Bleak future for NHS funding

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The professional organisations representing the doctors, managers, and nurses rarely present an agreed view. So it is all the more welcome that the BMA, the Royal College of Nursing, and the Institute of Health Services Management have given their collective support to a report on the funding of the health service by the economist Mr Nick Bosanquet of the University of York.¹ The report examines the ever widening credibility and financial gap between the government's policy objectives for the health service and its willingness to pay for these.

It is unrealistic to think that the health service can be removed from the political arena, that "politics should be taken out of the National Health Service." Indeed, Professor Alan Williams, a colleague of Bosanquet's at York University, has recently argued with cogency that the best solution to running the NHS is for politicians, administrators, treasurers, and doctors to "interpenetrate" each other's territory.² Certainly because the health service absorbs so much public expenditure its aims remain essentially political, and the electorate still turns to its politicians to remedy failures in the service. No political party can therefore afford to allow the NHS to be divorced from politics. Thus the service continues to be subject to the vicissitudes of politicians and its funding will be determined ultimately by political rather than economic considerations.

Simply because politics have so much influence on the health service does not mean that we should abandon our attempts to introduce economic considerations into decisions affecting health care. Those who are concerned about the future of the NHS must not cynically surrender economic reasoning to political expediency. Nick Bosanquet clearly believes that politicians should be made to defend publicly their decisions on NHS funding in objective economic terms. This report is most timely; it can hardly be ignored (even if it remains unanswered) by the government and its Treasury officials during their present annual round of public spending reviews.

Government objectives for the NHS

The government has increased its range of objectives for the NHS during the past two years. These include programmes to increase efficiency and release resources for improvements and new developments; the development of community based services (especially for the elderly, mentally handicapped, and mentally ill); improving services for drug and alcohol abusers; and in the acute sector to expand services for renal failure, coronary bypass surgery, joint replacement, and bone marrow transplantation. In addition the NHS has been required to cope with the consequences of demographic and technological changes, and the transfer of resources between regions and districts according to the Resource Allocation Working Party criteria.

Governments have never fully costed their objectives for the NHS. Their approach to funding has started from the opposite direction. The government decides what level of spending on the health service can be afforded according to various political and financial considerations. As a separate exercise it develops its

On 30 October the Institute of Health Services Management, the British Medical Association, and the Royal College of Nursing launched a report, *Public Expenditure on the NHS: Recent Trends and the Outlook*, prepared by Nick Bosanquet from the centre for health economics, University of York. Norman Ellis of the BMA comments on the report on this page, and in a press statement the three organisations, who have endorsed the report, said:

"The Institute of Health Services Management, the British Medical Association, and the Royal College of Nursing are to urge the government to make more money available for the National Health Service. In cash terms they are to seek a doubling of the government's planned real growth in expenditure from one to 2% a year for the next three years. For next year (1986-7) this would require an injection of £100m over and above the £10 080m allocated for the hospital and community health service in England alone.

"The three organisations will emphasise that they regard this figure as an absolute minimum if the NHS, and in particular the hospital and community health service, is to fulfil the policy objectives not of the individual organisations but those which the government itself has set out. . . . The approach to the government takes the form of a policy statement to the Chancellor of the Exchequer and the Secretary of State for Social Services, which will be sent to them on the day of publication, Wednesday 30 October."

Copies of the report and the statement of policy may be obtained from the Institute of Health Services Management, 75 Portland Place, London W1N 4AN.

objectives for the NHS, many of which reflect short term political pressures and public concern. No attempt is made to relate these two processes; decisions about the level of funding and those about what the NHS should do remain separate and distinct. Because, however, governments have usually planned for some real growth in total NHS spending they have been able to deflect any public criticism from a pressure group seeking improvements in a particular service by pointing to this general increase in total spending. Inevitably, pressure groups are fragmented and their competing demands can be deflected by presenting the same increase in funds to different audiences as being earmarked for different purposes, a political adaptation of the "three card trick."

At last the government's objectives for the health service and the resources allotted to it have been analysed side by side. Not surprisingly, Bosanquet concludes that these simply do not tally. His report blows the whistle on a ploy used by the government to deflect criticism of health service funding.

Coping with an aging population

The quality of statistics used to measure NHS expenditure is surprisingly poor. These figures have always been among the weaker areas of any government's statistical output; long before they attracted any public interest they were given a "B grading," meaning that their reliability lay within a range of plus or minus 10%. Nevertheless, the available figures have to be used to measure

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both the overall rate of growth of NHS expenditure and the differential growth rates of various sectors in the NHS. Total NHS spending during the period 1980-5 has increased in real terms by 1.2%, 3.3%, 1.2%, 1.4%, and 1.1% in each of the five successive years. This hides a much lower growth rate in the hospital sector: 0.2% for 1982-3, 0.8% for 1983-4, and 0.1% for 1984-5.

These figures show some real growth in NHS funding but barely sufficient to cope with demographic and technological changes. One area where successive governments have consciously sought to adjust NHS budgets is to meet the consequences of an aging population. Bosanquet, however, shows, that even this provision has been inadequate. He identifies those services that are age sensitive—that is, most directly used by the elderly; during 1978-82 spending on these grew by 3.4% while spending on other services rose by 3.7%. For technological change calculations for adjusting NHS spending have never been precise. An allowance of 0.5% a year growth has been made as a contribution to the costs of a constant process of medical innovation.

Bosanquet's analysis shows that if measured in terms of NHS pay and prices the recent growth rate in NHS spending has barely reached the minimum level required to keep pace with demographic and technological change—that is, 1.2% a year. Indeed, the growth rate in hospital and community health services spending has been well below the amount needed to compensate for these factors. Furthermore, policy aims that have not been costed have absorbed some of this additional funding. Thus the general picture described is of a service receiving resources that cannot stretch to meet all policy commitments and the minimum requirements for change.

Until recently there has been a consensus between central government and the NHS on the amount of extra funding required to cope with the increasing number of elderly and changing technology (increases of 0.7% and 0.5% a year in real expenditure, respectively). Because this consensus has gone there is even greater uncertainty about what should be the appropriate minimum rate of growth in the NHS. During the past two years the growth rate of spending in important areas of hospital and community services has dropped to 1% or less in real terms. Even when the consensus seemed to work successive governments never explicitly costed their ambitious and expensive objectives for both community and acute care.

Changing pattern of care

As barely sufficient extra resources have been provided to cope with demographic and technological changes little if any money remains for the other objectives set by the government—the shift in the balance from the hospital to community sector and the reallocation of resources between regions.

Shifting care from the hospitals to the community can incur substantial short run costs. The past 15 years have seen a major shift: from 1970 to 1984 the proportion of total spending allotted to general and acute hospital services fell from 44% to 37%. Indeed, in a climate where it is generally assumed that the NHS is either contracting or at best just holding its own against financial cuts Bosanquet's study identifies several areas where there has been major expansion during the five year period 1978-9 to 1983-4—for example, spending on health visiting rose by 18% and on school health services by 12%.

The shift to community care and day treatment has created increased pressure on the family doctor service. While there has been increased spending during the past five years on community care, midwifery (18%), residential and day care for the mentally handicapped (38%) and mentally ill (37%), district nursing (21%), and day hospitals for the elderly (15%), the general medical services component of the family practitioner services as such has not developed to the same extent.

Among all the issues affecting health service funding most attention has been focused on the process of reallocating resources between regions and within regions. In recent years the pace of this reallocation has changed. From 1979 to 1982 all regions were achieving some growth in spending, even though this was modest in

certain “losing” regions, such as the Thames regions. The Thames regions are now faced with sharp reductions in total spending, and within regions even greater changes are required over the next years—for example, in North East Thames Southend District Health Authority is currently 19.4% under target, whereas Islington District Health Authority is 25% over target.

The health service has certainly shown a capacity to adapt and to improve its efficiency. Its throughput has increased during the past three years by 2.1% a year for inpatients and 5.6% a year for outpatients. Day treatment continues to increase—from 200 000 cases in 1972 to 787 000 in 1983—and it now accounts for 17% of all inpatient cases. There has also been a drop in the share of support services in total costs from 40.7% in 1978-9 to 36.2% in 1983-4. In other words, there has been a switch away from the hotel keeping towards direct patient care. Bosanquet's assessment is that during the past five years the NHS's record in improving productivity has been relatively good for a labour intensive service compared with relevant analogues in the private sector.

Poor prospects for health service spending

The present level of expenditure on hospital and community health services is planned to increase broadly in line with demographic change, 1% a year above the forecast rate of inflation. The assumptions that underpin this projected growth are clear and restrictive. The plan can be achieved only if pay increases are modest, inflation forecasts are accurate, and “efficiency savings” are achieved. Even if the total planned level of spending is met individual regions (particularly in the south east) will be facing planned real cuts in their resource allocations. These regional reductions, resulting from the RAWP redistribution, can be compensated for only by “efficiency savings.” It should also be noted that the 0.5% growth allowed for technological change evident in the 1984 policy statement has now been abandoned. In theory the only growth moneys are those earmarked for the elderly; thus the costs associated with improved technology must also be met from efficiency savings.

Even more draconian effects will be felt if the government declines to fund fully the review body awards for nurses', doctors', and dentists' pay, at least for the year in which they are made. To provide the necessary funds would ensure some budgetary stability.

This pattern of planned expenditure raises special problems for the funding of community care, especially in those areas favoured by the government—that is, for the elderly, mentally ill, and mentally handicapped.

Bosanquet takes this opportunity to propose some practicable guidelines for government policy that would give stability to the NHS—a necessary prerequisite for effective management. Firstly, there should be a commitment by the government to maintain a reasonable minimum rate of growth of NHS spending at 1.5% over a period of three years: this is slightly higher than the 1.2% growth rate previously assumed to be sufficient for demographic and technological change, since this has been found inadequate. Secondly, this rate of growth of spending should be assured for the hospital and community health services. Thirdly, the costs of any government decision on review body pay awards should be met in full for the year in which they are made. Fourthly, district health authorities and general managers should be given greater freedom to plan their spending, including greater freedom to defer consumption and carry over from one year to the next. Finally, it is proposed that there should be a review of the division between capital and revenue, to consider whether it should be removed altogether. This would encourage management to look at capital to save on manpower. Let us hope ministers are listening.

References

- 1 Bosanquet N. *Public expenditure on the NHS: recent trends and the outlook*. London: Institute of Health Services Management in association with the British Medical Association and the Royal College of Nursing, 1985.
- 2 William A. *Keep politics out of health!* (Discussion paper 8.) York: University of York, 1985.