

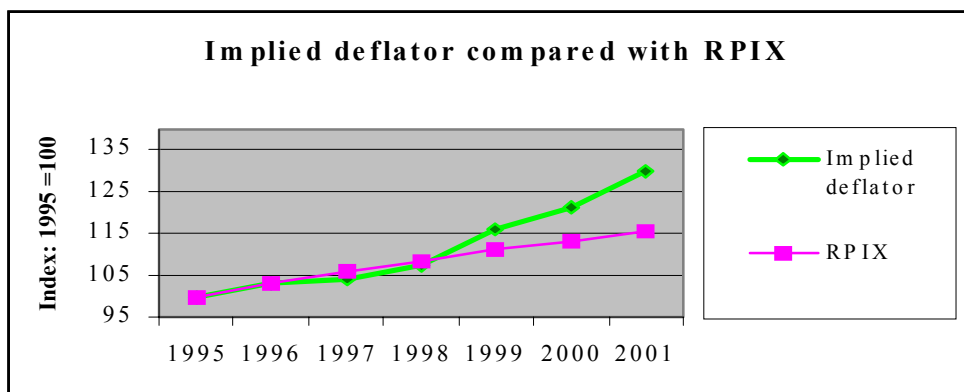
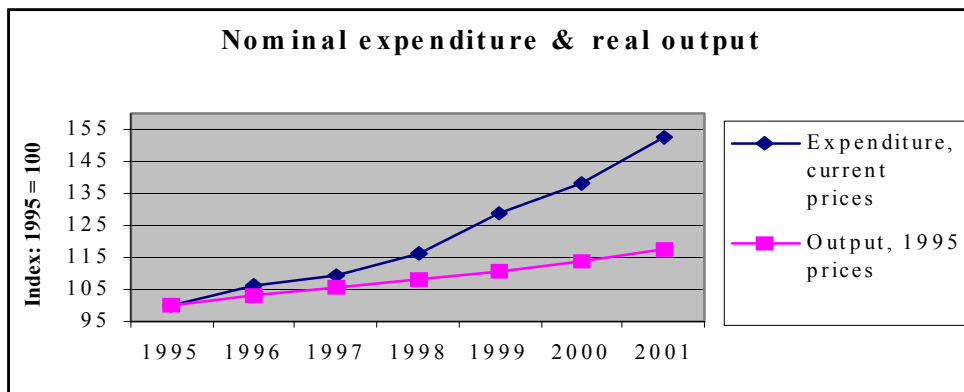
## General Government Final Consumption: Health

**Issue:** At the June briefing meeting for the Monetary Policy Committee, the ONS was asked for briefing on general government final consumption on health, a component of the expenditure and output measures of GDP. Their concern was with the implied deflator for this series and can be summarised as follows:

- why is it so high?
- how has it behaved recently?
- how different is this behaviour compared with the method used until 1998 which divided the current price series by an index of pay and procurement costs to obtain the constant price series?

**Background:** Government current expenditure on health has increased rapidly since 1995, more rapidly than for other government functions. ONS estimates show an increase of 53% between 1995 and 2001 - the table and charts below show the latest estimates. At constant prices, output rose only by 17%. The implied deflator reflects these movements and is often used as an indicator of price change. The rapid growth in the implied deflator for health has caught the attention of commentators - in particular because it has recently been higher than the price changes recorded for most goods and services.

### General government final consumption: health



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	1995	1996	1997	1998	1999	2000	2001
Expenditure, current prices	100.0	106.4	109.4	116.4	128.5	138.1	152.6
Output, 1995 prices	100.0	103.1	105.4	108.2	110.8	113.9	117.5
Implied deflator	100.0	103.2	103.9	107.6	116.0	121.3	129.9
RPIX	100.0	103.0	105.8	108.6	111.1	113.4	115.8

To understand the behaviour of the deflator, we need to understand what its two component parts - the current and constant price expenditure series, are measuring.

**Institutional background:** The bodies which produce health services (eg hospital trusts) are classified as public corporations and are outside government. The Government commissions their services on behalf of individuals and pays the bill. In the national accounts system, the consumption element of these transactions constitutes “final individual consumption of general government”

**General Government final consumption at current prices** measures the amount of money committed by the health departments for the account of health providers such as hospital trusts and bodies which commission health services. The money is given in the form of block funding to cover virtually all the needs of these bodies.

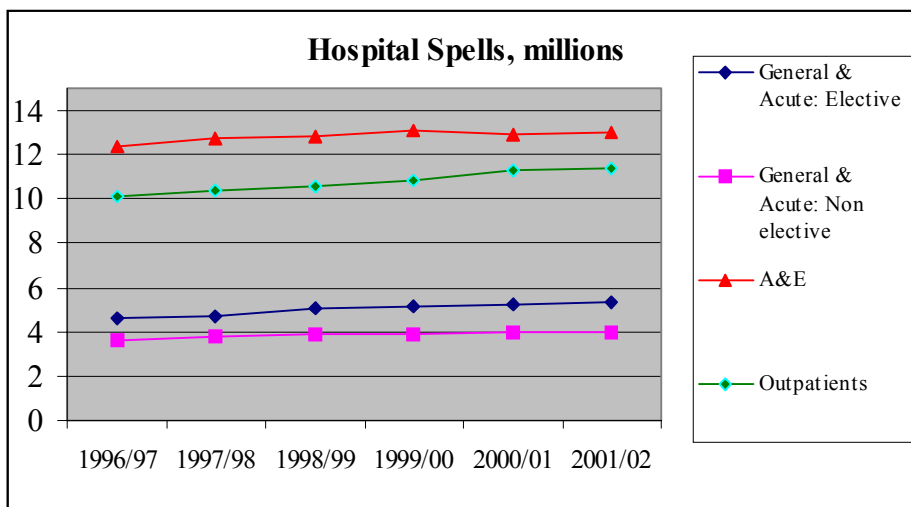
Why is all this expenditure classified as final consumption of government as opposed to, say, a transfer? Because this classification reflects the economic reality. In return for government funding, services will be produced for individuals: both production and consumption take place. In aggregate, the government funding pays for these services (even if they are not billed individually). In reality, the government funding will pay for staff wages and intermediate consumption (including payments under PFI schemes). This is a reasonable – though not perfect - way for government to value the services provided given that no billing takes place.

**General Government final consumption at constant prices** This measures contemporaneously both the volume of output of government and real consumption of beneficiaries. The System of National Accounts specifies that, as far as possible, government output should be measured by reference to the outputs produced, and not the volume of inputs used up in production. In the case of health services, these outputs are the treatments, consultations etc - the reason why people visit hospitals, clinics etc. Without these outputs, there would be no need for the hospitals, clinics etc. The table below shows the growth in some of the categories of treatments and consultations; these roughly “confirm” the published output figures shown in the table above (which are calculated through a more sophisticated process).

### Hospital spells, thousands

	<i>General &amp; Acute</i>	<i>of which: Elective</i>	<i>of which: Non elective</i>	<i>A&amp;E *</i>	<i>Outpatients *</i>
1996/97	8,186	4,565	3,621	12,351	10,153
1997/98	8,408	4,655	3,753	12,704	10,407
1998/99	8,966	5,093	3,873	12,797	10,546
1999/00	9,071	5,160	3,911	13,069	10,839
2000/01	9,244	5,277	3,967	12,925	11,271
2001/02	9,300	5,313	3,987	13,016	11,428
Overall growth	+13.6%	+16.4%	+10.1%	+5.4%	+12.6%

\* first attendances in a course of treatment



How therefore can we explain the growing gap between the nominal (current price) expenditure and the real output series? Are the output figures picking up all the outputs? Or is the expenditure being channelled in a way that does not increase the output? It is likely that there is some truth in both.

**What data could be missing?** Although there is an adequate and well established process for measuring hospital activity, what this does not reflect is the increasing tendency for certain treatments to be provided in an outpatient setting which once would have required hospitalisation. These should be regarded as one and the same treatment. The outpatient treatments probably do not carry the (base year) weight appropriate to a hospital treatment, leading to the growth rate being underestimated. Patients receiving NHS-funded treatment in private hospitals are another growing category excluded (for lack of data).

There is also evidence that the output should be adjusted upwards to reflect quality improvements. For patients, the most important indicator of quality is whether they are living for longer as a result of better quality treatments: there is evidence that this is the case. Work is in hand to bring this quality effect into the constant price measure: most likely, ONS will do this by counting as output only those treatments that are successful. A high percentage of patients normally survive operations so even the impressive fall seen in patient deaths is likely to translate into little extra output. (This point needs to be interpreted with care: measuring outputs just tells us what has been produced and consumed, not whether the government's spending is justified. A cost-benefit approach would count a wider range of secondary benefits from saving lives and could well justify continued spending to improve clinical effectiveness.)

**Is the extra money being spent on activities which do not give rise to more output?** In the health services, many activities take place which are not in themselves output but are incidental to the output. Examples are training, administration, cleaning, laboratories, security, provision of food, etc. The direct cost incurred by those delivering the treatment is likely to be small in relation to the overhead costs. It would be quite likely therefore that some of the increase in expenditure could have been spent on funding overhead costs.

There is evidence of a higher level of recruitment and training activities (which might increase output at some future date). And there is also evidence that spending initiatives have led to higher expenditure on what we would term overheads in this context. The factors which are likely to have contributed to higher overhead spending include initiatives to raise clinical standards, better supervision for junior doctors, clinical negligence costs, the build-up of payments for PFI schemes and pay rises. It is also known that there have been capacity constraints. The recently negotiated contracts for hospital doctors recognise that

capacity has been below what was needed, according to the Secretary of State for Health who also admitted that the current system provides insufficient incentives to maximise the use of available capacity.

**Alternative approaches:** Deflating health expenditure using price and pay indices would give a measure of the volume of inputs. This has grown faster than output because a large part of the inputs appear to have gone into the “support system” that produces the output - without increasing the output itself significantly. We estimate that the volume of inputs measured in this way grew by 20% between 1995 and 2000; over the same period, the output increased by 14%.

**Conclusion:** It is more relevant for economic policymaking to measure the outputs rather than the inputs of government. It is also in line with accepted national accounting standards. The results of the changeover to the output approach may seem surprising at first but they do suggest that a greater focus on outputs might be desirable. The figures available on the outputs can be improved and ONS is working with the health departments to ensure that all relevant outputs are measured. In the meantime, it is very difficult to estimate how the exclusion of some items has affected the output series over time.