Unsafe in their hands -

Health service statistics for England

Radical Statistics Health Group

In order to persuade sceptical health workers and Community Health Councils that 'the NHS is developing and improving' Norman Fowler has circulated, via Regional Health Authority chairmen, a leaflet 'The health service in England'. The way the statements and statistics on the leaflet are put together could well mislead readers who are unaware that it comes from DHSS, into mistaking it for a product of Conservative Central Office.

Most of the statistics relate to two years only, 1983 which is the most recent year for which a relatively complete set of statistics is available, and by a remarkable coincidence for which no explanation is offered, 1978, the year before the Conservatives returned to power. In some cases, the way the statistics were collected or defined changed between 1978 and 1983. For example, increases in numbers of nurses and midwives were artificially inflated by changes in the length of their working week.

Quoting statistics for just two years can give a very misleading picture. When we look at statistics for the years between 1978 and 1983 and before 1978, we can see that many of the changes are part of longer term trends which were already well established before 1978. For example, it is mentioned that the perinatal mortality rate fell by 33 per cent between 1978 and 1983. This is true, but the particularly rapid rate of fall had already started in 1976.

Apart from this, all the statistics are quoted as numbers rather than rates. In other words, changes in the services provided are not related to changes in the numbers of people for whom they are intended. Thus, no attempt is made to assess changes in unmet need.

In particular, the shift from hospital to community care is one which many people would support in principle, if adequate support was provided in the community. The leaflet does not reveal whether community services have expanded enough to both offset the contraction of hospitals and satisfy other unmet needs. This seems unlikely, however, when account is taken of fuller information included in the Annual Report of the Health Service in England, to which readers are referred.

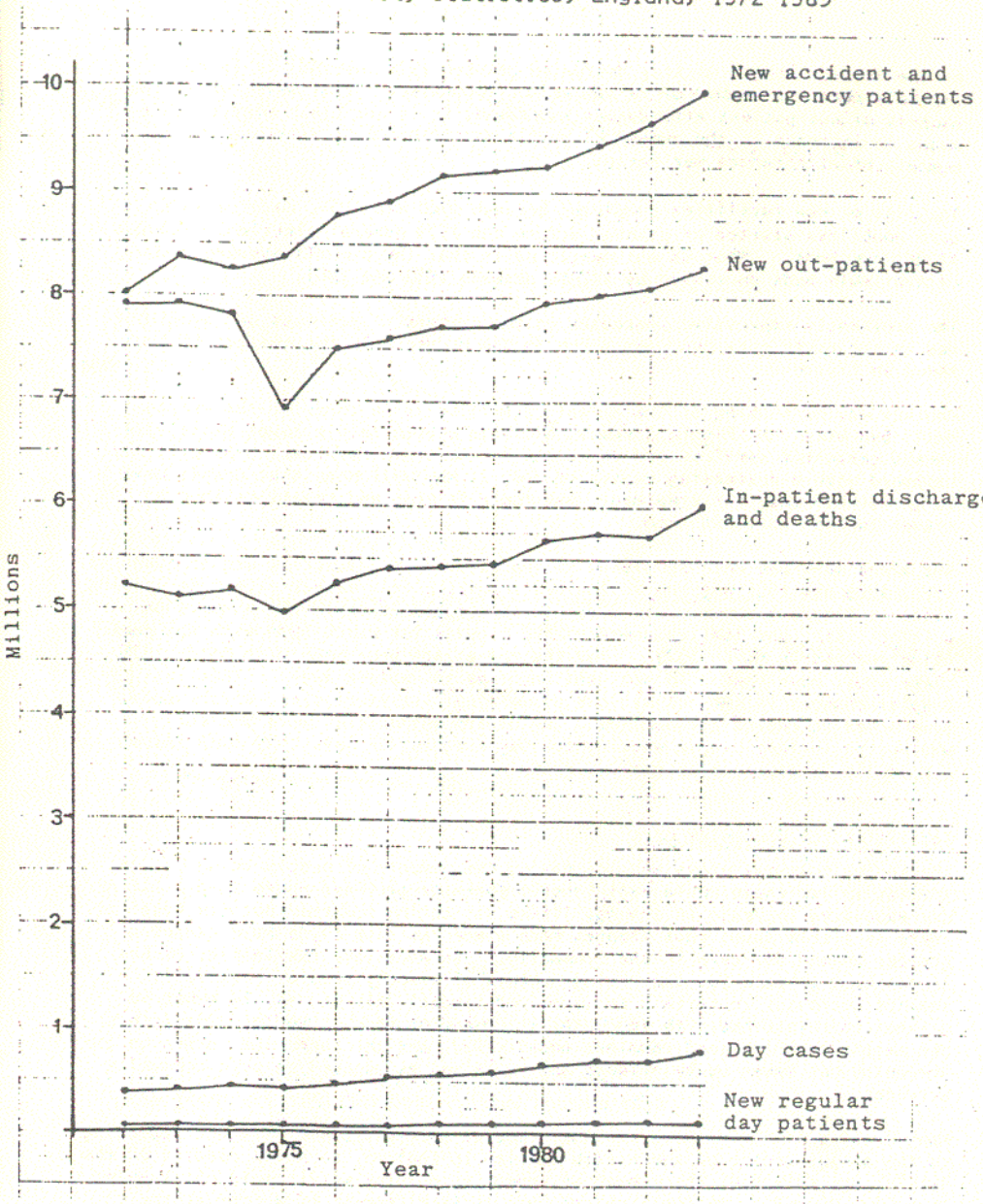
Even there, they will find statistics thin on the ground compared with the very much fuller set which, up until 1978, was published annually in 'Health and personal social services statistics for England'. Only one volume has emerged since then. It came out as long ago as 1982 and most of the statistics in it referred to 1980. As a result, it is difficult for anyone outside DHSS to compare the highly selected set of statistics on the leaflet with the many others which are no longer published.

Facilities for hospital patients

As with perinatal mortality, the trends in the availability and use of hospital facilities go back before 1978, as figure 1 shows. What is more, they may not be such good news as Norman Fowler's message claims.

The leaflet quotes a 12 per cent increase from 1978 to 1983 in the numbers of 'in-patient cases', a statistic which is often quoted in ministers' speeches. Once again it is not explained that this is not the same as the numbers of people treated. The number of in-patient cases are derived from adding up the numbers of discharges from hospital and the numbers of deaths in hospital. Thus a person who is re-admitted to hospital several times in the same year will be counted each time s/he is discharged, as there is no statistical link made between the same person's successive stays in hospital.

Figure 1 NHS hospital activity statistics, England, 1972-1983



Source: DHSS Statistical bulletins 1/84 and 2/84

As the average length of stay decreased between 1978 and 1983 it is not unlikely that the numbers of re-admissions increased. Similarly, while the numbers of out-patient attendances increased, it is not clear whether this means an increase in the number of people attending or an increase in the numbers of attendances per person.

The list of new facilities completed between 1980 and 1984, many of which were doubtless started or planned before the 1979 general election, includes 11,000 new beds. What is not mentioned is that the overall average number of available beds decreased by 12,900 between 1980 and 1983.

The apparently impressive increases in the numbers of patients per available bed in the acute services owes a lot to the decrease in the numbers of beds, shown in Figure 2.

Another way of looking at the extent of service is in terms of the average daily bed use. As Figure 3 shows, this has stayed fairly level since 1972 in the geriatric services and decreased in the acute services. As this has happened with a decreasing number of beds it may well mean that people have to go further away for treatment, and their friends and relatives have to travel further to visit them.

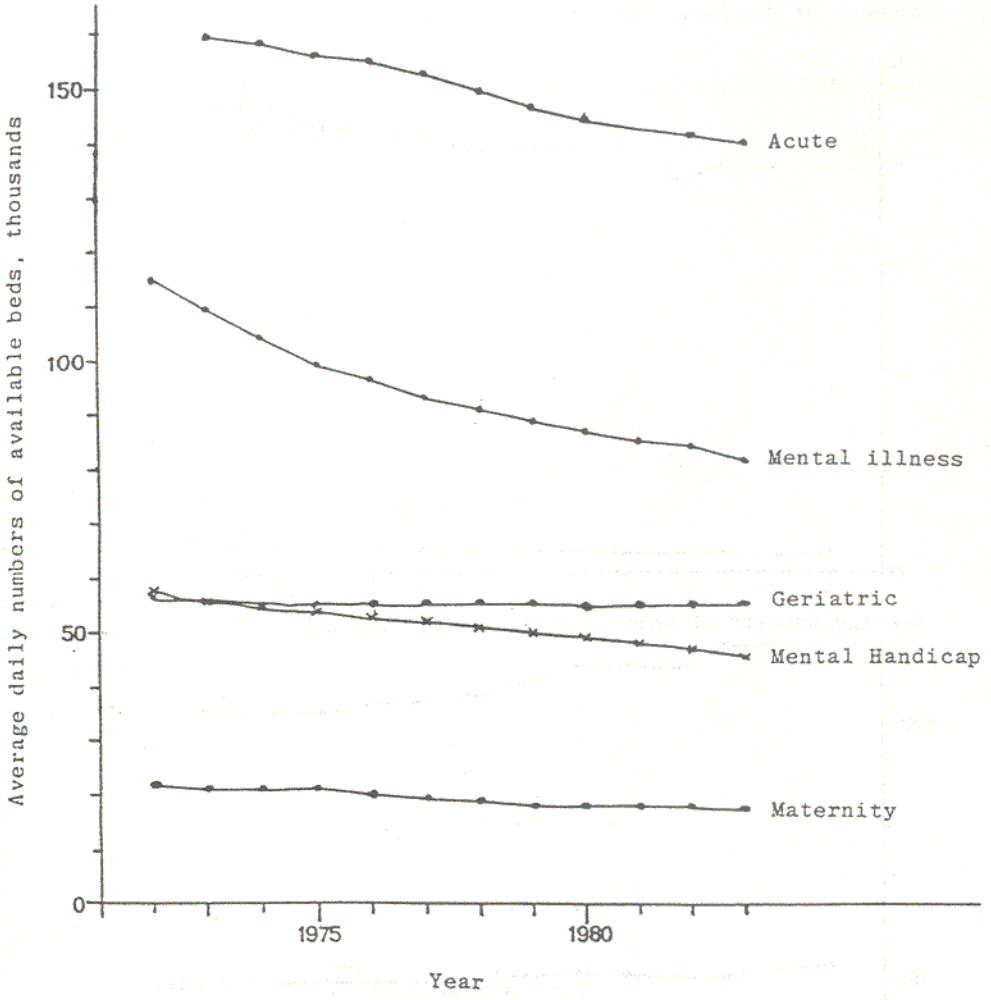
The acute services were sensitive to the effects of industrial action taken in 1975, 1979 and 1982 and the action had a particularly marked effect on waiting lists as Figure 4 shows. In order to show a reduction in the numbers on waiting lists, the leaflet compares the figures for March 1984 with the peak value reached in March 1979. Had the comparison been made with March 1978 there would have been a 15 per cent increase to explain away. This is despite changes in the definitions of waiting list statistics, which would have acted to reduce the numbers. As health authorities were unclear whether to include people waiting for day surgery, in late 1979 DHSS issued a specific instruction to exclude them.

Facilities for community care

Shortening hospital stays and increasing the numbers of people being treated as day cases could well benefit patients provided there is a corresponding increase in the facilities for caring for them outside hospital. There is little doubt that changes made since the late 1970s have caused a greater demand for care in the community. In addition, the leaflet points to the need to care for the rising numbers of elderly people. While it reports increases in certain services and special initiatives, it makes no attempt to relate these to increases in demand or need. Nor does it assess the extent to which need remained unsatisfied, and the increased burden on the community was taken up by friends and relatives as opposed to paid community services.

Many local authorities have cut their social services since 1978 and according to the annual report of the health service in England, to which readers of the leaflet are referred, the growth of community nursing services is not keeping pace with demand. In the light of this it is difficult to accept at their face value data in the leaflet about increases in the numbers of elderly people trated by district nurses or health visitors.

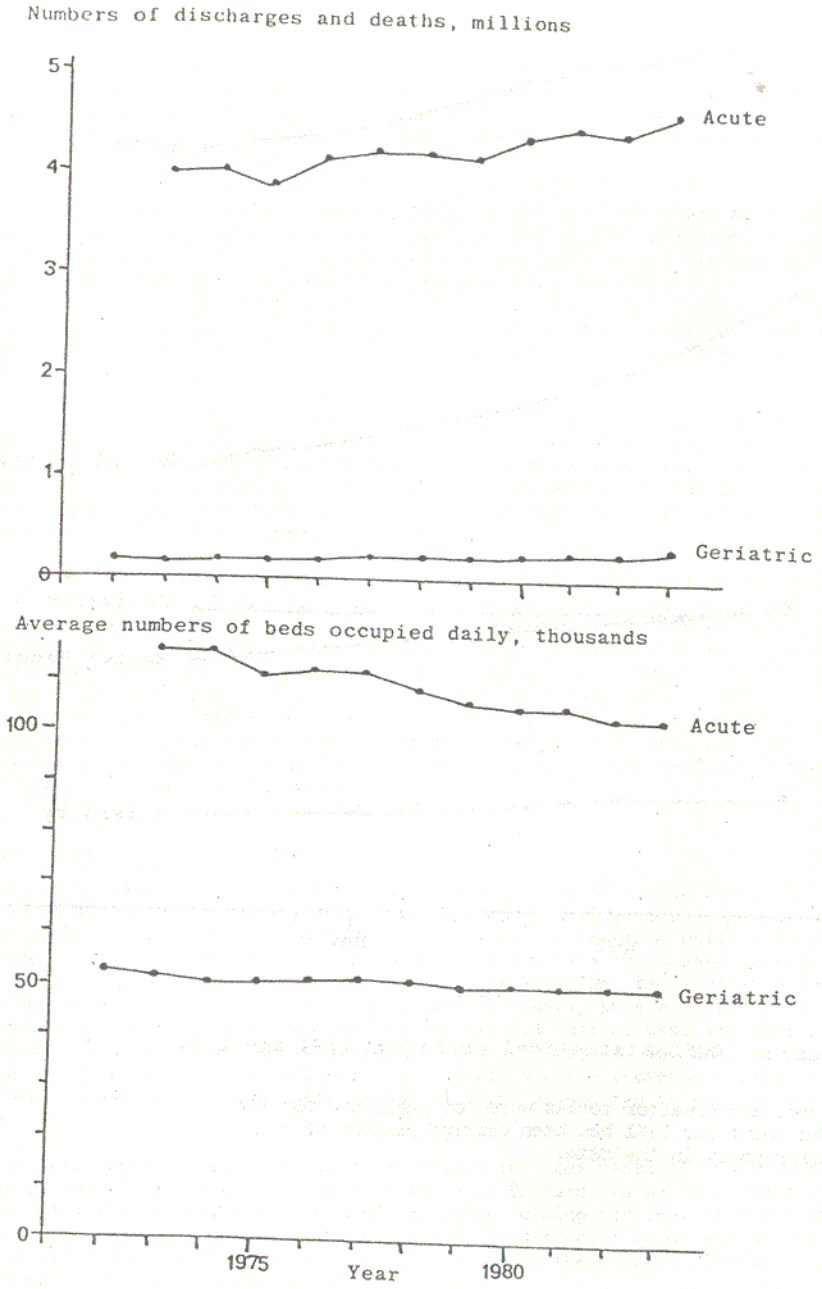
Figure 2 Average number of beds available daily, England, 1972-1983



Source: DHSS Statistical bulletins 1/84 and 2/84

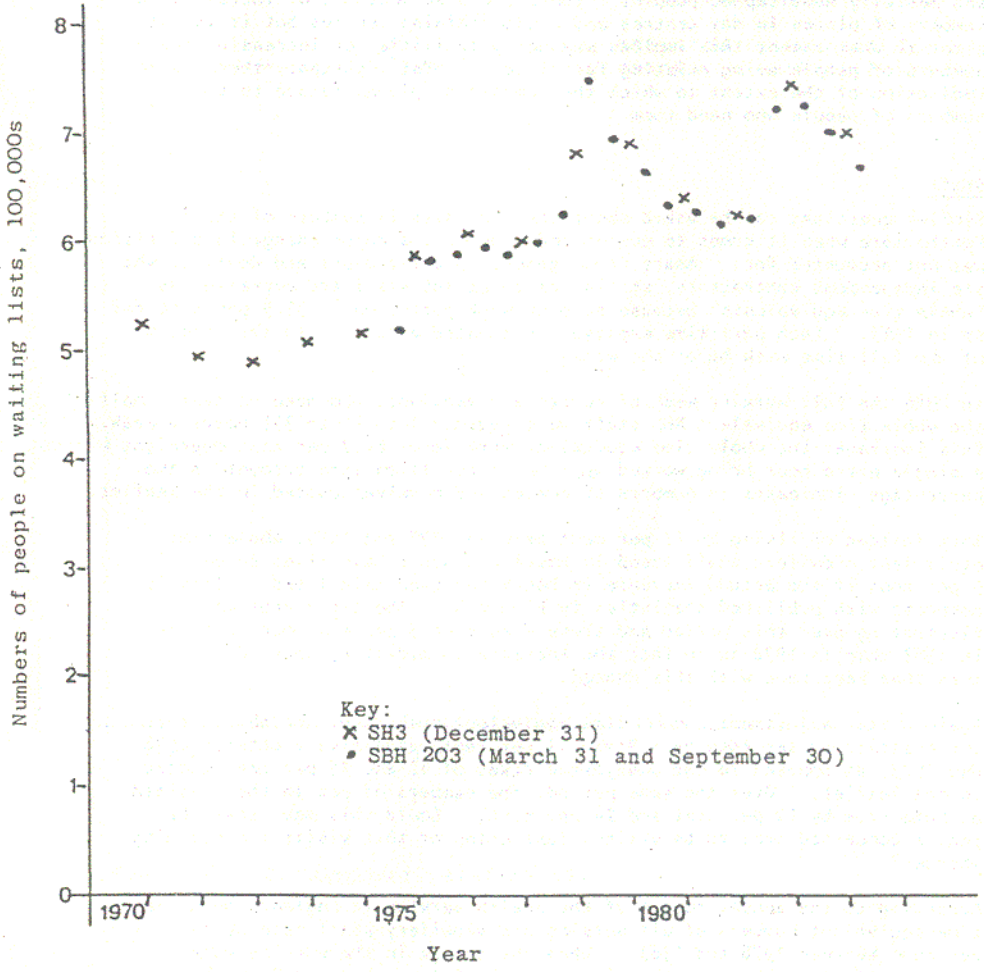
Note: Acute sector totals were not published for 1972. The point for 1981 has been omitted because of a discrepancy in the data.

Figure 3 Spells in hospital and bed use, England, 1972-1983



Source: DHSS Statistical bulletins 1/84 and 2/84

Figure 4 Numbers of people on waiting lists for in-patient treatment, England, 1970-84



Source: DHSS Hospital return (SH3) and Waiting list return (SBH 203)

Although the average family doctor list size decreased, there is no indication of the extent to which this compensated for the increases in the numbers of people aged 75 or over, nor whether the increases in numbers of general practitioners were in the areas of greatest need. Similarly, although the numbers of courses of dental treatment went up, no mention was made of the increase in fees paid by patients. According to the British Dental Association, revenue from fees rose much more than the cost of treatment which itself rose faster than the Retail Price Index.

Three of the nine increases referred to under the heading of community care are in numbers of places in residential institutions for elderly, mentally ill and mentally handicapped people. There are also mentions of increases in numbers of places in day centres and adult training centres but it is not clear to what extent this implies expanding facilities or increasing the numbers of people using existing facilities. Most important, there is no indication of the extent to which the numbers of places relate to the numbers of people who need them.

Staff

Similar questions can be asked about the increases in numbers of staff. Furthermore when it comes to nurses and midwives, a major change in definition was not accounted for. Apart from general practitioners and dentists who are independent contractors, statistics about NHS staff are expressed as 'whole time equivalents' because so many work part-time - 37.9 per cent did so in 1983. Each part-time employee is counted according to the fraction of the full-time week he or she works.

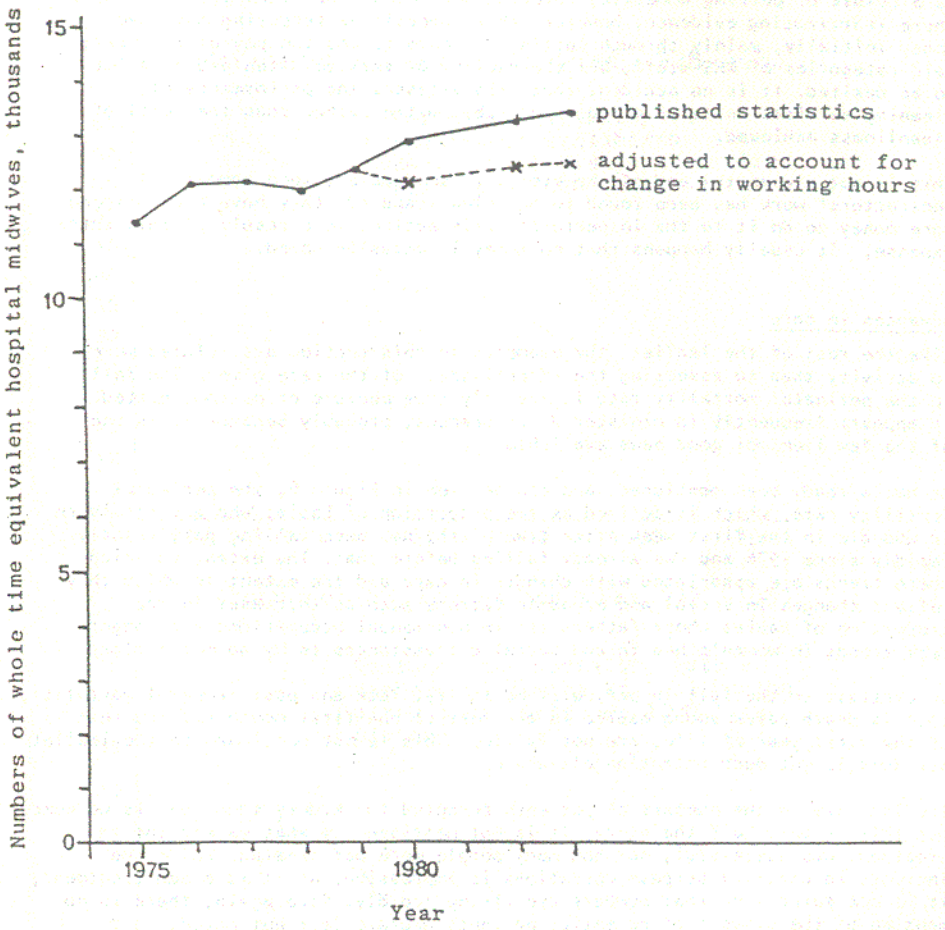
In 1980 the full working week of nurses and midwives, who make up nearly half the whole time equivalent NHS staff were reduced from 40 to 37½ hours a week. This increased the whole time equivalent work force by 7 per cent overnight without a single extra hour being worked but it is not taken into account in the percentage increases in numbers of nurses and midwives quoted in the leaflet.

Thus instead of rising by 12 per cent between 1978 and 1983, whole time equivalent midwifery staff based in hospitals would have risen by only 5 per cent if the actual increase in hours had been calculated. This is compared with published statistics in Figure 5. The birth rate was fluctuating over this period and there were over 5 per cent more births in 1983 than in 1978 so in fact the increase in midwifery hours did no more than keep pace with this change.

Again, after adjustment, whole time equivalent numbers of health visitors and district nurses rose by 4.9 and 11 per cent respectively between 1978 and 1983, as opposed to the unadjusted rises of 12 and 15 per cent quoted in the leaflet. Over the same period, the numbers of people they visited at home rose by 10 per cent and 24 per cent. Could this mean that the people concerned tend to be visited less often or that visits are becoming shorter?

According to the annual report of the health service in England the whole time equivalent numbers of all nursing and midwifery staff rose by 13 per cent between 1978 and 1983. When the change in the working week is accounted for, however, the rise was only 6.1 per cent. Even then, it is not clear to what extent this represents a real increase in nursing time. Whole time equivalent ancillary staff decreased by 3.5 per cent over the same period, so this might mean that some nurses and midwives had extra work to do to compensate for this.

Figure 5 Whole time equivalent hospital midwives, England, 1975-1983



Source: DHSS 'Manpower' statistics.

In the leaflet, Norman Fowler distinguishes between the regard he professes for 'front line' staff giving direct patient care and 'support staff' for whom he appears to have less respect. Thus he ignores the interdependence between staff doing different types of work.

He reinforces his view of support services in claiming 'worthwhile savings' as a result of putting domestic, catering and laundry services out to tender. There is increasing evidence, however, that competitive tendering may save money initially, mainly through cutting the numbers and the pay of the worst paid categories of NHS staff, but the quality of service often leaves a lot to be desired. It is no accident that DHSS assesses the performance of cleaning services in terms of cost per cubic metre rather than the level of cleanliness achieved.

This is not always the end of the story. In some cases, when commercial contractors' work has been found to be below standard, they have had to spend more money to do it to the inspectors' satisfaction. As a result of this extra expense, it usually happens that no money is actually saved.

Advances in care

Like the rest of the leaflet, the examples in this section are related more to activity than to assessing the effectiveness of the care given. The fall in the perinatal mortality rate is the only true measure of outcome quoted. It appears frequently in ministerial utterances, probably because it is one of the few items of good news available.

As has already been mentioned, and can be seen in Figure 6, the perinatal mortality rate, which is defined as the proportion of babies who are stillborn or who die in the first week after live birth, has been falling particularly rapidly since 1976 and was already falling before that. The extent to which these trends are associated with changes in care and the extent to which they reflect changes in social and economic factors such as increases in the proportion of babies whose fathers are in non-manual occupations and longer term trends in women's health and social circumstances is by no means clear.

In contrast to the fall in perinatal mortality, late and post neonatal mortality, that is death rates among babies in the rest of the first month and the rest of the first year of life, are not falling. This is not mentioned on the leaflet nor does it get much attention elsewhere.

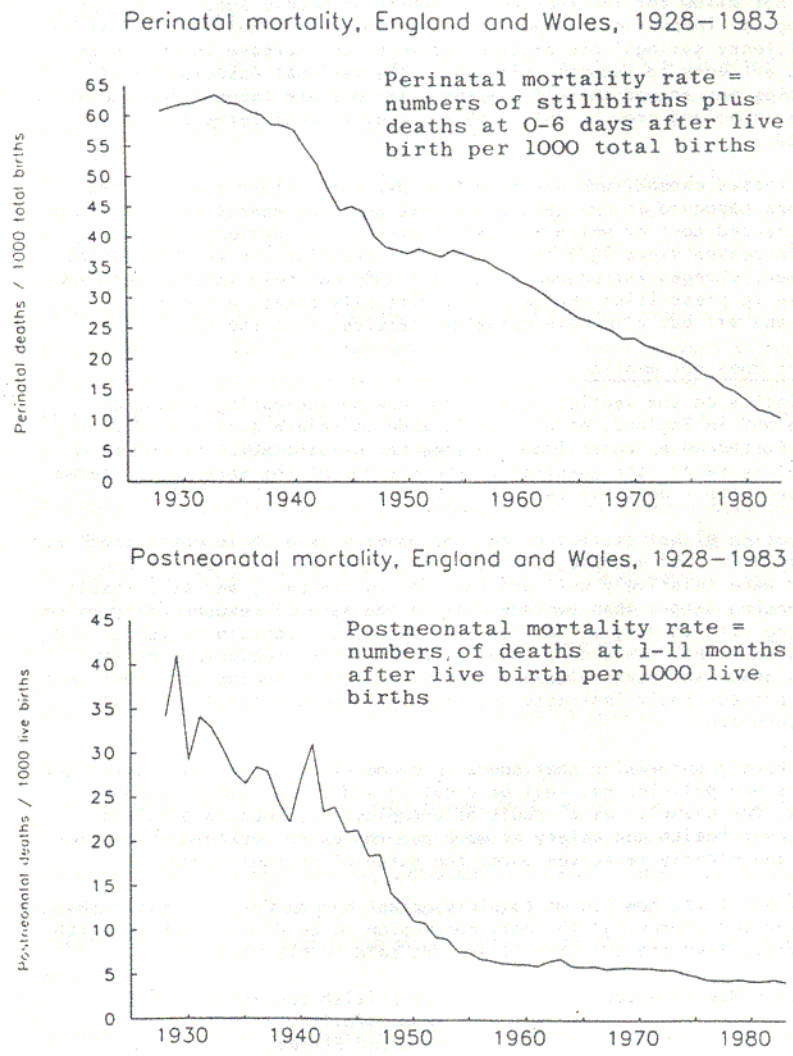
The increase in the numbers of patients accepted for kidney treatment is welcome, but this is only half the story. It is not mentioned to what extent the treatment was successful, nor how many people were not treated. While the increase in coronary by-pass operations is impressive, as it is a new treatment, it is not surprising that numbers are rising rapidly. Once again, there is no mention of the numbers of potential patients who are left untreated.

Similar comments could be made about the three new spinal cord injury units mentioned on the leaflet. What is conspicuously lacking is any account of progress in doing less glamorous and innovative operations, such as hernia repair, which deal with conditions which are not life threatening but cause much distress.

Prevention

All the measures mentioned - immunisation, prevention and treatment of drug misuse, discouraging smoking and encouraging a healthy life style, are aimed at individuals. None of them attempt to tackle the social and economic causes of ill health such as unhealthy working conditions, unemployment or the overwhelming adverse effects of the food and tobacco industry.

Figure 6 Perinatal and postneonatal mortality



Source: OPCS Mortality statistics. Series DH3

Resources

The leaflet reiterates the statement that the cash available to the health services in England doubled from £6 million in 1978/79 to nearly £13 billion in 1983/1984 and that,when adjusted for general inflation,the increase becomes 17 per cent. It ignores the fact that the costs of items and services bought by the health service increased by more than the cost of general inflation, so that the increase in 'input volume' (that is what money can buy for the health service) was only 7 per cent.

Even this does not allow for the increasing numbers of people aged 75 or over or for technological innovation. In addition, the Government has argued that so-called 'efficiency savings' are an alternative to an increase in NHS funds, but there is no evidence to support this claim. The National Association of Health Authorities has argued that if all these factors are taken into account, NHS expenditure inEngland grew by only 0.59 per cent in real terms over the five year period.

Some of the increased expenditure has come from patients rather than the NHS budget. This has happened in the general practitioner and dental services, some of the increased cost of which has fallen directly on patients in the form of large increases since 1979 in charges for prescriptions and NHS dental treatment. Indeed, changes introduced on April 1 1985 not only involve yet another increase in prescrition charges. They virtually create a two tier dental service and all but eliminate opthalmic services from the NHS.

What the leaflet does not mention

While the statistics on the leaflet purport to show an increasing volume of activity in the NHS in England, no attempt is made to relate activity to demand or unmet need. Furthermore, apart from the somewhat questionable reference to perinatal mortality rates, the question of the outcome of the services in terms of the care given simply does not feature.

In addition, quoting global statistics for the country as a whole masks the local differences within it. For example, difficulties are arising in regions and districts which were relatively well provided for in the past, and as a result are now experiencing larger than average cuts in the name of resource allocation. These are falling particularly on the four Thames regions containing London and the surrounding counties. Resource allocation within these regions means that some inner city areas are particularly vulnerable as the teaching hospitals are better able to protect their interests than less prestigious local hospitals and community services.

Finally, it is hardly surprising that there is no mention of the possibility that the Government's own policies may well be creating additional health problems. These can arise, for example, as a result of unemployment, housing problems, fewer controls over health and safety at work and the extra workload on people caring for ill and elderly relatives under the guise of community care.

In the light of all this, how can we possibly accept Norman Fowler's claim that the NHS is developing and improving? The only conclusion to be drawn is that health service statistics, like the NHS itself, are not safe in his hands.

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Unlike Norman Fowler, we do not have the resources at our disposal to circulate this report to everyone who received his leaflet. So we invite readers to photocopy our report and pass copies around. People who cannot obtain a copy in this way can get one from us at the above address at a cost of 50 p.