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health services in the 80s

LONDON'S HEALTH SERVICES IN THE 80s

Part 3

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PROBLEMS IN THE DEVELOPMENT OF LONDON'S COMMUNITY NURSING SERVICES

Jane Hughes and Jenny Roberts

INTRODUCTION

The study reported in this paper was undertaken for North East Thames and North West Thames Regional Health Authorities as part of a programme of research into primary and community health care. Concern about the adequacy of primary care services in London was stimulated by the D.H.S.S. consultative documents[1,2] which emphasised the need to adjust the balance of care to provide greater support for all groups of patients in the community. Restructuring patterns of care from the hospital sector was a particularly difficult challenge for two regions which had traditionally relied heavily on expensive hospital services, contained eight teaching hospitals, and which were allocated a reduced share of resources under the RAWP formula.[3] Studies were therefore designed to investigate the provision of primary and community services in the two regions and to explore the feasibility of developing them in accordance with the D.H.S.S. national policy guidelines.

A survey of the distribution and recruitment patterns of general practitioners in the North East Thames Region[4] showed that the concentration of elderly and single-handed practitioners in the inner London area maintained much the same as ten years earlier.[5] In inner London, where the population has declined rapidly and general practitioners often continue to practise well into their seventies, there are few opportunities for younger doctors to enter practice. Even when vacancies arise however, general practice in London attracts few British medical graduates and some areas were found to be almost dependent on immigrant doctors for both trainees and recruits.[6,7]

There was little the health authority could do to influence this pattern because general practitioners, as independent contractors, have no statutory retirement age and may enter into whatever practice or partnership arrangements they choose. Legislation, such as that discussed in the Report of the Royal Commission on the N.H.S,[8] would be required to bring about major changes in general practice. Strategies which were suggested to improve general practice in London included a statutory retirement age for general practitioners, administrative arrangements which would help young doctors to enter practice and tighter controls

over the standard of practice premises. These are all politically sensitive solutions which, even with the full co-operation of general practitioners, would take many years to bring about.

Our attention was therefore directed to another important aspect of primary and community health care, the community nursing services, which the health authorities must provide and develop to meet local needs. Health visiting and home nursing services were high on the list of D.H.S.S. priorities, being recommended for an increase of six per cent per annum in real terms at a time when minimal growth was projected for other services.[2] This proposed development raised questions about the availability of trained nurses and health visitors to ensure that expansion could take place when and where required. An initial investigation into the provision of community nursing services in the two regions revealed that little information was available about the community nursing workforce, apart from the numbers of staff employed. A study was therefore designed to compile some basic information about nurses in the community which would be useful for nurse managers involved in planning the future manpower needs of the service. Its aim was to document the size and characteristics of the community nursing workforce and to analyse patterns of wastage and recruitment.

THE SURVEY

To fulfil the aim of the study, information was required about the grade, date of birth, sex, marital status, date of appointment, qualifications, hours worked, place of residence and working base of each member of the community nursing staff employed in the two regions. These data are all routinely recorded items of personnel information and were collected directly from staff records. The same details about all leavers from the service during the year before the survey proved impossible to obtain from all districts and for the majority of leavers only their grade and length of service were available. In addition to data about individual members of staff, interviews were conducted with the head of the community division in each health district to obtain background information about the organisation of the community nursing services and deployment of staff, and to discuss the current problems faced by nurse managers.

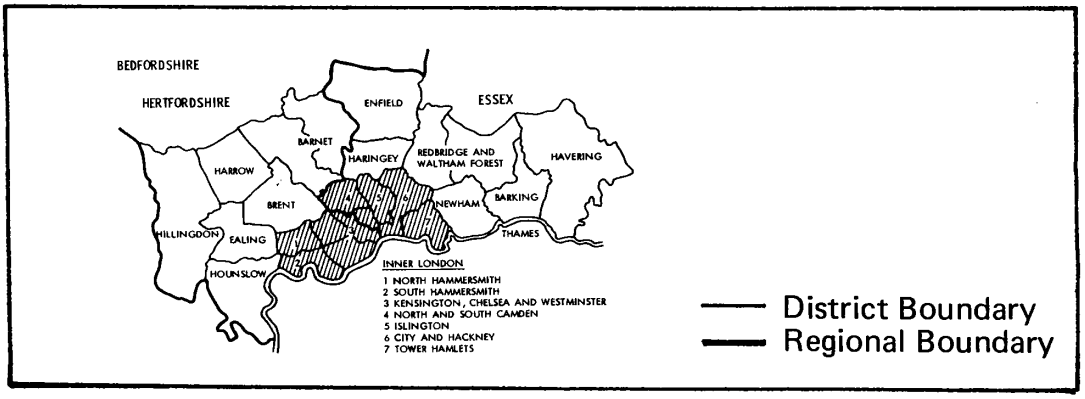
When the data collection was completed in early 1978, information had been compiled on 5033 community and auxiliary staff working in the

two regions, and over 600 leavers from the service. More than 60% of the staff in post were health visitors and home nurses and this paper focuses on these two grades.

The North West Thames and North East Thames Regions comprise 35 health districts which, for the purposes of the analysis, were divided into three parts on the basis of what was known about their social and demographic characteristics. The health districts shaded on the map of the two regions (figure 9.1) correspond as closely as possible to the G.L.C. inner London boroughs, where urban deprivation is greatest within the regions[9] and health and social problems are particularly prevalent and severe. [10,11] This group of districts was designated 'inner London' and the remainder of the regions divided into two parts, the outer London boroughs, which are named on the map, and the three counties outside Greater London (Bedfordshire, Hertfordshire and Essex). When the survey data were analysed in terms of these three parts of the regions important differences between them emerged in the level of provision of health visiting and home nursing services, the characteristics of the staff employed and their patterns of turnover. These finding confirmed in all major respects the nurse managers' reports and enabled us to quantify the extent of the difficulties nursing officers were dealing with in the day-to-day management of services.

FIGURE 9.1

NORTH WEST THAMES AND NORTH EAST THAMES REGIONAL HEALTH AUTHORITIES



RESULTS

Provision of health visitors and home nurses

1. Funded establishment of staff

On the basis of funded establishment figures in relation to the total population served in each health district, the inner London districts had higher average levels of provision of health visitors and home nurses than either outer London or the counties (Table 9.1). The range of establishment levels indicate the variation in provision between districts, some of which had more than twice the establishment of others. We were surprised to find that the range within the inner London districts was almost as great as within the whole of the two regions.

The data were analysed to discover whether the differences between districts in funded establishment levels of staff could be accounted for in a 'rational' way.[12] Our assumption was that establishment levels reflected an estimation of the need for services in each district, but on what basis had this been assessed? The first hypothesis tested, using regression analysis, was that the structure of the population as well as its size in each district was an important determinant of staffing establishments. Target populations were estimated on the premise that home nurses spend the majority of their time caring for elderly patients[1] and health visitors have a special responsibility to visit children under five years old.[13] No relationship was found however between establishment levels of health visitors and home nurses and proportions of the appropriate 'target group' in the population.

TABLE 9.1

FUNDED ESTABLISHMENT LEVELS OF HEALTH VISITORS AND HOME NURSES

	posts (WTE) per 100 000 population for	
	health visitors	home nurses
Inner London	22	34
Outer London	18	25
Counties	18	23
NET & NWT RHAs	19	26
RANGE		
All districts	13 - 26	17 - 39
Inner London districts	15 - 26	25 - 39

A second hypothesis to account for the variation between districts was that the mix of staff employed in each health district would affect the establishment levels of health visitors and home nurses required. Staffing patterns in each district were therefore explored to determine whether other grades of staff were substituting for health visitors or home nurses. Establishment levels of school/clinic nurses were found to be positively correlated with health visitor provision, giving no support to the hypothesis. For home nurses the picture was slightly more complicated: a much higher proportion of S.E.N home nurses were employed in inner London (27%), compared with either outer London (18%) or the counties (17%), but the variation between districts was wide, from 14% to 46% in inner London alone. Higher percentages of S.E.N's were not necessarily found in districts with large home nurse establishments and their employment appears to depend on management preference. Provision of auxiliary nurses however was found to be positively correlated with home nurse establishment levels. Thus no evidence was found to suggest that untrained staff were being employed to substitute for trained nurses; rather, the more home nurses a district provided, the more auxiliaries it also had to support them. These findings indicate that there was no substitution of less highly trained health visitors or home nurses in the two regions.

Our search for a rational explanation of the wide range in establishment levels of health visitors and home nurses proved unsuccessful. It seems most likely that an incremental growth of services has perpetuated differences between districts which existed before reorganisation of the N.H.S in 1974 and that their present establishment levels still reflect the very variable investments made by local authorities in community health services.

2. Vacancy rates

Comparison of establishment levels gives a rather distorted picture of the actual provision of health visitors because of variation in the proportion of vacant posts in the two regions. The average vacancy rate* for health visitors in inner London was 15%, compared with 9% in outer London and 6% in the counties. The high vacancy rate in inner London reduced

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*Vacancies (WTE) expressed as a percentage of the funded establishment (WTE) for a particular grade.

actual staffing to a level much closer to that found elsewhere in the regions, but did not diminish the variation between districts.[14] The high level of unfilled health visitor posts in inner London confirms nurse managers' reports that chronic recruitment difficulties prevented them from maintaining staffing at establishment levels. Recruitment of home nurses was said to be easier and this is reflected in the average vacancy rates for this grade, which were about 5% in all three parts of the regions.

TABLE 9.2

CHARACTERISTICS OF HEALTH VISITORS

	percentage of health visitors working in:		
	inner London	outer London	counties
In post < 2 years	53	37	35
Qualified as HV in previous 2 years	38	27	21
< 30 years of age	32	19	13
Unmarried	55	25	21
Working part time	14	27	24

Characteristics of health visitors and home nurses in post

The health visitors employed in inner London had very different characteristics from those employed in outer London and the counties (Table 9.2). On the basis of the proportion appointed to their present post within the previous two years, inner London health visitors were more mobile than their colleagues elsewhere in the regions. They were also a relatively younger and less experienced group, the majority of whom were not married and worked full-time. Age, marital status, health visiting experience and the number of hours worked were inter-related in complex ways which were difficult to unravel from the survey data. However, the combination of characteristics of the inner London health visitors suggests that the majority were at a different 'life stage', or an earlier point in their careers, than health visitors working in outer London or the counties. This means that inner London health visitors were less likely to have dependants or family commitments, factors which have clear implications for their potential geographical and job mobility.

Similar patterns were found in the characteristics of home nurses working in the three parts of the regions (Table 9.3). Inner London home nurses were younger, more recently appointed and less likely to be married than those working in either outer London or the counties. The lowest proportion of nurses working part-time in inner London, part-timers comprising a particularly low proportion of the day staff.

These findings illustrate one of the inner London nurse managers' main concerns, the relative inexperience of their staff, most of whom were recently appointed, and consequently unfamiliar with the district, and in addition many health visitors were newly-trained.

TABLE 9.3

CHARACTERISTICS OF HOME NURSES

	percentage of home nurses working in:		
	inner London	outer London	counties
In post < 2 years	34	28	26
< 30 years of age	24	11	11
Unmarried	35	12	13
Working part time	7	20	17
Day service and part time	3	13	15

Turnover of health visitors and home nurses

1. Leavers

To indicate the extent of movement out of each health district, wastage rates* were estimated from the information collected on leavers. It must be emphasized that wastage was defined from a district point of view, and

*Wastage rate: The number of leavers in the year expressed as a percentage of the total number in that grade in post at the time of the survey. (Wastage rates calculated using WTE rather than individual figures, where these were available, produced very similar results).

that loss of a nurse or health visitor from a district was not necessarily loss to the area, region or N.H.S. Movement of staff however, even between adjacent districts, may create replacement difficulties for nurse managers. A higher overall wastage rate was found for health visitors than home nurses, but within each grade wastage was highest from the inner London districts (Table 9.4). These average rates conceal a great deal of variation between districts, especially for health visitors, but the inner London districts had all lost a fairly high proportion of staff. Nurse managers' concern about recruitment difficulties is put into perspective when we consider that in some inner London districts they had to replace more than half their health visitors during the course of a year.

TABLE 9.4

CRUDE WASTAGE RATES

Health Districts	staff leaving the service during the year as a percentage of those in post	
	health visitors	home nurses
Inner London	27	18
Outer London	21	11
Counties	14	11
NET & NWT RHAs	20	12
Range	4 - 55	3 - 29

2. Recruits

To discover whether any changes were taking place in the characteristics of the staff employed in the two regions all health visitors and home nurses who had been appointed in the year before the survey were identified. The characteristics of the recruits to each part of the region showed a very similar pattern to that found for staff in post.

The high percentage of health visitor recruits who had qualified in the previous year (Table 9.5) demonstrates the reliance of the regions on their training programmes for recruits. The inner London districts however, had appointed the highest proportion of these newly-trained health visitors. Nurse managers' reports that very few experienced health visitors were available for recruitment in this area were supported by the low proportion of recruits who had qualified more than five years ago. Home nurse recruits to inner London were also less experienced than those appointed in outer London or the counties (Table 9.6).

TABLE 9.5

CHARACTERISTICS OF RECRUITS TO THE HEALTH VISITING SERVICE

	percentage of health visitor recruits to:		
	inner London	outer London	counties
Qualified as a health visitor in the previous year	73	68	50
Qualified as a health visitor more than 5 years ago	14	17	31
< 30 years of age	40	37	30
Unmarried	47	19	25
Working part time	8	15	25

For both health visitors and home nurses a higher proportion of recruits to inner London than elsewhere were in the youngest age group, unmarried and appointed to full-time posts. The survey was carried out at a time when many districts were establishing or expanding evening and night nursing services, which were staffed almost exclusively by part-timers, and evening staff therefore accounted for a fairly high proportion of recruits to part-time posts. Recruits to the day service were considered separately and during the year only one nurse (1% of recruits to the day service) took up a part-time post in inner London.

TABLE 9.6

CHARACTERISTICS OF RECRUITS TO THE HOME NURSING SERVICE

	percentage of home nurse recruits to: inner London	outer London	counties
Qualified SRN/SEN in the previous 5 years	42	32	20
< 30 years of age	46	30	29
Unmarried	42	15	14
Working part time	8	32	27
Day service and part time	1	23	15

It appears that existing staffing patterns were being reinforced by health visitors and home nurses entering the service. The inner London districts, which employed few experienced health visitors and home nurses, also recruited higher proportions of young, unmarried and recently-trained staff than districts elsewhere in the regions, where the community nursing workforce was more mature and experienced. In this way the inner London districts were maintaining a staff profile which has been shown to contribute to high turnover and wastage rates amoung nurses.[15,16]

DISCUSSION

Implications of the survey findings

The survey findings and nurse managers' reports illustrate important differences between inner London and the rest of the regions in the size and composition of the community nursing workforce, and patterns of wastage and recruitment. What are the wider implications of these results for the delivery of community nursing care and the development of home nursing and health visiting services in inner London?

The variation in staffing levels within the regions raises questions about the equity of provision of health visitors and home nurses. Health and social problems have been shown to be particularly prevalent in inner London, suggesting that this area required a higher level of service than elsewhere in the two regions. On average, inner London did have higher staffing levels, but some districts had fewer staff than districts in the more surburban parts of the regions. These discrepancies between districts in staffing levels could not be explained by differences in population structure or the mix of staff employed. If the need for health visitors and home nurses is assumed to be of a similar order throughout inner London, then the survey uncovered gross disparities in the services provided there. Nurse managers are unlikely to be able to eradicate these inequalities until clear guidelines for estimating the need for staff in a district are established and accepted.

The implications of high turnover rates and inexperienced staff for the quality of services provided in inner London are much more difficult to evaluate, and we must rely on widely-held but as yet untested assumptions about the determinants of quality of care. Rapid turnover of staff is likely to interrupt continuity of care to patients and clients, and interfere with the development of colleague and professional relationships, which are especially important if primary health care teams are to function effectively. The disproportionate numbers of inexperienced staff employed in inner London were particularly worrying for nurse managers, who attempted to maintain a balance of experience and expertise in their health visiting and home nursing teams. They agreed that greater support from nursing officers was required by newly appointed and recently qualified staff than by their more experienced colleagues. The results of the survey suggest that management structures in inner London may have evolved to counter the high mobility and inexperience of the staff employed there. This area had one nursing officer for every 14 WTE qualified staff compared with one to 17 in outer London and one to 25 in the counties. These differences between the parts of the regions increase when individuals rather than whole-time equivalents are considered.

High turnover rates also have important cost implications for the inner London districts, where the administrative costs of recruitment and termination will be proportionately higher than elsewhere in the regions. An American study[17] has drawn attention to the cost of filling a vacancy,

which can be the equivalent of 1.8 months salary. Training costs must also be taken into account, especially for health visitors. To maintain a supply of health visitor recruits inner London invests more than other parts of the region in health visitor training programmes. In 1977/8, the inner London A.H.A.s filled student posts equivalent to 23% of their health visitor establishment compared with 16% in outer London and 11% in the counties. In addition to the costs of formal training schemes, there are hidden costs associated with recruitment. These may be impossible to estimate, but should not be forgotten: new recruits need induction courses, time to get to know a district and settle in, during which they will not be working at maximum efficiency. No good evidence is available about the effectiveness of newly-trained health visitors, but experienced staff agree that they require between one and two years to get to know the families on their caseload and the statutory and voluntary agencies in a district.

The problems associated with the mobility and inexperience of staff in inner London could be solved fairly rapidly by recruiting more mature and experienced nurses and health visitors. This strategy might also be expected to improve the stability of the workforce, but nurse managers had little scope to put it into practice as they received so few applications from experienced nurses and health visitors. They were quick to suggest changes which might increase recruitment or keep staff for longer, and in some cases had been able to introduce their ideas, including interest-free loans for season tickets, temporary accommodation in nurses' homes and increased uniform or clothing allowances. Inner London nurse managers were pessimistic about the possibilities for reducing wastage because many of their staff were likely to leave for what were seen as unavoidable reasons, such as marriage, pregnancy, moving house or a husband changing job. The difficulties of eliciting and interpreting nurses' reasons for leaving have been discussed by Mercer,[15] who concludes that to understand why nurses leave we must also understand the complex economic, social and occupational background against which these individual decisions are taken. Before solutions to staffing difficulties can be identified therefore, more information is required about the problems and costs of working in inner London and the career patterns of nurses in the community. These and other gaps in our knowledge will be further illustrated by considering some policy strategies which have been suggested to attract staff to a district and keep them there.

Policy suggestions

In this section some approaches to alleviating the staffing difficulties in inner London are discussed. Without further research however, policy suggestions are merely hypotheses about the factors likely to effect the recruitment and mobility of health visitors and home nurses, and it is not possible to identify which policies would be effective or the extent of the changes necessary to bring about improvements. The causes of high wastage rates are complex and it is likely that no single policy will have much impact on this problem. Thus the policies suggested are not alternatives; it may be necessary to introduce changes in many aspects of the service and its organisation.

1. Incentives

The Report of the Royal Commission on the N.H.S. states that nurses and health visitors "are no more likely than anyone else to want to live and work in unattractive urban areas" and in the discussion of attracting staff to London suggests that "New financial inducements to attract G.P.s and other health personnel to work in inner London and elsewhere in severely deprived urban areas may be required". The principle of incentive payments is simple enough, but there would seem to be many difficulties in implementing such a scheme. The Royal Commission's report does not clarify exactly what the extra payments would be compensating for, although it seems to imply that they would be a bonus for working in 'unattractive' areas of unsatisfactory working conditions, rather than to meet the extra expense of living and working in London. This raises problems about which A.H.A.s should offer increased remuneration, as urban deprivation does not effect them all equally and the various parts of inner London have different disadvantages associated with working or living in them Further research is required to investigate the stresses on staff and the extra costs associated with working in inner London, whether these factors discourage health visitors and home nurses from working there, and to what extent they could be compensated for by financial incentive schemes.

Other possible incentives which have been suggested to attract or retain staff are the provision of housing, cars or car loans, improved office accommodation, creches or nurseries, clerical support and subsidies for travel.[15, 18-21]

The availability of these benefits varies between A.H.A.s, but there is no evidence that any have had a significant effect on recruitment or length of service. Nurse managers pointed out complications to the introduction of these apparently simple suggestions: the housing offered may not be appropriate to the needs of staff, and in some of the most central districts it is impractical to use a car for work. They agreed however that there was a need to examine how conditions of service might be improved for health visitors and home nurses working in inner London.

2. Job enhancement

Many factors contribute to the appeal of health visiting and home nursing and the satisfactions which can be derived from this work. Its attractiveness may therefore be increased by extending its scope or expanding the roles of health visitors and home nurses as suggested by the Royal Commission on the N.H.S. The possibilities for achieving such expansion for those who work in inner London is likely to be limited by staffing difficulties. The low staffing levels in some districts indicate that heavy caseloads were common, which June Clark has argued reduces health visitors' job satisfaction and perpetuates traditional ways of working.

> ".....unless the ratio of health visitors to the practice population is adequate the health visitor will be unable to utilise the opportunities available and the skills which her training has given her and her work will tend to be limited to performance of traditional roles whatever changes there may be in training policies and philosophies of health care."[22]

Thus for some inner London districts job enhancement may be achieved simply by increasing establishment levels of staff to ensure that all aspects of health visitors' and home nurses' roles can be fulfilled and that some are not neglected because of pressure of work.

If health visitors and home nurses are to expand their roles, what kind of staff will be required to cope with the increased workload this development will inevitably produce? An increase in staffing levels may suffice, but greater differentiation may be needed to match skills to the new requirements of the job. The two strategies of specialisation and substitution might be considered to achieve an appropriate mix of staff.

The Royal Commission on the N.H.S. recommended the development of specialist knowledge and skills in both the hospital and community, but did not discuss the very controversial issue of specialist posts for community staff.[23] Many nurse managers expressed strong views against specialisation, arguing that it could lead to a two-tier service with an elite of specialists creaming off the 'interesting' work and leaving the routine chores for the generalist. Others were more favourable and had appointed specialists to ensure the needs of certain patient and client groups were met. The creation of specialist posts appears to depend entirely on management preference and was found to be progressing in a piecemeal fashion in the two regions.

Nurses and health visitors may be able to use their skills more appropriately and increase the scope of their work is some tasks could be delegated to less highly qualified personnel. This is also a controversial topic[18] and few studies have been carried out to evaluate attempts at substitution, although Hockey[24] has argued that greater use could be made of S.E.N.s in the community, and the Briggs report[25] recommended that maximum use should be made of 'aides'.

We also know little about how well training courses prepare health visitors and home nurses for practice in inner London, where the organisation of services and the characteristics of the patients and clients served are different from those in more surburban areas.[26, 27] Inner London's high proportions of elderly and single-handed G.P.s, who often work from inadequate premises and accept patients from a wide area, have prevented progress towards general practice-based community health care in this area. Many nurse managers still prefer to deploy their staff geographically, making attachments selectively to health centres and large group practices. There were therefore few opportunities in most inner London districts for health visitors and home nurses to work as part of primary health care teams, a form of organisation which McIntosh and Dingwall[28] have shown to be held up as an ideal during training. June Clark warned of the dangers of this mismatch between training and practice.

> "If changes in the training of health visitors are not reflected in changes in the service then there is a danger that newly qualified

> health visitors have been trained for a job which they are not allowed to do. Lack of congruence between expectation and reality in the work situation is well recognised as a factor which reduces job satisfaction, damages recruitment and increases wastage."[22]

Dingwall[29] also found that when expectations about teamwork were not fulfilled in practice, many newly-qualified health visitors rapidly became disillusioned and frustrated with their work.

Lack of attachment schemes have been shown to reduce the scope of home nursing in inner London when compared with elsewhere in the regions.[27] Inner London home nurses have little opportunity to undertake treatment sessions in G.P.s' surgeries and almost all their patients are elderly persons who are nursed at home. In contrast, home nurses elsewhere in the two regions treat almost as many patients in surgeries as at home and consequently carry out a greater variety of nursing tasks for patients of a much wider age range. From the information available it is much more difficult to discover how the work of inner London health visitors differs from those employed elsewhere, although Marris[26] found variations in the time spent with particular client groups, and other studies have described differences in the work of attached and geographically deployed staff[30-32]

Without knowing which aspects of their roles health visitors and home nurses value most, it is impossible to design manpower policies to staff the community services for the inner London population.

3. Change in recruitment policies

To attract the experienced staff required in inner London recruitment policies may need to be re-examined as they may be reinforcing the patterns shown by the survey. To illustrate this point with one example, a conspicuously small proportion of inner London health visitors and home nurses were married women working part-time and there were even fewer recruits in this category. We do not have sufficient information to enable us to decide whether variation in the employment of part-time staff occurred because of differences in recruitment policy or their availability, but some districts held a tradition of offering only full-time posts. The shortage of trained nursing staff in general has generated much discussion about encour-

aging married women to return to work, but we know nothing about the numbers of experiences nurses who would return if conditions were right for them. A study of registered nurses not currently working showed that only 8% definitely did not intend to return to nursing.[20] Assuming that a pool of 'inactive' nurses and health visitors exists, recruitment and staffing policies may need to be modified to attract them back into service.

Mercer and Long have argued that the policies designed to alleviate nursing turnover have given insufficient attention to the difficulties of being a woman in work:

> "While there is little reason to suppose that administrative policies will change the broad outline of women's role in society, there may be scope for improving a nurse's ability to cope with looking after a family and having a job; for example by the provision of nursery facilities or flexible working hours."[21]

This observation is supported by the results of two studies which sought nurses' views on their requirements for returning to part-time employment.[18, 20] In both studies over 70% of nurses thought that the availability of convenient and flexible working hours was an important factor, over 60% thought there was a need for creches and nurseries, while only about 30% mentioned increased rates of pay.

Of nurses who had returned after bringing up a family, 23% reported that need for extra income was their main reason for returning to work.[18] A further 10% of this group returned because they had been asked to, which illustrates the importance of managers retaining contact with nurses who are not currently working. This is part of the value of the 'nurse banks' which some districts in our survey had established, but most nurse managers had no knowledge of local nursing resources.

From the information presently available it is difficult to ascertain whether nurse managers may be able to change the staffing pattern of inner London by more selective recruitment policies. If this is not possible some districts may have to accept that recruits are only likely to remain in post for a short time and organise health visiting and home nursing and their workload accordingly.

CONCLUSION

This paper has illustrated some of the deficiencies of the health visiting and home nursing services in inner London and explored the complexities of alleviating the acute staffing difficulties in this area. The success of the planned reduction of hospital care depends on strengthening primary and community services, which must cope with an increased amount and scope of work. Without radical changes in professional attitudes and legislation relating to general practice, little can be done to improve the inadequacies which have been identified in London's general practitioner services. In addition, our study has shown how any development of community nursing services is likely to be severely constrained by a lack of suitably qualified and experienced health visitors and home nurses. Unless the problems described can be alleviated, the feasibility of relying on community nurses as the backbone of primary health care in inner London must be questioned.

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THE IMPLICATIONS OF THE PRIVATE SECTOR FOR THE NHS

Berry Beaumont

The relationship between the NHS and the private sector, and its implications for the organisation of health services in Greater London, is a complex and extensive subject to explore. This paper does not claim to present a comprehensive picture, not least because of the paucity of information about the activities of the private sector of health care.

Private health care can be defined in various ways. A working definition might be 'the provision of services relating to health, for which the providers are paid directly by the patient, or on behalf of the patient'. Private health care, thus defined, is structured in several ways. Private medical practice, involving inpatient, day patient and outpatient care, is carried out in NHS hospitals by consultants holding part-time NHS contracts. These consultants may also undertake private work in non-NHS premises. General practitioners, dentists and opticians too may legitimately divide their time between private and NHS work. All professional health workers – including doctors, dentists, nurses, physiotherapists, radiographers, technicians and chiropodists – may choose to do NHS work but practice exclusively in the private sector, although the opportunities for this are greater in some parts of the country and for some staff than others.

There is a large grey area of activities which could be included in a definition of private care, which will not be explored further in any depth. These include the organisation of medical and nursing agencies which employ staff who are then often contracted out to, and paid for by the NHS; income for doctors from signing cremation forms, performing insurance examinations, acting as medical officers to Local Authority homes and the like; the work of doctors and nurses within industry in the occupational health field; and the activities of practitioners such as osteopaths who rarely have the option of working within the NHS.

HISTORICAL ASPECTS OF PRIVATE HEALTH CARE IN BRITAIN

Prior to the establishment of the national health service, both public and private health care systems existed in Britain. The effect of the

introduction of a nationalised health service was to bring about a significant change in the nature of both these systems, and a change in their relationship to each other. Table 10.1 shows the proportion of hospital consultants holding part time contracts over the years. This proportion has declined since 1948, although the absolute numbers of consultants holding such contracts has increased due to the increase in the total size of the consultant body.

Table 10.2 illustrates the considerable variation between specialties in the proportion of consultants holding such contracts.

TABLE 10.1

HOSPITAL CONSULTANTS HOLDING PART TIME CONTRACTS

Year	% part time	numbers
1959	73	- (E & W)
1964	69	5106 (E & W)
1978	53.3	6003 (England)
Source:	Mencher, S. Private Practice in Britain. Occasional papers on social administration. No 24 G Ball & Sons Report of the Royal Commission on the NHS 1979. Cmnd 7615 HMSO	

Although there is little up to date information about trends in private practice among general practitioners, it appears that the numbers undertaking significant amounts of private work have remained low over the past 30 years (Table 10.3). In 1962, the Minister of Health estimated that income from all non NHS work contributed less than 8% of the average net income for GPs.[1] The figure for 1971, published by the Doctors' and Dentists' Review Body was similarily 8%.[2] It has not been possible to find information about the extent of private practice amongst other health professionals.

TABLE 10.2

PERCENTAGE OF CONSULTANTS HOLDING PART TIME NHS CONTRACTS BY SPECIALTY - ENGLAND & WALES 1978

Ophthalmology	92.2
General surgery	85.6
ENT	74.5
Trauma & orthopaedics	74.1
Obstetrics & gynaecology	72.4
Mental illness	25.9
Paediatrics	19.1
Chest disease	18.7
Pathology	14.7
Accident & emergency	14.2
Mental handicap	8.3
Geriatric medicine	6.0

Source: Royal Commission on the NHS (ibid)

TABLE 10.3

GENERAL PRACTITIONER PARTICIPATION IN PRIVATE PRACTICE

1951	80% GPs had more than 20 private patients
1964	75% GPs had more than 20 private patients, 4% had more than 100, 31% had none
1952 and 1964	a number of GPs equivalent to 3% of total NHS GPs had entirely private practice

Source: Mencher, S (ibid)

The number of pay beds in NHS hospitals has declined since 1948, a decline which was accelerated following the passage of the Health Services Act in 1976 (Table 10.4). There are now 2712 pay beds in Great Britain. Table 10.5 shows the rather incomplete information available about private health service facilities outside the NHS, where it seems the numbers of hospital beds have increased over that period, with some 34 500 private beds now in existence in the UK.

TABLE 10.4

PAY BEDS IN NHS HOSPITALS

Year	number of paybeds
1949	6647 (E & W)
1959	5759 (E & W)
1969	4350 (E & W)
1979	2712 (GB)

Source: DHSS - SH3 Returns and Health Services Board - personal communication

TABLE 10.5

PRIVATE HOSPITALS AND NURSING HOMES IN UK

Year	Institutions	Beds
1948	250	-
1965	-	2900
1977	1249	34546

Source: Mencher, S (ibid) and Royal Commission on the NHS (ibid)

Even after the establishment of the NHS, patients have been at liberty to choose to receive all or part of their medical care privately, whilst still retaining full rights to NHS treatment. Today, approximately 40% of British patients using private hospital services pay for their treatment directly. The remainder have some or all of the costs of their treatment paid for by one of the three major provident associations to which they have subscribed under insurance schemes. Table 10.6 shows that increasing numbers of people are now covered by such schemes, suggesting that the numbers able to make use of private health facilities will increase. More group cover is being negotiated by employers and trade unions. In 1978, £100 million was collected in subscriptions.[3] The balance from this sum, after paying out for treatments, is used by Provident Associations (in particular the British United Provident Association) to finance other aspects of private care such as the building of hospitals, and the operation of the private British Nursing Agency. Thus the increasing number of subscriptions to provident schemes enhances the ability of the private sector to expand the scale of its operations. BUPA is also now providing Health Promotion Centres, and screening clinics, where in 1978, 30 000 people received 'medical checks'.[4]

TABLE 10.6

SUBSCRIPTIONS TO PROVIDENT ASSOCIATIONS

Year	subscriptions	persons covered
1949	50 000	-
1964	175 000	1 350 000
1978	1 118 000	2 388 000
GROUP PRESCRIPTIONS AS PERCENTAGE OF TOTAL		
1968	62%	
1978	78%	

Source: Mencher, S (ibid)
Lee Donaldson Associates. "UK Private Medical Care - Provident Schemes Statistics, 1978"

PRIVATE HEALTH CARE IN LONDON

Within Greater London, the decrease in pay beds on the advice of the Health Services Board has been proportionately less than in other parts of the country (Table 10.7). There are now 944 paybeds, which represent 35% of the total in Great Britain. Table 10.8 shows the considerable variation in numbers of paybeds between Area Health Authorities in London, with the teaching Areas having the most. Table 10.9 illustrates similar variation between the postgraduate hospitals.

TABLE 10.7

DECLINE IN PAY BEDS IN NHS HOSPITALS

Area	number of paybeds	
	23.11.76	1.10.79
Great Britain	4444	2712
GLC - AHA hospitals	1071	753
- postgraduate hospitals	227	191
Total GLC	1298	944
GLC as % Great Britain	29.2%	34.8%

Source: Health Services Board - personal communication

The total number of private admissions and treatments in NHS hospitals in London is shown in Table 10.10. The relatively large numbers of out-patients treated in the postgraduate hospitals are largely accounted for by the activities of the Royal Marsden. It is difficult to comment on these numbers in respect of their effect on NHS workload were there to be more or less private practice within the NHS, because there is no information available about the place of residence of these patients, their diagnosis, or the nature of the treatment which they received. This information was requested by the Health Services Board, and may become available in the future.

TABLE 10.8

PAY BEDS BY LONDON AREA HEALTH AUTHORITY AT 1.10.79

Authority	no of pay beds
Kensington, Chelsea & Westminster	173
Lambeth, Lewisham & Southwark	146
Camden & Islington	140
Ealing, Hounslow & Hammersmith	51
Merton, Sutton & Wandsworth	51
City & East London	49
Hillingdon	30
Brent & Harrow	23
Bromley	22
Redbridge & Waltham Forest	15
Enfield & Haringey	13
Barnet	12
Greenwich & Bexley	10
Croydon	6
Kingston & Richmond	6
Barking & Havering	6

Source: Health Service Board - personal communication

Table 10.11 illustrates the considerable variation in the utilisation of paybeds. Again, without knowing the diagnosis of the patients occupying these beds, it is not possible to compare this with the equivalent utilisation of beds by NHS patients in these hospitals. It could be suggested that paybeds might be used more efficiently and, in places where there is a shortage of NHS beds, redesignating under-used paybeds for use by NHS patients would be advantageous. The utilisation of paybeds in the post-graduate hospitals appears to be more efficient. This may reflect differences in diagnosis, and/or differences in demand.

TABLE 10.9

PAY BEDS IN LONDON POSTGRADUATE HOSPITALS 31.12.78

Hospital	no of pay beds
National Heart & Chest	38
Great Ormond Street	27
Royal Marsden	27
Moorfields	25
Queen Charlotte's	18
Royal National Orthopaedic	17
Hospital for Nervous Diseases	14
St Peter's	12
Royal Ear Nose & Throat	9
Bethlem & Maudsley	6
St John's	1
Eastman Dental	-

Source: DHSS - SH3 Returns

TABLE 10.10

PRIVATE WORKLOAD IN LONDON NHS HOSPITALS 1978

	AHA hospitals	postgraduate hospitals
Deaths & discharges (paybeds)	23 163	6381
Private day cases	3 164	650
Private outpatient attendances	42 566	23 138

Source: DHSS - SH3 Returns

TABLE 10.11

UTILISATION OF PAYBEDS IN LONDON NHS HOSPITALS
YEAR ENDING 31.12.78

	AHA hospitals		postgraduate hospitals	
	average	range	average	range
Occupancy %	56.7	30-81	73.4	40-89
Throughput %	25.7	17.6-48.3	32.9	6-53.6
Length of stay (days)	8.1	4.3-9.5	8.1	4.2-24.3
Turnover interval (days)	6.1	2.1-14.6	3.0	1.1-36.5

Source: DHSS - SH3 Returns

TABLE 10.12

PRIVATE BEDS IN REGISTERED HOMES IN LONDON DECEMBER 1978

AHA	no of units	no of beds mat	med	surg	psych	total
Barnet	11	1	372	205	-	413
Brent & Harrow	6	-	162	-	67	229
Ealing, Hounslow & Hammersmith	18	-	754	375	95	885
Hillingdon	2	-	5	89	12	128
Kensington, Chelsea & Westminster	18	25	1201	1173	28	1254
Barking & Havering	2	-	46	-	-	46
Camden & Islington	10	-	163	150	33	346
City & East London	2	20	96	-	-	116
Enfield & Haringey	9	-	62	187	-	249
Redbridge & Waltham Forest	2	-	12	-	55	67
Greenwich & Bexley	3	-	51	-	-	51
Bromley	11	-	321	-	-	321
Lambeth, Lewisham & Southwark	13	36	205	75	-	316
Croydon	14	-	386	-	-	386
Kingston & Richmond	6	40	158	74	-	272
Merton, Sutton & Wandsworth	15	40	291	93	143	567
Totals	142	162	4285	2421	433	5646

(totals in last column are less than the sum of the other columns since beds designated for either medical or surgical use are counted twice)

Source: DHSS - SBL 685 Returns

Within the private sector outside of the NHS, there now exist 142 units in London registered under the Nursing Homes Act of 1975 (Table 10.12). These units provide 5646 beds, which is nearly six times the number of paybeds in London. Of these 5646 beds, 162 are allocated for maternity patient use, 433 for psychiatry, and the remainder for medical and surgical cases. Private hospitals are permitted to retain flexibility in the designation of these latter beds for either medicine or surgery, so the figures in the Table represent the maximum number of beds which may be used for surgical cases. In the country as a whole, there are estimated to be 5400 beds in private hospitals which have facilities for surgery, giving London 45% of the national private surgical bed complement.[5] Since London only has 16% of all private beds, there is a relative concentration of private surgical facilities within the capital. Beds designated for medical use are mainly used for convalescent, terminal or geriatric care.

Table 10.13 shows some of the changes which have taken place since the Health Services Board was set up, at which time it was popularly predicted that there would be a boom in private hospital development. Overall, London has lost 8 units and 27 beds in the private sector. However, in Areas where there has been a net gain in beds, particularly in Kensington & Chelsea and Westminster, these new beds have been mainly acute surgical beds.[6]

It is important to recognise the heterogeneity of private sector hospital provision. Within Kensington & Chelsea and Westminster AHA, which has the highest concentration of private facilities, the variation is widespread as information supplied by the hospitals themselves illustrates. For example, the Harley Street Clinic operates as a commercial enterprise, providing 136 acute medical and surgical beds with 5 intensive care beds, operating theatres, catheter laboratories, x-ray and pathology facilities. The Clinic claims to perform 16 open heart operations per week, as well as other major procedures such as renal transplants. Between August 1978 and August 1979, there were 4023 deaths and discharges at the hospital, with approximately 90% of patients coming from overseas. The Nightingale BUPA hospital is a non-profit making enterprise, with 72 beds for acute medical and surgical cases and on-site diagnostic pathology and x-ray facilities. In the period September 1978/79, there were 1664 deaths and discharges at this hospital, almost all the patients being UK nationals. The St John and St Elizabeth hospital has 142 beds, almost a third of

TABLE 10.13

CHANGES IN REGISTERED PRIVATE HOMES IN LONDON - 1978

UNITS	
opened in 1978	closed in 1978
3 Kensington, Chelsea & Westminster	5 Barnet
1 Croydon	2 Brent & Harrow
1 Merton, Sutton & Wandsworth	1 Kensington, Chelsea & Westminster
	2 Enfield & Haringey
	1 Bromley
	2 Merton, Sutton & Wandsworth
NET LOSS = 8 units	

BEDS	
net gain in 1978	net loss in 1978
15 Ealing, Hounslow & Hammersmith	61 Barnet
22 Hillingdon	54 Brent & Harrow
186 Kensington, Chelsea & Westminster	37 Enfield & Haringey
58 Croydon	3 Redbridge & Waltham Forest
	5 Bromley
	9 Lambeth, Lewisham & Southwark
	139 Merton, Sutton & Wandsworth
OVERALL NET LOSS = 27 beds	
Source: DHSS - SBL 685 Returns	

which are concentrated for use by the AHA for geriatric patients, the remainder being used for acute medicine and surgery. The Convent of Bon Secours is a charitable institution staffed by nuns, whose 10 beds are occupied by UK residents aged between 80 and 100, some of whom stay there for many years. The heterogeneity of the private sector means that each Area would need to be studied in close detail before any statement could be made about the impact of the private sector on the NHS in London as a whole.

As far as the involvement of health service staff in private health care in London is concerned, once more the information available is limited. Table 10.14 suggests that a higher proportion of consultants in London than elsewhere hold part-time contracts. A survey be Mechanic[7] appears to show that general practitioners in London engage in more private practice than elsewhere, 40% of Southern GPs had more than 25 private patients, and 25% had more than 50 private patients, the comparable figures for GPs in the Northern Region and Wales being 4% and 2%. He also found that more private work was undertaken by GPs who had small NHS list sizes, and who were already in practice before 1948. The information in Table 10.15, showing the percentage of GPs over 65 years old, and those with small list sizes in London, lends weight to the contention that more private general practice work is undertaken in the capital.

TABLE 10.14

HOSPITAL CONSULTANTS HOLDING PART TIME CONTRACTS IN THE THAMES REGIONS 1978

Region	% part time
North West Thames	71.0
North East Thames	68.5
South East Thames	63.7
South West Thames	62.7
(England)	(53.3)

TABLE 10.15

RELEVANT CHARACTERISTICS OF GENERAL PRACTICE WITHIN LONDON

Area	% GPs with less than 1000 patients on NHS list	% GPs over 70 years old
Barnet	5	9
Brent & Harrow	5	7
Ealing, Hounslow & Hammersmith	3	9
Hillingdon	3	3
Kensington, Chelsea & Westminster	17	13
Barking & Havering	2	5
Camden & Islington	8	12
City & East London	3	9
Enfield & Haringey	2	7
Redbridge & Waltham Forest	5	5
Greenwich & Bexley	1	2
Bromley	2	1
Lambeth, Lewisham & Southwark	3	6
Croydon	1	4
Kingston & Richmond	3	5
Merton, Sutton & Wandsworth	4	6
England & Wales	2	3

Source: Jarman et al : A survey of primary care in London produced for Royal College of General Practitioners. 1979

There are no figures available about the involvement of other health professionals in private health care in London, although it seems reasonable to suggest, given the concentration of private facilities in the city, that London loses more than its fair share of NHS trained staff to the private sector, staff who might otherwise work in the NHS.

FUTURE DEVELOPMENTS IN THE PRIVATE SECTOR

It is hazardous to guess how private health care will develop in London, although there are some pointers to the direction it will take:

1 The Health Services Board is now abolished, implying that NHS paybeds will not be reduced further, and might be increased.

2 The regulation of developments in the private sector outside of the NHS will in future devolve on Area Health Authorities, but the exact mechanism by which this will operate is not clear. Certainly, it was simple for private hospitals to expand under the Health Services Board, since they were required only to notify the Board of a planned development, unless this involved 100 beds or more. Table 10.16 lists some of the proposed developments notified to the Board in 1978 and 1979. Some developments listed will not come to fruition, due to lack of planning permission or finance, but others not listed here have been reported in the national press as being pursued, for example, the plan by a consortium of Guy's Hospital consultants to establish a private hospital on the South Bank, and the hopes of BUPA to build another 150 bed hospital in London.

3 Private health companies have also suggested that they may embark on new activities, such as training doctors and nurses, or providing accommodation for general practitioners who do not wish to work in health centres.

4 The implementation of the new consultant contract would mean that any hospital consultant, even those on wholetime NHS contacts, could undertake private practice. Consultants already on maximum part-time contracts will receive additional payment equivalent to one NHS session a week, and there will be more flexibility in the kinds of part-time contract available.

TABLE 10.16

SOME DEVELOPMENTS IN THE PRIVATE SECTOR NOTIFIED TO HEALTH SERVICES BOARD 1978/1979

Area	beds	other information
Harrow	99	American Medical International
Hillingdon	7	St Vincent's Orthopaedic Hospital
Kensington, Chelsea &	77	+ 3 op,labs, x-ray - Allied Investments
Westminster	100	incl cardiac surgery - Wellington Hospital
	99	+ 3 op, labs, x-ray - BUPA
	12	for terminal care + 2 ops + OPD extension
	12	for rehab + labs - King Edward VII Hospital
Barnet	4	
Lambeth, Lewisham &	70	acute surgical - formerly Catholic Nursing Inst.
Southwark	15	+ 2 op, x-ray, labs - Churchill Clinic
Bromley	30	+ op, x-ray, labs
	13	+ op, x-ray
Greenwich & Bexley	50	+ 2 op and coronary care unit
Kingston & Richmond		add 3 consulting rooms - New Victoria Hospital
Merton, Sutton & Wandsworth	70	+ 2 op, x-ray, labs, ITU

5 Contributions to provident schemes are likely to continue to rise, particularly group contributions which are negotiated as fringe benefits for key employees. The numbers of patients from overseas coming to London for private treatment on the other hand are declining, as the EEC health market opens up, and health care facilities are being developed in their native countries.

IMPLICATIONS FOR THE NHS

The existence of a large private health sector in London obviously has implications for the organisation and funtioning of the NHS. The tentative conclusions which follow represent an attempt to suggest some of the implications, on the basis of the information presented in the preceding paragraphs.

Deficiencies

The private sector makes good some of the deficiencies in NHS services, deficiencies which in the present financial climate for the NHS in London there is little possibility for the NHS itself to remedy in the forseeable future.

a) Convalescent, terminal and geriatric care, and facilities for the younger chronic sick: this is easily recognised by the fact that AHAs have contractual arrangements with private hospitals for these facilities. However, it should be noted that organisations like BUPA and the international private hospital companies have made it clear that the provision of such facilities is not 'economic' and will not be undertaken in the future by them.

b) Fertility control services, including abortion and male and female sterilisation services: Table 10.17 shows the numbers of women resident in London who use the private sector to obtain a legal abortion. Although a proportion of them will have chosen private care, it is generally believed that many use the private sector because of a lack of NHS provision for abortions.

c) Provision of agency staff: the NHS does not run its own agencies to provide cover at times of staff sickness, holidays or delay in filling substantive posts, nor does it organise a general practitioner deputising service.

d) Screening: This is a dubious lack in the NHS, since the value of most screening procedures carried out in the private sector in unproven. The publicising of their availability and supposed worth adds to demands on the NHS to perform them, demands which it may well be correct to resist.

The private sector reduces the availability of trained health care staff to work in the NHS.

a) Consultants: this may or may not be significant. The shortage specialties are those in which there are few opportunities to practise

TABLE 10.17

LEGAL ABORTIONS TO LONDON RESIDENTS 1977

Area of residence	total abortions	non NHS premises	% abortions non NHS
Barnet	1059	638	60.2
Brent & Harrow	1617	1043	64.5
Ealing, Hounslow & Hammersmith	2821	1306	46.3
Hillingdon	586	269	45.9
Kensington, Chelsea & Westminster	3266	2124	65.0
Barking & Havering	989	329	33.3
Camden & Islington	1852	1142	61.7
City & East London	2554	1320	51.7
Enfield & Haringey	1782	829	46.5
Redbridge & Waltham Forest	1426	1066	74.8
Greenwich & Bexley	1016	387	38.1
Bromley	615	300	48.8
Lambeth, Lewisham & Southwark	3100	1144	36.9
Croydon	855	586	68.5
Kingston & Richmond	732	272	37.2
Merton, Sutton & Wandsworth	2077	1089	52.4
ALL LONDON AHAs	26347	13844	52.5

Source: OPCS Monitor AB 78/10

privately, and it could be argues that the relatively good opportunities for private work make it easier to attract consultants in other specialties to NHS posts in London. Possibly the availability of private work at consultant level influences the specialty choice of younger doctors, thus perpetuating the problem of 'shortage specialties'.

b) General practitioners: the fact that some GPs have small NHS list sizes in order to be able to undertake private work has an effect on the availability of NHS primary medical care, because of the way in which the Medical Practices Committee calculates relative need for GPs. General practitioners with list sizes of over 700 are all counted as if they provided equal amounts of NHS service when calculating GP/population ratios for difference districts. This leads to restrictions on additional GPs moving into places where there are a significant proportion of practitioners with small lists, since on paper these districts are over doctored whereas in practice, local residents may have difficulty in finding an NHS GP willing to take them onto the list.

c) Nurses: the evidence submitted by Area Health Authorities to the recent public enquiry into the proposed expansion of the Wellington private hospital indicates that the existence of the private sector in London add to the difficulties of nurse recruitment in the NHS.

d) Similar arguments could be put forward regarding the availability of dentists, physiotherapists and chiropodists for NHS employment.

Finance

The NHS suffers financially from the existence of private practice in NHS hospitals, and from the operation of private staff agencies.

a) Money paid by patients in paybeds does not cover the revenue costs of their care, and is paid into district funds, but there is a shortfall in terms of the capital costs of affording private patients facilities in NHS hospitals.[8] Balanced against this should be the income received from private patients treated by consultants holding

honorary NHS contracts, which may not be used by the consultant for his/her personal use but is contributed mainly to research activities.

b) The implementation of the new consultant contract which allows greater freedom for private medical practice is estimated to cost £3 million nationally. The payment of an extra NHS session a week to consultants currently holding maximum part time contracts is likely to fall heavily on London, and it is not yet certain whether this additional money has to be found from within cash limits.

c) If the NHS ran its own agencies for medical and nursing staff, it might be cheaper than the existing reliance on private agencies.

Duplication

The private sector operates in parallel with some NHS services, particularly surgical and maternity services. It is argued that this relieves the NHS of a proportion of its workload. This is certainly true in respect of some surgical and maternity procedures carried out on British residents in the private sector. However, particularly given the underuse of paybeds, it is hard to see why these procedures could not be carried out within the NHS, if more finances were made available for this purpose. There is no evidence that standards of medical care in the private sector are superior to those in the NHS, and with careful administrative attention, there seems little reason why the standards afforded by private treatment should not also be more readily available in the NHS.

Planning

The existence of a large private sector in London impedes NHS planning in its aim of making the most effective and appropriate use of health care resources. Health care resources are limited, whilst demand for health care is infinite. Planning within the NHS tries to match resources with demand, taking into account such factors as urgency with which care must be received, and balance of needs and priorities between different patient groups. A proportion of health care resources within London — those for private use — are not available to be controlled and allocated according to current planning policies. They are planned in accordance with different criteria, including profitability of the services which might be provided, and used

by an undefined and changing population who wish to choose private care, and are in a position to pay for it. This restricts the ability of the NHS to ration health care for a defined population on the basis of relative health needs, however the priorities of need are decided, because not all health care resources are subject to those rationing decisions. This decreases the amount of resources available to be 'rationed' and thus reduces the quantity of planned NHS provision to the population to be served, most of whom rely entirely on the NHS for health care, and almost all of whom will depend on the NHS for some aspects of care.

CONCLUSIONS

This paper has attempted to gather together the information available about private health care in London, and to suggest some of the implications of the existence of the private sector for NHS services. This can only be a partial contribution to any discussion about the desirability or otherwise of the presence of private health care in a country with a nationalised health service. It is to be hoped that any conclusions drawn by those concerned with this issue will take account of the facts of the situation, in as much as they are known.

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THE WORK OF THE LONDON HEALTH PLANNING CONSORTIUM

Geoffrey Rivett

Although the themes of these papers in planning for the future, one might be forgiven for feeling there were so many uncertainties that planning was virtually impossible. The Royal Commission has reported, Ministers have made statements about the future structure of the National Health Service, a consultative document has appeared and there are grave problems in remaining within cash limits. But whatever happens patients will continue to need for care and treatment. Within London there are and will remain fundamental problems on which planning can and must proceed, and this is the field in which the London Health Planning Consortium operates.

The LPHC was established in 1978 "to identify planning issues relating to the health services and clinical teaching in London as a whole; to decide how, by whom and with what priority they should be studied; to evaluate planning options and to make recommendations to other bodies as appropriate; and to recommend means of coordinating planning by health and academic authorities in London". Its membership is derived from the University of London, the RHAs, the UGC, specialist post-graduate hospitals and the DHSS.

Whilst Ministers wish there to be greater power at hospital and district level, inevitably in London cross-boundary planning will be necessary and the smaller the districts are, the more problems will require coord-ination.

This paper will consider five related problems that have been considered by the LHPC: population size and the consequent service requirements; allocation of resources; highly specialised services; medical education; and hospital stock.

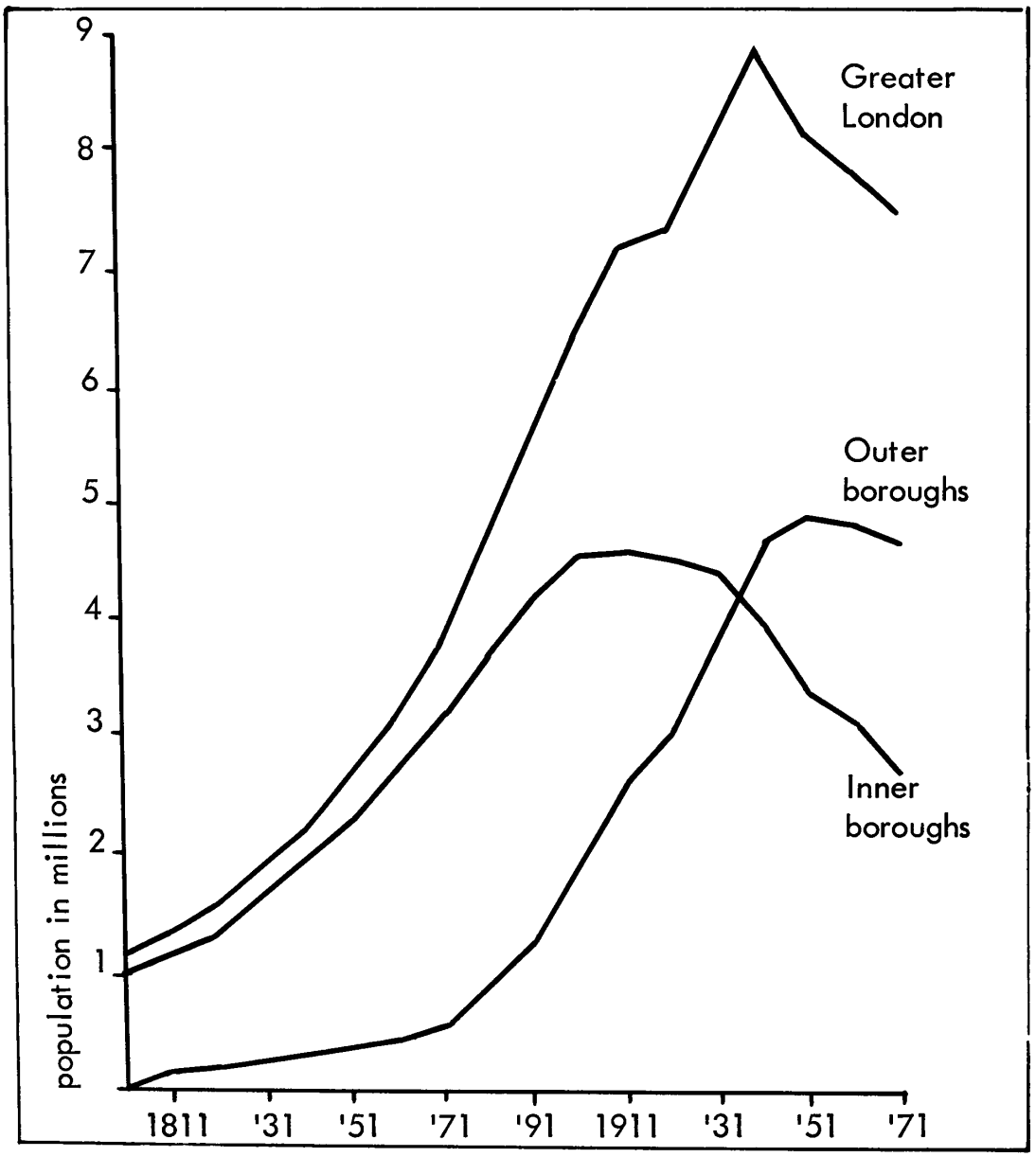
Population size and planning

In his introductory paper, Professor Eversley has described the changes in London's population and social structure, and indicated the strains this places on health planning policies. The movement of population

is not new and has been taken into consideration by planners for many years. The changes are best seen graphically (Figure 11.1). The inner boroughs reached their greatest population at the turn of the century since when they have declined. The outer boroughs did not reach their peak until 1951, since when the decline has been marginal.

FIGURE 11.1

POPULATION OF LONDON 1801-1971



Letters to the Daily Mail in 1902 commented on the declining population of the City and an editorial said there were too many large voluntary general hospitals within a mile and a half of St. Bartholomew's. The Hospital Survey in 1945[1] commented on the fall in the population in central London between 1931 and 1938 of 12.6% and in the outer boroughs of 6.2%. The surveyors' proposals for post-war hospital development and relocation were based upon population changes within "natural districts" which they defined. They also suggested an appropriate functional content for a "District Hospital" (Table 11.1).

TABLE 11.1

A DISTRICT HOSPITAL'S CONTENTS (1945)

	beds
General medical	220
General surgical	220
Children	100
Maternity	50
Gynaecological	30
ENT	30
Total	650

But reliance upon the crude numbers resident is not an adequate basis for planning. The age structure of the population and variation in mortality patterns are also important. There are cross-boundary flows which will continue. Patients may come into central London for treatment because of inadequate services near their homes, although planning may aim to reduce these flows. Others are treated because they fall ill while in central London, or because the facilities they need are centrally sited and could not be sensibly provided elsewhere. There must be allowances for such groups of patients.

Many will know that a sub-group of the London Health Planning Consortium has developed a method of predicting bed needs in the

Thames Regions in 1988, taking into account factors such as migration, the changing pattern of age and sex, and trends in the use of beds in different specialties. The method used in making this projection are described in the LHPC's profile of Acute Hospital Services in London.[2] Although the status of the method is simply that of a tool which can be used by planners should they so desire, it provides a useful means to looking at London and the four Thames Regions. on a consistent basis. But the population movements are an imperative to which the NHS must repond and respond more effectively than in the past.

Although the population of London has been falling for many years – and may well continue to fall – the change in the pattern of hospital services has been far smaller. Yet London's hospitals remain busy places – even in the "overprovided" Districts. So what is happening? Where are the patients coming from?

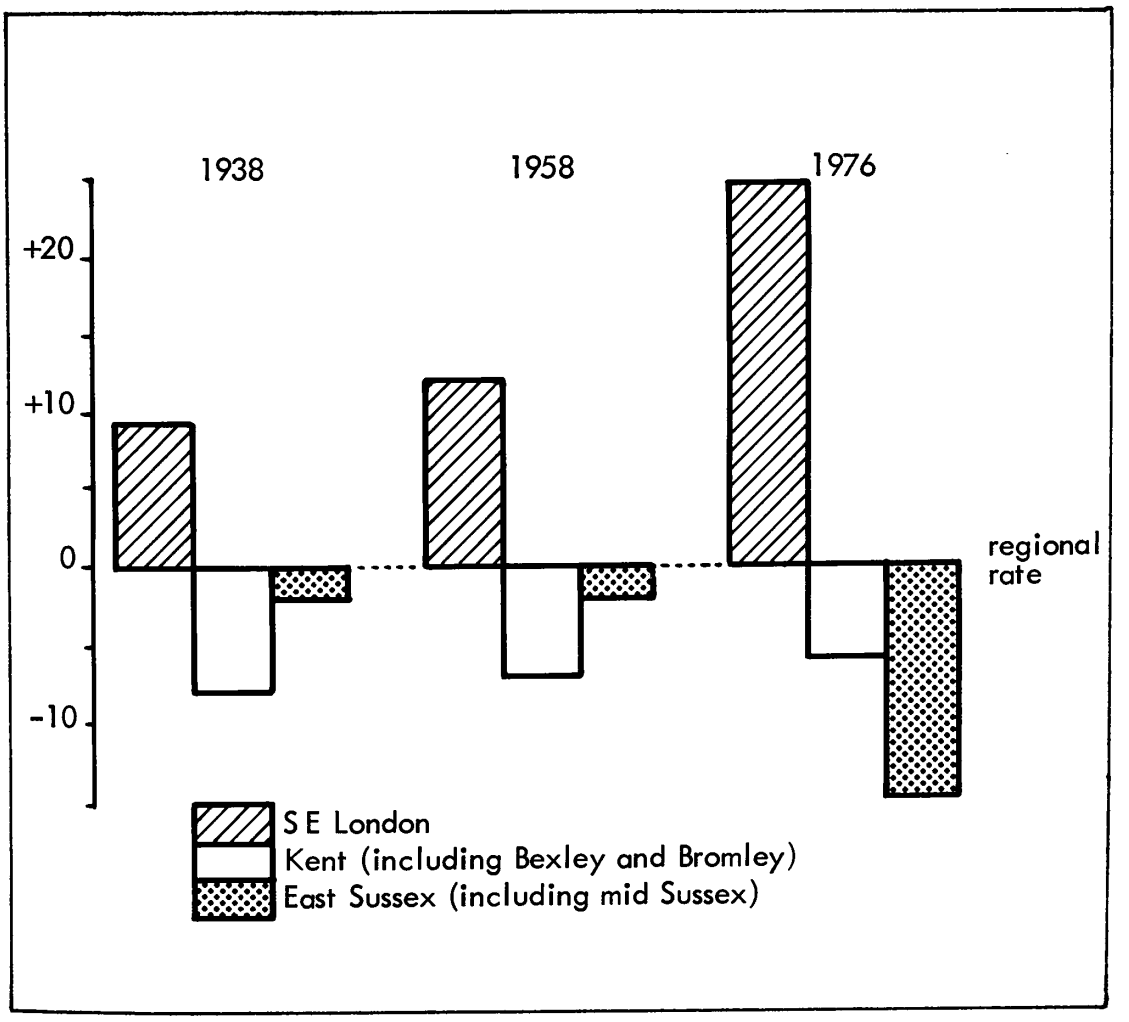
The teaching hospitals still depend mainly upon inner London for their patients. And more importantly, the areas around London have to treat most of their own people, only a minority travelling into London for care. Our analysis shows that for non-regional specialties most people living in inner London go to hospitals in teaching districts but 10% or less of people in the Thames counties use central London hospitals. The picture is different for the regional services. Almost half the patients from the counties requiring this type of treatment come into London for in-patient care, and for the more centralised services, like cardiac surgery or neurosurgery, the figure is higher still.

What is surprising is that the pattern has not changed much over the last 30 years. Despite the flood of population out of London and its home Counties, the proportion of people living in the counties who come into London for treatment has not changed significantly and the proportion of patients in teaching hospitals who are from the counties also remains constant. Around 10% of the admissions to King's, Guy's and St Thomas' came from Kent and East Sussex and the proportion is the same now as in 1938. This analysis involved research into the Hospital Survey of 1945, and an LCC and Voluntary Hospitals Association survey of 1931 as well as the Hospital Activity Analysis records of recent years. The only explanation for the stability of the pattern of patient flows is that the hospitalisation rate in the two areas has changed differently. As the

population in inner London declined, the hospitalisation rate has risen sharply; whereas in the counties it has always been lower and it has grown more slowly (Figure 11.2). (The hospitalisation rate is the number of inpatient and day cases per 1000 population).

FIGURE 11.2

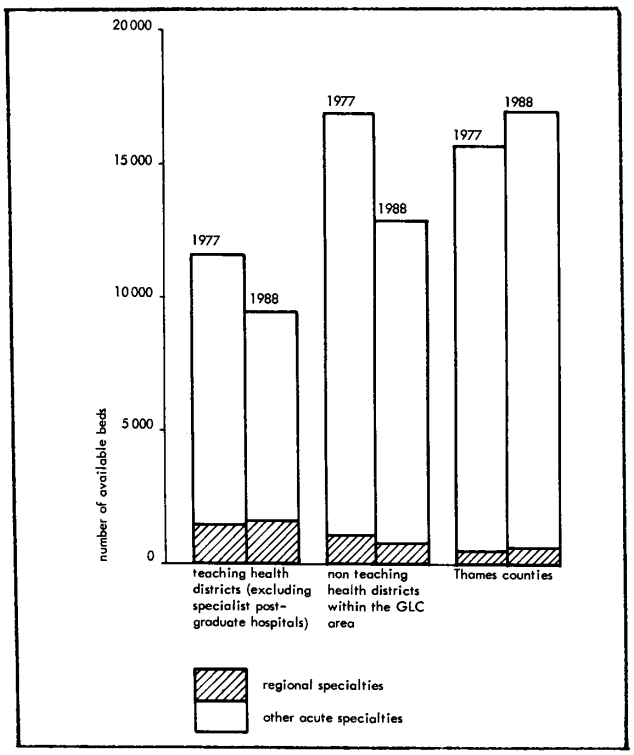
COMPARISON OF REGIONAL ADMISSION RATE
with rates for South East London, Kent and East Sussex
1938, 1958, 1976



We have been able to collect information from a wide enough area — the four Thames RHAs, the Boards of Govenors, and the surrounding RHAs — to produce reasonably reliable hospitalisation rates for each part of the Thames Regions. This shows a remarkable disparity between inner London and the surrounding areas. For inner London the average rate per year is 115 cases per 1000 population compared with a national average of 91 and 86 for the Thames Counties. What this means quite simply is that if you live in inner London you are 35% more likely to undergo hospital treatment than if you live in the counties within the Thames Regions. What is more, if you are admitted to a hospital in London you will stay there for longer than you would in most other parts of the country. This paper does not postulate reasons for this state of affairs, justify it or excuse it. But in deciding whether we should relocate our health services we need to know where we now stand.

FIGURE 11.3

COMPARISON BETWEEN 1988 PROJECTED BED LEVELS and available beds in regional and other specialties



The calculations made for LHPC suggested that to achieve a pattern of provision of acute services more appropriate to the population distribution expected in the Thames Regions in 10 years time it would be necessary to reduce the level of services in the teaching Districts by 20 - 25% (Figure 11.3). And this on the perhaps generous assumption that the same proportion of people from outside will continue to come to the teaching hospitals for treatment. We must accept that London has more beds for its population than most other parts of the country, and that the admission rate is related to the supply of available beds. This relationship can be demonstrated both on a national basis (Figure 11.4) and within the Thames Regions (Figures 11.5).

FIGURE 11.4

RELATIONSHIP BETWEEN DEATHS/DISCHARGES and available beds for acute specialties based on 1977 crude population

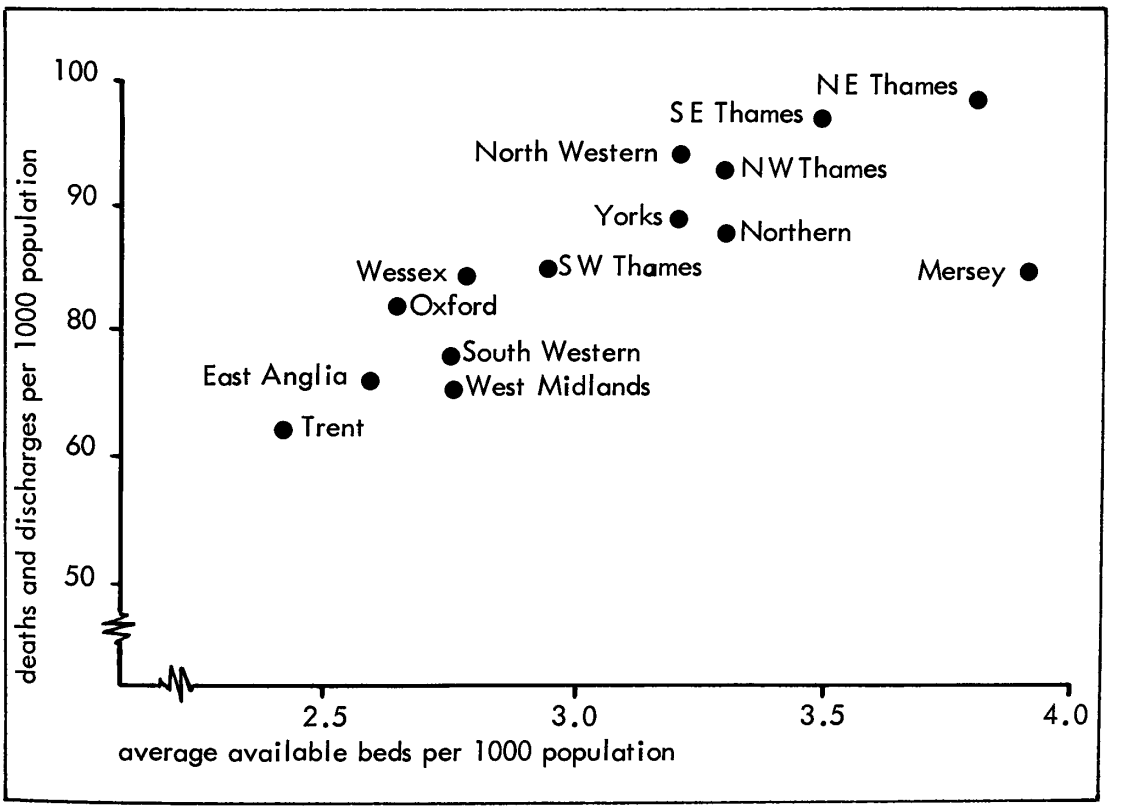
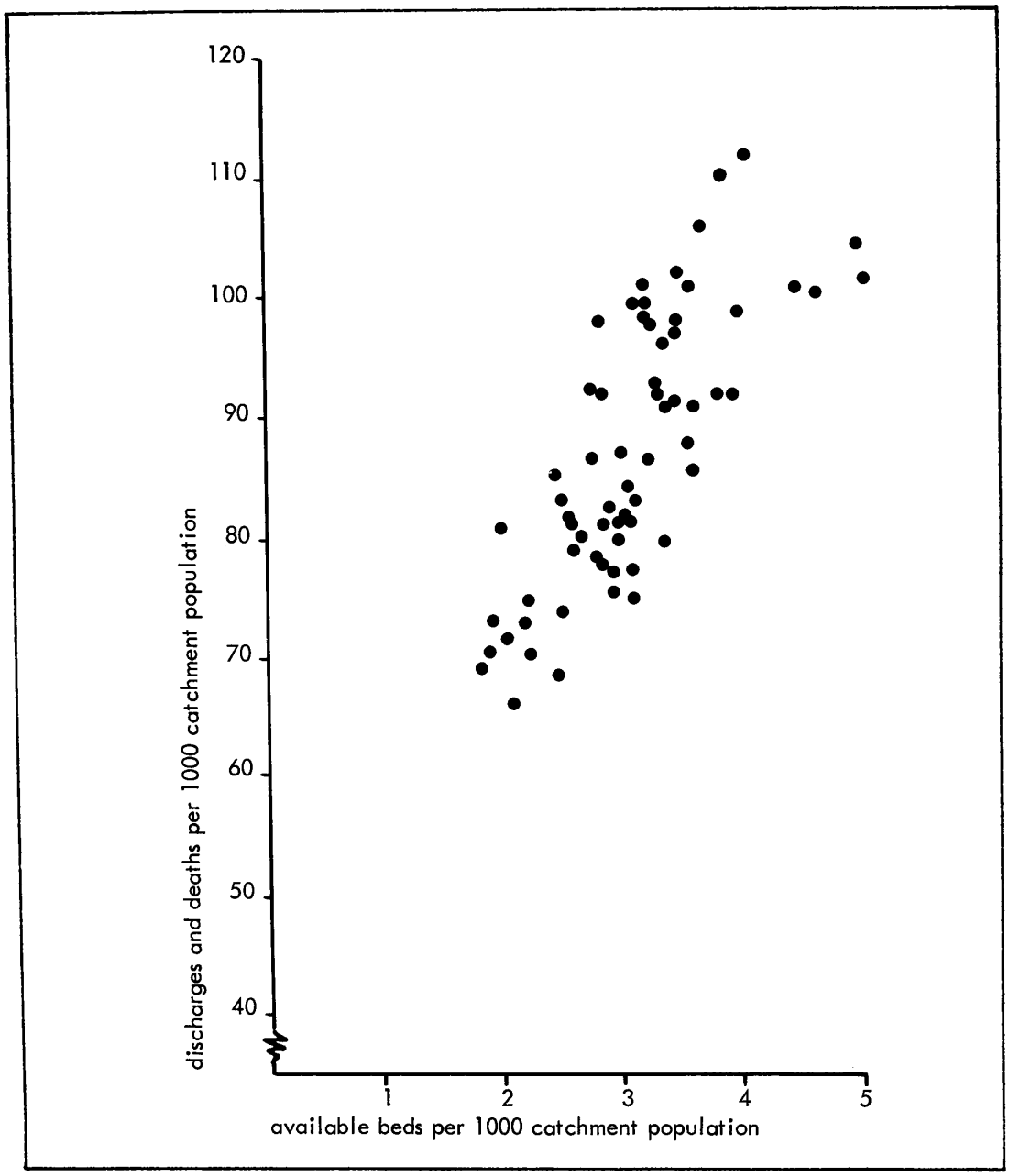


FIGURE 11.5

RELATIONSHIP BETWEEN NON-REGIONAL
acute cases and beds per 1000 catchment population
in the health districts of the four Thames Regions



This rate of change required is not only to meet an abstract norm of provision. The relatively higher levels of resources which have in the past been devoted to London have tended to be concentrated in the acute sector. It is necessary to rationalise the acute sector if other services are to be built up and if a strategy of providing services nearer to people is to be developed.

Resource allocation

Those with an interest in costing and resource allocation can find a mine of information in the Report of the Committee of Enquiry into the Cost of the National Health Service.[3] When the NHS started there was no better way of allocating funds than by reference to the historic level of hospitals' bugets. Guillebaud agreed that the main weakness of that system was "the apparent lack of a consistent long term objective" and considered whether any formula might be devised (related to regional populations, numbers of beds and/or other factors) which might serve as a guide to the Health Departments when sharing out the annual allocations to the Regional Boards. The Report concluded "that any national formula would have to be weighted to take account of such a wide range of variables in hospital regions that it could not be considered as a practical proposition, at least for the present".

Twenty years later that step was taken, and few people would argue that RAWP, whatever its defects, is actually inferior in principle to older methods of determining Regional targets. But just as Guillebaud believed that the problem of imbalance between Regions was too great for solution by a formula in 1956, so the authors of the RAWP Report appreciated that difficulties arose sub-regionally from RHAs, faced with the problem of division of their allocation amongst the areas. This has led to the adoption by RHAs of a variety of approaches, for whilst it is theoretically possible to calculate a district target by formula, in the much smaller world of the district the presence of absence of teaching hospitals, large mental subnormality hospitals and the uneven distribution of units providing regional specialty services make it hard to apply purely a population based formula and produce sensible results.

The health service has never aimed for total district self-sufficiency, nor desired to erect barriers preventing the flow of patients from one district

to another when it is in patients' interests to do so. Total "equity" of the provision of services or of the allocation of resources, is therefore impracticable. But London presents particular problems in respect of sub-regional allocations. In most parts of the country it is defensible to allow a Regional Health Authority to disperse its funds in accordance with any method which seems right in its own situation. In London, with a radial distribution of Regions one could still main this view, but some might think it unfair for comparable hospitals and units within a mile or two of each other to be treated financially in different ways because of the existence of an invisible regional boundary between them. For this reason, a group of senior officers, including the Treasurers of the four Thames Regions, a Regional Medical Officer and a Regional Nursing Officer under the chairmanship of a departmental officer have produced a common method of calculating targets in the Thames Regions and the RHAs are considering this approach.

It is a fact of life that it is more expensive to purchase some services in the centre of London than in the surrounding county areas. It is inevitable that some districts provide expensive technological services which others do not, and whilst there may be a variation from hospital to hospital in the actual cost of providing services there is no doubt at all that the district which is called upon to provide heart surgery incurs a considerable expenditure in doing so. The Report on Sub-regional Target Allocations in the Thames Regions[4] takes into account a number of these factors, not least the factor of social deprivation. Inevitably an element of judgement must be imposed upon the data available, and some will feel that this invalidates the whole procedure. Personally I do not share this view, and it is my hope that a method which has been developed by the Thames Regions may find general acceptance within this part of the country.

Special services

Having considered population and money, let us move to other features of the London medical scene, the provision of highly specialised facilities and the existence of many medical schools. When the health service was established in 1948 specialisation already had a century's history, but the process has continued. In the early years of the health service the problem of coordinating high technology services was less important than the other difficulties the new service faced. Regions were faced with the need to

make consultant services available in the main specialties on a local basis. The problem was recognised by the hospital surveyors, who proposed rationalisation of radiotherapy as early as 1945. But there has developed in the last 15 years a belief that, whilst elsewhere in the country it is generally possible to plan supra-district services within a single region, it is difficult to do so in London, divided as it is into four. It was for this reason that a Joint Working Group was established under Dame Albertine Winner in 1967 and this coordinating function now falls to the London Health Planning Consortium.

The Consortium established a number of study groups to consider cardiac surgery and cardiology, radiotherapy and oncology, and neurology and neurosurgery. North of the Thames two further groups are considering ENT and ophthalmological services. These reports are now appearing and it is our hope that they will provide a sound basis for planning, and provide a realistic framework for the development of the services concerned along professionally agreed lines. Concentration of these services creates problems but is generally consistent with improving the effectiveness of the service. There is often reason to believe that a larger clinical unit provides a better service to patients than a smaller one; it certainly can offer better professional experience, research and training facilities. At the same time there is the hope that the efficiency of the units, the ability to deliver service at a competitive cost, can be increased. The study groups contain representatives both of the academic world, and those primarily concerned with the provision of services to patients. They have a difficult job to do in reconciling the service need to concentrate high technology facilities with the educational desire to expose medical students to a wide variety of disciplines. These study groups have shown that two sets of people, each with their own responsibilities, can work together, cooperate and even enjoy the experience. It will be even more important for such cooperation to be developed in the implementation of their report. This is just one aspect of the last problem on which I must touch: the symbiotic relationship of the health service and teaching hospital, with the universities and medical schools.

As we have seen the membership of the LHPC brings together people with an academic background and those concerned with NHS services to face major problems together. One problem is to provide appropriate clinical facilities for medical education, and yet to avoid distorting the

pattern of service provided which the limited resources of the NHS can buy. All involved wish to see the best possible circumstances for their work, and most people appreciate the inevitable closeness of the partnership. I have already mentioned the attempts we have made to indicate the provision required by patients, and the way in which resources might be allocated to provide these. What of the education side? Here I am at risk of trespassing upon academic territory. But it is essential for those concerned with service provision to take educational factors into consideration, and I make no apology for trying to do so. The first precise statement of the facilities required in England by medical schools for clinical teaching seems to be that of the Goodenough Report of 1944.[5] The UGC recommendations of 1976 are similar (Table 11.2).

TABLE 11.2

SUGGESTED CLINICAL TEACHING FACILITIES REQUIRED FOR AN ANNUAL ENTRY 100 MEDICAL STUDENTS

Goodenough (1944)			UGC (1976)
250	General medicine		200
250	General surgery		200
	Orthopaedics		100
100	Obstetrics		100
50	Gynaecology		50
100	Paediatrics		50
150-200	Special depts.	Surgical and medical specialties	170
50	Beds for special purposes	Geriatric assessment	40
950 - 1000			910

With the inception of the Health Service a duty was placed on the Minister of Health to provide the clinical facilities reasonably required by universities with medical schools. Assessments such as that of the Goodenough Report have formed a basis for planning. Goodenough noted that many London teaching hospitals fell short of the level of provision required by their students, and made recommendations as to hospitals which might be associated with the medical schools to make good the deficiency. They proposed the closure of one school, the West London, and the relocation of Charing Cross, St George's and the Royal Free Hospital Medical Schools. They believed that teaching hospitals should be full partners in the hospital service of the districts in which they were located, and it is salutory to recognise that only now, after 30 years, are many of their recommendations coming to implementation.

The change for Charing Cross and the Royal Free was traumatic at the time, but I suspect that few of the staff would wish themselves back in their old premises. St George's is still enmeshed in the problem of transfer. Since these schemes were planned the intake of the London clinical schools has grown, and the population has continued to fall. Our prediction is that the bed provision in ten years time which will inevitably be smaller even though more patients will pass through each bed, at greater cost. Will the medical schools then have the facilities they require? We believe that in some parts of London medical schools could only solve their problems by even more extensive use of complementary hospitals at a considerable distance from the university campus. The UGC do not believe that students should spend more than a third of their time away from the centre but is unlikely that the Health Service will be able to provide all the necessary clinical facilities where the medical schools would wish. Health service facilities should be sited as near as possible to centres of population, paying regard to the need to centralise more specialised services. Outside London such a distribution seldom produces difficulties for the academic authorities. Inside London it does. The medical school pattern is now subject to the Report of Lord Flowers' Working Party of February 1980. Perhaps their recommendations and the LHPC's work will give us the basis for a strategy for central London to the long term benefit of all concerned. It might be painful, but it is difficuly to see how else the long term future of London's health service can be secured.

Hospitals

Finally what is the District Hospital service like in London? We have a legacy of "outworn and outdated buildings on constricted sites", words used by the Hospital Surveyors in 1945 but still true today. Millions still live in central London, but since the War the usual British compromises of a certain amount of rebuilding, the closure of some old hospitals where services can be provided in a better way, and the upgrading of old buildings has taken place.

There has been the rebuilding in the centre of London at Guy's and St Thomas', districts where the population has fallen. But further out in a semi-circle north of the Thames, covering Hammersmith, Camden, Islington, Hackney and Newham, the population remains considerable. Those in this zone live some way from the old voluntary hospitals, which were established when London was smaller and more compact. This semi-circle is served mainly by hospitals built initially as Poor Law Infirmaries when the population of London was growing a hundred years ago. Many are now in dire need of major capital investment and have a huge backlog of maintenance work. But District General Hospitals are being developed slowly and if one includes schemes now in the pipeline a pattern emerges. Regions have recognised the needs of this zone and the new Charing Cross Hospital in Fulham, the plans for the Hammersmith Hospital and for St Mary's, the newly developed Royal Free Hospital, the major development envisaged at the Whittington, the Homerton Hospital, redevelopment at the London Hospital Whitechapel, and the Nucleus Hospital in Newham should all come to fruition within the next ten years, This band of dense population will then have a hospital service mainly in modern structure.

In support there is likely to be a number of existing medium sized hospitals where these can play an efficient part in the provision of services. How well this pattern of facility, and the location of the regional specialty units, will meet the requirements of medical education remains to be seen. The publication of the Report of the Flowers Working Party and a report from LHPC on service and teaching facilities and the consideration of the consequentials by LHPC will provide a basis for debate.

In an ideal world we would have a system in which the central university hospitals would be situated within a zone where enough people lived to justify the beds and facilities which a medical school and teaching hospital require to provide services and education of the highest level. In the twenties the declining central population led to the movement of King's to Denmark Hill. The continuing pressure arising from central depopulation led to the recommendations of the forties that Charing Cross, the Royal Free and St George's moved. The depopulation has continued and perhaps the time is now right for further action. If as a result people can receive a good service in modern surroundings, students in teaching hospitals have to travel less from their main centre, and the supporting DGHs are in better fabric, we will have an accomplishment of which we can be proud. I remain optimistic that this is possible, not withstanding our present problems and the knowledge that many people feel that change is threatening.

It is impossible to compress problems such as those faced by London into a short paper, and do them justice. But we must accept that coordinating planning of London services, though difficult and sometimes disheartening, will remain essential in the years ahead. We are entering a time in which many reports are appearing and proposals will be made which are not to everyone's liking. We have the Flower's Report, three reports on regional services and a report by LHPC on the match between service facilities and teaching requirements. There seems to be no way to avoid decisions which will be uncomfortable in the short term for some people, but which are essential if London is to maintain in the future the place it has held in the past in the medical world.

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5 Goodenough W (Chairman). Report of the Inter-departmental Committee on Medical Schools. HMSO 1944

RESEARCH NEEDS FOR LONDON

Walter Holland

It is difficult to discuss research needs for London without first determining precisely what is meant. Do we mean research for Health Services or do we mean research as a whole? Let us examine some of the major problems existing in London today.

London is a large urban environment and over the last few years has undergone a change in its population structure. The total population of the inner city has been moving away from the centre. Old established communities have been rehoused in some of the new towns, such as Harlow and Milton Keynes. Immigrant groups, not only from the Commonwealth but from other countries, have settled in overcrowded areas in the city. This is not necessarily a new phenomenon but the problems of the newcomers are likely to be different and require difference forms of care, compared to those of the people who used to live in such areas. As a consequence of the fall in the population of central London, hospital facilities which, for the last 50-60 years, were considered to be over concentrated in central London are now under even greater threat because of the Regional Health Authorities policies aimed at redeploying these facilities in outlying areas.

Changes in patterns of employment and industry have influenced the lifestyle of the population. Formerly many small industries existed in parts of London like Lambeth; now most industries tend to be labour intensive and few small industries can survive easily in the present economic climate. Many areas of London have severe unemployment; for example, in Lambeth over 30% of black school leavers are unemployed. Among white school leavers, about 15% may be unemployed in the 16-25 age group. These problems are familiar to all of us here in this room. The question that we have to answer is what sort of research can best serve these needs. I do not intend to try to lay down any sort of prescriptive list of priorities, nor do I presume that what I will say is novel to many of you. Research needs in London are rather different to research needs elsewhere.

The first priority for research should, I think, be concerned with one of our major problems, namely unemployment, particularly of young people. I feel it is important to discover its effects on the health and behaviour of young people. What are their smoking habits? What are their drug habits? How do they use health services? Do they develop any forms of psychological, psychiatric or psychosomatic illnesses? How do they react to various external stimuli? Can any of these effects be prevented by providing employment or by improving education? How can we use the skills of individuals to carry out some of the services that we lack at present? For example, could we use the unemployed as manual labour in some of our hospitals and other Social Service institutions paying them no more than at present, and filling some of our undermanned areas?

The second area for concern is activities of daily living, that is the public's behaviour and attitudes towards such factors as road accidents, smoking, nutrition, eating and exercise. How can we best alter these attitudes? How can we influence people to be more responsible with regard to behaviour which may effect their health status?

Thirdly, we must examine changes in health care deliver. We should study the efficiency and effectiveness of the procedures undertaken in large institutions. London has one of the largest concentrations of acute general hospitals per head of population of any part of the country. Is this the most appropriate use of resources? We must develop methods of evaluation to investigate both process and outcome of services, e.g. whole body scanners or cardiac surgery or many of the other new treatments which are introduced in London hospitals.

Fourthly, the quality of primary care and, in particular, general practice in London is appalling in many areas. How can be change the patterns in employment of primary care? What are the methods of care that should be applied in general practice and how can we attract some of the better graduates to work in run down areas, such as Lambeth, the East End and so on? What can we do about pharmacies which are now few and far between in many of these urban areas.

Fifthly, are we providing the appropriate care for the mentally handicapped, psychiatrically ill and the elderly? London used to place its psychiatric

patients in large long-stay institutions dotted around the outskirts. Is this the appropriate way to deal with the situation? What can be done in order to improve it? An area such as St Thomas' with excellent facilities for acute care has no facilities for mental handicap. How can we best lead the way to new and better methods of treatment?

Finally, what about education? What should we teach our administrators and managers? Are there better methods of educating our medical students? What are the criteria for education, skills and attitudes required by the changes of the next generation? What skills will they require?

I am certain that I have not satisfied everyone in the menu that I have suggested for the sort of research that is required. I have not attemped to discuss studies of aetiology. I have been concerned with the studies that a group like the London Health Services Research Group might foster more than any other.