Facing the figures - an update

Radical Statistics Health Group

'I give the right hon. Gentleman the figures because they show that no Government in history have given the the Health service more resources, more doctors, more nurses, or better pay for the nurses, than this. This is what the right hon. Gentleman does not like.'

Margaret Thatcher, reply to Neil Kinnock on December 15 1987[1] and on many other occasions.

Over the last winter, the statistics which the Government has been using for some years to claim that the NHS was 'safe in its hands', played a heightened role in the ritual exchanges between Government and Opposition about the state of the NHS. Faced with questions from opposition MPs about constituents who had been denied access to care, the Government inevitably responded with a stream of statistics selected to present its record in a favourable light. These statistics blatantly contradicted the personal experience of many people faced with crises in local health services in different parts of the United Kingdom. It is hardly surprising, therefore, that people who are campaigning for adequate levels of appropriate health care may be reluctant to accept seriously the suggestion that statistics might be of some relevance to them.

Our book, 'Facing the figures: what really is happening to the National Health Service?'[2], published just before the 1987 general election, aimed to expose the emptiness of the way the Government used statistics in its claims about the National Health Service. It did so against the background of the growing need and demand for health care and widening inequalities in health. This article summarises some of the arguments in our book and updates them in the light of subsequent events.

More money?

Announcing the Government's decision to make available an extra £749 million to fund the April 1988 nurses' pay rise, John Moore said, 'It raises the total resources available to the health service in 1988-89 to £23.5 billion, a real terms increase in revenue expenditure of 39.2 per cent since 1978-79 and of 5.3 per cent since 1987-88.'[3]

Although the Government frequently claims to have tripled spending on the NHS since the financial year 1978-79, it readily admits that this does not allow for inflation. Government statements, such as the one quoted above adjust for inflation, to give figures in so-called 'real terms', by using a statistic called the Gross Domestic Product (GDP) deflator. This reflects the way inflation affects the economy as a whole. Spending figures adjusted in this way measure changes in the cost of the NHS to the economy and are sometimes referred to as its 'economic

cost'.

John Moore's statement about the nurses' pay award is slightly unusual in that it refers to total spending in all four countries of the United Kingdom. Usually figures are quoted for each country separately. Over the period 1978-79 to 1986-87, the economic cost of the NHS in England increased by 26.6 per cent.[2,4] This is less impressive than it seems as nearly half of this increase had already occurred by 1981. In 1980, the government implemented the Clegg pay awards agreed with the last Labour government and was obliged to shorten nurses' and midwives' working week to comply with an EEC directive.

The way the NHS spends its money is not, however, typical of the economy as a whole, partly because so much it of goes on pay. A much more realistic picture can be obtained, therefore, by adjusting spending figures using the NHS Pay and Prices Index. Figures adjusted in this way are referred to as 'input volume' and give a measure of changes in what the NHS can buy with its money. Between the years 1978-79 and 1986-87, this rose by the much smaller amount of 10.6 per cent.[2,4]

Even this applies to England as a whole and thus masks differences both between regions and districts and between different types of spending. The Family Practitioner Services took up a quarter of NHS resources in 1986-87. Spending on them rose by 38.7 per cent in economic cost terms and 15.7 per cent in input volume terms between 1978-79 and 1986-87.

Who pays?

This did not all come from the exchequer, though. The percentage of Family Practitioner Services spending in the United Kingdom as a whole which was raised from charges to patients rose from 6.0 per cent in 1978-79 to 8.8 per cent in 1984-85[2]. Although provisional figures for 1986-87 suggested that this had fallen marginally to 8.4 per cent[5], this trend is likely to be reversed once the Health and Medicines Bill becomes law and charges are made for dental checks and sight tests. The introduction of these was hardly surprising. It was already apparent from figures in the 1987 Public Expenditure White Paper, which was published before the general election, that increased charges were likely to follow it.[6]

The Government gives great publicity to its programme of hospital building, yet capital spending accounted for only 6.4 per cent of NHS costs in 1986-87.[4] Although the economic cost of the capital spending on the Hospital and Community Health Services rose by 38.7 between 1078-79 and 1986-87, an ever increasing proportion of this has come from land and property sales. These paid for 14.4 per cent of spending in 1986-87 compared with 2.8 per cent in 1982-83.[4] There may well be a case for selling off unwanted property to finance new development, but the supply of this will not go on forever.

Running costs

Nearly two thirds of NHS spending goes on the running costs of the Hospital and Community Health Services. In contrast with

the areas just discussed, the cost of these services rose by only 21.2 per cent in economic cost terms and 6.0 per cent in input volume terms over the years 1978-79 to 1986-87. For the reasons explained given earlier, this rise was not uniform over time. In input volume terms, spending increased by 4.4 per cent over the three year period 1978-79 to 1981-82, compared with 0.7 per cent over the next three years and 0.5 per cent over the two years 1984-85 to 1986-87.[2,4]

These increases have to be set against changes in the population using the services. Its age structure has changed considerably. In particular, there have been increases in the numbers of people in the over 75 age group who, on average, make heavier use of the services. DHSS makes estimates of the increase in current spending needed to keep pace with demographic change and adds a notional 0.5 per cent per annum to allow for the increased costs resulting from technological innovation. According to these DHSS estimates, to keep up with these factors, current spending would have to have to have risen by 4.4 per cent between 1978-79 and 1981-82, 3.0 per cent between 1981-82 and 1984-85 and 3.3 per cent between 1984-85 and 1986-87.[8] DHSS constantly revises these estimates, so they differ marginally from those quoted in 'Facing the figures'. In any case, it is clear that actual spending has lagged well behind since 1982. What is more these estimates do not allow for other changes in demand on the NHS, including the AIDS epidemic, and the introduction of breast cancer screening amongst others.

The figures quoted above are for England as a whole and therefore do not take into account of the consequences of resource allocation away from the south and east of England. The original ostensible aim of this was that spending in regions which had been better funded in the past should grow more slowly than in those which had been less favoured. Now it means actual cuts. Input volume in the four Thames regions taken together decreased by 1.6 per cent over the years 1981-82 to 1984-85.[2] Because of reallocation within these regions, to follow the population out of London, inner city districts have been particularly badly hit,[7] although there have also been severe financial problems in the outer districts of these regions.

An end to underfunding?

A major cause of underfunding was the Government's failure to provide health authorities with additional funds to meet the full costs of the pay rises it awarded in 1985, 1986 and 1987 to doctors, nurses, midwives and professions supplementary to medicine. Although nurses are badly paid, there are a lot of them and their pay accounts for a third of current spending on the hospital and community health services, so the shortfall created severe problems for many health authorities. In 1988, the government proclaimed loudly its intention to meet the full costs of the pay awards in full[3], but the consequences of the major regrading exercise it entails are difficult to predict.

It is clear though, that the changes in nurse education announced in May 1988[9] will have profound financial implications. At present the NHS relies heavily on staff in training for cheap labour, and it will find this difficult to replace. Of the

397,240 whole time equivalent nursing and midwifery staff in post on September 30 1986, there were 62,524 students or pupils training to be registered or enrolled nurses, 4,179 student midwives, 832 student health visitors and 680 student district nurses.[10] Meanwhile, health authorities are still suffering from the backlog of earlier underfunded pay awards, and the government has quietly admitted that it does not intend to meet the full cost of the 1988 ancillary staff pay settlement.[11]

The Government's response to this evidence of underfunding is that money is being spent more efficiently through its programme of 'cash releasing cost improvement programmes' or 'efficiency savings', as they used to be known. It hoped to 'save' £152 million in this way in 1987-88.[4] The extent to which this represents real savings and the extent to which it reflects cuts in services, delays in repairs, or superficial savings which generate additional costs elsewhere is not known.

For example, about a quarter of the 'savings are from competitive tendering, but this form of privatisation carries many hidden costs.[2] These include management costs in setting up and monitoring contracts, costs of making existing staff redundant, the effects of increased workloads on the health of ancillary staff on contracts and the effects on patients of lower standards of cleanliness.

The whole nature of the debate about NHS fundingwas changed in the summer of 1987 when the Kings Fund and the Institute of NHS Management set up working parties on alternative methods of funding the NHS. Neither of these two bodies had doubted that the NHS was underfunded and both had spelled this out in a number of reports. Their initiatives gave the cue for a flood of publications from right wing pressure groups containing what purported to be radical new ideas for funding the NHS and thus paved the way for the government's review of the NHS. Closer examination of the 'radical new ideas revealed close resemblances to arrangements which have failed us in the past,[12,13] but this is unlikely to deter the government from taking them seriously. While considering them behind closed doors in its review of the NHS, the government continues to claim that it is providing the NHS with increased resources and setting all time records in the care provided tp patients.

More staff?

We are often told that the NHS is employing increasing numbers of doctors and nurses. This is actually true, but it is not the whole story.

The numbers of doctors and dentists in the Family Practitioner Servives have been increasing steadily over the years under both Labour and Tory governments. In fact, the British Dental Association now takes the view that we have too many dentists and has called for a reduction in the numbers of dental students. As for doctors, it is not clear whether the increase is large enough to meet the needs of the increasing numbers of very elderly people, to offset the effects of shorter hospital stays and to allow GPs to take on the additional role set out in the government's document 'Promoting better health'.[14]

The numbers of nurses and midwives working in the hospital and community health services have also risen, also as part of a longer term trend, but the increase since 1979 is not as great as the government would have us believe. Because so many work part time, statistics about nurses and midwives are counted in terms of 'whole time equivalents'. Each nurse or midwife is counted in terms of the proportion of the full working week that she or he works. In 1980, their full working week was reduced from 40 to 37.5 hours to comply with an EEC directive. This meant that part-time staff who continued to work the same hours became a larger whole time equivalent overnight. Then additional staff had to be employed to make up for the shorter hours worked by full-time staff. As a result, the whole time equivalent numbers of nurses and midwives increased by 7 per cent without a single extra hour being worked.

This is not always taken into account in published statistics which show an apparent increase of 62,969 nurses and midwives in Great Britain over the years 1978 to 1986.[5] Adjusted for changes in the working week, the increase goes down to 32,514 or 8 per cent. Over the same period, though, the numbers of whole time equivalent ancillary fell by 49,438. A few of these will have been replaced by people working for private companies, but not many as most contracts for ancillary services have been won by in-house tenders rather than by private companies.

It is government policy to increase the numbers of what it calls 'front line staff', nurses, doctors and midwives, who it recognises as giving direct services to patients. At the same time, it aims to reduce the numbers of 'support staff', including ancillary, secretarial and maintenance staff who it does not perceive as helping patients. It claims that, as a result, 'The service as a whole has been able to deliver more care of a greater complexity'.[15] This ignores the way people's work is interrelated. In addition, there is abundant anecdotal evidence of nurses doing tasks which used to be done by ancillary staff and of doctors doing their own typing or failing to write letters at all because of shortages of secretarial staff.

As with spending figures, national statistics about staff may obscure what has happened locally. For example, although numbers of whole-time equivalent nurses and midwives in England increased from 397,100 in 1982 to 402,700 in 1986, there were net decreases in the four Thames regions, including the special health authorities and in the Mersey Region, and increased in the other regions.[15] It is likely that there were even greater differences between districts within the regions.

Taken as a whole, the whole time equivalent numbers of staff in the hospital and community health services in Great Britain have been decreasing since 1982, and fell by 30,000 between 1982 and 1986.[5]

More beds?

The government is proud of its building programme. The annual report of the NHS in England reported that 'In the five years 1981-96, 210 new hospital schemes each costing over £1

million were completed and it is expected that a further 77 such schemes will be completed in 1987.'[16]

Three or four years ago, the government talked in terms of schemes costing over £5 million. Lowering the threshold to £1 million increases the number of schemes which can be counted and makes the total more impressive. In addition, if development in a given hospital is done in stages, each phase is counted as a separate scheme. Thus there were certainly not as many as 210 new hospitals built between 1981 and 1986.

Unlike its predecessors, the 1986-87 Annual Report[15] made no mention of the numbers of new beds provided. This was not of much use in any case, as the numbers of beds in hospitals and wards which had been closed was never disclosed. Overall, the average number of beds available daily in England decreased by 46,000 over the period 1979-86. While 27,200 of this decrease was in beds in mental illness and mental handicap hospitals, there was a decrease of 15,700 acute and 2,400 maternity beds.

This decrease in numbers of hospital beds is, however, part of a long term trend, which dates back well before 1979. The government's response is that it is providing more care in the community and that it is using hospital beds more efficiently by treating more patients than ever before? Is there any evidence for this?

More patients treated?

The government continues to quote impressive sounding figures, telling us, for example, that in 1986 there were 6.41 million in-patient cases, 1.05 million day cases and 37.7 million out-patient, and that this represented a marked increase on figures for the preceding year. It continues to be reluctant to admit that these figures tell us nothing about the numbers of people treated as there is no linkage between successive stays in hospital or visits to out-patient departments by the same person. Thus there is still no way of assessing the extent to which this increasing activity is sufficient to meet the changing needs and age structure of the population. Some further information may be available in the future, when the new computer systems being implemented in the NHS are working fully, but as these, like everything else, are underfunded, this is unlikely to appear quickly.

Meanwhile, some additional insight has been gained from local research. A newspaper report described an unpublished study in a home counties health authority of hospital admissions for cancer and heart, respiratory and digestive diseases. This showed that readmissions of the same people increased from 27 per cent of hospital admissions in 1979 to 36 per cent in 1984.[17] The Oxford Record Linkage Study, which brings together information about people living in part of the Oxford Region was used to look at changes over time in hospital admission rates. It found that over the 10 year period 1975-84, about 80 per cent of the increase in in-patient cases represented an increase in numbers of people admitted to hospital and about 20 per cent represented a rise in multiple admissions of the same person within the same year. The authors of the report commented:

'The fact that rates of admission to hospital tend to be considerably lower in England than in many other developed countries, that the prevalence of self-reported chronic illness in England seems to have risen, that the number of elderly people in the population continues to rise, and that the trend in admission to hospital over the years has been steadily upwards all suggest that the pressure for hospital care may continue to rise.'[18]

The crucial question is not whether the NHS is setting 'all time records', but whether it is capable of meeting this pressure. Is this why the government is so sensitive about waiting lists?

Shorter waiting lists?

Waiting lists statistics have always been of notoriously low quality. Trends over time have been difficult to interpret as a result of successive changes introduced to improve the quality of the data. As with unemployment statistics, the improvements have been made in ways which should have reduced the numbers on the lists. Despite this, and the government's drive to reduce waiting lists, the numbers on them in England rose from 661,249 in September 1985 to 687,945 in March 1987.[19]

On April 1 1987, major changes were made in the methods of data collection. When figures for September 1987 were published, Tony Newton claimed that, 'on a comparable basis with previous waiting list statistics', the numbers had fallen by 4 per cent since the end of March.[20] Closer inspection revealed that some health authorities had experienced problems in introducing the new data collection systems. As a result, 26 health authorities had been unable to fully complete one of the new returns. With another, 2 special health authorities and 35 district health authorities had either been unable to complete the return, or had supplied information which was clearly incorrect.[21] As a result, it is difficult to know what really is happening to waiting lists.

Of course, there are many instances when, instead of going into hospital, people's needs would be better met by care in the community. Is this happening?

More community care?

Although many health authorities are actively trying to develop community care schemes, there are still few statistics about them. It is becoming increasingly apparent that, if taken seriously, community care is not a cheap option. In this context, the continuing growth of private mini-institutions, whose residents can get support from the social security budget is not surprising. Indeed, according to a newspaper report[22], two health authorities are planning to build private homes themselves and move elderly people into them from their long-stay wards. The numbers of places in private homes for elderly and physically handicapped people rose by 12,654, or 15.7 between 1985 and 1986. At the same time, there were decreases of 471 and 1,466 in the numbers of places in local authority and voluntary homes.[23]

The government is in somewhat of a quandary on the subject of community care, after commissioning its favourite supermarket magnate, Roy Griffiths to review the problems. In his report,[24] he said many of the things the governemt wanted to hear, such as giving an enhanced role to the private sector. It was peeved, however, when he came up with the ideologically distasteful recommendation that local authority social services departments should act as 'gatekeepers' for community care. The government 'published' the report by placing a copy in the House of Commons Library, at a time when its author was in hospital recovering from an operation.

What is left out?

A great deal is left unmentioned in goverment statements. Some of the omissions have been mentioned here, and others are discussed at greater length in 'Facing the figures?'[2] Rather than trying to repeat this, we leave the final word to none other then a former Chief Medical Officer of the Ministry of Health, George Godber:

'For 40 years, Britain has had the least costly and most comprehensive health care system in the developed world, but its performance must now be judged by the shortfall in the provision of certain effective and commonly needed services, not by high-profile technical procedures of uncertain benefit to a few. It is useless for ministers to repeat barely relevant multiples of past expenditure, staff employed or numbers going in and out of hospital doors. What matters is the volume of services not provided or too long delayed.'[25]

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A youth, who bore, 'mid snow and ice,
A banner with the strange device.

—"Excelsior"