Do We Spend Enough on Health Care?

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Trains of thought . . . . . .

DO WE SPEND ENOUGH ON HEALTH CARE ?

These notes have been produced to accompany a small panel-display exhibition at the Hospital Centre from July - December, 1971. The Centre acknowledges with gratitude the help given by the Office of Health Economics in preparing this material.

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DO WE SPEND ENOUGH ON HEALTH CARE ?

As a nation, we get the health service we deserve. The government of the day decides overall policies for health care, as it does for housing, education, defence, pensions and so on. It is the government that decides how much public money should be spent on health care and, indirectly, how much should be spent on private treatment. As voters we put governments into and out of power. In the long run it is public opinion and the ballot-box that determine the standard of health care.

But how much does the public really know and care about the standard of care and about the priorities for expenditure on and within the health and social services? How well-informed is the man in the street about the facts and figures of these services and about the options open for their future development? How well-informed are the members of health and social service authorities and their staff? . . And how well-defined and publicised is the government's overall strategy for the health and social services?

If we want to improve the standard of health care, what questions should we be asking of ourselves, of our health and social service authorities, and of our government? The questions, facts and options shown in the following pages indicate some of the problems that concern us all. Do we think enough about these problems and their possible solutions? Do we talk enough about them? Do we do enough about them?

As members of the public we should think and talk about these problems in the context of our own work and our own homes and local services: our opinions can help to influence decisions and policies at local and national level. As members or staff of health and social service authorities, we should also be thinking and talking about these matters, and doing what we can to make sure the public are better informed about problems and options.

We hope that these notes will help to promote more widespread discussion and debate about problems and priorities in health care.

We get the health service we deserve.

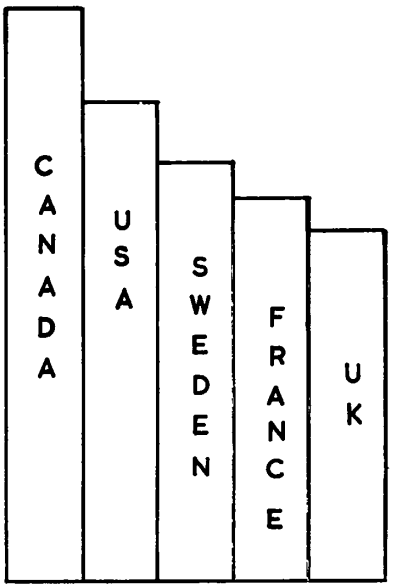
Miles Hardie

Director
King's Fund Hospital Centre

July 1971

1. IF WE DEVOTED AS HIGH A PROPORTION OF NATIONAL INCOME TO HEALTH CARE AS USA, WE WOULD HAVE SPENT OVER £2700 MILLION ON HEALTH SERVICES IN 1969/70, INSTEAD OF UNDER £2000 MILLION

Percentage of national income spent on health services



CANADA	9.66%
USA	8.22%
SWEDEN	7.12%
FRANCE	6.56%
UK	6.02%

These percentages represent total expenditure on health services as a percentage of national income in the late 1960's. The baseline for the calculations is the World Health Organisation Public Health Paper No.32 (1962) by B Abel Smith, updated by index numbers constructed from various series for health expenditure in each country. The figures shown are therefore not precise. For individual countries, they may not tally with equally valid figures based on different definitions of total medical care. Furthermore, variations in prices and purchasing power from country to country make comparisons on the absolute levels of expenditure for a single year particularly prone to misinterpretation

(Source: Office of Health Economics (OHE) Information Sheet No. 9, September 1970)

2. BUT DOES MORE NECESSARILY MEAN BETTER? WHO GETS BEST VALUE FOR MONEY ?

If the rankings on standardised death rates, late foetal death rate, infant mortality rate and maternal mortality rate are combined, the following rankings emerge, with Sweden having the best record.

A) For the five countries shown on the previous page

B) For 15 countries throughout the world

A

1 SWEDEN

2 CANADA

3 UK / USA

5 FRANCE

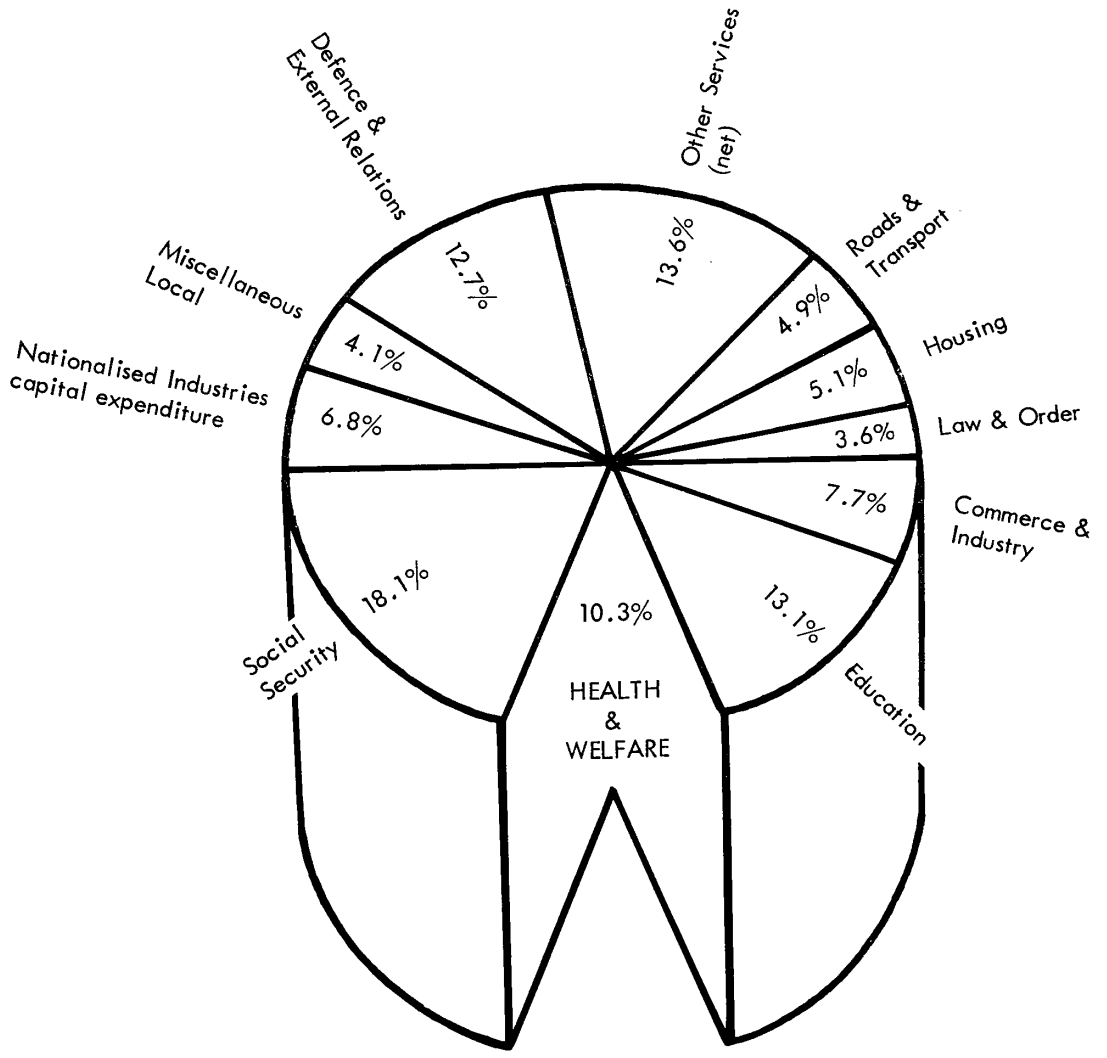
B

1 SWEDEN
2 SWITZERLAND
3 AUSTRALIA
4 NETHERLANDS
5 CANADA
6 CZECHOSLOVAKIA
7 BELGIUM
8 UNITED KINGDOM / UNITED STATES OF AMERICA
9 FRANCE
10 WEST GERMANY
11 AUSTRIA
12 HUNGARY
13 JAPAN
14 ITALY
15 PORTUGAL

(Source: Annual report of the Chief Medical Officer of the Ministry of Health, 1966, "On the state of the public health")

3 WOULD MORE MONEY BE BETTER SPENT ON HEALTH ? . . . OR ON SOCIAL SECURITY ? . . . OR ON EDUCATION ? . . . OR ON HOUSING ? . . . OR ON DEFENCE ? . . . OR ON . . . .

This diagram shows how the total UK government expenditure estimate of £22,259,000,000 for 1971/2 is divided between different sectors:



(Source: Public Expenditure 1969/70 - 1974/5)

The table on the following page shows the gross cost of the NHS for each year between 1950 - 1969.

Expenditure on the National Health Service (United Kingdom)

This table shows the gross cost of the NHS and the cost as a proportion of National Income. It includes current and capital expenditure by central and local government and payments by NHS patients. It also shows the cost of the NHS in terms of the 1949 level of the £

Year	NHS as % of National Income	Gross Cost of NHS £million	Purchasing Power of £ (1949 = 100)	Cost of NHS at 1949 level of £ £million
1950	4.42	477	97.3	464
1951	4.22	500	89.2	446
1952	4.09	523	84.1	440
1953	3.98	548	82.7	453
1954	3.89	567	81.3	461
1955	3.91	607	78.6	477
1956	3.93	662	75.3	498
1957	4.04	721	73.0	526
1958	4.11	764	71.0	542
1959	4.24	828	70.5	584
1960	4.33	902	69.9	631
1961	4.40	981	67.9	666
1962	4.41	1025	65.4	670
1963	4.42	1092	64.2	701
1964	4.46	1186	62.1	737
1965	4.62	1308	59.4	775
1966	4.85	1434	57.3	822
1967	5.12	1594	55.9	891
1968	5.23	1741	53.5	931
1969	5.39	1880	50.8	955

(Source: Office of Health Economics Information Sheet No. 11, February 1971)

National income. National income is equivalent to Gross National Product less Capital Consumption

Gross National Product. The total income of residents of the United Kingdom, before providing for depreciation or capital consumption. It is equal to the value at factor cost of the goods and services produced by United Kingdom residents plus their income from economic activity abroad and from property held abroad less the corresponding income of non-residents.

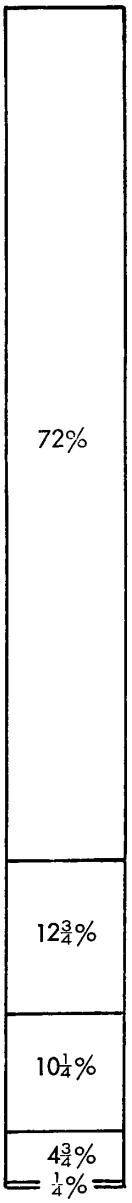
Capital consumption. This is a measure of the amount of fixed capital resources used up in the process of production during the year. It is deducted from the gross national product to obtain a measure of the national income, and from gross domestic fixed capital formation to obtain a measure of net domestic fixed capital formation. Capital consumption is not an identifiable set of transactions: it is an imputed transaction which can be measured only by a system of conventions.

(Source: National Income & Expenditure, 1969. Central Statistical Office)

4. IN WHAT WAYS COULD MORE MONEY BE RAISED FOR HEALTH SERVICES ?

These are the existing sources of finance

1968/9



		£ million (England & Wales)
72%	General taxation	£1084
12¾%	Local authority rates and government grants	194
10¼%	NHS share of weekly insurance stamp	154
4¾%	Charges to patients	71
¼%	Other income	4
		£1507 million

(Source: Department of Health and Social Security, Annual Report for 1969)

The tables on the next two pages show -

a) how Britain compares with other countries in taxation
b) how an extra £50 million might be raised

International comparison of taxes

The following table shows taxes, including social security contributions, as a percentage of gross national product at factor cost.

Country	Percentages		
	1966	1967	1968
Sweden	44.3	46.0	48.4
Austria	42.0	41.7	43.2
Norway	40.7	42.5	42.7
France	43.0	42.7	42.5
Netherlands	39.3	40.8	42.2
Denmark	36.7	36.9	40.8
United Kingdom	35.7	37.2	40.1
Germany	40.0	40.7	39.8
Belgium	35.6	36.9	37.4
Canada	33.2	34.8	36.4
Italy	31.7	33.6	34.1
United States	30.5	39.9	32.9
Switzerland	23.4	23.6	24.2
Japan	20.0	20.0	20.3

(Source: Economic Trends No.202, August 1970)

? Are we really so desperately over-taxed in Britain ? ?

? How could an extra £50 million be raised ? ?

	Income tax	An increase of 1p on the standard rate
or	Petrol	An increase of 1p a gallon
"	Tobacco	An increase of 1p on a packet of 20 cigarettes
"	National insurance	A flat-rate increase of 4p on the weekly stamp
"	GP visits	A charge of 40p for each surgery or home visit, with 50% of visits exempt
"	Prescription charges	An increase of 35p in flat-rate prescription charges, with 50% of patients exempt
"	Hotel charges	£6 per week to offset some of the hotel costs of in-patient care, excluding mental treatment and assuming 50% of patients exempt

(Source: Office of Health Economics estimates)

. . . . and other ways of getting more money for health care . . . .

Road traffic accidents

Treatment of these accident patients costs the hospital service around £20 million pa... should these costs be paid by the motorist through the motor insurance system?

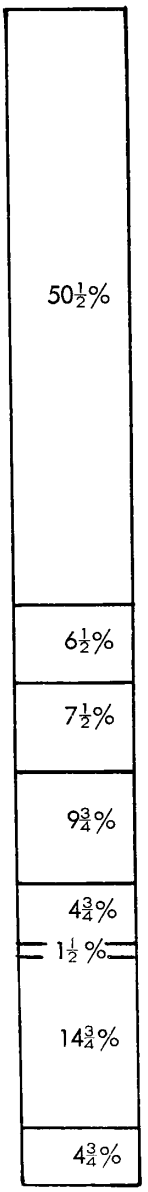
Private treatment

In 1969 about 2 million people were covered for private treatment under private insurance schemes. Benefits paid under these schemes amounted to around £20 million (equivalent to about 1% of total NHS expenditure). Should more encouragement be given to private insurance schemes?

5. WHICH WAYS OF RAISING MONEY WOULD BE FAIREST ? . . .
AND EASIEST TO COLLECT ? . . .
AND HELP MOST TO IMPROVE UTILISATION OF HEALTH CARE RESOURCES ? . . .

6. BUT DO WE SPEND THE MONEY WE HAVE GOT AS WISELY AND AS WELL AS WE SHOULD ? HAVE WE GOT THE RIGHT BALANCE BETWEEN THE DIFFERENT BRANCHES OF THE HEALTH SERVICE ?

This diagram shows how NHS expenditure for 1968/9 was allocated:



		£ million (England & Wales)
50½%	Hospitals - current	761
6½%	Hospitals - capital	99
7½%	General medical	113
9¾%	Pharmaceutical	148
4¾%	General dental	72
1½%	General ophthalmic	21
14¾%	Local health authority and local welfare	223
4¾%	Welfare foods, central administration & other costs . . .	70
		£1507 million

(Source: Department of Health & Social Security Annual Report for 1969)

The table on the following page shows how the allocation of funds has changed between 1950 - 1969.

Allocation of funds within the National Health Service (United Kingdom)

Since 1950 hospital services have been taking a gradually increasing proportion of the total cost of the NHS, as the following table shows:

Year	Hospital Services %	Pharmaceutical[1] Services %	General Medical[1] Services %	General Dental Services %	General Ophthalmic Services %	Local Authority Health Services %	Other[2] %	Total %
1950	54.9	8.4	11.7	9.9	5.2	7.8	2.1	100
1951	56.0	9.8	11.0	7.8	2.8	8.4	4.2	100
1952	56.0	9.8	11.1	5.9	2.1	8.4	6.7	100
1953	55.3	9.5	10.8	5.5	2.2	8.9	7.8	100
1954	56.4	9.3	10.6	5.8	2.3	9.2	6.4	100
1955	57.3	9.6	10.2	6.3	2.5	8.7	5.4	100
1956	57.6	9.8	10.0	6.3	2.3	8.6	5.4	100
1957	57.0	9.7	10.3	6.4	2.2	8.7	5.7	100
1958	58.0	10.0	10.3	6.5	2.1	8.9	4.2	100
1959	57.4	10.1	9.7	6.5	2.1	9.3	4.9	100
1960	56.4	10.1	9.8	6.3	1.9	9.0	6.5	100
1961	56.8	9.8	9.0	6.2	1.8	9.3	7.1	100
1962	59.0	9.7	8.5	6.0	1.7	9.7	5.4	100
1963	60.1	10.1	8.3	5.7	1.6	9.9	4.3	100
1964	60.5	10.2	7.9	5.6	1.7	10.0	4.1	100
1965	60.5	11.1	7.8	5.1	1.6	10.2	3.7	100
1966	60.9	11.2	7.5	5.2	1.5	10.2	3.5	100
1967	59.9	10.6	7.9	5.0	1.4	10.7	4.5	100
1968	60.0	10.2	7.9	4.7	1.4	10.6	5.2	100
1969	61.2	10.1	7.8	4.7	1.4	10.4	4.5	100

1 Expenditure has been adjusted to include, for the appropriate year, any arrears of remuneration subsequently granted.

2 Includes grants, central administration and items such as laboratory, vaccine and research costs not falling within the finance of any one service.

(Source: OHE Information Sheet No. 11, February 1971)

? Do we strike the right balance between hospital services and other branches of the NHS? ?

7 AND WHAT ABOUT ALL THOSE REGIONAL VARIATIONS ?

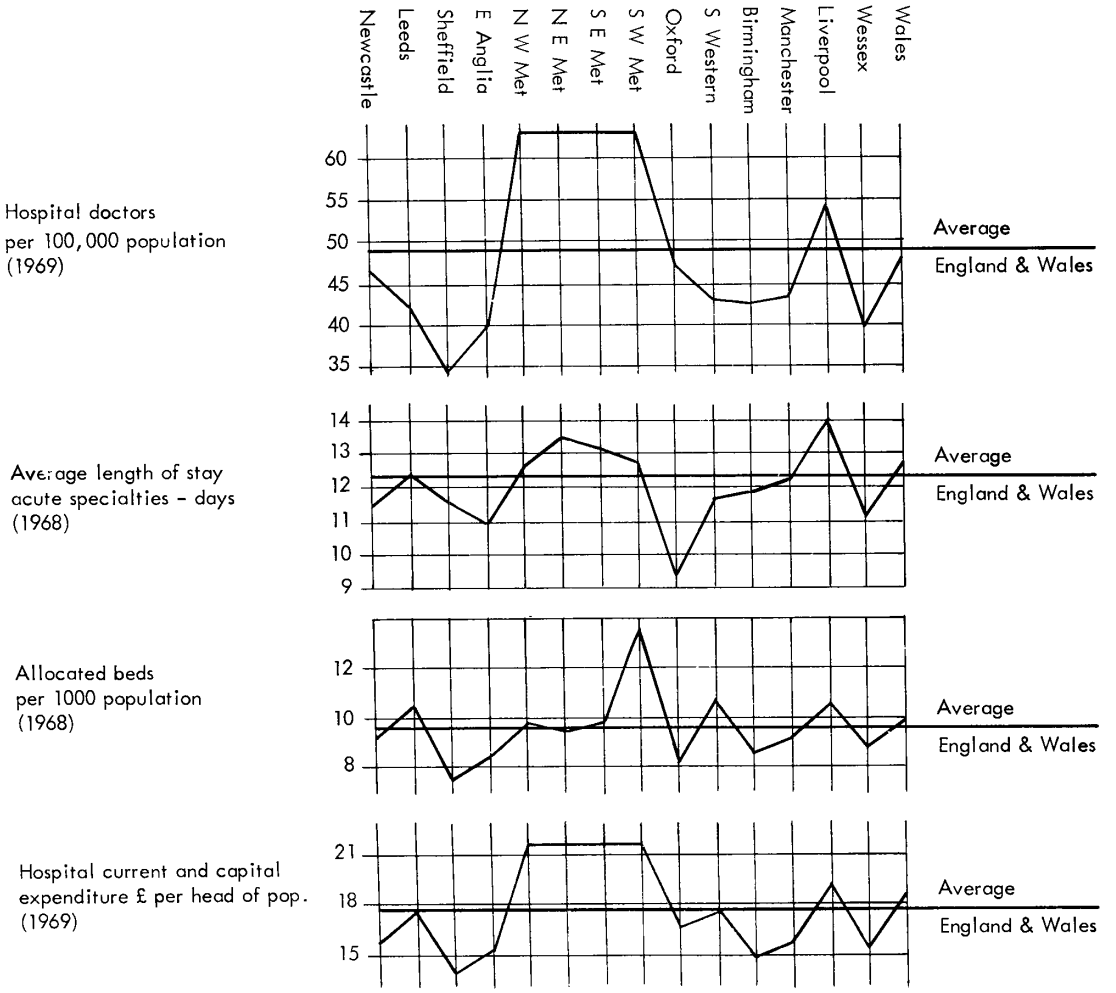
The illustration below shows just a few of the many variations in standards of provision between hospital regions in England and Wales, and prompts such questions as:

a) Why does annual hospital expenditure per head of population vary from £13.9 in one region to £21.8 in another?

b) Why do we have 62.9 hospital doctors per 100,000 population in one part of the country and only 34.3 in another?

c) Why does the average length of stay for acute specialties vary from 14.0 days in one region to 9.4 in another?

d) Why does one region have 13.5 hospital beds per 1000, and another only 7.6?



(Sources: Digest of Health Statistics for 1970. Tables 1.3, 2.5, 3.18, and 4.11 and unpublished tables from DHSS)

? There are probably good reasons for many variations, but can they all really be justified? Should we be moving more swiftly towards a system of providing for each region or area an allocation of funds related to its population, weighted for age-structure and other factors? ?

8. IF WE DID HAVE MORE MONEY, WHAT SHOULD WE SPEND IT ON ?

Mental health? Although 45% of patients in NHS hospital beds are for the mentally, disordered, only 11% of all consultants are psychiatrists and only 21% of nurses work in psychiatric wards. Less than 14% of NHS expenditure goes on hospital and community services for the mentally disordered, and less than 9% of the Medical Research Council budget goes on research into mental disorder. Do we care enough for the mentally disordered?

Care of the elderly? About 12.9% of the population are now aged 65 and over; by 1981 the proportion may rise to 13.8%. Over 35% of hospital beds are occupied by patients over 65. Do they all need to be there? Should we be spending more on better pensions? More day centres? Better housing?

Health centres? In 1960 there were 24 health centres in Britain; in 1970 there were 254. By the beginning of 1975 there are expected to be 1040, providing facilities for about 28% of all GP's. Should we encourage this trend still further?

Health education? The expenditure of the Health Education Council in 1969/70 was just over £300,000, equivalent to approx 0.01% of the total expenditure on the NHS in Britain. Should we be spending more on health education?

Help for the handicapped? There are estimated to be over 3 million people living in private households in Britain who have some physical, mental or sensory impairment. Of this total, some 760,000 women and 370,000 men can be classified as being handicapped, 70% of whom are elderly. Should we be spending more on health and social services for the handicapped?

Research? About £100 million p.a. is being spent on medical and health care research and development by government, industry and voluntary organisations. Is this enough? Is it being spent on the most useful projects? Is enough attention paid to implementing the results of research?

Support for volunteers? Volunteers should not be used to do work that should be done by paid staff. But they can and do supplement the work of paid staff and improve the quality of life for patients in hospital and community. Can hospital and health service authorities do more to encourage and support voluntary help?

More buildings? In the ten years 1958-1968 five times as much new hospital building was completed as in the previous ten years. Now at least £100 million of new buildings are being completed each year. Are the new hospitals being planned of the right size and in the right places? Should we be spending more on better housing and more health centres and local authority residential accommodation?

More staff? Some sectors of the health service appear to be short of staff. Yet since 1949 the total number of hospital staff has increased by over 70%, whilst in the country as a whole the working population has increased by only 10.5%. Can the health service expect to continue to increase its staff at this rate indefinitely?

Family planning? It is estimated by the Family Planning Association that in Britain there are between 200,000 - 300,000 unwanted pregnancies every year, and that the expenditure of £40 million a year on effective birth control could save between £200 - £400 million of public spending on maternity and child care and other services each year. At present, expenditure on family planning services by the FPA and local authorities amounts to between £3 - £4 million p.a.

More details about each of these topics are shown on the following pages

MENTAL HEALTH ?

Although 45.7% of patients in NHS hospital beds are for the mentally disordered, only 11% of all consultants are psychiatrists and only 21% of nurses work in psychiatris wards. Less than 14% of NHS expenditure goes on hospital and community services for the mentally disordered, and less than 9% of the Medical Research Council budget goes on research into mental disorder.

And . . . how many mentally disordered people are there in England?

	Mentally ill	Mentally handicapped	Total
In hospital	107,455	60,803	168,846
In the care of local authorities	82,321	96,024	178,345
Total	189,776	156,827	347,191

Great advances and improvements have been made in the care of the mentally disordered under the NHS, particularly since the Mental Health Act of 1959. BUT . . . .

65 % of British mental hospitals were built before 1891, 40% more than 100 years ago.

In 1969 there were still 53 mental illness hospitals with over 1,000 beds, and 7 with over 2,000 beds . . . and there were still 17 hospitals for the mentally handicapped with over 1,000 beds, and 2 with over 2,000 beds.

15% of patients in mental illness hospitals are in wards of 50 or more beds, as are 25% of patients in hospitals for the mentally handicapped.

In mental illness hospitals there is one consultant to 120 patients.

In hospitals for the mentally handicapped there is one consultant to 495 patients.

In 1967/8 only 13.5% of the total NHS expenditure was spent on hospital and community services for the mentally handicapped.

Over 30 million working days were lost in 1967/8 in Great Britain through mental disorder.

One child in every 100 is born subnormal.

1 woman in 6 and 1 man in 9 will enter hospital because of mental illness once in their life.

(Source: Factsheet from National Association for Mental Health, January 1971, which was based mainly on official statistics)

. . . . . .

? Should we be devoting more of our resources to the mentally ill and the mentally handicapped ? ?

CARE OF THE ELDERLY ?

About 12.9% of the population are now aged 65 and over; by 1981 the proportion may rise to 13.8%. Over 37% of hospital beds are occupied by patients over 65.

Over 95% of people aged 65 and over live in private households or lodgings, so that only a small proportion are in hospital or local authority residential accommodation at any one time. Could this proportion be made even smaller?

Hospital care

The following table shows the number of hospital beds occupied by patients over 65 in 1968 in England and Wales (excluding convalescent, private and staff beds).

		Average daily no. of occupied beds	of which	Average daily no. occupied by patients over 65
A)	Mental illness	120,367		52,321
B)	Mental handicap	59,380		4,200
C)	All other beds	199,123		85,603
	Total	378,870		142,124

This table also shows that 70% of all hospital beds are occupied by patients who are mentally ill, mentally handicapped or over 65.

In its report for 1969/70, the NHS Hospital Advisory Service stated that "Space is of great importance on geriatric wards. The team has reported that it is sometimes necessary for nurses to move one bed before they can give attention to the occupant of another. Space is also necessary if it is to be possible to screen off or cubiclize every bed.... Elderly patients suffer many inevitable indignities but should at least be able to wash in privacy, excrete in privacy and die in privacy. Too often these take place in view of others on the ward."

Day care

The first purpose-built day hospital was opened in 1958. By the end of 1970 there were at least 120 day hospitals attached to departments of geriatric medicine, and scores of day centres run by local authorities or voluntary bodies.

In its 1969/70 report the NHS Hospital Advisory Service also stated that "Although the Department of Health has advised on the need for day hospitals (HM(65) 77) for the elderly, these are still too few in the areas we have visited, often have a limited function, and even new ones have sometimes been built incomplete."

(Sources: DHSS personal communication, 1971
NHS Hospital Advisory Service, Annual Report 1969/70
The Geriatric Day Hospital, by Prof J C Brocklehurst, 1970)

. . . . . .

Should greater emphasis be placed on geriatric medicine in our teaching hospitals? . . . By the end of 1970 there were still only three professorial chairs in this subject in Britain.

?

Should we be spending more on day centres and day hospitals ?

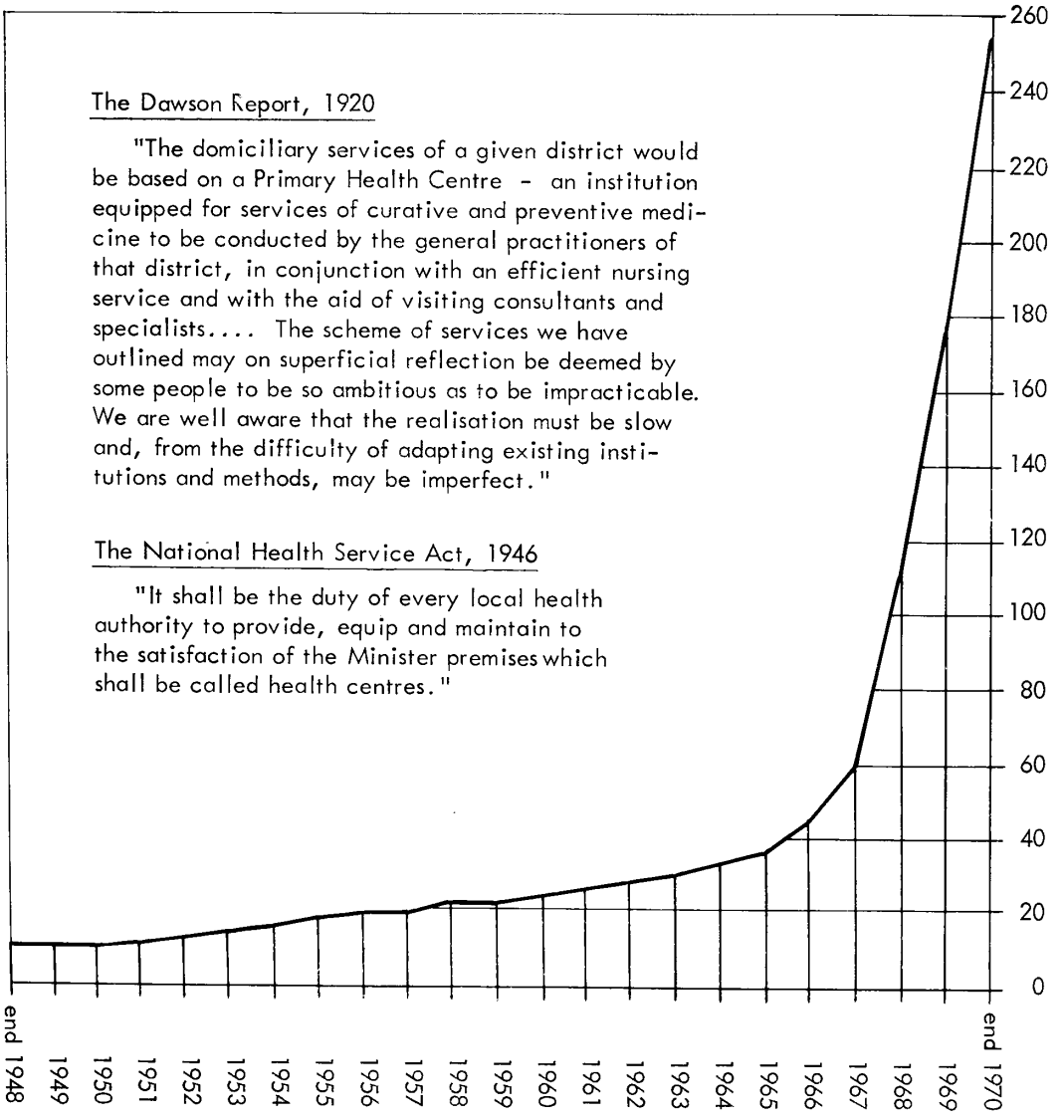
?

Do we really care enough for the elderly?

HEALTH CENTRES ?

In 1950 there were 10 health centres in Britain, by the end of 1960 there were 24 and by the end of 1970, 254. By the beginning of 1975 there are expected to be about 1040, providing facilities for about 28% of all GP's.

The graph below illustrates the great growth of health centres in recent years:



The Dawson Report, 1920

"The domiciliary services of a given district would be based on a Primary Health Centre - an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists.... The scheme of services we have outlined may on superficial reflection be deemed by some people to be so ambitious as to be impracticable. We are well aware that the realisation must be slow and, from the difficulty of adapting existing institutions and methods, may be imperfect."

The National Health Service Act, 1946

"It shall be the duty of every local health authority to provide, equip and maintain to the satisfaction of the Minister premises which shall be called health centres."

(Source: Directory of British Health Centres
King's Fund Hospital Centre Working Paper, 1971)

? Is this a trend we should be encouraging still further? ?

HEALTH EDUCATION ?

The expenditure of the Health Education Council in 1969/70 was just over £300,000 - equivalent to approx 0.01% of the total expenditure on the NHS.

The objects of the Health Education Council are "to promote and encourage in England, Wales and Northern Ireland education and research in the science and art of healthy living and the principles of hygiene and the teaching thereof, and to assist Government Departments, local authorities and other statutory and voluntary bodies in so far as their work comprises health education and propaganda directed to the promotion or safeguarding of public health or to the prevention and care of disease, and to provide analogous service for bodies and for individuals overseas"

If we spent more on health education, could we hope to spend less on treating:

Lung cancer	In 1969 there were nearly 30,000 deaths from cancer of trachea, bronchus and lung in England and Wales (1)
Alcoholism	OHE estimates indicate that there are about 220,000 alcoholics in England and Wales (2)
Home accidents and poisoning	The number of deaths from accidents in the home are estimated to be between 5000-7000 each year (3)
Abortions and illegitimate births	In 1969 there were over 67,000 illegitimate births and over 52,000 notified abortions in England and Wales (1)
Venereal diseases	In 1968 there were 1618 cases of early syphilis reported in England, and 50,037 cases of gonorrhea (1)
Dental treatment	In 1968 dentists in England and Wales carried out nearly 28 million fillings in permanent teeth (1)
Mental illness	There are nearly 350,000 people suffering from mental disorder in England. In 1967/68 over 30 million working days were lost in Great Britain through mental disorder (4)
Obesity	In any given age group, for every 1000 men of average weight who die, 1310 men who are 20% overweight will accompany them (5)

Sources: (1) Annual Report of Chief Medical Officer, DHSS, for 1969

(2) Alcohol Abuse, Office of Health Economics, 1970

(3) Health Education Council Annual Report for 1969-1970

(4) National Association for Mental Health, Factsheet, January 1971

(5) Dr M Davies, Sunday Times Magazine, 9.5.71

? Should we be spending more on health education ? . . . ?

HELP FOR THE HANDICAPPED ?

There are estimated to be over 3 million people living in private households in Britain who have some physical, mental or sensory impairment. Of this total, some 760,000 women and 370,000 men can be classified as being handicapped, 70% of whom are elderly.

In 1971, the Government Social Survey report 'Handicapped and impaired in Great Britain' showed that in 1968/9 there were, living in private households:

25,000 people, mainly elderly women, so impaired as to need special care during the day, and usually some care at night,
130,000 people, again mainly elderly, and predominantly women, who cannot be left alone for lengthy periods during the day,
360,000 people who are severely handicapped and
600,000 who are appreciably handicapped.

The report also showed that:

Between 35% and 40% of the handicapped were in receipt of supplementary benefit, and, on the whole, the incomes of handicapped and impaired people were lower than those for the general population.

Nearly 30% of the handicapped had not seen their doctor for at least three months.

Only 18% of the very severely handicapped were registered on the local authority register of substantially and permanently handicapped persons.

200,000 households containing people who were very severely, severely or appreciably handicapped need rehousing or improvement to their accommodation because they lack the basic amenity of an inside WC

Over 12% of the housebound living alone had no telephone.

Only 5% of the handicapped were living in purpose-built accommodation.

? Should we be spending more on health and social services for the handicapped ? ?

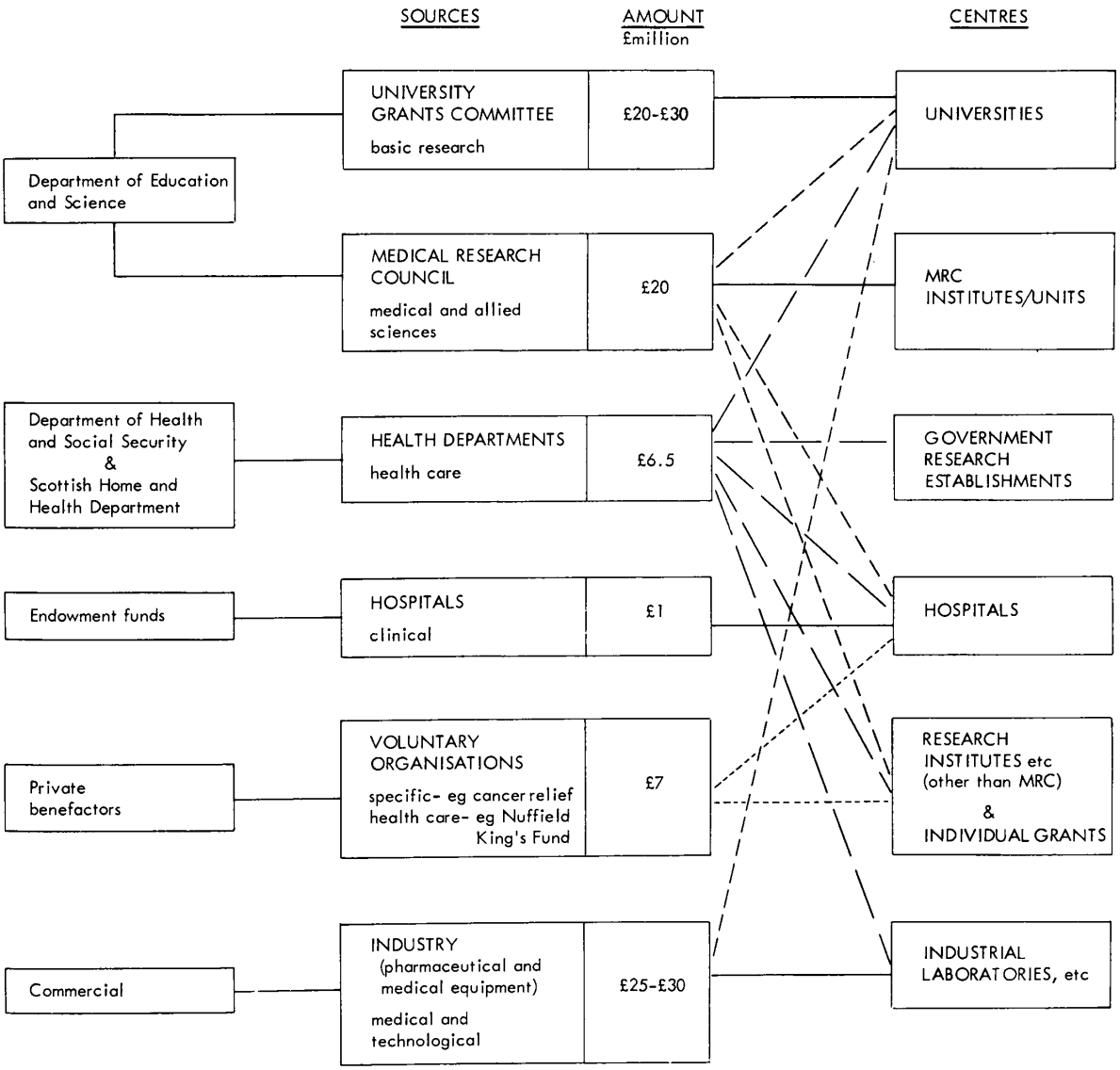
RESEARCH & DEVELOPMENT?

About £100 million was spent on medical and health care research and development in 1970 by government, industry and voluntary organisations

Is this enough?

Is it being spent on the most useful projects?

Is enough attention paid to implementing the results of research?



(Source: Funds for research come from a variety of different public and private organisations. There is no one simple source of information, and the figures shown above can therefore be considered only as rough estimates)

SUPPORT FOR VOLUNTEERS ?

Volunteers should not be used to do work that should be done by paid staff. But they can and do supplement the work of paid staff and improve the quality of life for patients in hospital and community. The Under Secretary of State for Health has suggested that every hospital with over 200 beds should have a paid organiser of voluntary services ....

Voluntary support for hospitals is nothing new in Britain: Although many people feared that it would be extinguished with the introduction of the NHS in 1948, in fact the spirit of voluntary service is still flourishing and expanding.

Leagues of Friends, British Red Cross, Women's Royal Voluntary Service and many other voluntary organisations have for years been providing invaluable help for hospitals and in the community. More recently there has been a great increase in the number of volunteers, young and old, wishing to give service without belonging to any particular organisation.

To help co-ordinate the activities of volunteers and voluntary organisations, a growing number of hospitals are appointing paid organisers of voluntary services. In 1967 there were 13 such organisers in Britain, and by the end of 1970 there were about 80. If every hospital with over 200 beds is to have an organiser, we shall need at least 500 organisers, as the table below indicates:

Hospitals (England and Wales)	1969
With up to 50 beds	916
51 - 250 "	1072
251 - 500 "	267
501 -1000 "	158
1001 -2000 "	68
Over 2000 "	9
Total of all hospitals	2490 (of which 502 have over 250 beds)

Hospitals that have used voluntary services effectively all emphasise that before introducing any form of voluntary help, there must obviously be the closest consultation and co-operation with doctors, nurses and others professionally concerned in the care of the patient, as well as with management and trade unions and with voluntary organisations already providing services. Likewise, these hospitals recognise that the proper and efficient functioning of a voluntary help scheme can be of immense benefit to

a) the patient, who receives more care and attention,

b) the paid staff, who are enabled to make their services to the patient more effective,

c) the community, who get to know and understand their hospital, and the services which it provides for them.

(Sources: Organisers of voluntary services in hospitals. King Edward's Hospital Fund, 1968. Digest of Health Statistics, 1970. Table 4.5)

.....

? Can health service and social service authorities do still more to encourage and support voluntary help in hospital and community ? ?

MORE BUILDINGS ?

In the years of reconstruction immediately after the last war, schools and housing had high priority in Britain's capital building programme, and relatively little money was allocated for new hospitals. Between 1948 - 1958, about £100 million was spent on new hospital construction. From the late 1950's the health service began to receive a rather higher proportion of the funds available for capital development, and in the ten years between 1958 - 1968 five times as much new building was completed as in the previous ten years. Now at least £100 million of new buildings are being completed each year.

By the end of 1969, hospital schemes to the value of over £770 million had been completed with a further £420 million in progress. In physical terms, this has meant the provision in new or converted buildings since the start of the National Health Service in 1948 of:

82,000	beds
850	operating theatres
600	x-ray diagnostic and radiotherapy departments
480	pathological laboratories
420	nurse training schools

(Source: Unpublished communication from DHSS)

The table and graph on the following pages show the growth of hospital capital expenditure between 1949 - 1969.

. . . . . .

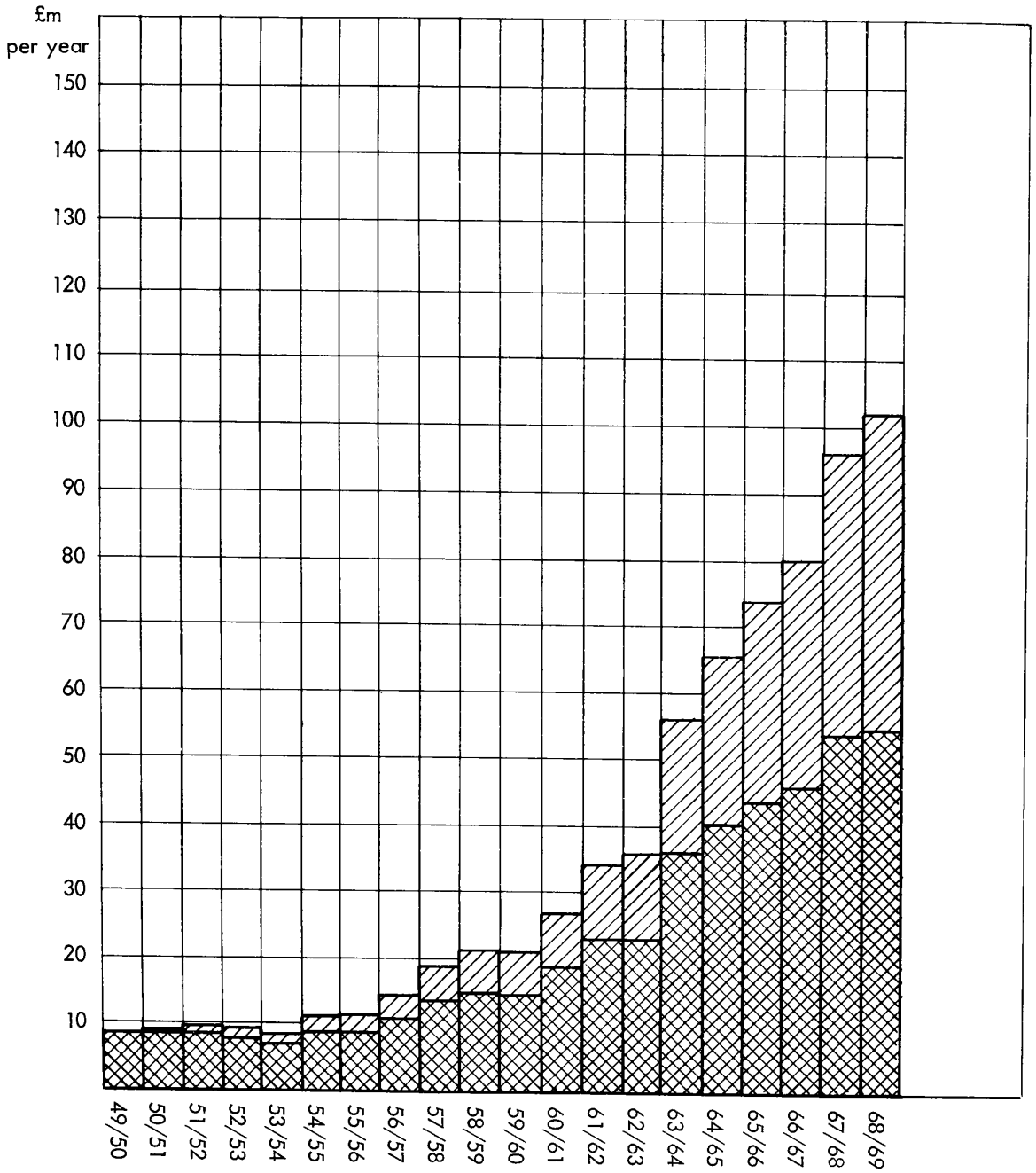
Are the new hospitals now being planned and built of the right size and in the right places ?

Are they being planned as part of a truly comprehensive health service ?

? Is enough encouragement given to innovation and experiment in health service organisation and hospital design ? And to evaluation ? ?

Should we be spending more on health centres ? Or on local authority residential accommodation ? Or on slum-clearance and better housing ?

ANNUAL CAPITAL EXPENDITURE ON HOSPITAL BUILDING - ENGLAND & WALES
1949 - 1969



SOURCES:

a) For years 1949-1960, Annual reports of the Ministry of Health for each year
b) For years 1961-1969, Digest of Health Statistics, 1970 Table 2.7
c) For internal purchasing power of the pound, Central Statistical Office

Annual Capital Expenditure on Hospital Building - England & Wales
1949 - 1969

Year	Hospital Capital Expenditure Actual	Purchasing Power of £1 (1949 = 100)	Hospital Capital Expenditure at 1949 level of £
	£million		£million
1949/50	8.57	100	8.57
1950/1	8.73	97.3	8.49
1951/2	9.58	89.2	8.55
1952/3	9.13	84.1	7.68
1953/4	8.75	82.7	7.24
1954/5	11.31	81.3	9.20
1955/6	11.46	78.6	9.01
1956/7	14.21	75.3	10.70
1957/8	18.70	73.0	13.65
1958/9	21.13	71.0	15.00
1959/60	20.97	70.5	14.78
1960/1	27.12	69.9	18.96
1961/2	34.15	67.9	23.19
1962/3	35.68	65.4	23.33
1963/4	56.35	64.2	36.18
1964/5	65.48	62.1	40.66
1965/6	73.68	59.4	43.77
1966/7	80.13	57.3	45.91
1967/8	96.26	55.9	53.80
1968/9	102.05	53.5	54.60

(Sources: a) For years 1949-1960, Annual Reports of the Ministry of Health for each year
b) For years 1961-1969, Digest of Health Statistics, 1970. Table 2.7
c) For internal purchasing power of the pound, Central Statistical Office)

MORE STAFF ?

Some sectors of the health service appear to be short of staff. Yet since 1949 the total number of hospital staff has increased by over 70%, whilst in the country as a whole the working population has increased by only 10.5%.

In some services great increases in 'productivity' have been made since the health service started. National statistics show that whilst the total population of Great Britain has increased over the past ten years, the number of hospital beds has decreased. During the same period the overall 'productivity' of the hospital service has greatly increased, as the following figures show:

	1959	1969	Change
Population of Great Britain	50,548,000	54,023,000	+ 7%
No. of hospital beds	548,676	528,917	- 4%
No. of in-patients treated	4,544,000	5,975,000	+ 31%
Average length of stay (excluding psychiatric, chronic and geriatric)	15.6 days	11.1 days	- 29%
No. of discharges or deaths per available bed per year	18.2	24.6	+ 35%
Total out-patient attendances	48,746,000	54,944,000	+ 13%
Hospital staff (England and Wales)	470,621	613,285	+ 30%

(Sources: Digest of health statistics, 1970. Tables 1.1; 2.9; 3.2; 4.1; 4.2; 4.8)

These are impressive figures, but staff numbers have increased at least as much as the throughput of patients, as the statistics on the following pages show in more detail. In fact, if the numbers of hospital staff continue to increase at the present rate, within 120 years half the entire working population will be employed in hospitals.

? Can the health service expect to continue to increase its staff at this rate indefinitely ? ?

Population and manpower

The numbers of staff employed in the hospital and health services are increasing at a much greater rate than is the total population of the country or the working population within that total.

	1949	1959	1969
Total population of United Kingdom (thousands)	50,363	51,956	55,534
Working population of United Kingdom (thousands)	23,339	24,714	25,802
Hospital staff in England & Wales * (thousands)	355	470	613

Percentage growth	Total population	Working population	Hospital staff
1949 - 1959	+ 3.1%	+ 6%	+ 32%
1959 - 1969	+ 6.9%	+ 4.4%	+ 30%
1949 - 1969	+10.3%	+10.5%	+ 72%

. . . . . .

* The totals for hospital staff in England and Wales are based on Table 3.2 of the Digest of Health Statistics for 1970. In the table below, the figures represent the actual number of staff employed (whole-time and part-time) for nursing, midwifery, RHB and ancillary staff, and for all other staff they represent the whole-time equivalent (wte) of whole-time and part-time staff. The totals shown for the three years 1949, 1959 and 1969 are comparable with each other. The figures on hospital manpower shown on the following page are based on the annual report of the DHSS for 1969, which calculates the totals in a slightly different way.

		1949	1959	1969
Medical	wte	11,735	16,033	22,001
Dental	wte	206	444	723
Nursing	no.	137,636	190,946	262,644
Midwifery	no.	9,043	11,360	16,599
Prof & Tech	wte	13,940	21,878	33,245
Ancillary	no.	157,112	197,189	228,674
Admin and clerical	wte	23,797	30,270	43,328
RHB Hq staff	no.	1,320	2,501	6,071
		354,789	470,621	613,285

(Sources: Digest of health statistics 1970, Table 3.2
Annual abstracts of statistics for 1952, 1960 and 1970)

. . . . . .

The working population is now declining as a proportion of the total population, yet the total of hospital and health service staff is still increasing.

? For how much longer can the health service enjoy this favoured position? ?

Hospital manpower

Over 700,000 people are employed in the NHS in Britain, most of them in the hospital service. Since 1948, there have been considerable increases in the numbers of staff employed, particularly in hospitals, as the table below illustrates:

Hospital Staff (England and Wales)	1949	1969	
Doctors and dentists (equivalent of whole-time)	11,940	22,724	+ 90%
Professional and technical (equivalent of whole-time)	12,518	33,245	+ 165%
Nursing and midwifery (whole-time)	125,752	188,639	+ 50%
Nursing and midwifery (part-time)	23,060	90,604	+ 292%
Works, maintenance and domestic (whole-time)	)	157,663	+
	156,586		
Works, maintenance and domestic (part-time)	)	70,586	+
	)		
Administrative and clerical (equivalent of whole-time)	23,797	43,328	+ 82%

(Source: Annual report of DHSS for 1969. Table 57)

. . . . . .

There is growing competition now for recruits for the skilled professions in all sectors of the economy. The position is likely to worsen over the next decade as the age-structure of the population changes. By 1975, for example, it is estimated that the total population of Britain will, at nearly 58 million, be over 3 million more than it was in 1966, but the working population of $25\frac{1}{2}$ million will be marginally smaller. This means that it may be manpower rather than money that will be the determining factor in health service development.

? Should we give still higher priority in the future to making the best use of our manpower resources ?

What is the manpower policy for the health service? ?

Medical manpower

Amongst the most pressing of our problems is that of medical manpower. It is true that Britain has as many doctors per head of population as most countries and that the NHS has brought about a much better distribution of doctors, but all is yet far from ideal.

Figures compiled from the Central Medical Recruitment Committee index show that in Great Britain in 1968 there were 77,507 doctors fully and provisionally registered in this country (excluding about 1600 doctors serving with the Armed Forces). Of these, 13,083 were not working in medicine or were retired, leaving a total of 64,424 active in medicine, distributed as follows:

In senior hospital posts	14,722
" junior hospital posts	14,463
" general practice	23,541
" local authorities	3,590
" GP/hospital part-time posts	1,021
" universities	1,663
" industrial medical posts	623
" other medical employment	3,181
" occupations unknown	1,615
	64,424

With the present NHS system, nearly 40% of the country's doctors are needed in general practice..... In 1966/7 only 16.3% of the entering class of medical students expressed an interest in general practice.

Within the hospital service itself, there are imbalances between training posts and permanent posts in many specialties. For example, in general medicine, general surgery, gynaecology and obstetrics there are more doctors in training than there are likely to be permanent senior vacancies, whilst in other specialties, like geriatrics, paediatrics and mental handicap there are more vacancies than there are doctors in training.

Between 1962-1967, about 4,500 British-born or Irish-born doctors left Britain, and about 2,900 returned, giving an annual net loss of about 320 doctors. The present rate of net loss is estimated to be about 380-400 each year - about one fifth of the total output of British medical schools. Most of these emigrant doctors go to 'developed' countries like USA, Canada and Australia.

In 1968/9, there was an annual inflow into Britain of 3,000 overseas doctors, against an outflow of 2,300 overseas doctors, giving an annual net gain to the country of about 700 overseas doctors, mainly from 'developing' countries.

One third of the doctors working in hospitals in England in 1969 were born overseas, and over one half of the junior doctors below the grade of senior registrar. Most of these overseas-born doctors came from developing countries.

In its report in 1968, the Royal Commission on Medical Education stated that in USA there were about 1600 doctors per million population and in Britain about 1200 per million, whilst India had about 170 per million, and Nigeria about 25....

(Sources: Medical staffing in the NHS in England and Wales, Health Trends, May 1971
Dr J Kilgour, Health Trends, May 1971
Dr J Ellis, British Journal of Medical Education, March 1969
Annual report of the DHSS for 1969. Table 61. Unpublished communication from DHSS)

?

For how much longer can Britain (or USA) expect to rely so heavily upon the services of doctors from countries that are far worse off?

?

How quickly can the output of British-born doctors from British medical schools be brought to match the needs of Britain for doctors in hospital and community?

General practitioners

Since 1948, the results of nation-wide planning by the health authorities can be seen in an improved distribution of GP's and hospital specialists throughout the country. The following table gives the basic details of the distribution of GP's in general practice in England and Wales

	1952	1958	1967	1970
a) Total no. of GP's (Principals)	17,272	19,684	19,849	20,357
b) Total population served by these GP's	42.1 m	44.6 m	49 m	50 m
c) Population in "designated" areas	21.6 m	8.3 m	16.5 m	18.1 m
d) "Designated" population as % of total	51%	19%	33%	36%
e) Average no. of patients per GP over whole country	2,436	2,267	2,472	2,460
f) Average no. of patients per GP in "designated" areas	2,851	2,672	2,840	2,791

"Designated" areas are, broadly speaking, those in which the Medical Practices Committee considers the number of general practitioners in an area to be insufficient for the population in that area.

The figures above illustrate both the strength and the weakness of the NHS. In the first place, they show how at the start of the NHS over half the population of the country lived in designated areas where the supply of GP's was considered inadequate. By 1958 the situation had been improved to the extent that less than 20% of the population lived in designated areas. But 1958 represented the peak of success in this field. Since then, the situation has gradually deteriorated, and in 1970 the proportion of the population living in designated areas had risen to 36%.

(Sources: Annual reports of Ministry of Health/DHSS
for 1952 Table J; 1958 Table E; 1967 Table 6:
and unpublished figures for 1970 from DHSS)

?

What can be done to improve the distribution of GP services throughout the country?

How can general practice be made more attractive as a career?

?

FAMILY PLANNING ?

It is estimated by the Family Planning Association that in Britain there are between 200,000 - 300,000 unwanted pregnancies every year, and that the expenditure of £40 million a year on effective birth control could save between £200 - £400 million of public spending on maternity and child care and other services each year. At present, expenditure on family planning services by the FPA and local authorities amounts to between £ 3 - £4 million p.a.

In 1969 there were over 67,000 illegitimate births and over 52,000 notified abortions in England and Wales (1)

Only one third of local authorities are providing the full family planning service suggested by the NHS Family Planning Act of 1967 (2)

The equivalent of three Harlow New Towns needs to be built each year to cope with the growth of population resulting from unwanted pregnancies in Britain (2)

Only 5,000 of Britain's 77,000 doctors have had any specific training in contraceptive techniques (2)

It would cost less than £40 million a year to provide effective birth control for every woman at risk - under £5 each for the eight million 15 to 44 year-olds who are not pregnant, not infertile or trying to have a pregnancy (2)

If current rates of population growth are maintained:

"by the year 2000, a mere six years will add an increment equal to the entire expansion in the world's population size from the formation of the Roman Empire to the middle of the nineteenth century" (3)

"in six and a half centuries from now - the same insignificant period of time separating us from the poet Dante - there would be one human being standing on every square foot of land on earth: a fantasy of horror that even the Inferno could not match" (3)

(Sources:
(1) Annual report of Chief Medical Officers, Department of Health & Social Security, for 1969
(2) Family Planning Association
(3) Robert Macnamara, Address to the University of Notre Dame, USA 1969, quoted by A E Keir Nash in Milbank Memorial Fund Quarterly, January 1971)

? Should we be spending more on family planning ? ?

9. WHAT SHOULD OUR PRIORITIES FOR THE FUTURE BE ?

The demand for health care is unlimited

Resources of manpower and money for meeting that demand will always be limited. Choices have therefore constantly to be faced and decisions, consciously or unconsciously, taken to provide this and not to provide that. What should our priorities be? . . .

Health services/social services/housing/pensions

Hospitals/health centres/community services

Taxation/insurance/charges

Health education/prevention/treatment

Organ transplants/mental health

Family planning/abortions

Renal dialysis/psychogeriatrics

Young chronic sick/surgical waiting-lists

Mental handicap/accident services

Central authority/regional responsibility/local initiative

.....?

.....?

.....?

How carefully are the options analysed by governments in power?
How fairly and rationally are the priorities decided?

?

How thoroughly do political parties out of power do their homework on preparing policies and priorities for the future?

?

How well-informed is the public about the options?

10 HOW SHOULD PRIORITIES AND POLICIES BE DECIDED AND BY WHOM ?

Who are involved in defining and deciding options, priorities, policies and objectives?

The decision-makers

Members of Parliament
" " Local authorities
" " Health service boards, committees and councils
" " University and other education authorities
" " Research councils

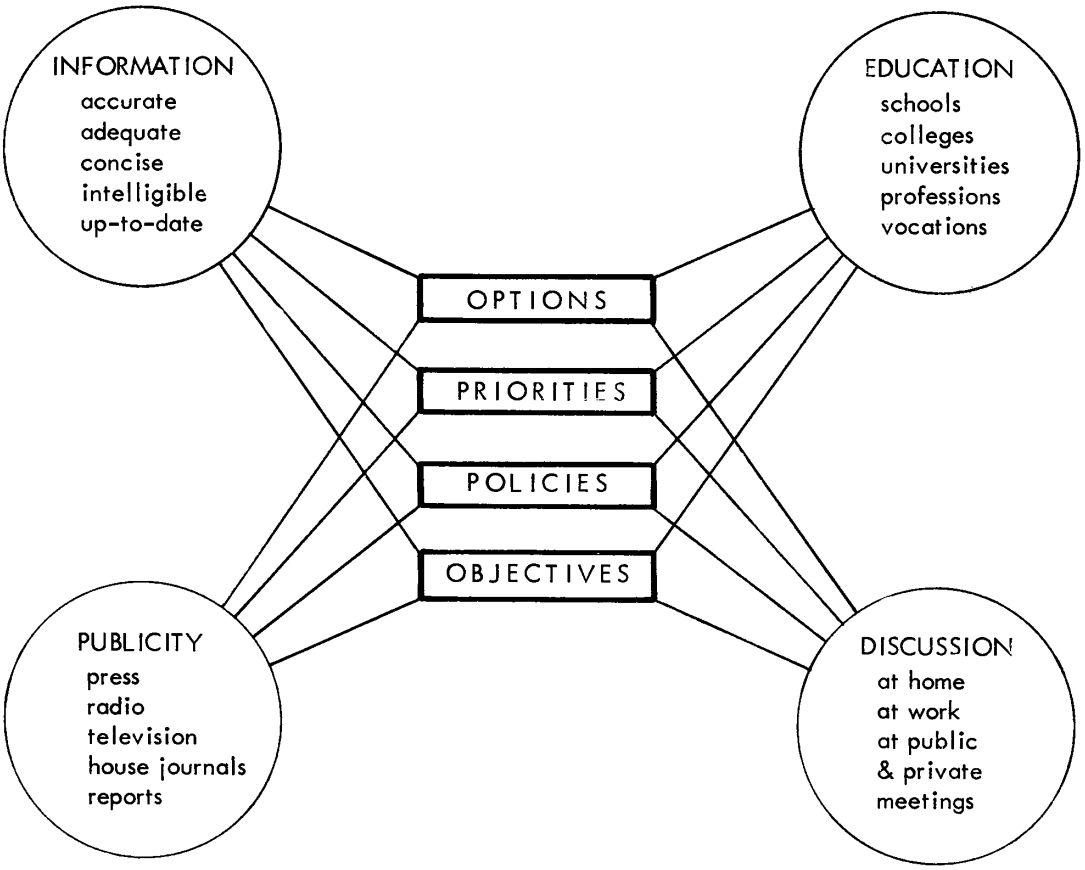
The wielders of influence

Civil servants
Health and social service staff
Staff of universities, colleges and schools
Press, radio and TV
Professional organisations
Trade unions
Voluntary organisations
Consumer associations and pressure groups

The public

The patient
The consumer
The taxpayer
The ratepayer
You and me

Right decisions do not just happen, they are based upon:



Do we have the machinery for making right decisions?

? Do we use it effectively? ?

What can you do to help ensure that right decisions are made?

WE GET THE HEALTH SERVICE WE DESERVE