LETTER FROM WESTMINSTER

Metaphysics from Mr Moore

JOHN WARDEN

There is no underfunding of the National Health Service, and that's official. Head office said so last week in the person of Mr John Moore, Secretary of State for Social Services. Occupying the chair where others had agonised over exactly how much the NHS had been short changed, Mr Moore felt himself under no obligation to offer refunds.

On the contrary, he told the Social Services Committee that it was all an illusion. A capacity gallery had turned up to watch Mr Moore face inquisition by the parliamentary committee whose wrath he had incurred by summarily dismissing its report calling for a £1 billion injection of funds. In the event, the audience saw Mr Moore the magician perform his Houdini act, escape smiling, and leave the committee scowling.

Indeed, the confrontation was less exciting than entertaining, with Mr Moore having rather the better of the exchanges. The real issue that emerges, however, is not so much about the lost billions as the conflicting perceptions of the health service. Seen from above, at Mr Moore's level, the system is working well. From below, the evidence from the field is of hard times. It is not unlike the tensions in big business between head office and the outlying branches.

Mr Moore adopted the pose of a company chairman smoothly explaining a shortfall in the accounts to troublesome shareholders who thought that they had identified a missing £1.9 billion. A scent of scandal was in the air. The customers were complaining. Mr Moore set out to be reassuring but firm. They were at fault, he said, in assuming that the NHS had been starved of funds. According to the Secretary of State there was nothing under the counter, underhand, or underpaid. It was not instantly clear if his evidence was understood.

In summary, Mr Moore was saying that the shortfall was illusory. Any apparent gap in the NHS between resources and growth had been filled by increases in efficiency. So to compensate with cash now would amount to double accounting—paying for something already achieved by a combination of increased funding and added efficiency.

"It is these two which produce the increase in activity," he said. "Historically there is no cumulative underfunding. There is a pattern of activity which makes it clear that the resources do enable services to be provided."

Mr Moore was not a Treasury minister for nothing. Gradually the committee's £1.9 billion figure for underfunding disappeared to the point of invisibility, until Mr Frank Field, the committee chairman, described it as an amount measured in metaphysical terms. But what then of real beds being closed in real wards? Had not a BMA survey shown that out of 3611 bed closures 2104 were for short term financial reasons? Mr Moore said that the survey was conducted before the injection of £75m extra funds last year, and that could be a factor.

Nor could he accept Mr Field's view that service reductions were inevitable as health managers were "driven to the point of madness" trying to keep within their budgets. Overall activity in the NHS was increasing, not decreasing.

Health Minister Mr Tony Newton, sitting alongside Mr Moore, wanted it to be recognised that conditions varied between health

districts. He noted observations made to him by authorities which manage with the resources allocated to them about the deficiencies of those who don't. To Mr Newton, beds were often closed for subjective reasons, like Christmas or defective planning. Some did go beyond what head office wished and it had put in more money—as with £15m last week from the RAWP budget, mainly for London hospitals. It is now becoming clear that the hospital sector is to be kept going by drip feed.

The only hint of a concession from Mr Moore was his acknowledgment of the "efficiency trap." This happens when more patients treated means higher total spending. The Secretary of State admitted that in the NHS review—on which he would not be drawn—it was being suggested that the government ought to find ways of encouraging and rewarding those who were caught in the efficiency trap. He added: "This is something—whether money should follow patients—we would want to look at carefully. It is a difficulty clearly associated with efficiency improvement."

Which goes to reinforce the view that the Thatcher/Moore package later this year will propel the NHS not in a radically new direction but further along the route it is already following of cost improvement and efficiency. Members of the select committee had the same impression that Mr Moore was going for "optimum output." Mr Field, however, suspects that this will be achieved by setting targets, so that when they are met then by definition there cannot be underfunding.

Low key launch of passive smoking warning

Was it fear of upstaging Mr Moore that caused his head office on the same day to give such a low key launch to the report *Smoking and Health* by Sir Peter Froggatt's independent scientific committee? Or is it that the government is unsure which way to jump? The Froggatt report will be a test of the government's attitude to smoking and health. At the moment its instincts are to be liberal rather than restrictive, tipping the balance against health.

The feature of this report is its verdict on passive smoking. It confirms that there is a small but real increase in the risk of lung cancer to non-smokers for prolonged exposure to environmental tobacco smoke. It might amount to several hundred deaths a year. The first action that should follow from this is to segregate smokers in public buildings, on transport, and in the workplace. Ways to encourage this are now before a Cabinet committee.

More sensitive, perhaps, is what to do about the Froggatt observation that while cigar and pipe smokers run lower health risks for themselves, the sidestream smoke carries much the same risk to non-smokers as from cigarettes. That should point to cigar and pipe tobacco advertising being banned from television in the same way as cigarette ads. This government, however, is not in the business of restricting trade.

An important chapter documents the risks of maternal smoking during pregnancy. In particular it draws attention to the effect in pregnancy of women being exposed to other people's tobacco smoke. It finds that the association between such exposure and low birthweight seems to be larger than would be expected. Given that young women are the growth market for cigarette sales, this is a challenge that the government cannot fudge. Where are you Mrs Currie?

BMA writes to committee on abortion bill

The Abortion (Amendment) Bill, which aims to reduce the legal limit for abortions to 18 weeks, entered the committee stage in the House of Commons last week and the committee voted to sit for three days a week. Dr John Havard, secretary of the BMA, has sent the following letter to all committee members reiterating the association's views on the subject.

"We believe that any limitation to 18 weeks of the gestational age at which an abortion can be carried out would seriously disadvantage women most in need of an abortion.

"Twenty-four weeks' gestation marks a physiological and anatomical boundary below which the lungs are not expected to function. Advances in clinical medicine have made it possible for a number of babies of 24 to 28 weeks' gestation to be saved. Consequently, although we do not believe that the Abortion Act 1967 should be amended in any way, we would support a move to amend the Infant Life (Preservation) Act to lower the gestational age limit of viability from 28 to 24 weeks.

"There has been an amendment tabled by Jo Richardson and others (No 18) which proposes that the bill be extended to Northern Ireland. It is the BMA's policy that the Abortion Act 1967 should be extended to Northern Ireland, and we would support a move to achieve this."

Extra cash for Thames regions and the north west

Six health regions are to receive £15 million to help them make longer term changes in the pattern of their health services. This is the second part of a £30 million boost for those regions that receive the lowest increases in funds under the Resource Allocation Working Party formula. Some of the funds will be used to develop priority care services for mental handicap patients in Camberwell, to extend and improve the accident and emergency services at the North Manchester General Hospital, to provide 50 geriatric rehabilitation beds and 10 beds for the younger chronically sick at Broad Green Hospital, Liverpool, and to help with the opening of phase 2a of St George's Hospital, Tooting (table I).

TABLE I—Distribution of extra funds

Regional health authority	£000
North West Thames	3100
North East Thames	6270
South East Thames	2400
South West Thames	1300
Mersey	809
North Western	1502

Waiting list fund

In the second phase of its waiting list initiative the Department of Health has published the allocations to regional health authorities for 1988-9 (table II). In a parliamentary written answer the Minister for Health, Mr Tony Newton, said that the allocations

TABLE II—Waiting list allocations

Region	Allocation (£m)
Northern	1·925
Yorkshire	2·072
Trent	2·845
East Anglian	1·046
North West Thames	2·316
North East Thames	2·637
South East Thames	2·350
South West Thames	1·853
Wessex	1·609
Oxford	1·163
South Western	1·915
West Midlands	3·304
Mersey	1·633
North Western	2·531

would allow at least 100 000 additional patients to be treated. In 1989 the department has asked regions to concentrate on patients who have been waiting excessively for treatment, especially for serious and disabling conditions. There are plans to make effective use of £30 million for next year and to continue the initiative for a further two years after that.

Reducing London's waiting lists

In 1987-8, 15 000 more patients were treated in London's hospitals than in the previous year. Announcing this in the House of Lords recently, the Parliamentary Under Secretary of State at the DHSS, Lord Skelmersdale, said that out of the special £25m waiting list fund £7·08m had been made available to the four Thames regions. Of this, £3·75m was specifically for projects in the Greater London area. The department was now looking for

bids for the £30m available for 1988-9. The minister went on to say that although 4% more inpatient treatments were carried out in 1986 than in 1978, the four Thames regions accounted for 31% of the total waiting lists and the average waiting time of more than one year was higher in the four regions than the national average.

Study of generic medicines

Management consultants Touche Ross are to examine the generic medicines market in Britain, particularly prices and competition among suppliers. The white paper *Promoting Better Health* commended voluntary generic prescribing as good professional practice so the firm has been asked to examine the extent of competition in supplies in NHS hospitals and to family practitioner service contractors, the prices paid, the effectiveness of the systems for setting the prices of the medicines, and the extent to which the United Kingdom and other manufacturers can enter and remain in the market.

Touche Ross has been asked to present proposals within six months for improving the arrangements for procuring, distributing, and pricing generic medicines which are compatible with international trading obligations and the independent contractor status of retail pharmacists and dispensing doctors, would ensure the availability of generic medicines at reimbursable prices throughout Great Britain, and would lead to reductions in the cost of medicines to the NHS as a whole.

Appeals procedure on selected list

In future pharmaceutical manufacturers whose products are affected by the selected list scheme can appeal to the Advisory Committee on NHS Drugs or the Advisory Committee on Borderline Substances against proposed unfavourable recommendations of these committees. The latter advise ministers which drugs and other substances should not be prescribed by general practitioners at NHS expense and which should remain or become available under the selected list scheme. When the committees advise manufacturers of unfavourable recommendations that they intend to make to ministers manufacturers will be given 30 days to appeal. The Minister for Health, Mr Tony Newton, said in a parliamentary answer that the committees would take full account of any representations received in formulating their recommendations to ministers.

Savings on limited list less than expected

In April 1985 the range of drugs that general practitioners could prescribe for NHS patients was restricted. A study from the University of Aberdeen's Health Economics Research Unit has

Second round of pump primed consultant posts

A further 55 consultant posts have been allocated to regional health authorities as part of the package of proposals in *Hospital Medical Staffing: Achieving a Balance*. Forty five posts were allocated in 1987-8 in the first round of the agreement to pump prime 100 posts in general medicine and general, thoracic, and orthopaedic surgery (1 August 1987, p 343).

New consultant posts

Health authority	No of posts
Regional health authority:	
Northern	4
Yorkshire	3
Trent	4
East Anglian	4
North West Thames	4
North East Thames	4
South East Thames	2
South West Thames	2
Wessex	3
Oxford	4
South Western	4
West Midlands	7
Mersey	5
North Western	2
Special health authorities	3

examined the impact on the costs and effectiveness of prescribing of a small group of general practitioners in north east Scotland. The study concluded that while the restriction cut the annual cost of drugs for the NHS the savings were probably much less than the government's forecast of £75 million when the limited list was introduced. Furthermore, a substantial part of the savings were made at the expense of patients, who were given private prescriptions or advised to buy over the counter medicines at pharmacists. The general practitioners surveyed also believed that in many cases the quality of drugs they had prescribed had suffered. The authors concluded that in future restricted drugs would have to be chosen more carefully to avoid the shortcomings of the present limited list. The government should also consider the costs that fall on patients as well as those of the health service.

The "Limited List" in *General Practice: Implications for the Costs and Effectiveness of Prescribing* is available from the Health Economics Research Unit, Medical School, Foresterhill, Aberdeen AB9 2ZD, price £2.50.

BMA guidance on NI contributions, student grants, and product liability

New National Insurance contributions and earnings levels come into effect on 6 April and the BMA has updated its guidance to reflect changes to doctors' contributions. *National Insurance Contributions* covers salaried doctors, including those with private practice earnings, and self employed doctors, including those holding salaried appointments. The sliding scale of class 1 (standard rate) contributions introduced in October 1985 remains in force, but the rates of contribution have increased slightly following a reduction of 0.15% in the contracted out rebate.

The BMA's tax leaflets will be revised in the light of the budget changes when the Finance Act is published in the summer and they will be available from local BMA offices in due course. The guidance note *Grants for Medical Students* is also being amended because of the budget changes relating to tax relief on deeds of covenant.

The association has also prepared an information sheet (15151/11.3.88), *Product Liability: the*

Effect on the Medical Profession, which explains the product liability provisions of the Consumer Protection Act 1987 that came into effect on 1 March of this year. The act makes the producers of defective products liable for any damage without an injured consumer needing to prove negligence. Drugs, medical appliances, and equipment are included in the legislation.

BMA members may obtain copies of guidance notes (and leaflets) from their local BMA office by quoting their current membership number and sending a stamped addressed envelope.

NHS private patient charges

The department of health's recommended charges for private inpatients in NHS hospitals have gone up by an average of 6.3%. The daily charge for a single room in a London teaching hospital has risen from £219 to £226 (3.5% increase) and the daily charge for a single room in a psychiatric hospital has gone up from £70 to £85 (20.3% increase). For private outpatients the model charges are on average 6.5% higher than for 1987-8. Charges for amenity beds are unchanged.

From 1 April 1987 health authorities have had to set the charges for private patient facilities from 1 April each year. They may either set their own charges or adopt a centrally calculated list of model charges.

Health services for ethnic minorities

Health authority chairmen have received a report of a seminar on the management challenges for the health of ethnic minorities, which Mr Tony Newton, the Minister for Health, chaired last year. In a covering letter Mr Newton has reiterated the government's commitment to equal opportunities in employment in the NHS and in service delivery. Mr Newton has also issued a report on the Asian mother and baby campaign and on the employment of link workers between patients and health professionals. Government funding for producing

leaflets, audio tapes, and videos in ethnic languages will be increased to more than £500 000 in 1988.

BMA council election 1988-90

The names of the candidates in the election of members of the BMA council were published on 5 March (p 727). Dr Christopher John Spencer-Jones has withdrawn from the election so that the ballot papers, which were sent to BMA members in the training grades on 28 March, will show only eight candidates for the seven available places.

A decision has not yet been taken on how the vacancy in the South Western region in the regional and country election will be filled.

The results will be published in the *BMJ* on 7 May.

BMA NOTICE

Cooption of junior members to the armed forces committee

The constitution of the armed forces committee provides for the cooption of two members from each of the services, normally of no higher rank than major or equivalent and permissibly to the rank of lieutenant colonel or equivalent. At least one from each service must be hospital based and the intention is to provide a balance between specialists and those undertaking general duties.

Nominations for cooption to the committee, which meets thrice annually, for the 12 months period commencing in July 1988 are now being sought. In the event of there being more nominations than cooptive places an election will be conducted among serving medical officers. This election will be advisory, and the committee will determine the names of those to be invited to serve, having regard to the result of the ballot and the need for balanced representation.

Nominations are sought by *Friday 22 April*. They should be accompanied by up to 20 words about the candidate for inclusion on the ballot paper.

J D HAVARD
Secretary

Inpatient and outpatient costs

The following table reproduced in *Hansard* in response to a written question on 4 March gives the costs of treating patients in different types of hospital.

Hospital costs

	Inpatients		Outpatients		A and E patients	
	Cost per inpatient day (£)	Cost per case (£)	Cost per attendance (£)	Cost per new case (£)	Cost per attendance (£)	Cost per new case (£)
Acute hospitals (over 300 beds): London teaching districts	133.91	1 138.93	37.86	174.32	22.80	27.82
Mainly acute hospitals: London teaching districts	129.91	1 227.58	46.53	187.14	30.53	38.65
Acute hospitals (over 300 beds): provincial teaching districts	114.97	855.45	28.38	128.75	23.25	27.94
Mainly acute hospitals: provincial teaching districts	90.43	813.13	29.36	137.46	19.69	25.28
Acute hospitals (over 300 beds): England	107.32	767.53	29.37	127.00	20.89	25.55
Mainly acute hospitals: England	85.92	763.79	26.05	111.20	19.76	24.84