe symptoms of angina. These

criteria indicate that in the USA something in excess of 200 000 people presently have symptoms that suggest they might possibly benefit from coronary artery bypass graft. Thus about 200 000 people between the ages of 35 and 65 should be screened and something between 15 000 and 40 000 are likely to be candidates for surgery. The cost of each case at June 1979 figures was \$12 674 for each patient undergoing bypass surgery or \$507 000 000 for 40 000 patients. Even for a rich country such as the United States sums of this sort are clearly a matter of political importance and not simply matters that can be left to the individual consultant and patient, particularly as this cost does not include the cost of investigating 200 000 patients with angina to see if they are suitable for surgery (that adds about \$120 000 000 at 1979 prices).

In other words, once a technique such as coronary artery bypass graft is proved to be effective¹⁹ and can be applied to a large number of people than it becomes necessary to make some sort of decision on how to ration it. Districts undertaking coronary artery bypass grafts will need to decide on the numbers of such operations—for example, that they should be limited to 400 a year. The next step is to provide the surgeons with a budget to cover that number of operations and to insist that they keep within it. Operating at weekends and at other inconvenient times increases the cost of nursing services. Similarly there are major problems if the intensive care unit is overused. By careful organisation substantial savings can be made and I would suggest that districts need, in this sort of instance, firstly, to provide some fairly crude limit—which may be the numbers of patients treated—and then by continued discussion with the consultants and other staff concerned to refine the figures so that either the costs can be reduced without an equivalent reduction in the number of patients treated effectively or more patients can be treated for the same cost. In other words, the most economical use of resources would be encouraged by adequate discussion of budgets with the staff concerned.

Another example is the management of renal dialysis and transplants. The cost in one district may well exceed £1 000 000 a year on this programme, which is divided into a number of components. Until recently these were: renal dialysis in the home, renal dialysis in the hospital, and renal transplants.²⁰ Some of these issues were considered in an earlier paper.²¹ Renal transplants in suitable patients are likely to be much more effective than renal dialysis and undoubtedly suitable patients should be referred to renal transplant programmes both because they are likely to be better off and because it costs less. The problem arises when new expensive drugs become available. District management teams are likely to be told that the decision to use the drug is a clinical matter and not one with which the management committee should interfere. The management committee should, however, have identified a budget, and the problem then is either to use the new drugs to treat fewer patients or not to use the new drugs. When there is considerable doubt about the effectiveness of a drug it is necessary to have some form of controlled trial and the drug manufacturers themselves should pay for the trials.

I have already shown that the costs of the health service are inevitably at the expense of other services and one therefore needs to identify what is a reasonable cost. The gross yearly earnings of male manual workers in 1981 (median) were £5800 and are now around £6000²² and there must be some relation between the amount of money it is reasonable to spend on a sick person and what we can afford to pay a fit person. For example, if a haemophiliac boy who is bleeding needs a drug that would cost £56 000 should this be provided? Would the decision have been altered, (a) if the boy was mentally or physically handicapped, (b) if the treatment was unlikely to be curative and would merely tide the boy over a crisis? These

are difficult decisions, not lightly taken. £56 000 is roughly the cost of providing five long stay beds for one year.

We live in difficult times—no country has sufficient resources to allow doctors to provide unlimited care. No country ever has been able to make available all known medical techniques to more than a small portion of the population which might benefit. The challenge we now face is to make sure that we allocate the resources available to us in ways that will improve the health of the population to the maximum possible.

The views expressed in this paper are my own and do not necessarily reflect the views of the Camberwell Health Authority or management team.

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MEDICINE AND THE MEDIA

THE BBC's RECENT programme on stillbirths, *The Lost Babies*, which our reviewer, Dr David Morris, praised (19 November, p 1543), is now available for hire on video cassette from Concord Films Council, 201 Felixstowe Road, Ipswich IP3 9BJ (0473 79300).