is an example of good practice. This was a major policy issue and one about which many of us had a view.

Should the RSS be a more democratic society? Statisticians are quite often fairly unstuffy people and the lack of formality in some areas is welcome. On the other hand the sections seem rather remote. Maybe this is because I have never actively participated in one myself.

There should certainly be an international and European dimension to our activities and such links with sister organisations should be fostered.

GROUP CONTRIBUTIONS

THE HEALTH GROUP

A GROWING HEALTH SERVICE?

The government repeatedly claims that it has been pouring unprecedented sums of money into the NHS. During the general election campaign Conservative politicians asserted that spending had increased by 50 per cent in 'real terms' since 1979. This paints a picture of the NHS which few of its staff or users would recognise. The government used similar claims to argue that the sweeping changes it made to the NHS in April 1991, were needed because 'simply injecting more and more money is not, by itself, the answer.'

Figures quoted by the government compare changes in total spending on the NHS, either in the four countries of the United Kingdom, or in England alone with trends in general inflation. This measures the 'economic cost', the cost of the NHS to the country. It is not a realistic measure of what the NHS can buy, as the way it spends its money is not typical of the economy as a whole. The costs of the goods and services it buys, particularly staff salaries, which accounted for 76 per cent of the running costs of the hospital and community health services in 1989-90, have risen faster than general inflation. To measure trends in what the NHS can buy with its money, which is called 'input volume', cash spending can be compared with the index of NHS pay and prices.

Thus between the financial years 1978-79 and 1990-91 (see figure 1), the 'economic cost' of total spending on the NHS in England increased by 42.8 per cent ahead of general inflation. 'Input volume', NHS purchasing power, increased by only 19.3 cent over the same period. These increases apply to the NHS as a whole. Changes had been occurring at a different rate, both regionally and within different part of the NHS. It is becoming increasingly difficult to follow these consistently, because of successive changes both in the way the NHS is organised and in its accounting methods. Because of this, the graphs used here to illustrate spending in different parts of the NHS use two different symbols to highlight a major change of definition during 1985-86 (see figure 2).

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 1990-91, spending on these increased by 37.2 per cent ahead of general inflation, but only 13.7 per cent ahead of NHS pay and prices. Even this presents a favourable picture, as input volume increased by only 8.3 per cent over the 11 year period 1978-79 to 1989-90, and then rose by 5.0 per cent in the single financial year 1990-91. Much of the discrepancy resulted from the government's failure to fully fund the series of pay rises it has awarded to doctors, nurses, midwives, health visitors and professions supplementary to medicine, such as physiotherapists and occupational therapists.

Figure 1 **Total spending on the NHS in England**

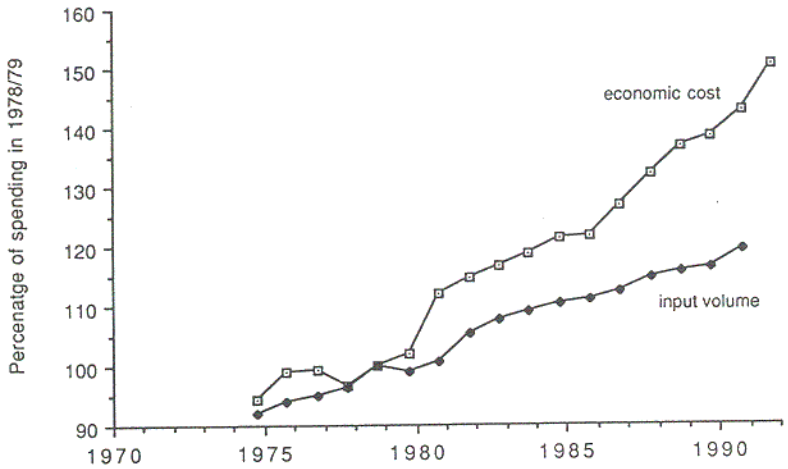


Figure 2 **Current spending on the hospital and community health services in England**

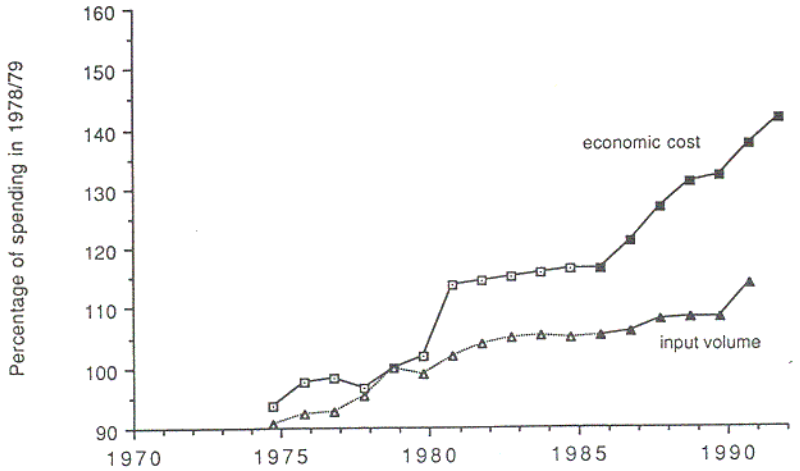


Figure 3 **Percentage of capital spending on the NHS in England which came from land sales and other receipts**

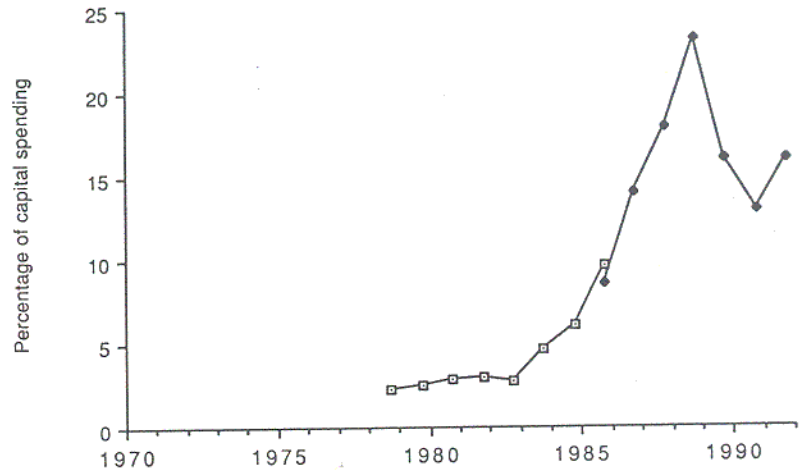
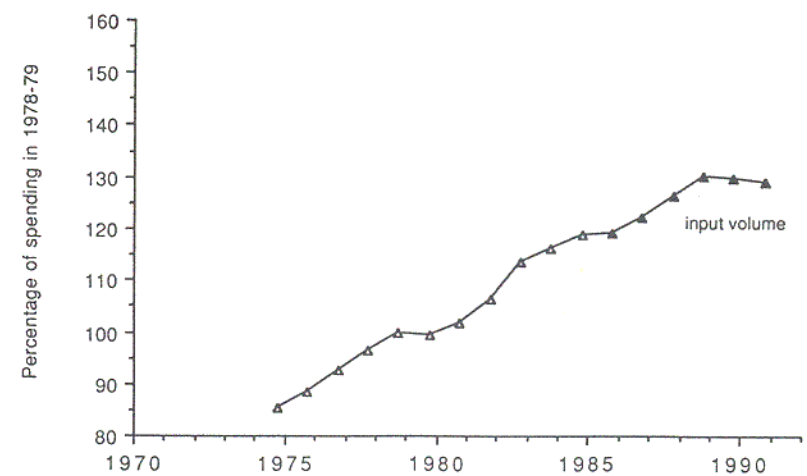


Figure 4 **Current spending on the family health services in England**



Even the apparent 13.7 per cent increase disappears when changes in the age structure of the population, particularly the increasing numbers of people in the 75+ age group, who make the heaviest use of the NHS, are taken into account. According to the government's own estimates, spending would have need to increase by 17.8 per cent to simply keep pace with these changes and the costs of technological innovation. 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 increases in efficiency rather than cuts in services. Of the £55.5million 'savings' achieved in 1989-90, 35.0 per cent came from 'rationalisation of patient services' and a further 22.4 per cent from 'other reductions in labour costs'.

The government constantly boasts of its hospital building programme, although capital spending 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. The percentage of capital spending on the hospital and community health services which came from this source rose from 4.6 per cent in 1983-84 to 23.2 per cent in 1988-89 and then fell with the collapse of the property market (see figure 3).

Spending on the family practitioner services includes payments for general practitioner, dental, and pharmaceutical services, and vouchers for spectacles. These make up about a third of the NHS budget in England. As there were no cash limits before the new contract for general practitioners, spending on these services in England increased by 30.2 per cent ahead of NHS pay and prices over the period 1978-79 to 1988-89, but then fell by 2.2 per cent of the 1978-79 value in the next two years from 1988-89 to 1990-91 (see figure 4). Yet there are no estimates of the extent to which this apparently generous increase was 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 increased spending came from the government anyway. As well as the increased contribution from land and property sales, there has also been a rise in direct charges to users of services. The proportion of the costs of the family practitioner services in the United Kingdom which came from charges to users of the services rose from 6.0 per cent in 1978-79 to 8.8 per cent in 1984-85, and levelled off to 8.3 per cent by 1989-90.

Although, compared with England, NHS spending is at a slightly higher level in Wales, Scotland and Northern Ireland, similar arguments could be made about the figures for these countries. They show that the although the cost of the NHS to the economy has increased, this has been totally inadequate to keep pace with changes in the population.

Now that the general election is over, it would not be surprising if the recent spurt in NHS spending comes to a swift halt, as cuts in public expenditure are expected. This is likely to put rationing of health care on health authority agendas, and lead them to turn to exercises on the lines of that in Oregon to justify cuts in service provision. The public may therefore find itself stampeded into allegedly democratic decision making processes.

Up until now, there has been little coordinated discussion of the democratic and ethical considerations of rationing of health care. Because of this, Radical Statistics Health Group is getting together with other relevant groups and individuals to discuss the issues and consider trying to intervene in the wider debate on rationing. It is hope that the conference to be held on November 14 will stimulate further activity.

Anyone interested in joining us is invited to contact **Allyson Pollock on 081 682 6729 (work) or 081 769 2514 (home) or Alison Macfarlane on 0727 52111.**