LETTER FROM WESTMINSTER

From budgets to babies

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The Chancellor of the Exchequer's 1988 budget is over but the shouting is not. Neither has done much to advance the cause of the NHS. Indeed, to a chancellor of the city school such as Nigel Lawson there is clearly more to life than the NHS. The budget was primarily about the health of the economy and only incidentally about the health of the people.

Another illustration of this is the government's timidity over the taxation of cigarettes, the price of which rose by as little as 3p a packet. In another year that might have drawn more fire than it actually did. Instead, it was overshadowed by assertions that £2 billion that should have gone to the health service has been handed over in tax cuts to the wealthy (as an incentive to such as top surgeons, the Treasury says). Both changes, however, are consistent with a budget that is strictly an instrument of economic rather than social reform.

That is not to say that a chancellor who takes Mr Lawson's pride in being clever could not have contrived a way of channelling some of his surplus billions towards health funding. But the budget was always intended to be about revenue, not spending, and Mr Lawson is not one to be bullied by the exercise of political muscle inside or outside parliament. Along with the prime minister and the cabinet he is prepared with eyes open to take the manifest political risks his strategy entails. If it frightens his friends there is no saying what it will do to his enemies.

It is central to the government's strategy that adequately funded health care can be underpinned only by a strong economy. Failure in one denotes failure in the other. Friends of the health service who do not see the two objectives keeping in step wonder when more of the proclaimed economic success will rub off on it. They take what encouragement they can from a textual analysis of the budget speech. When the chancellor mentioned the increased spending previously allocated for the NHS in the coming year he referred to "at least" £1.1 billion.

This was taken to imply a tacit commitment that there will be more available than the planned amount, which anyway will scarcely meet NHS inflation. Certainly, the government will be riding a tiger if it fails to fund the review bodies' pay awards in full next month.

Moreover, there is reason to speculate about another tranche coming in the autumn. The DHSS is to start a quarterly monitor of health authority spending, with the first results coming through in August and presumably these will show the amber lights that failed to alert the government in time last year. Mrs Thatcher in the House of Commons the other week gave her blessing to any additional money being "targeted," in the manner of the £30m waiting list fund, to make it more effective. There is in Whitehall a disposition to find money that can be targeted accurately.

Ad hoc cash injections of this sort, though counted in millions rather than billions, are also consistent with the behaviour of a government engaged in overhauling the health service. It produces a tendency to do as little as possible. Similar uncertainty must now cloud last week's report by Sir Roy Griffiths on how to close the gap between "policy and reality" in providing community care (p 945). Ministers are less enthusiastic than Sir Roy about paying local authorities, which they regard as spendthrift, to take a larger share of the work.

Perinatal mortality

Meanwhile, the Secretary of State for Social Services, Mr John Moore, has gone into even deeper purdah than a chancellor before a budget while he works on the NHS review. Pending his appearance before it on 23 March, the Social Services Committee called a truce over funding and held a session with his officials last week on perinatal and infant mortality.

This is a topic close to the committee's heart, having been the subject of two reports in 1980 and 1984. I have heard it acknowledged by a health minister that the action initiated by these reports has saved thousands of infant lives. Surely there can be no greater tribute than that to set against the often unrewarded toils of the select committees.

So it was not surprising that the successor committee should want to pursue the first increase since 1970 in the infant mortality in England. In 1986 the rate per 1000 live births rose from 9.2 to 9.5 (in number from 5716 to 5917). The better news, however, is that figures for 1987 indicate a return to the downward trend. Provisional data available suggest an infant mortality for England in 1987 of the order of 9.1 per 1000 live births. A firmer figure will emerge in a few weeks, but the DHSS says that the 1986 upturn may have been exceptional, though puzzling. Medical statisticians are trying to get to the bottom of it.

Preliminary work suggests that the 1986 increase occurred mostly among boys and was across all birth weights and social classes. The rise was also accounted for by deaths associated with the sudden infant death syndrome. This in turn has been linked with low ambient temperatures. The statistical sleuths are therefore following that trail to discover if the overall rise in cot deaths coincides with cold spells.

The MPs are unconvinced by the cold weather hypothesis, especially since the official data, derived from death certificates, fail to show whether parents are unemployed. If that is unknown how can it be said that cot deaths are unaffected by social factors? It seems to the committee another example of the facts about health care being obscured through the use of sloppy statistics.

Indeed, the committee was a jump ahead of the officials with some even more disquieting figures. These relate to 32 perinatal deaths in 1986-7, which are in no way mysterious but are attributed to the non-availability of cots in specialist perinatal centres. The figure was quoted by Dr Lewis Moonie, a Labour member of the committee.

It comes from a forthcoming report of a working party of the British Association of Perinatal Medicine, chaired by Professor Neil McIntosh of Edinburgh University. According to Dr Moonie, the 32 deaths related to cases in which district hospitals had trouble in transferring to intensive neonatal units. The report identifies them as avoidable deaths—12 in utero and 20 newborn—due to marked delays or because cots were not available. Considering the effort being put in at official level to explain some 200 apparently unavoidable cot deaths in 1986, these 32 avoidable baby deaths in NHS care assume some significance.

The DHSS does admit that there is a shortage of experienced doctors in hospitals to deal with obstetric emergencies, and a review of the number of registrar posts needed in paediatrics and obstetrics is planned. As a first step regions have been asked to consider redeploying junior doctors and possibly using the new staff grade. There will then be further discussion with the profession about how to secure 24 hour emergency cover in acute units.

By reopening the inquiry into infant deaths the select committee has shown there are still more babies to be saved.