PLANNING WITHOUT STATISTICS

by Cllr.Pete Ruhemann
(TU member, West Berkshire DHA)

Up and down the country, officers of Health Authorities, with less rather than more guidance from Health Authority members who have nominal responsibility for ensuring the delivery of the service, are working on the first drafts of revised ten-year strategic plans, which are meant to cover the period 1989-99.

These plans will supersede the present strategic plans, which were meant to cover 1984-94. It is however unlikely that they will have any greater validity, either in terms of their relationship to the needs of the local population or in terms of actual achievement. One major cause of this dual unreality of the planning process is that there is no real culture in the NHS of planning on a factual, which means largely a statistical, basis.

These rather sorry conclusions are based on four years experience as a member of the West Berkshire District Health Authority, and also on discussions with members of other Health Authorities. They are not intended to deny the need for proper statistical understanding of the NHS, just to point out that as of now there is no fulcrum in the planning process where the lever of statistics can be applied to change, hopefully to improve, the service.

The pattern of health care today is dominated by the historical pattern of local hospital provision, as it was inherited by the Area Health Authorities in 1974, a pattern that was itself largely established prior to the formation of the National Health Service in 1948. Most of our hospitals, and even probably most of the buildings in them, date from pre-war and many from the nineteenth century. Functions have changed somewhat: old workhouses, old fever hospitals, old cottage hospitals have frequently become hospitals for the elderly or the elderly mentally infirm and so on. But changes of function do not have all that big an effect on running costs: even if ypu take the casualty service or surgery away from a hospital you are still faced with the cost of staffing the wards, as well of course as the "domestic" costs of feeding the patients, heating, laundry and cleaning. The pattern of hospital provision predetermines a very large part of the Health Authority budget.

This of course is why Health Authority budgets are set historically: on the need to continue to run existing hospitals rather than on the need to provide a norm of health care for the actual population. There are huge discrepancies in the per capita expenditure of Health Authorities: that in Scotland, for example, is about 60% higher than that in West Berkshire. I suspect that is more a tribute to the greater philanthropy of earlier Scottish generations and a consequence of the rapid growth of population in the Thames Valley than of any rational assessment of need.

Just as present budgets are determined by the historic pattern of hospital provision, future budgets, at least in the Oxford Region, are capital-led, i.e. determined by agreed changes in the future pattern of hospital provision. West Berkshire's strategic plan for 1984-94 was based on Regional projections of the capital that would be available to build new hospitals in areas of population growth and to extend or replace existing hospitals.

But the Region had to correlate the capital programmes across all its nine Districts. Although West Berkshire has the second highest population growth in the Region, and indeed in the country, the Region put two-thirds of our ten-year capital programme into the last half of the decade and indeed half of it in the last third of the decade. Furthermore, since 1984 they have revised their projections four times, downwards in each case. Our present capital programme is a shrunken, pitiful object which in effect offers no new hospital beds till after 1994. The programme of hospital closures that was intended in the strategic plan to rationalise health care into some of the new developments is, however, continuing!

Worse still, the reductions in our capital programme reflect into the so-called growth money that we might have been able to put towards developing our service. The Oxford Region has been told by the DHSS to plan on a 2% growth in budget in 1988-9, because of its expanding population. West Berkshire has been told to plan on a 0.9% growth only in 1988-9 : as the Treasurer says, "the RHA reserves a significant proportion of growth funds for strategic purposes...however West Berkshire is not in a position to benefit from the strategic revenue reserve because it has no capital-led developments that are classified as strategic.". Actually, as I've said, we have in effect no capital-led developments at all. So our revenue budget is increasing more slowly than the population we serve, and that's without taking any account of the even more rapid increase in the number of elderly people or of the increasing costs associated with developing medical technology.

Taking the BMA/RCN/IHSM target of a 2% growth to cope with these last two factors, and adding 1% to allow for population growth, we need 3% budget growth a year just to stand still. The 0.9% allocation means a 2.1% cut. And as that's just the latest of a series of similar cuts we're actually falling more and more behind. In fact, due to the underfunding of pay awards, a working group is actually looking for £800,000+ savings in 1987-8; carried forward into 1988-9 those savings will more than cancel out the £600,000 "growth" that is now on offer.

Under these financial constraints, planning is a farce. The 1984-94 strategic plan is already a nonsence. The 1989-99 plan is being approached the same way and will no doubt self-destruct the same way round about the time of the next General Election. And the health care we offer the people of West Berkshire will continue to deteriorate.

But there must be an alternative. It must be possible to construct models of care and hence models of funding, even if only on the same sort of basis as Grant Related Expenditure is calculated for local authorities, which at least seeks to take into account the nature and needs of the local population not just, as RAWP does, the way they die. That's what I look to statisticians to provide and some more sensitive Government to fund.