COMMENTARY

Puzzling out public expenditure

RUDOLF KLEIN

Once upon a time the publication of the annual White Paper on Public Expenditure was the signal for a rush to the calculators. What was the planned percentage increase for spending on the National Health Service for the coming years? How did this compare with the expenditure proposals for other, competing services? Did the White Paper suggest any changes in the Government's priorities as between different policy objectives and forms of spending? Such questions remain as relevant as ever for those working in the NHS and the rest of the public sector. But when trying to analyse the 1978 White Paper¹ it is hard to be confident that a meaningful answer to any of them is possible.

The main message of the White Paper is clear enough and is independent of the precise figures given for specific services or programmes. The boom years are over for the social services. There is to be no return to the relatively rapid rate of expansion of the early seventies, before the economic crisis forced a reassessment of policy. In sharing out any extra wealth that may be generated over the next few years, as a result of economic growth fuelled by North Sea oil revenues, priority will be given to cutting taxes and stimulating investment. The overall aim of policy is to lower the proportion of national income devoted to public spending—an aim which now seems to be common ground between the Labour Government and the Conservative Opposition.

Change of emphasis

This said, the 1978 White Paper does mark a change of emphasis when compared with the documents published in 1976² and 1977.³ The spending plans for the health and personal social services have been revised upwards instead of downwards. These services have not done as well as social security but rather better than education or housing in terms of the growth envisaged by the White Paper for the period 1977-8 to 1981-2. Even so, the growth rate for the next four years is going to be less than that for the past four years. Current spending on health is planned to rise by 6.8% between 1977-8 and 1981-2: the recorded rise for the period 1973-4 to 1977-8 was 11.2%. The equivalent figures for the personal social services are more striking still—10% and 33%, respectively. As the White Paper recognises, these growth rates do little more than keep pace with the extra demands generated by an aging population, with "some margin for development" in the early eighties.

The White Paper does not, unfortunately, give figures for this "margin for development." So it is not at all clear how much—if any—money will be available for improving the service as distinct from managing to keep afloat as the tide of demand rises. The only safe, if crude, conclusion is that, on present

plans, all those working in the NHS will be struggling with much the same kind of resource problems in 1981-2 as they are today and may, at best, expect only very slight relief—given success in the campaign to generate extra resources from within the existing budget of the NHS by the more efficient use of people and plant.

Growth in NHS budget

But how much credence should be given to the White Paper figures and intentions? Expenditure plans tend to be volatile. They alter in line with changes in the economic and political climate, and in the past have tended to show a manic-depressive pattern of hopeful expansion and savage retrenchment. This is particularly true of the Government's building programme, where the latest White Paper suggests that the NHS may just be about to move out of the depressive phase. It is less true of current spending programmes, where the rate of growth tends to be vulnerable but where cuts in the scale of activity are rare. The NHS budget has continued to grow, in real terms, even in a period when the national income has fallen and when there has been a general reduction in living standards. The so-called cuts have been reductions in the expected and planned-for growth rate.

Political and economic uncertainty apart, there are other problems in interpreting the White Paper. The expenditure figures, as set out by the Treasury, are designed to show the burden falling on public resources. They are therefore net of income, and understate the amount spent on the health and personal social services to the extent that revenue is raised from charges to users. So a decision to double the prescription charge, which has been yielding a declining income to the NHS because of the present Government's refusal to increase it in line with inflation, would add £27m to the Service's resources without adding anything to the White Paper figures (unless, that is, the Treasury insisted on deducting an equivalent amount from its contribution).

Statistical artefacts

More important still, the White Paper figures are statistical artefacts. They are not expressed in terms of the money we use in paying our taxes or bills but are calculated in such a way as to exclude the effects of inflation and to "measure the amounts of goods and services purchased by the public sector and thus provide an indication of the volume of services supplied." So if the White Paper shows a planned rise in NHS spending, this implies a planned increase in the volume of services provided to the customer.

Unfortunately, from the point of view of the NHS, if not from that of national

economic management, Treasury control of public expenditure is now exercised through the cash limits system. This means that each programme is allocated a budget fixed on certain assumptions about the rise in costs during the financial year. If those assumptions turn out to be wrong—if the expected rate of inflation is exceeded—then the programme has to cut its "purchase of goods and services" accordingly. Cash limits take priority over White Paper targets, as the DHSS informed the Parliamentary Expenditure Committee which carried out a post-mortem examination on the 1977 document.⁴ In the case of the NHS this meant an unannounced and unplanned-for cut of £40m in 1976-7, in terms of the volume of services provided, while the personal social services suffered even more proportionately to their budget. The White Paper offers no clues as to what has been happening in the current financial year, though the DHSS and the Treasury must have a pretty accurate impression by now whether or not the rise in costs has exceeded the rate permitted under the cash limits formula. It may well be that the spending total for 1977-8, given in the White Paper, will have to be revised downwards. In other words, the difficulty in interpreting the White Paper is to know not only where we are going but from where we are starting.

To emphasise the significance of cash limits is also to underline a crucial issue for the future prospects of the NHS, and other public services. It suggests that the debate about public expenditure will have to take as much account of the formula used for setting cash limits as of the White Paper figures. If the allowance for cost increases is unrealistic—if they make over-optimistic assumptions about the Government's ability to translate aspirations into effective action about incomes and policy—then so are the White Paper figures. Additionally, however, the new system implies that those working in the NHS, and their negotiators, will have to make an explicit choice as to their priorities between promoting higher pay and generating more jobs. If they wish to press for increases in pay above the level envisaged in the cash limits formula, this can be achieved only by cutting the number of posts available. On the other hand, expanding the number of jobs may mean reducing pay aspirations.

Lack of coherence

But the White Paper as a whole prompts some scepticism about the extent to which the Government, for its part, has worked out a coherent strategy for public sector manpower. The expenditure figures for the social services seem to reflect the assumption that there will be little, if any, expansion in the number of people employed. This is explicit in the case of education, where the White Paper sensibly

provides for a fall in the number of teachers employed in line with the declining birth rate. It is implicit in the low growth target for expenditure set for the NHS and the personal social services. Yet the White Paper shows a continuing high level of spending—£354m in 1977-8—on various forms of subsidies and programmes designed to create or preserve jobs. The logic of subsidising overmanning in the industrial sector at the expense of perpetuating undermanning in parts of the social services is far from persuasive. Government policy continues perversely to be to limit the growth of public sector manpower though—as Swedish budgetary planning, for example, has recognised³—the increasing participation of women in the labour force, as well as the aging of the population, means that there will be continuing demands for more workers in the social services.

For the statistics of the number of people employed in the NHS—and the rest of the public sector—provide a misleadingly over-optimistic picture of an expanding service to the public. There was, indeed, a sharp increase in the number of people employed in the NHS during the seventies—and not just of administrators. For instance, the number of nurses rose from 272 000 to 330 000 between 1971 and 1976. But their hours of work and entitlements to leave also changed. As the DHSS explained to the expenditure committee, this therefore represented an increase of 21.4% in numbers but of only 11.8% in terms of hours effectively worked. Given continuing pressure for a shorter working week and longer holidays, it seems quite possible that a rising number of people will be required to deliver a given amount of service to the patient. It is not clear to what extent, if any, the White Paper takes account of this trend.

No coherent strategies

The failure to adopt coherent strategies is also illustrated by the White Paper in a different context. In the case of the NHS, the frictional costs of the DHSS's policies for redistributing resources—of closing unwanted hospitals, etc—have to be carried within the existing budget. But the social costs of making the coal industry more efficient—of closing

redundant pits—are met by a special grant designed to cover extras such as early retirement benefits. This failure to budget explicitly and publicly for the costs of new policies in the NHS compounds the problem of assessing the White Paper figures. It is difficult to disentangle the costs of new commitments, such as the extension of family planning, from spending on improvements in existing services—though the DHSS has now made a start in providing relevant information to the expenditure committee.

On the other side of the balance sheet, the White Paper's budget for the DHSS understates—in certain important respects—the Government's expenditure on the promotion of health, or at least on measures designed to limit the demands for medical care. Thus the expenditure of £41m a year on health and safety at work appears under the heading of "Trade, industry, and employment." This example indicates the importance of analysing public expenditure—and public policy in general—in terms of its net health-enhancement or illness-prevention effect, as distinct from concentrating exclusively on the NHS. It cannot be assumed without argument that the latter should invariably have priority. As the BMA wisely told the Royal Commission, "The organisation of a National Health Insurance Scheme is not necessarily, or even probably, the best means of utilising limited resources for the promotion of national health. It is more likely that there are a number of other directions in which, severally or collectively, a corresponding expenditure would produce an even more satisfactory return." And the BMA instanced spending on housing, clean air, and education. The fact that this evidence was submitted to a Royal Commission sitting in 1925⁶—and not 1978—does not invalidate the point.

It would be wrong to conclude, on the basis of the White Paper's figures, that expenditure on health is inadequate. A more reasonable, if also more limited, conclusion is that the spending plans barely match the present commitments of, and demands on, the NHS. They also make optimistic assumptions about the future willingness of those working in the Service to make scarce resources stretch a long way. Beyond that, we lack the criteria needed to make a sensible judgment about what would be an "adequate" level of provision and there-

fore expenditure. The White Paper is an unsatisfactory guide to the present state of affairs, let alone to the future. Furthermore, it reflects a wider failure—for which the academic community must share responsibility with the civil servants—to develop the intellectual tools needed to assess the adequacy or otherwise of different levels of public spending and different mixes of public services.

References

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- ² *Public Expenditure to 1979-80*, Cmnd 6393. London, HMSO, 1976.
- ³ *The Government's Expenditure Plans*, Cmnd 6721. London, HMSO, 1977.
- ⁴ House of Commons, *Ninth Report from the Expenditure Committee*, Session 1976, Chapter V. London, HMSO, 1977.
- ⁵ Ministry of Finance, *The Swedish Economy 1975-80*. Stockholm, 1976.
- ⁶ *Royal Commission on National Health Insurance*, Appendix to Minutes of Evidence, Part III. London, HMSO, 1925.

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In brief . . .

GOS 1 (ex OSC 1) to go

On 1 February Form GOS 1 (successor to Form OSC 1) will be abolished in England and Wales. The National Health Service (General Ophthalmic Services) Amendment Regulations 1977 were laid in December. These exempt all children under 16, or older and still attending school full time, from most NHS charges for the repair and replacement of their spectacles. They also abolish the requirement that a patient must obtain a doctor's recommendation—on GOS 1—before he can have a sight test for the first time under the general ophthalmic services.

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repeat the 1974 debacle of having to reapply for jobs. What would have been said, they asked, if GPs or consultants had been placed in the same position?

Some of the best administrators had been lost in 1974, someone suggested, but one of the consultants defended administrators, from whom he had learnt how to handle awkward, complaining patients and potentially disruptive union actions. Furthermore, another said, the profession would probably not accept the same degree of "government" by doctors. The conclusions of my random sample was that region, areas, and districts seemed to be running reasonably smoothly. Both the RHA and AHAs moved around the region and areas for their meetings and documents went out on time, with the reports predigested. One AHA, I was told, held frequent symposia on specific subjects and its members also made a point of meeting

staff of local hospitals, and once a month representatives from all disciplines in the area meet.

Though there seemed to be little difficulty in getting doctors to serve on administrative committees, it was a different matter when it came to advisory machinery. It was also difficult—though essential—for the clinician on the DMT to keep in contact with respective electorates via LMCs, RCHMs, etc. One consultant's view was that the district medical committee was a dead loss but that the area and regional medical committees worked well. It was the lower tiers which were confusing, with people uncertain what advice was going where from whom.

Clearly, I would be rash to draw any firm conclusions from this ride to the North. My impressions, however, are of some reasonably contented doctors worried about the growth of unionism in the NHS, who want a simpler administration with fewer and more effective channels for medical advice. Will the doctors I shall be visiting in the Midlands on my next regional ride confirm these impressions?