Whose *priorities and whose statistics*

Misleading use of statistics by government has been on the increase over the past ten years. A recent programme in the *Dispatches* series on Channel 4 showed blatant examples.

Since then, suspicions have been heightened by the reorganisation of government economic statistics, which concentrates responsibility for them in the Central Statistical Office. Most worrying is the way the Office has been made answerable to Nigel Lawson, with whom it had been in disagreement about his demand for mortgage interest rates to be taken out of the Retail Price Index.

Direct pressures such as these pose the most immediate threat to the integrity of government statistics, but other factors operate in the longer term. Like all statistics, government statistics are coloured by the way they are collected, analysed, presented and disseminated.

Most government statistics are collected as by-products of administrative processes such as running services or paying benefits, and this can affect choices about which statistics are collected. For example, the government is extremely keen to tell us about the numbers of beds which have been provided in new hospital developments. Yet, when asked in a parliamentary question about the numbers of beds lost through closures, the Secretary of State replied, 'I see no purpose in keeping centrally a full inventory of furniture in each of our hospitals'.

Administrative processes also affect the way statistics are collected. The time-honoured way of collecting health service statistics is to count people each time they are discharged from hospital, go to an out-patient clinic or are visited by a community nurse (this method *is* changing in some localities). So someone who has ten stays in hospital in a year, is counted as ten 'in-patient cases'.

Changes in administrative arrangements usually affect the statistics they generate, meaning that it is difficult to compare like with like when looking at time trends. The unemployment statistics may be the most spectacular example of this but NHS staff numbers also illustrate the problem.

Because so many nurses and midwives work part time, statistics about them are expressed as 'whole-time equivalents': each nurse or midwife is counted as the proportion of the full-time hours she or he works. When their working week was reduced from 40 to 37½ hours per week in 1980, part-time staff became a larger whole-time equivalent overnight; additional staff had to be taken on to make up for the shorter hours worked by full-time staff. The 63,000 extra nurses and midwives which featured so prominently in the Tories' 1987 general election advertisements were actually 'whole-time equivalents': if allowance had been made for the change in hours, there would have only been 32,000.

Statistics are also affected by the way they are classified, tabulated and analysed. Government politicians usually quote NHS spending figures, for example, which have been adjusted to allow for trends in general inflation. If figures are adjusted for NHS pay and prices, which have risen more quickly than general inflation over the past ten years, the less optimistic picture gives a more realistic measure of changes in NHS spending power.

Much of the misleading use of health statistics arises after they have left the hands of statisticians. Politicians and their speech-writers rely on the fact that the most people are unaware of the way the statistics are defined and produced. As a result figures are accepted, or perhaps rejected, at their face value. Although it is the Government Statistical Service's policy for explanations to be in the public domain, they are often placed in obscure publications which are not easily accessible. Added to this is the management by government press offices of the timing and method of release of government statistics.

Most of these problems have existed for a long time, but they have become more acute since 1979. A review in 1981 not only cut the Government Statistical Service, but defined its purpose more narrowly as serving the needs of Government. More recent developments need to be seen in the context of a more general tightening of political control over the Civil Service.

The net result is a growing distrust of government statistics. Any future government which wants to use statistics constructively, rather than as a smokescreen, will have to work hard to overcome this distrust.

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STRAIGHT TALKING

How much do we spend on the NHS? The government's talk of 'remarkable growth' is contested by the RADICAL HEALTH STATISTICS GROUP.

A growing health service?

'The NHS is growing at a truly remarkable pace . . . Total gross expenditure will increase from £8 billion in 1978-79 to £28 billion in 1989-90, an increase of 40 per cent after allowing for general inflation . . . It has also been recognised that simply injecting more and more money is not, by itself, the answer.'

THESE EXTRACTS from the introduction to the white paper, 'Working for patients', represent the government's attempts to justify the changes it plans to impose on the NHS. Yet they paint a picture of the NHS which few of its staff or users would recognise.

In the face of this contradiction, it is tempting to jump to the conclusion that the figures have been 'cooked'. Strange as it may seem, this is unlikely. It is rather that the statistics have been carefully selected, and that there are other statistics which could give a more credible picture.

The figures from the white paper compare changes in total spending on the NHS in the four countries of the United Kingdom with trends in general inflation. This is inappropriate as the way the NHS spends its money is not typical of the economy as a whole and the costs of the goods and services it buys, particularly staff salaries, have risen ahead of general inflation. Thus between the financial years 1978-79 and 1987-88, total spending on the NHS in England increased by 31.7 per cent ahead of general inflation. Compared with the index of NHS pay and prices, however, it increased by only 12.9 per cent over the same period. This applies to the NHS as a whole. Changes had been occurring at a different rate, both regionally and within different parts of the NHS.

Nearly two-thirds of NHS spending in England goes on the running costs of the hospital and community health services. Over the period 1978-79 to 1987-88, spending on these increased by 33.1 per cent ahead of general inflation, but only 7.6 per cent ahead of NHS pay and prices. Much of the discrepancy resulted from the government's failure to fully fund a series of pay rises it awarded to nurses, midwives, health visitors and professions supplementary to medicine, such as physiotherapists and occupational therapists.

Even the apparent 7.6 per cent increase disappears when changes in the age structure of the population, particularly the increased numbers of people in the 75+ age group, are taken into account. According to the government's own estimates, spending would have needed to increase by 12.8 per cent to keep pace with these changes. The government argues that some of the shortfall has been offset by health authorities' 'cash-releasing cost improvement programmes'. It is far from clear, though, whether these represent real improvements in efficiency rather than cuts in services.

The government constantly reminds us of its hospital building programme, although capital spending of this sort accounts for only about 6 per cent of the NHS budget. It is rather quieter about the increasing extent to which new building developments are funded by land and property sales. Funds from these accounted for 20 per cent of capital spending on the hospital and community health services in England in the financial year 1987-88 compared with just under 5 per cent in 1983-84.

Spending on the family practitioner services includes payments for general practitioner, dental, pharmaceutical and optical services, and these make up about a third of the NHS budget in England. As there have been no cash limits so far, spending on these services in England increased by 42.1 per cent ahead of general inflation and 25.7 per cent ahead of NHS pay and prices over the period 1978-79 to 1987-88. Yet there are no estimates of the extent to which this apparently generous increase has been offset by the effects of increases in the numbers of very elderly people, earlier discharge from hospital and general practitioners taking on new work which they did not do in the past and employing additional staff to do it.

Not all of the increase came from the government anyway. The proportion of the costs of the family practitioner services which came from charges to users of the services rose from 6 per cent in 1978-79 to 8.8 per cent in 1984-85. The abolition of free eye tests and dental checks is likely to add to this.

These more detailed statistics paint a picture which fits more closely with people's experience of an underfunded NHS. As the table shows, the United Kingdom spends a far lower proportion of its gross domestic product on health care than all but the poorest EEC countries. It lags far behind the United States which spent 10.5 per cent of its gross domestic product in 1982, and 10.7 per cent in 1984 on an inefficient system where people with insurance cover run the risk of over-treatment, while considerable numbers of others are wholly or partially excluded from access to care.

The present NHS crisis is one of underfunding, and the argument that it is not just how much money is spent, but how it is spent that matters, is often used merely as an excuse for this. Of course both new and existing patterns of care should be properly evaluated in terms of their effectiveness, efficiency and appropriateness before deciding to start or continue using them in the NHS. This applies not only to specific procedures in health care but also, more urgently, to the unevaluated and unjustified plans in the NHS white paper.

Health care expenditure in the European Community as a percentage of the Gross Domestic Product, 1982, 1985 and 1986.

Country	Percentage		
	1982	1985	1986
France	9.3	8.4	8.5
Netherlands	8.7	8.3	8.3
West Germany	8.2	8.2	8.1
Ireland	8.2	8.0	n/a
Italy	7.2	6.7	6.7
Denmark	6.8	6.2	n/a
Spain	6.3	6.0	n/a
Belgium	6.2	7.2	7.1
UK	5.9	6.1	6.2
Portugal	5.7	5.7	n/a
Greece	4.4	4.2	3.9

Source: Organisation for European Cooperation and Development.

● *For further information, or copies of* Facing the figures, *price £3.95 plus 50p p&p, Radical Statistics Health Group can be contacted c/o British Society for Social Responsibility in Science, 25 Horsell Road, London N5 1XL.*

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