For Debate . . .

The ever interesting topic

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"The simple statement that the Health Service in this country is under-financed is undoubtedly true, but as the scope of medical care continues to expand at an increasing rate, it is highly improbable that any country in the world can, or will ever be able to, claim truthfully that they are spending as much as could be desired on medical care in all its aspects. In this situation, all health services will be under-financed."

The quotation comes from a report commissioned by the British Medical Association 20 years ago.¹ It provides a warning against any excessive expectations that may be aroused by the sudden explosion of inquiries into the financing of health care in Britain as well as a reminder that there is nothing new about the current concern. The Institute of Health Services Management has set up an inquiry; so has the King's Fund Institute. The health unit of the Institute of Economic Affairs is about to publish a report; so is the Centre for Policy Studies. Next year's celebrations of the 40th anniversary of the National Health Service look like sinking under the weight of competing diagnoses and prescriptions. Why has this decennial ritual been revived? What has stirred up all this activity? Is the patient now, 40 years on, in such a precarious condition that something radical or heroic needs to be done?

The obvious answer to this is that the proliferation of inquiries and reports accurately reflect the growing gap between the National Health Service's resources and expectations. As the government has squeezed the annual growth rate, it is argued, so this gap has widened. The interpretation is plausible. But some scepticism may be advisable (as well as some self awareness: perhaps we all need the NHS to be imperfect to justify ourselves professionally and politically). Otherwise we may find ourselves searching for desperate remedies when none are needed. Firstly, there always has been a gap between resources and expectations throughout the history of the NHS, leading to spasmodic crises of self examination such as the 1967 BMA inquiry. Secondly, the evidence about a *widening* of the gap is less than conclusive. There has, indeed, been a widening of the gap between the rate of growth in the input of funds into the NHS in the 'eighties and the rate of increase in resources that, on various assumptions, are deemed to be necessary to meet expanding demands. Yet, paradoxically, there also seems to have been a rapid expansion in the output of services provided to the public because, as the government argues, of the improved efficiency with which the resources are being used. Depending on whether the focus is on the input of resources into the NHS or the output of services, a different interpretation of what is actually happening emerges.

Two recently published reports help us to explore this paradox. The latest Economic Review published by the National Association of Health Authorities seems to accept the government's version of

what has been happening—that is, an improvement in the scale and scope of services provided, while using this evidence of improved efficiency as ground for arguing for more money in future.² So it puts much emphasis on the by now familiar figure of increases, between 1980 and 1986, of 12% in inpatients and of 45% in day patients, of a rise of nearly 8% in medical and dental staff, and of 5% in the actual nursing time available. Such statistics are not compatible with the picture of a service on the edge of disintegration and the widespread perception of crisis. While there may be some misgivings about output statistics, such as whether higher productivity is being achieved at the cost of lower quality,³ there are equally serious shortcomings in the figures of inputs, and much of the debate of health care finance revolves around the selective use of either input or output figures (and a selective neglect of the objections that can be raised against both).

Reconciling personal experience and statistics

Yet many people working in the NHS remain convinced that there is indeed a crisis. How can personal experience and statistics be reconciled? Again, the report from the National Association of Health Authorities is helpful. For it illustrates its arguments by taking the example of five health districts and analysing their financial experience and plans. Strikingly, if predictably, there is a wide range in their experience. In the three years, 1982-3 to 1985-6, one district increased its input of resources (in real terms) by 15%, while yet another suffered a cut of 3%, and three stood still. The point is further reinforced by the report just published by the Chartered Institute of Public Finance and Accountancy, using the expertise of NHS treasurers.⁴ This disaggregates much NHS data about spending and services by district and underlines the fact that, in crucial respects, it is misleading to analyse the performance of the NHS as such, instead of examining the varying performance of 192 districts. So, for example, it shows that spending per head of population varies from almost 60% of the national average in Lewisham and North Southwark to 30% below in Chichester. Similarly, there are equally striking differences in the rate of change—whether expansion or cut back—experienced by districts in recent years.

There are, of course, well known problems about all such calculations: how to calculate the baseline population and allow for its characteristics, as well as how to treat cross boundary flows. But the differences are gross enough to justify the report's conclusion that "the amount of growth in resources experienced will depend to a large extent on the standpoint within the NHS from which the situation is viewed." Indeed much of the agony experienced in some districts at present may reflect not so much underfunding of the NHS as a whole (whatever that may mean) but the attempts to redistribute existing resources, both geographically and between different services, in an attempt to achieve greater equity: the grease of growth may be needed to make change acceptable by lessening the pains of adjustment.

So we come back to the central question that has prompted the

eruption of inquiries and reports: whether or not the NHS is "underfunded." In one sense, as the 1970 BMA report made clear, this is a nonsense question. All health services are always underfunded: even in Sweden, which spends a much higher proportion of a much larger national income on health care than Britain, there has in recent years been a growth in waiting lists—so prompting the growth of a small private sector (P Garpenby, personal communication). It still remains important, however, to ask whether—leaving the metaphysics of underfunding apart—there is good evidence about a *widening* gap between supply and demand (granting that there always will be a gap). Conventionally, this gap is calculated on the basis of the government's own published assumption that a 2% a year growth rate in real terms is required to accommodate demographic change (1.0%), technological advance (0.5%), and new service requirements (0.5%).

Once again there are formidable technical problems about how the growth rate should be calculated in real terms.³ But more important are the conceptual problems. Consider the contention that a 1% annual rise is needed to finance health care for an aging population. This has been calculated on the basis of extrapolating into the future the extra cost in the past to the NHS of people over 65. But given that public policy is aiming to change the policies that have led to this particular pattern of costs—for example, by cutting the institutional population—this does not seem to be a reliable method for calculating "need." And no one, so far as I am aware, has ever provided a convincing rationale for the figure of 0.5% as the extra resources required to accommodate technological change. Some time in the 1970s this figure seems to have been invented by a clever civil servant at the Department of Health and Social Security in order to extract extra funds from the Treasury, and the figure has survived to haunt successive generations of ministers. Its precision is entirely spurious; it might well be either much lower or much higher.

Is there a widening gap?

So here there is no solid ground to be found for postulating a widening gap, any more than in the calculations of Sir Brian Thwaites.⁵ To illustrate the widening gap Sir Brian calculated an annual growth rate of expectations or demands "by inquiring how much more money our region in Wessex could spend year after year while keeping in accord with current departmental policies." Given the elastic or vague nature of so many of these policies and the natural inclination of service providers to interpret them in the most generous way possible this produced a figure of 5% a year. No wonder, then, that Sir Brian was able to show an exponentially growing gap. Similar calculations could, no doubt, have been made at any time in the past 40 years, and the exponentially growing gap would now be an unbridgeable chasm.

There are other problems about interpreting what is happening. Most of the complaints about falling standards and inadequate services have come from the hospital sector. As already argued this partly mirrors the sheer diversity of experience. It also reflects the fact that it is the hospital and community services that have fared worst in recent years. As the National Association of Health Authorities report emphasises the cumulative growth in their resources from 1980 to 1986 was a mere 3.3%. In contrast, as the report from the National Association of Health Authorities also shows, the family practitioner services have done rather well since they are not cash limited. Their budgets have grown, in real terms, at an average of well over 2% a year. Should not this be taken into account when assessing the overall picture in the NHS? Might it not be argued that an expansion of the family practitioner services should, if they are effective, lead to a drop in demands on expensive hospital services? Is this not an essential part of the argument of investing further in primary health care? Again, much of the accounting ignores other inputs that might be supposed to diminish demand on the NHS. For example, it ignores the £500 million spent in 1985-6 through the social security system of financing care in nursing and residential homes: a figure that is now probably approaching £1000 million a year.^{6,7} It is impossible to calculate with

precision how much of this should be seen as a way of financing care that would otherwise be provided by health authorities as distinct from local authorities: a rough guess would be that the NHS benefits by some £200 million a year from this source.

But there is another source of funds for health care which is conventionally ignored. This is the money going into private health care. This is doubly interesting. Firstly, it provides an indication of demand frustrated in the NHS. It is *not* an accurate or complete index: it excludes the demands of those who lack the money or the insurance coverage required to give expression to their wants. It does, however, have the advantage of being based on people's behaviour rather than contestable statistics or public opinion polls which may tap fleeting views rather than deep rooted attitudes. Secondly, if our concern is with the level of resources for health care in Britain then just looking at the NHS provides an incomplete picture.

Private spending has been taking an increasing share of all expenditure on health care, although it remains a small one. The Office of Health Economics has calculated that private spending on health care doubled between 1973 and 1985 in real terms, while expenditure on the NHS increased by only 26%.⁸ Even so, it still represents only 6% of spending on the NHS (if we include over the counter buying of pharmaceuticals private spending is about 10% of all expenditure on health care; if we could accurately cost spending on osteopathy and fringe medicine the figure would be higher still). But the most important aspect of private health care spending and use is that it does not represent a direct or immediate response to the financial position of the NHS. It started to expand in the 1970s when the NHS was enjoying an annual expenditure increment which, from the perspective of the 1980s, was generous. And it started to stabilise in the 1980s just at the time that the government's expenditure policies were really beginning to bite. If the past few years had really been disastrous for the NHS then it would be reasonable to expect this to be reflected in accelerated consumer exit into the private sector. In practice, the growth in insurance coverage has slowed down and the expansion in the number of private hospital beds has stopped.⁹

Paradox of demand for private care

So even consumer demand as expressed through the private market is, at best, an equivocal and ambiguous indicator of the extent to which the NHS fails to meet public expectations. Not only does the NHS itself help to mould expectations but consumer demand for private care may often be a function of quite different factors, such as employer decisions about taking out health insurance for that labour force. Moreover, the distribution of the demand for private care suggests a paradox.¹⁰ Demand is highest, curiously, in those parts of England that have the highest per caput spending on the NHS—that is, the London regions—rather than those parts of the country with the least resources. And this remains true, even after controlling for the population's capacity to pay as measured by the proportion of those falling into social classes I and II. So demand for private health care seems to be largely a cultural phenomenon, a status perk and symbol. It is the emergent entrepreneurial culture of the south east that seems to breed higher expectations—and thus demands for private care—than the traditional, more solidaristic culture of the north.

If this interpretation has any strength then the debate about the financing of health care in Britain should be less concerned with the actual, current funding of the NHS than with our assessment of the kind of society likely to develop over the next 40 years. The whole repertoire of possible options has been on show for 20 years or more, and little has changed since the 1967 BMA inquiry in the way of new thinking about alternative ways of funding. The main option of moving towards an insurance based system, possibly financed by vouchers issued to every member of the population (varying in value with age and need), has for long been expounded by the Institute of Economic Affairs.¹¹ This is certainly a feasible alternative to the present system, although it brings its own problems: higher administrative expenditure and the kind of cost inflation that has

been evident in countries with an insurance based system. Quite simply, it is illogical to adopt a system explicitly designed to bring more money into the health care system than the present tax financed basis of funding for the NHS and then complain that health care is costing more money.

There are, then, no new ideas about alternative ways of funding health care waiting to be discovered. But are the old ideas being considered in a new context? If we are moving towards a society increasingly divided between those working in the prosperous service, technology intensive industries and those working (or, more often, not working) in the traditional declining industries—a divide that has only a little to do with the conventional south and north, middle class and working class divides—then is it feasible to expect the survival of institutions, like the NHS, which are based on assumptions about common expectations, common interests, and common attitudes? If there are trends in managerial and information technology, which make it possible to move towards a constellation of smaller units of production that are more responsive to both producer and consumer needs, then should we expect large, hierarchic organisations like the NHS to survive?¹² And if such changes suggest that we may be moving towards a new pluralism then should we be perhaps worrying less about the funding of the NHS as such and more about the financing of health care and its distribution in the largest sense? To ask these questions is, once again, to emphasise that there is no magic formula for disposing of the problems of the NHS as currently perceived. Proposals such as the one to tie NHS spending to growth in the national income are likely to be, rightly, dismissed.¹³ Why is health care spending a

special case, why should not the same formula be applied to education or the police, and what happens in years when the national income falls? Both the problems themselves, and even more the way in which they are perceived through the lenses of our evolving ideas about the nature of our society, are in the process of change. And if we are seriously concerned about the next 40 years of health care in Britain it is this process of transformation that should be the focus of attention rather than the mechanics of financing the NHS.

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Medicine and the Media

A STRIDENT ambulance siren at the beginning led me to expect a documentary about the routine heroism of the men and women of the ambulance service from this video called *Everyday Miracles* produced by Video Arts for Thames and Wessex health authorities (available from Isobel Smith, Publications Officer, South East Thames Regional Health Authority, Thrift House, Collington Avenue, Bexhill-on-Sea, East Sussex TN39 3NQ. VHS or Betamax £41.40, or 16 mm film £402.50, including VAT, package, and posting). What actually follows is perhaps blander stuff but is dedicated no less deservedly to the quiet industry of those who perform the small daily miracles that make life tolerable and sustainable for the chronic sick. Margaret Howard's commentary guides us through glimpses into the daily work of, among others, the district nurse, the speech therapist, the physiotherapist, and the community psychiatric nurse. The video portrays not just the patient application of skill but also the special bond of trust and friendship between caring and cared for.

Arguably this film is about the "unglamorous" but irreplaceable end of health care—much of it community based—that is often unseen and underappreciated by the many. As with all Cinderellas, there is more graft and toil than limelight. The "miracles" can occur "overnight" when dressings are removed after an operation for cataracts or when the hip prosthesis offers the hope of renewed vitality. This modestly stated testimony to the tireless care provided by thousands of health care professionals is welcome, but who is it intended for? As a public relations exercise it is not riveting viewing.

Perhaps its message is encapsulated by the scene of the district nurse, indefatigably cheerful, tackling a brace of leg ulcers with no more distaste than if she were arranging peonies for a flower show. "Not for the squeamish," observes Miss Howard. No—and not for the private health sector either. Many of the parts of hospital and community care shown in *Everyday Miracles* are besieged by staff and funding shortages and waiting list problems. If the film sought

to hint that only a health service broadly as we know it cares enough to provide these essential services then for me that message was obtuse and deserved more prominence.—TIM FOX, general practitioner, Huntingdon, Cambs.

Should vault smears be taken at regular intervals from patients whose uterus has been removed or should these patients be removed from the computerised recall program for cervical cytology?

The main purpose of cervical cytology is to detect cancer of the cervix in its premalignant phase. Cervical cancer starts at the squamocolumnar junction¹ and removal of this area by total hysterectomy will prevent the disease, though subtotal (or "supracervical") hysterectomy gives no protection. In a recent American study of elderly women an intact cervix was found in one third of those who said they had had a hysterectomy,² so the history should be checked. Vault smears are not usually carried out after hysterectomy for benign disease: it has been suggested that they should be done to detect early vaginal cancer³ but this is such a rare disease that regular smears are probably not worth while. Vault smears are part of the normal follow up after hysterectomy for malignant disease or cervical intraepithelial neoplasia, though their importance is uncertain.⁴ After radical hysterectomy for cervical carcinoma vault smears may detect up to 50% of central pelvic recurrences, which occur in about 3% of cases.⁴ After radiotherapy, however, vault smears are of limited value: taking the smear is uncomfortable for the patient and the quality of the smear is often poor.⁵—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

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