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PUBLIC EXPENDITURE AND THE NHS: TRENDS AND PROSPECTS

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SUMMARY

Exactly what is happening to public expenditure on the NHS? Is the Government spending more than ever before, as Ministers claim? Or is the health service being starved of resources, as the Government's critics argue? And what are the prospects for the future? Can we expect service improvements or a decline in standards? This report endeavours to answer these questions. By looking at the record of public expenditure on health in the 1980s, and the plans for 1987/88, it provides some systematic, non-partisan analysis in an area of frequently contentious public debate.

Expenditure Trends

Between 1980/81 and 1986/87 spending on the NHS increased by nearly 60 per cent in cash terms. However, after allowing for general inflation, the rate of growth in real terms was just over 12 per cent, while the more rapid increase in NHS prices meant that volume expenditure (i.e. the best measure of the purchasing power of NHS expenditure) grew by a little under 10 per cent.

Current expenditure on Hospital and Community Health Services (HCHS) was heavily constrained by cash limits over the period 1981/82 to 1985/86 when it grew at an average rate of less than 0.5 per cent per year in real terms. In 1986/87 there was a considerable improvement: current estimates suggest an increase of 4.7 per cent in real terms and 2.7 per cent in volume terms.

Capital expenditure on HCHS has been fairly buoyant throughout the 1980s. However, it is noticeable that the proportion of expenditure financed from the sale of land and buildings has increased considerably: from 2.9 per cent in 1980/81 to 14.7 per cent in 1985/86.

Non cash-limited Family Practitioner Services have benefitted from sizeable increases in expenditure allocations for most of the 1980s. Between 1980/81 and 1986/87 the sector grew at an average rate of over 4 per cent per year in real terms. Activity statistics indicate improved service levels on a broad range of fronts. The one exception has occurred in the case of drug prescriptions. Successive increases in charges, from 20p in 1979 to the current level of £2.40 per item, have resulted in falls in the number of prescriptions in some years and a consequent erratic rate of growth.

Efficiency Savings

Cost Improvement Programmes have been heavily relied upon as a source of funds for service development since 1984/85. In 1986/87 they were expected to produce an additional £158 million through cash releasing savings. But these programmes require careful monitoring. Recent reports from the National Audit Office point to the potential dangers of reductions in the quality of service and allude to the prospects of diminishing returns in this area.

Resources to Meet Extra Demands

In their 1986 Report the House of Commons Social Services Committee criticised the Government for failing to provide no more than half of the expenditure growth necessary to meet the needs of an ageing population, advances in medical technology and specified service development aims. The precise figures on which this charge was based have been the source of some dispute. However, in the light of the most recent data revisions, it still appears that it was not until 1986/87 that the requirements of these extra demands were adequately funded through the combined resources provided through expenditure growth and cost improvement programmes.

Output Measurement

In recent years considerable efforts have been made by the DHSS to improve the measurement of NHS outputs. This has resulted in the construction of a cost weighted index of activity. This index records an increase in activity within the HCHS sector of nearly 20 per cent between 1979 and 1985: a rate of growth substantially above the 5 per cent increase in volume expenditure over the same period. But the index is still in the early stages of development and needs to be interpreted with caution. Reductions in the length of hospital stay, earlier discharge and a greater reliance on day cases all indicate genuine increases in activity, but they are not always necessarily synonymous with improvements in the quantity and quality of total output.

The Prospects for 1987/88

The Public Expenditure White Paper published in January 1987 planned increases in real terms expenditure of 2.2 per cent (HCHS current), 4.5 per cent (FPS current) and 2.7 per cent (NHS total). A subsequent upward revision to the 1987/88 inflation forecast published at the time of the Annual Budget and Financial Statement in March 1987 led to some reductions in the expected rate of real expenditure growth. The planned increases for 1987/88 are now: 1.4 per cent (HCHS current), 3.7 per cent (FPS current) and 1.9 per cent (NHS total).

On 23 April 1987 the Secretary of State for Social Services announced the Government's decision to implement the 1987 Pay Review Body recommendations in full from 1 April. The additional cost of these awards to the HCHS in England — over and above the sums already budgeted for — will be £288 million. The Governments' general Reserve will cover £264 million, leaving health authorities to find £24 million from their cost improvement programmes.

How do these changes affect the adequacy of the 1987 plans? If, as is expected, new cost improvement programmes release cash savings amounting to about £150 million, the increase in real resources available to the HCHS (i.e. cash plus CIPs) will be equivalent to about 2.9 per cent. This should be enough to cover the additional demands of demography, medical technology and service development. However, there is little margin for error, particularly in the light of probable Whitley council pay settlements above 3.75 per cent, which the government has said it will not provide extra funds to finance.

INTRODUCTION

Details of the government's plans for spending on the NHS over the next three years are contained in this year's Public Expenditure White Paper, *The Government's Expenditure Plans 1987-88 to 1989-90* (Cm 56). The most striking feature of the White Paper is the planned increase of 6 per cent in current expenditure on the Hospital and Community Health Services (HCHS) for the year 1987/88. After allowing for inflation, this was expected to represent a real terms increase of 2.2 per cent: a marked improvement on the average rate of increase of less than one half per cent per year recorded over the period 1980/81 to 1985/86.

Since the publication of the White Paper, however, there have been some major changes affecting the assumptions on which the plans were based. For example, at the time of the Annual Budget Statement, the Chancellor of the Exchequer announced a revised inflation forecast for 1987/88. This had the effect of reducing the growth in real HCHS expenditure for the year to 1.4 per cent. More recently, the Government has announced that it is going to implement the recommendations of the Pay Review Bodies for nurses, midwives and health visitors; professions allied to medicine; and doctors and dentists, in full, from 1 April, 1987. With rates of pay increase averaging between 7.7 and 9.5 per cent, the recommendations are substantially above the rate of inflation of 3.75 per cent upon which the expenditure plans were based originally. Although, in this case, extra funds are to be made available to finance the award.

These changes in economic and financial circumstances are typical of the uncertainties that inevitably surround any expenditure planning process. The aim of this report is to examine the present state of the 1987 plans in the light of the most up-to-date information available. But it also has a more general intent. By analysing the development of health expenditure planning during the 1980s — pointing to both its strengths and its weaknesses — it seeks to inform debate on an area of major, and often contentious, public policy; and also, in the longer term, to contribute towards discussions aimed at the improvement of planning methods for the future.

The report, which relates to England only, is organised as follows. It begins with a discussion of the different ways in which public expenditure can be measured. Because much of the debate between the government and its critics has centred on the use of alternative measures of expenditure, it is important to clarify, at the outset, precisely what each of them means. This is followed by an examination of expenditure on Hospital and Community Health Services during the 1980s. In this section, we consider the contribution of efficiency savings; the growth in demand placed on the system by an ageing population, medical advances and service developments; and recent attempts to improve output measurement. The next section examines expenditure trends and output measures in the Family Practitioner Services sector. Having considered the medium term context within which this year's plans were formulated, the penultimate section looks at the plans for 1987/88. Finally, we offer a few concluding remarks based upon public attitudes towards the recent developments within the NHS.

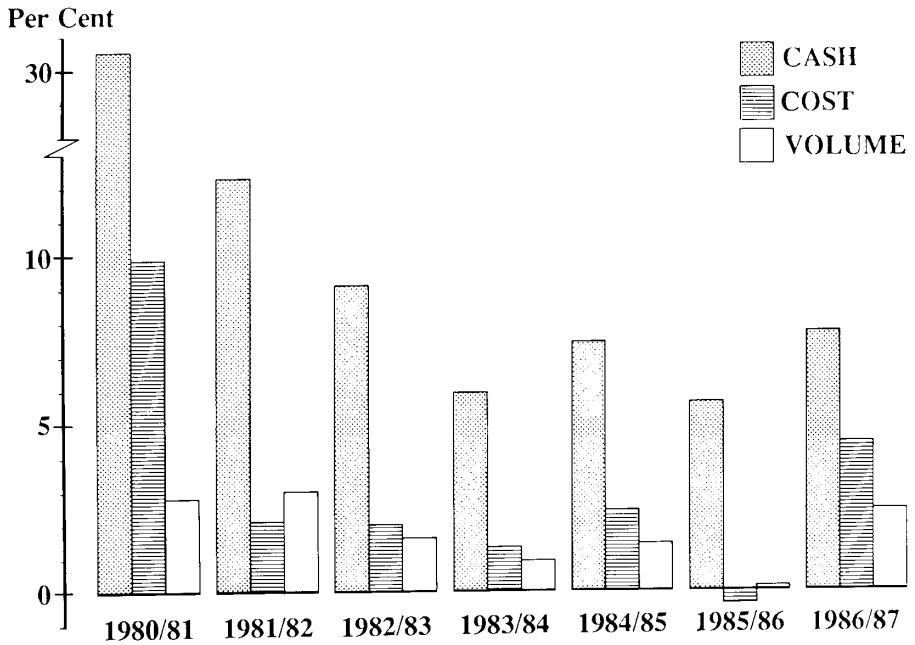
MEASURING HEALTH EXPENDITURE

Since the change from constant-price to cash planning which took place in 1981, three separate ways have been used to measure health expenditure.

- **Cash expenditure** measures the cost of inputs at the price levels current during the year in which the spending is incurred. If, however, we are looking forwards (or backwards) and want to know what the money allocated to health will actually buy in future years (past years), we need to take account of the way in which prices change. There are two main ways of doing this.
- **Cost expenditure** adjusts cash spending for changes in the economy-wide price level. To do this it uses the GDP deflator which is an average price index based upon the prices of all the goods and services recorded in the Gross Domestic Product (GDP). Cost spending is nowadays also referred to by the government as *real terms* expenditure. It is the measure currently favoured by Ministers — when adjusting cash expenditure figures — because it indicates the cost to the rest of the economy of a given level of public expenditure. That is, it reflects the scale of purchasing power on other goods and services that is forgone in order to finance health expenditure. This measure does not, however, always tell us what the money spent on health will actually buy in the health sector.
- **Volume expenditure** adjusts cash spending for changes in the prices of inputs within the health sector. It is, therefore, the best measure for assessing changes in the quantity of resources devoted to health care if prices within the health service change at a different rate to prices generally.

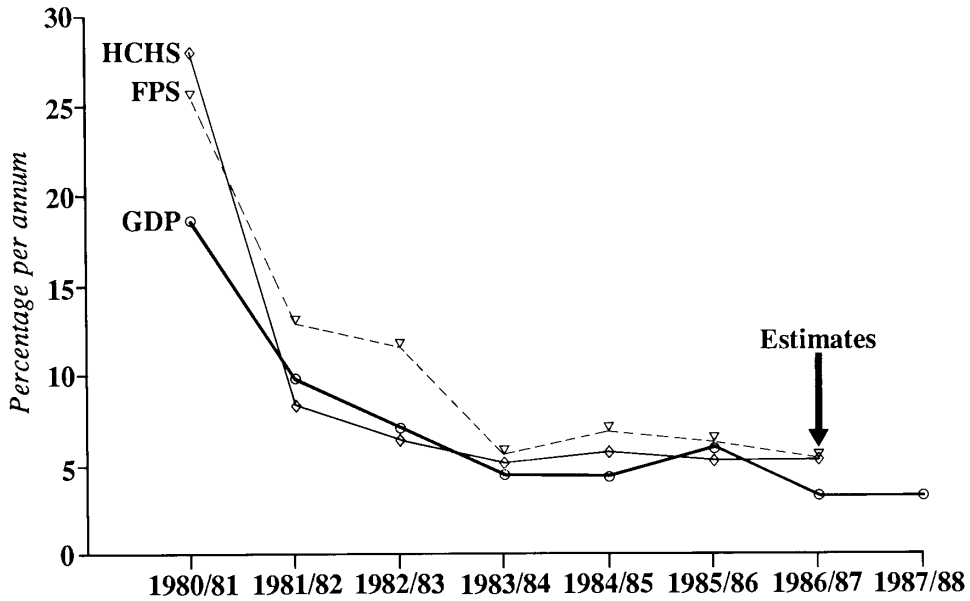
The rate of growth associated with each of these measures is shown in Figure 1.

Figure 1. Growth in NHS Expenditure, 1980/81 - 1986/87
(per cent per year)



Clearly, the rate of growth of cash spending is substantially above that of either cost or volume expenditure. The differential is particularly pronounced at the beginning of the period when pay awards to nurses and midwives, resulting from the recommendations of the *Standing Commission on Pay Comparability* (the 'Clegg Award'), added nearly 20 per cent to the pay bill in 1980/81. Moreover, this settlement was appreciably above those recorded in the economy generally and meant that the price of labour inputs in the NHS grew faster than elsewhere. This explains why there was a far greater recorded increase in cost expenditure than volume expenditure in that year.

FIGURE 2. Relative Rates of Price Inflation



Since the Clegg awards, NHS pay settlements have been far more modest. So much so that in two years — 1981/82 and 1985/86 — the NHS price index rose more slowly than the GDP deflator. As a result, volume expenditure grew at a rate slightly above that recorded in cost terms. However, these are likely to have been only short run aberrations. For one thing, restrictions on public sector pay awards often result in catch-up settlements at a later date. (See the discussion of the 1986 and 1987 settlements.) More generally, there is the well documented tendency for labour intensive services, such as the NHS, to experience an above average rate of cost inflation because of their only limited scope for productivity gains in comparison with the manufacturing sector. This is the well known *relative price effect.*

HCHS SPENDING

Movements in the relative price effect are crucial to any assessment of the adequacy of public expenditure plans for the future. However, as far as the last five years are concerned, it has been the marked difference between increases in cash ex-

penditure and cost and volume expenditure, that has been so striking. This is especially pronounced in the case of current spending on the Hospital and Community Health Services (HCHS) which account for nearly 70 per cent of total NHS expenditure. While cash spending on HCHS grew at an average rate of around 7 per cent per year in the five years to 1985/86, increases in both cost and volume terms averaged less than one per cent per year.

TABLE 1. Public Expenditure on Health, 1980/81 - 1986/87
(*Annual increases, per cent per year*)

	HCHS (Current)			FPS(Current)			NHS(Total)		
	Cash	*Cost*	*Vol.*	*Cash*	*Cost*	*Vol.*	*Cash*	*Cost*	*Vol.*
1980/81	31.9	11.0	3.0	25.5	5.7	-1.2	30.5	9.9	2.8
1981/82	10.4	0.4	2.0	15.2	4.7	2.0	12.1	2.1	3.0
1982/83	7.4	0.4	0.8	15.5	7.9	3.5	9.1	2.0	1.6
1983/84	5.1	0.6	0.0	7.5	2.9	2.0	5.9	1.3	0.9
1984/85	5.7	1.3	-0.1	9.9	4.8	2.8	7.4	2.4	1.4
1985/86	5.4	-0.8	0.2	5.3	-0.6	-1.1	5.6	-0.4	0.1
1986/87*	8.0	4.7	2.7	8.2	4.8	2.9	7.7	4.4	2.4

Notes: * Estimated outturn based on assumptions of a 3.2 per cent increase in the GDP deflator and a 5.2 per cent increase in the NHS pay and price index.

Sources: HM Treasury (1987); House of Commons (1986a)

For 1986/87, the current indications are that HCHS expenditure has grown a good deal more than in the recent past, although some of the figures are still provisional and require some explanation. The 1986 White Paper planned a cash increase of 7.3 per cent. Subsequently an extra £50m was added to the cash allocation to cover part of the Doctors and Dentists Pay Review Board award. This raised the cash increase for the year to 8 per cent. The 1987 White Paper forecasts an increase in the GDP deflator of 2.8 per cent in 1986/87: this would produce an increase in cost expenditure of 5.1 per cent. However, the most recently available estimates of movements in the GDP deflator suggest an increase of 3.2 per cent in 1986/87. This would reduce the rate of increase in cost expenditure to 4.7 per cent. No official full-year estimates of movements in the NHS pay and price index are yet available, so cash figures cannot be converted into volume terms with complete precision. However, there is a good deal of information on pay and price movements during 1986/87 which enables some fairly reliable estimates to be made.

For example, the Pay Review Bodies for Doctors and Dentists; Nurses, Midwives and Health Visitors; and Professions Allied to Medicine recommended pay awards which, they estimated, would add just under 8 per cent to the combined pay bills in 1986/87. In the event, the implementation of these awards was delayed from 1 April to 1 July 1986. This kept the increase in the pay bill down to approximately 6 per cent. Although not all Whitley Council settlements have yet been finalised, awards to ancillary workers and other groups have also added about 6 per cent to the cost of their paybills. Finally, as far as non-wage costs are concerned, the

Health Services Prices Index increased by 3.2 per cent between 1985/86 and 1986/87. Taken together these pay and price increases suggest a rise in the overall NHS price index of 5.2 per cent in 1986/87. This implies a volume expenditure increase of 2.7 per cent; by some way, the largest annual increase recorded since 1980/81.

In contrast to the picture on current spending, HCHS capital expenditure has been quite buoyant throughout the 1980s; although timing leads and lags, and the inevitable 'lumpiness' of capital spending, has meant that its rate of growth has been subject to considerable variation. Nonetheless, over the period 1980/81 to 1985/86, volume expenditure grew at an average rate of 6.5 per cent per year. It is very noticeable, however, that the extent to which the capital programme is financed by sales of NHS land and buildings has grown substantially. In 1980/81 receipts represented 2.9 per cent of gross expenditure whereas by 1985/86 they had grown to 14.7 per cent.

Efficiency Savings

One of the government's main responses to criticisms of inadequate expenditure growth on HCHS over the period to 1985/86 has been to point to the limitations of conventional public expenditure figures as indicators of the resources actually available to the NHS. A crucial aspect of this counter argument has centred on the contribution of efficiency savings. The sums realised through greater efficiency are now routinely added to the expenditure figures provided by the DHSS in their submissions to the House of Commons Social Services Committee.

Recent DHSS initiatives designed to increase the efficiency with which resources are deployed started when Health Authorities were set specific efficiency savings targets of £30m and £39m for the years 1981/82 and 1982/83 respectively. These sums represented about 0.5 per cent of total revenue allocations. In the event savings of £29m and £25.5m were reported. However, apart from the substantial increase in the shortfall between actual and target savings in the second year, it became clear that only 50 to 60 per cent of reported savings resulted from the more efficient use of resources. Transfers from capital accounts, deferred developments, the use of savings from previous years, revenue from land sales and increased income were all being reported as savings. Recognising the shortcomings of this approach, the DHSS did not set and monitor targets in the same way in 1983/84. Instead, reflecting the findings of the NHS Management Inquiry led by Sir Roy Griffiths, the concept of a *cost improvement programme (CIP)* was introduced in 1984/85. It is this programme upon which the current drive for greater efficiency is based.

DHSS guidance to Health Authorities defines cost improvements as:
measures which are aimed at releasing cash or manpower used in providing a service by getting the same service output for a smaller input of resources; or improving productivity by getting a higher output for the same input or a less than proportionate increase in input.

The DHSS believes that the search for greater efficiency is primarily a local responsibility. No top-down targets are set. However, each District and Region is expected to incorporate a 'satisfactory' CIP within its short term (two year) plan-

ning programme. Success in implementing short term programmes is one of the issues which, where necessary, is covered in the annual management review process.

TABLE 2. Cost Improvement Programmes
(Annual Savings, Cash)

Year		*Amount*
		£m
1984/85		105
1985/86		138
1986/87		158
The 1986/87 planned programme		
1	Rationalisation of patient services	37
2	Competitive tendering	48
3	Other reductions in labour costs	24
4	'Rayner scrutiny' savings	8
5	Supply cost savings	8
6	Fuel cost savings	9
7	Other savings	25
8	Total	158

Note: Figures do not sum due to rounding.
Sources: HM Treasury (1987); NAO (1986); Maynard and Bosanquet (1986).

In comparison with the additional finance made available to the HCHS through annual budget increases, the contribution of cash releasing cost improvements has been quite considerable. In 1984/85 and 1985/86 they yielded 1.1 and 1.4 per cent respectively of the total amount of current spending. This occurred at a time when overall volume expenditure fell by 0.1 per cent in the first year and rose by only 0.4 per cent in the second year. Clearly CIPs have been an important source of 'additional' funding. How long this scale of saving can be expected to continue is unknown. At some stage the quest for greater efficiency will obviously encounter diminishing returns. A recent report on *Competitive Tendering for Support Services in the NHS* from the National Audit Office confirms that savings on domestic contracts fell from 32 per cent of previous costs in 1984/85 to 18 per cent in September 1986. Policy that relies upon the contribution of efficiency savings for service development will need to take careful account of when and at what rate these diminishing returns set in.

At the same time, concern has been expressed in some quarters that the savings achieved through CIPs actually involve service reductions rather than efficiency

gains. Following another of its earlier investigations, the National Audit Office concluded that:

at some District Health Authorities there was evidence that the focus was on saving costs without necessarily any matching improvement in efficiency. For example, some emphasis had been on setting lower budgets and expecting individual managers to remain within them. In such cases it was not always clear whether savings had been made without corresponding reductions in the standards of health care provided.

The DHSS is unequivocal in its rejection of this practice:

The definitions which are given to Regional Health Authorities are very clear: cuts in services are not — not — to be counted as cost improvements.

Despite this emphatic rebuttal, the concern about deteriorating service quality expressed by many NHS professionals and other employees does confirm the continuing need for careful monitoring of District CIPs.

Demographic Change, Medical Advance and Service Development

Even after allowing for the contribution of efficiency savings, however, expenditure figures only measure the growth of inputs. In assessing the adequacy of this growth, one of the major concerns of recent years has been the extra demand placed upon the NHS as a result of an ageing population, advances in medical technology and service development.

TABLE 3. Estimated Gross Current Expenditure Per Head, 1984/85
(£ Cash)

Age Groups	*HCHS*	*FPS*
All Ages (Total)	193	70
All Births	1074	80
0 - 4	173	70
5 - 15	80	60
16 - 64	99	60
65 - 74	395	100
75+	925	150

Source: Department of Health and Social Security

The number of people in the UK of 75 years of age and over has increased from 2.8 million in 1976 to approximately 3.6 million in 1985, and is expected to grow to 4 million by 1991 (Social Trends, 1987). As the HCHS costs incurred per person within this age group are over *nine* times greater than expenditure on people in

the 16-64 years age range, these demographic trends clearly represent a considerable extra call on resources.

As part of its normal planning procedures, the DHSS calculates the actual increase in expenditure that it estimates will be necessary each year to meet these extra requirements. The method used by the Department involves the following stages.

- Total HCHS expenditure is apportioned to individual service categories e.g. acute in-patient, out-patient, mental illness, mental handicap, geriatrics, etc.
- Age-specific use rates for each service category — adjusted for higher degrees of 'dependency' of very young and elderly patients — are used to allocate the total costs of each service by age group.
- Total HCHS costs by age group are obtained by adding the age specific costs for each service category.
- Total HCHS costs incurred by each age group are divided by total population numbers in that group to obtain *per capita* expenditure.
- *Per capita* expenditure figures are combined with changes in total population numbers estimated by the Office of Population Censuses and Surveys (OPCS) to obtain the final estimates of total expenditure requirements.

In fact, this year, the estimates of expenditure requirements resulting from demographic change have been revised upwards since the 1987 public expenditure plans were formulated. Following OPCS revisions to population figures, both past

TABLE 4. Increases in HCHS Volume Expenditure Required to meet Demographic Change
(Annual increases, per cent per year)

1980/81	0.9	1986/87	1.0
1981/82	0.3	1987/88	1.0
1982/83	0.5	1988/89	1.0
1983/84	0.5	1989/90	1.0
1984/85	0.6	1990/91	0.9
1985/86	1.3	1991/92	0.7

*Sources:*House of Commons (1986c,1987a,1987b)

and future requirements are now put some way above the previously estimated levels. The revised figures for 1985/86 suggest that a 1.3 per cent increase in HCHS expenditure was needed in that year and not the 1 per cent that was thought necessary when the Social Services Committee reported in July, 1986. In fact, it now appears that the shortfall between actual and target expenditure — in a year when volume expenditure grew by only 0.2 per cent and cost expenditure actually fell by 0.8 per cent — was even greater than it was thought to be by the Select Committee. In cash terms it was over £19m greater than they estimated. Clearly if standards of service provision are to meet previous expectations, this shortfall will need to be made good at some stage in the future. This task will be made all the

more difficult because of upward revisions to future requirements. Rather than rising by 0.9, 0.8 and 0.7 per cent in the three years 1987/88, 1988/89 and 1989/90 respectively, it is now estimated that a constant rate of growth of 1 per cent per year will be needed throughout the period, until it begins to moderate in the 1990s.

Apart from the inevitable uncertainty surrounding this type of forecasting, however, there are some more general considerations raised by the Department's approach. For example, the methodology used contains a commitment to the *status quo* that is not always appreciated. To be specific, this arises because expenditure requirements are based on the total costs of treatment at *existing rates of treatment.* At the moment health services for the elderly are rationed through waiting lists and other devices in the face of considerable excess demand. By assuming that it will only be necessary for the same proportion of demand to be met in the future as is met at present, the current forecasting method makes no provision for improved performance. (Of course, some service developments are allowed for separately — see below — and it would involve double counting to include them within the demographic assessment as well. But these by no means cover the bulk of services for the elderly.) The assumption of unchanged service levels seems to be a particularly parsimonious element to build into a forecast of future health needs of the elderly, especially in the light of rising expectations which can reasonably be expected to develop into the 1990s.

Finally, there is some evidence that the sums which central government says are necessary to meet the requirements of the extra numbers of elderly people are not actually being spent on those services which the elderly use (Bosanquet, 1985). While the allocation of funds is properly left to Regions, Districts and Units — and is not directly administered by central government — this does suggest a failure to mesh Regional and District plans with stated national requirements.

Rising expectations in relation to health care also play an important part in determining the resource requirements of medical advance and service developments. At present the DHSS maintains that:

Increases in activity arising from medical advance are estimated to absorb in the region of half a per cent of resources annually. The level of spending required to improve services will depend on decisions as to specific policy objectives over the period. In the current year (i.e. 1986/87) these are estimated at some half of one per cent.

Medical advance comprises the introduction of new technology, the wider application of existing advanced techniques and their application to older age groups. The need for extra resources to enable the introduction of new technology, perhaps, requires some explanation. In many productive activities new techniques are introduced to *reduce* costs. Within the health services, however, new techniques are often more expensive than the ones they replace or supplement. Nevertheless, if these techniques are cost effective, the quantity and/or quality of output should rise more than total costs, and the *cost per unit output fall.* (In practice, though, such a precise judgement is rarely possible in view of the uncertainty surrounding output measurement — see page 12.)

The Department's view of the figure of 0.5 per cent per year is that it:

is not a measure of demand but the best observation we can presently make of the extent to which, within existing supply constraints, resources ***are being absorbed*** *by medical advance* (emphasis added).

Thus it is not claimed that the 0.5 per cent represents what is needed or is feasible medically; rather, it represents what is, according to the Department, actually taking place. In 1985/86 this represented about £50m. Given the problems of costing new procedures and the lack of comprehensive national accounts it is not possible to say with any degree of certainty what scale of medical advance this level of expenditure represents; or, indeed, whether it is actually taking place (Health Care UK, 1986). However, on the basis of the rates of technological innovation in other countries, the indications are that the scale upon which many new techniques have been adopted in this country has been rather modest. This tends to confirm that 0.5 per cent is essentially a supply-constrained figure which reflects public expenditure aims more than health care considerations.

FIGURE 3. New Targets for HCHS Service Growth Set in 1987

By 1990

- to increase the number of coronary artery bypass grafts by 6000 to 17000
- to increase the number of hip replacement operations by 10000 to 50000
- to increase the number of cataract operations by 15000 to over 70000
- to increase the number of bone marrow transplants by 200 to 550

By 1988

- all health authorities to have call and recall schemes for cervical cancer screening and to ensure that laboratory tests do not take longer than one month
- no mentally handicapped children to be in long term care in hospital

Resources for service development fall into a rather different category. Each year the Department sets a series of specific policy objectives which it expects Health Authorities to pursue as part of their service plans. In recent years priority has been attached to the development of renal services and heart surgery; combating drug abuse and the spread of AIDS; and to the reduction of waiting lists and waiting times. Clearly these represent quite explicit statements of policy priorities. As such, it is quite logical to expect the Department to cost these policies and to ensure that the requisite funds are made available. What is less plausible, however, is that this diverse and changing set of objectives should amount to a figure of 0.5 per cent additional demand over more than one year. Once again, there is a strong hint of

arbitrariness in the use of this figure. This makes it difficult to be confident that the consequences of service development are truly integrated within the expenditure planning process.

Resources for Extra Demands

By comparing information on the annual increases in volume expenditure *plus* the additional sums made available through cash releasing cost improvements *with* the extra demands for resources arising from demographic change, medical advance and service development, it is possible to examine the extent to which expenditure on HCHS has kept pace with increased demand. The Social Services Committee — in their 1986 report — carried out these calculations and concluded that:

...the Government has done no more than half what, by its own admission, should have been done: resources for hospital and community health service ought to have grown by 2 per cent a year in volume terms, but they have actually grown by only 1 per cent since 1980-81.

In its Response to the Committee, the Government argued that this conclusion was based on a misunderstanding and that it had not said that resources needed to grow by 2 per cent per year in every year prior to 1985/86. In particular, it pointed out that extra resources necessary to cope with demographic change have varied

TABLE 5. HCHS Expenditure and Demand, 1980/81 - 1986/87
(Annual Increases per cent per year)

Year	*Volume Expenditure*	*Demand*
1980/81	3.0	1.4
1981/82	2.0	0.8
1982/83	0.8	1.0
1983/84	0.0	1.0
1984/85	1.1^{+}	1.1
1985/86	1.5^{+}	1.6
1986/87	4.0^{+}	1.5

Notes: * Demography plus medical advance; no allowance for service development
$^{+}$Includes cash releasing cost improvements
Sources: see Tables 1 and 2

from year to year and that the current figure of 0.5 per cent for service development was not necessarily relevant to earlier years. However, even after taking account of these qualifications, Table 5 shows that the growth in volume expenditure (supplemented by CIPs) was still below the revised requirements of demography and medical advance in a number of recent years without *any* allowance being made for service development. It was not until 1986/87 — when the growth of volume expendi-

ture plus CIP savings looks like it reached 4 per cent — that the extra demands were met comfortably.

From Inputs to Outputs

It has long been recognised that public expenditure figures measure spending on *inputs* whereas what really matters, as far as the users of health services — or indeed any other productive activity — are concerned, is the quantity and quality of *outputs*. In recent years considerable efforts have been made to improve output measurement within the public sector, and in its Response to the 1986 Report of the Select Committee the Government emphasised the importance of this approach.

The ultimate test however must lie not in any artificial and theoretical comparison between inputs (as defined by changes in Authorities purchasing power and cash releasing cost improvements) and estimates of required service growth to maintain standards and deliver policy aims, but in what has actually happened to output i.e. services provided and policy aims met.

Although — as some of its critics would no doubt suggest — the timing of this statement seems to reflect the need to shift the focus of attention from inputs at a time of expenditure shortfalls, the underlying argument is nonetheless a sound one.

In measuring the output of health services, it should ideally be expressed in terms of the changes in the health status of the population which it produces. But, in practice, it is extremely difficult to disentangle the effects of health services from other diverse influences on health status. This may be possible to some extent in carefully selected research projects, but for everyday management purposes it is usually necessary to consider outputs in a more limited sense. For this purpose, activity statistics — that is, the number of operations performed, the number of in patients treated, the number of day case attendances, etc., — are often used.

In line with this approach, the 1987 Public Expenditure White Paper devotes considerable space to lists of changes in activity. It reports sizeable increases in the number of in-patients (18 per cent) treated, in day cases (71 per cent) and outpatient attendances (10 per cent) between 1978 and 1985. In addition, it provides specific information on the increased numbers of, *inter alia*, coronary artery bypass grafts, hip replacements and cataract operations. However, while activity statistics provide information about changes in output within particular specialties, they are not combined in a way that enables changes in *total* output to be gauged. In an attempt to meet this aim the DHSS has developed a *cost weighted index of activity*.

This index takes the year-on-year changes in activity in seven main HCHS categories and 'weights' each one by the proportion of total expenditure spent on the activity during the base year. Each weighted component change is then added up to produce an overall index of change in activity.

This index indicates that HCHS activities increased by nearly 20 per cent between 1979 and 1985 whereas the increase in volume expenditure over the six years 1979/80 to 1985/86 was less than 5 per cent. Clearly this suggests a major improvement in the efficiency of resource use in the NHS in recent years. But the index is

still in the early stages of its development and should be interpreted with caution. At the moment it has a number of limitations. For example, most activity is determined by reference to the throughput of hospital cases, where cases are defined as deaths and discharges. The more rapidly patients are processed through the hospital system, the greater the level of activity that is recorded. According to this criterion, activity in the acute sector has increased substantially since 1980 because of a greater reliance on day cases — up by 44 per cent — and reductions in the average length of stay — down by 15 per cent. Both of these measures no doubt reflect increases in productivity. But they also raise some questions. Misgivings about reductions in the *quality* of care, in a service where this is an important component of output, need to be addressed. Moreover, there is the possible increase in readmissions following earlier discharge. One piece of empirical evidence on this — the Oxford Record Linkage Study — suggests that the rate of increase in readmissions over the period 1978 to 1985 has been minimal. But more evidence is needed.

TABLE 6. HCHS Cost Weighted Index of Activity

	Actual Index	*Linear Trend**
1975	100.0	101.2
1976	106.1	104.1
1977	108.8	107.0
1978	110.0	109.9
1979	110.2	112.8
1980	116.6	115.7
1981	118.6	118.6
1982	118.0	121.5
1983	124.5	124.4
1984	128.2	127.3
1985	131.7	130.2

Note: * Adjusted to smooth out the sharp fluctuations in the index in 1975, 1979 and 1982 attributable to industrial disputes.

Source: House of Commons (1986a)

It is within the long stay sector, however, that rather more serious reservations about using discharge data arise. Between 1980 and 1985, geriatric cases increased by 45 per cent largely due to a 32 per cent reduction in the average length of stay from 70 to 48 days. But it is most unlikely that such a huge reduction in length of stay over such a short period can be attributed solely to efficiency gains. Other explanations for the phenomenon include: elderly patients are being admitted to hospital at a later stage in their illness; more patients are dying in hospital; or — most plausible of all — patients are being discharged to the care of third parties, whether relatives or nursing homes, sooner than they used to be.

There is also room for doubt about the appropriateness of the methodology in its application to the mental handicap sector. Between 1980 and 1985 the number of cases almost doubled from 20,100 to 39,800. As a result, activity statistics record large productivity gains. This was made possible because the number of resident patients declined by 18.2 per cent from 44,400 to 36,300 and part of the slack was taken up by an increase in the number of short term (less than one month) admissions. Of course, the shift away from long term residential care is an explicit policy aim. But the changing mix of short and long term cases does reduce the reliability that can be placed on cases as a single index of output. If, for example, an alternative measure based on the number of people being cared for on any particular day was used instead, the steady decline in their numbers during the first half of the 1980s would indicate a reduction in output, possibly as large as 15 per cent between 1980 and 1985.

One reaction to these criticisms of the current method of output measurement would be to conclude that it is simply too crude to provide adequate information and to abandon it. But, in our opinion, wholesale rejection of the index would be a great mistake. The government is undoubtedly correct in its claim that the 'ultimate test' of NHS performance should be conducted in terms of outputs. To this end, attempts directed towards the more precise measurement of service outputs and their costs are to be welcomed. Already much work of this nature is being conducted as part of the search for greater value for money at the District level. This should provide data for improvements to be made to the aggregate index. In the meantime, though, it seems to be a mistake to seek to use output data at the aggregate level to replace input data. Until considerably more refinement is achieved it is best viewed as a supplement to more established measures of volume expenditure.

FAMILY PRACTITIONER SERVICES

In comparison with the HCHS sector, the Family Practitioner Services (FPS) have fared relatively well in recent years. With the exception of 1985/86, volume expenditure has grown at an average rate of over 2.5 per cent per year since 1980/81. In 1986/87 it is likely to have grown by nearly 3 per cent. Similarly, activity statistics indicate improved service levels on a wide range of fronts (see Table 7).

The one exception to the smooth pattern of service expansion has occurred in the case of pharmaceutical and appliance prescriptions. The Pharmaceutical Service currently accounts for 48 per cent of total FPS expenditure and, because it has not been subject to cash limits, has been a major source of increased spending. Government efforts to control this spending have been aimed at both users and suppliers. On the users side, prescription charges have been increased substantially: since 1979 the cost per item has risen from 20p to the present level of £2.40. The fall in the number of prescriptions dispensed in 1980/81 and 1981/82 followed periods when charges rose steeply: from 20p to 45p per item in 1979/80 and from 45p to £1.00 per item in 1980/81. On the supply side, the Government has sought to control both the number of prescriptions dispensed to patients and their cost to the NHS. The main vehicle for restricting the quantity of drugs prescribed has been

the Selected List. This was introduced in 1985 and was designed to encourage doctors to be more cost efficient in their prescribing habits. It is estimated that the list resulted in savings of £75m in 1985/86. At the same time, the Pharmaceutical Price Regulation Scheme has sought to control the price at which the NHS purchases drugs from manufacturers. The combined impact of these measures resulted in a 1.2 per cent reduction in the number of prescriptions dispensed in 1985/86 and contributed towards the unexpected fall in volume expenditure in that year.

TABLE 7. Family Practitioner Services: Activity Statistics
(Annual increases, per cent per year)

	1980/81	*1981/82*	*1982/83*	*1983/84*	*1984/85*	*1985/86*
Number of GPs	2.1	2.3	2.2	2.1	1.7	1.6
Average List Size	-1.7	-2.2	-1.9	-1.8	-1.4	-1.0
Number of Dentists	2.3	3.4	3.4	3.1	2.9	2.0
Courses of Dental Treatment	2.5	2.1	3.4	1.8	1.6	1.1
Number of Opticians	3.8	2.0	2.0	1.9	3.5	1.5
Number of Sight Tests	0.0	1.7	2.5	6.7	6.7	3.7
Number of Contracting Pharmacists	-1.2	1.1	1.4	1.5	1.6	3.2
Number of Prescriptions Dispensed	-0.3	-0.6	4.0	1.5	2.5	-1.2

Source: HM Treasury (1987)

The increased use of prescription and other user charges within the NHS has attracted considerable criticism from those opposed to the extension of private financing. The relative importance of these charges as a source of finance within the FPS is shown in table 8. Apart from prescription charges, the other main service for which charges have been increased quite sharply in recent years is the dental service. (The withdrawal of the supply of subsidised optical appliances has also increased the incidence of user charges, but as these are private transactions, they do not appear in the public accounts.) In cash terms, income from charges expanded quite steadily throughout the 1980s. Between 1980/81 and 1986/87 it almost doubled. However, as a proportion of gross spending the expansion is less dramatic. It rose by only just over one percentage point between 1980/81 and 1983/84; thereafter, it fell back — although the estimates for 1986/87 suggest that it has climbed back to the 1984/85 level.

The reason for the relative stability of income from charges as a proportion of expenditure — in a period of rapidly rising prescription and dental charges — lies with the large number of users who are exempt from charges, and reductions in demand from those who are subject to them. In the case of prescription charges, for example, the exemptions offered to children under 16 years of age, the elderly, those on low incomes and several other groups means that nearly 4 out of 5 prescriptions are dispensed without direct charge. Furthermore, as the reductions in the number of prescriptions dispensed indicate, those people who are subject to user

charges have been sensitive to price increases. In the case of dental charges, there has been a more marked increase in the proportion of expenditure financed by patient charges (see Birch, 1986) but, as the cost of the dental service constitutes less than 20 per cent of total FPS expenditure, their impact on the overall picture has been less marked than in the case of prescriptions.

TABLE 8. FPS: Gross Expenditure and Income from Charges

Year	*Gross Expenditure*	*Charges*	*Proportion*
	£m	*£m*	*%*
1980/81	2173	192	8.8
1981/82	2504	234	9.3
1982/83	2894	282	9.7
1983/84	3110	309	9.9
1984/85	3419	336	9.8
1985/86	3601	336	9.3
1986/87	3895	381	9.8

Source: HM Treasury (1987)

THE 1987 EXPENDITURE PLANS

The 1987 Public Expenditure White Paper planned for an increase in current expenditure on HCHS of £631m in 1987/88. This represented an increase of 6 per cent in cash terms. Current spending on FPS was planned to rise by £328m — an increase of 8.4 per cent. Overall, cash expenditure on the NHS (current plus capital) in England was planned to rise by £1,020 or 6.5 per cent. At the time, the predicted increase in the GDP deflator for 1987/88 of 3.75 per cent meant that cost expenditure was expected to grow by 2.2 per cent (HCHS current), 4.5 per cent (FPS current) and 2.7 per cent (NHS total).

These plans received a generally favourable response at the time of their initial announcement by the Chancellor of the Exchequer in his 1986 *Autumn Statement* and their subsequent elaboration by the Secretary of State for Social Services in a DHSS Press Release of 6 November, 1986. The general view was that they represented a significant improvement in the treatment of the NHS, possibly as part of a run-up to a general election in 1987. Since then, though, there have been a number of changes to the expected outcomes. When the 1987 *Annual Budget and Financial Statement* was announced in March, an upward revision to the general inflation forecast for 1987/88 — from 3.75 per cent to 4.5 per cent — meant that the increases in cost expenditure were reduced. The plans now suggest cost expenditure increases of 1.4 per cent (HCHS current), 3.7 per cent (FPS current) and 1.9 per cent (NHS total). However, these adjustments are marginal compared with the changes that could be expected to result from larger-than-budgeted-for wage and salary settlements in 1987.

The NHS is a labour intensive service. Within the HCHS, wages and salaries represent approximately 70 per cent of total expenditure. Each year increases in pay

are based upon the recommendations of Pay Review Bodies (for doctors and dentists; nurses, midwives and health visitors; and professions allied to medicine) and Whitley Councils. The Pay Review Bodies — which account for 64 per cent of HCHS pay — make recommendations to take effect from 1 April of the relevant year. Their Reports are not, however, usually received until about a month after this date, and sometimes later. The Whitley Councils tend to wait for the outcome of the Pay Review Body recommendations before starting serious discussions and so their settlements are not finalised until much later in the year.

The timing of these pay settlements means that there is always a good deal of uncertainty surrounding the eventual NHS wage and salary bill. The actual cost is never known when the public expenditure plans are made. Indeed, the final cost is often not known until well into the planning period. Judgements about the 1987

TABLE 9. The 1987 Public Expenditure Plans
(Annual increases, per cent per year)

	HCHS (Current)		*FPS (Total)*		*NHS (Total)*	
	Cash	Cost	Cash	Cost	Cash	Cost
1987/88	6.0	1.4	8.4	3.7	6.5	1.9
1988/89	4.5	1.0	4.9	3.9	4.3	3.3
1989/90	3.9	0.9	6.8	5.8	4.7	3.8

Source: HM Treasury (1987)

plans were particularly susceptible to this uncertainty. The original cash allocations were based on an assumed increase in the pay bill of 3.75 per cent. Under a system of cash limits any increase in excess of that figure would mean a reduction in the rate of increase of other resource inputs. But the mounting pressure resulting from the Government's persistent failure to implement recent recommendations in full always made this seem an unrealistically low figure. The mood in which the 1987 Pay Review Bodies got down to work was aptly summarised by the sentiments expressed in the 1986 Report of the Doctors and Dentists Review Body:

1985 was therefore the fifth consecutive year in which the Government failed to implement in full from the due date the increases which we had recommended after carefully considering all the evidence. We deplore the effect of these decisions on the incomes of doctors and dentists...

As we have explained in previous reports, we take account of economic circumstances in formulating our recommendations. Accordingly we have sympathy with the complaint of the professions that they are placed in 'double jeopardy' when the Government then decides to modify our recommendations because of economic considerations.

In recommending the creation of a Review Body, the Pilkington Commission, while accepting that the final decision rested with the Government were 'insistent that the

recommendations of the Review Body must only very rarely and for most obviously compelling reasons be rejected'. Although the Government has repeatedly affirmed its commitment to implement our recommendations unless there are clear and compelling reasons to prevent it from doing so, it has modified or staged our recommendations year after year.

After welcoming an undertaking from the Chairman of the NHS Management Board that the 1986 recommendations would not be 'prejudged' or 'automatically tailored to fit the Government's funding assumptions', the Report concluded:

We trust that our recommendations this year will be implemented in full from 1 April 1986.

They were not.

However the combination of the mounting backlog of incomplete and/or delayed past pay settlements, concern about the retention and recruitment of adequate numbers of nursing staff and, no doubt, political considerations preceding a general election has had its effect this year. On 23 April the Secretary of State for Social Services announced the Government's decision to implement the 1987 Review Body recommendations in full from 1 April. These will mean pay increases averaging 7.7 per cent for doctors and dentists; 9.5 per cent for nurses, midwives and health visitors; and 9.1 per cent for professions allied to medicine.

The government estimates that in 1987/88 the additional cost of these awards to the HCHS in England — over and above the sums already budgeted for in the public expenditure plans — will be £288m. The bulk of this extra cost will be covered by a payment of £264m from the Government's general Reserve and will not, therefore, necessitate any reduction in other areas of NHS expenditure. However, health authorities will be expected to finance the remaining £24m from their cost improvement programmes. How will this affect the adequacy of the 1987 expenditure plans?

The revised estimates of the expenditure requirements necessary to meet demographic change have been discussed already. It is now expected that an increase of 1 per cent will be required in 1987/88. In addition, the government still expects medical advance to absorb 0.5 per cent. No precise figure has been cited for the future needs of service development. But it is currently estimated also to require 0.5 per cent and it seems reasonable to assume that this requirement will continue in at least the short term future. Clearly, therefore, the combined resource needs of demography, technology and service development — at 2.0 per cent — are already some way above the expected increase of cost expenditure of 1.4 per cent. As such, any improvements in HCHS service levels will depend crucially on the savings resulting from the cost improvement programmes. If, as is expected, these produce cash releasing cost savings of around £150m, this would produce an overall increase in cost expenditure (i.e. cash plus CIPs) equivalent to 2.9 per cent. This should be sufficient to accommodate the additional funds for the pay awards and the extra demands of demography, medical advance and service development. But there is not much margin for error.

Finally, although they tend to be subject to substantial revision and therefore possibly too much attention should not be focused upon them, it is worth just noting that the HCHS cost expenditure increases of 0.9 per cent and 1.0 per cent for 1988/89 and 1989/90 do no more than meet the expenditure requirements of demographic change alone, assuming rates of price increase of 3.5 per cent and 3.0 per cent.

CONCLUDING REMARKS

For most of the present government's period of office, controlling the level of public expenditure has been one of the major macro economic policy objectives. Within this context of tight budgetary constraints, the NHS has fared more favourably than most other areas of public expenditure. Among the main spending departments and programmes only Defence and Social Security expenditure have registered larger increases in cost terms. Within the NHS itself, expenditure on the Family Practitioner Services has grown at quite a buoyant rate in practically every year during the 1980s. It is the rate of growth on expenditure on Hospital and Community Health services that has given cause for concern for much of this period. But even here there is reason for some guarded optimism for the future. The rate of expenditure growth in 1986/87 — at 2.7 per cent in volume terms — shows a marked improvement on the recent past, especially when allowance is made for the savings resulting from the cost improvement programmes. Similarly, the plans for 1987/88 indicate some scope for service improvements.

However, the relatively favourable treatment of the NHS does not seem to have been sufficiently pronounced, or has come too late, to satisfy public opinion on the desired level of health care expenditure. For example, the *1986 Social Attitudes Survey* (Taylor-Gooby, 1987) confirms that health remains the sector which most people rank first in terms of their priorities for extra government spending. Of course, questions that simply ask about desirable outcomes without making the costs of these outcomes clear should be treated with caution. In the light of this reservation, it is probably more significant that the same survey reveals that between 1983 and 1986 the number of respondents who would favour increased expenditure on health, education and social benefits *and* increased taxation to finance it rose from 32 per cent to 46 per cent. This trend is accompanied by a substantial increase in the numbers expressing dissatisfaction with the current level of HCHS provision (although not with FPS). Furthermore, although the levels of responses vary, the trend through time is common to supporters of all the main political parties. A similar trend is revealed by a recent Marplan opinion poll carried out between 6 and 10 March, 1987 (Davies, 1987). This shows that between 1985 and 1987 there was a substantial increase in the proportion of respondents who felt that additional taxes should be raised to finance more NHS expenditure. Taken together, these results raise serious doubts about whether the levels of expenditure on health during most of the 1980s have accorded with the wishes of large sections of the electorate. Whether the improvements of this year have been sufficient to alter this conclusion remains to be seen.

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