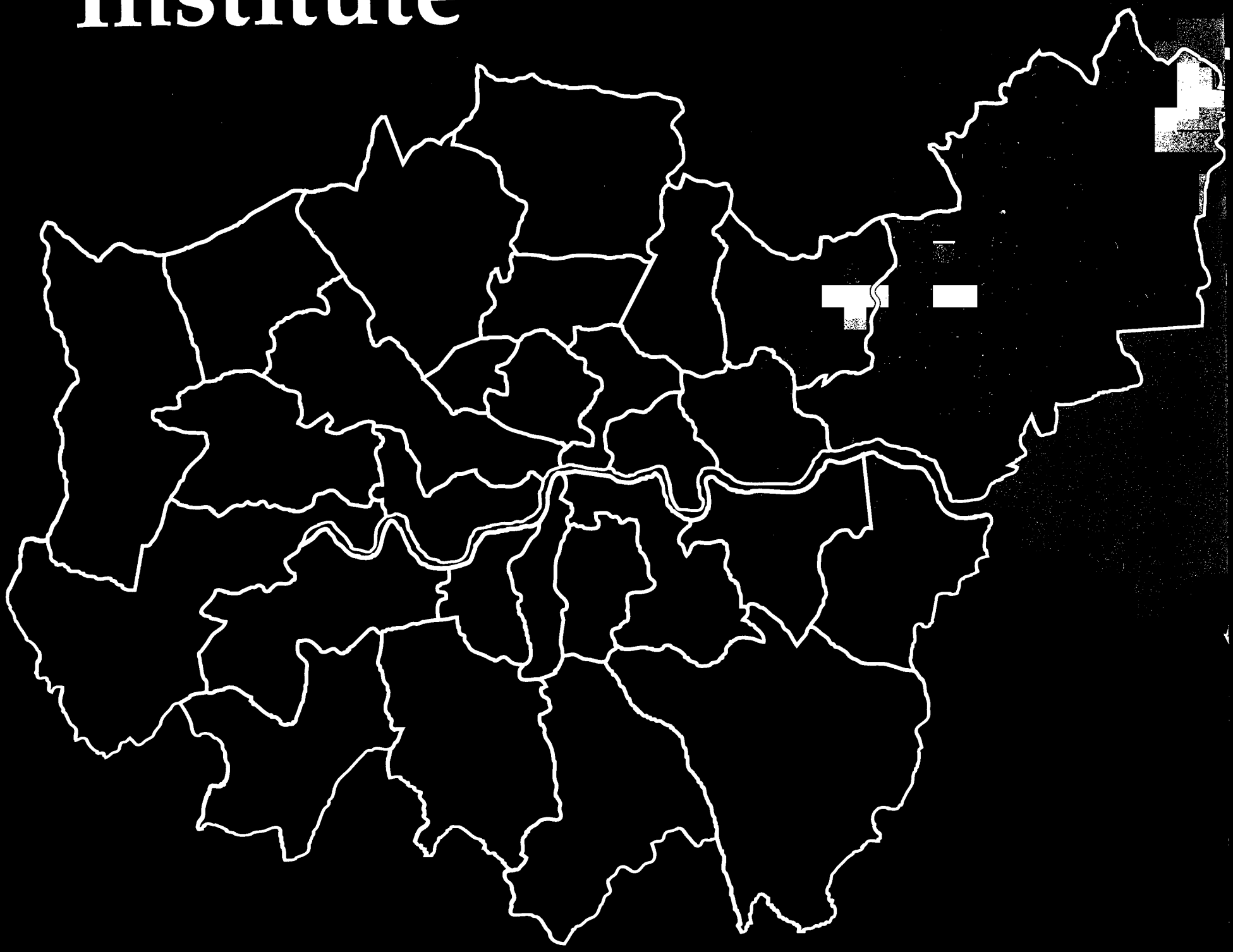
King's Fund Institute



Focus on Health and Health Care in London

The King's Fund Institute
Monday, 21 Septe

09.15	**Registration & Coffee**
09.45	**Opening Address** by Robert Maxwell
10.00	**Primary Health Services in London** Sean Boyle & Chris Smaje - King's Fun
10.45	**Discussants** Richard Lewis - South West Thames R Chris Gostick - North West Thames RH
11.05	*** **Coffee** ***
11.20	**Discussion**
11.50	**What do Londoners think of their serv** Mike Solomon - King's Fund Institute
12.10	**Discussant** Ros Levinson - Director, GLACHC
12.20	**Discussion**
12.30	*** **Lunch** ***
13.30	**21st Century Health Care: The King's** Virginia Beardshaw - King's Fund Lond
13.50	**An Optimal Balance for Services in Lo** Pat Gordon & Diane Plamping - King's
14.35	**Discussants** David Taylor - King's Fund Institute Jill McDougall - South Derbyshire DHA
15.00	*** **Tea** ***
15.15	**Priorities for Action: a panel discussi**
16.00	**Conference Closes**

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A Focus on health and health care in London

The London Monitor

The King's Fund has a long-term objective of promoting health and health care in London. As part of this commitment, the King's Fund Institute is establishing a first class database containing information about public health, the utilisation of hospital, primary and community services and the availability of resources in London.

The Institute has developed the capacity to analyse and interpret patterns and trends in data, and is also establishing a network of statisticians, planners and analysts in other London agencies.

The Institute is planning a series of annual events and publications on London, which will, among other things, review and analyse data about issues of topical interest, summarise important trends and present key statistical facts in an easily digestible form.

For further information please contact:

The King's Fund Institute
126 Albert Street
London NW1 7NF
Tel: 071-485 9589

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13.30	**21st Century Health Care: The King's Fund Commission's Vision** Virginia Beardshaw - King's Fund London Commission
13.50	**An Optimal Balance for Services in London** Pat Gordon & Diane Plamping - King's Fund Primary Health Care Team
14.35	**Discussants** David Taylor - King's Fund Institute Jill McDougall - South Derbyshire DHA
15.00	*** **Tea** ***
15.15	**Priorities for Action: a panel discussion**
16.00	**Conference Closes**

****

King's Fund Institute

King's Fund Institute London Conference: 21 September 1992

Participants

Dr Howard Baderman	-	Accident & Emergency Dept, University College Hospital
Jack Barnes	-	Under Secretary, NHS Management Executive, Department of Health
Alan Bennett	-	General Manager, City & East London FHSA
Claire Blackman	-	Project Manager - Health Studies, Audit Commission
Dr Ann Bowling	-	Health Needs Assessment Unit, Department of General Practice, St Bartholomew's Hospital Medical College
Pearl Brown	-	Primary Services Manager, Riverside Health Authority
David Browning	-	Associate Director - Health Studies, Audit Commission
Professor Martin Buxton	-	Director, Health Economics Research Group, Brunel University
Dr Pam Constantinides	-	Planning & Development Officer, Haringey Health Authority
Dr Deirdre Cunningham	-	Director of Public Health, North East Thames Regional Health Authority
Ami David	-	Development Worker, Primary Health Care, King's Fund Centre
Dr Sharon Daye	-	Quality Assurance Manager, Ealing Health Authority
Tom Dean	-	Chief Executive, Bromley Health
Nancy Dennis	-	Head of Consumer Audit, College of Health
Julie Dent	-	Acting General Manager Ealing, Hammersmith & Hounslow FHSA
Sue Dewar	-	Senior Nurse, Primary & Community Care, South West Thames Regional Health Authority
Dr Jennifer Dixon	-	Senior Registrar in Public Health Medicine, North West Thames Regional Health Authority
Dr Frances Duggan	-	Primary Health Care Project Officer, Health Education Authority

King's Fund Institute London Conference: 21 September 1992

Participants

Ainna Fawcett-Henesy	-	Regional Director of Nursing and Quality, South East Thames Regional Health Authority
Dr Rosemary Field	-	General Practitioner
Dr Anthony Furness	-	Elizabeth Avenue Group Practice
Dr Ed Glucksman	-	Accident & Emergency Department, King's College Hospital
Shirley Goodwin	-	Health Services Consultant
Gerry Green	-	General Manager, South East Thames Regional Health Authority
Dr Sian Griffiths	-	Director of Public Health, South West Thames Regional Health Authority
Lucy Hadfield	-	General Manager, Primary Care & Learning Disabilities, Wandsworth Health Authority
Professor Andy Haines	-	Department of Primary Health Care, Whittington Hospital
Alice Harding	-	General Manager, Barnet FHSA
Professor Conrad M Harris	-	Prescribing Research Unit, University of Leeds
Dr Deborah Hennessy	-	Regional Chief Nurse, Nursing Directorate, South West Thames Regional Health Authority
Richard Higgins	-	Chief Executive, Parkside Health NHS Trust
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David Hobbs	-	Assistant Regional General Manager (London), South West Thames Regional Health Authority
Lesley Humber	-	Therapy Manager, Optimum Health Services NHS Trust
Dr Bobbie Jacobson	-	Director of Public Health, City and Hackney Health Authority
Professor Brian Jarman	-	Department of General Practice, St Mary's Hospital Medical School
Sally Jones	-	Team Manager, London Borough of Newham

King's Fund Institute London Conference: 21 September 1992

Participants

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Mercedes Kelly	-	Manager, GP Fundholding Project, South East Thames Regional Health Authority
Ron Kerr	-	Chief Executive, South East London Commissioning Agency
Bill Kirk	-	Primary Care Manager, North West Thames Regional Health Authority
Professor Maureen Lahiff	-	Lead Adviser/Management Association, Royal College of Nursing
Margaret Lally	-	General Manager, Haringey Health Authority
Hilary Lance	-	Strategic Development Director, Forest Healthcare Trust
Michael Lee	-	Researcher - David Blunkett MP, House of Commons
Dr Philip Leech	-	Principal Medical Officer, Department of Health
Andrea Leonard	-	Health Care Directorate, NHS Management Executive, Department of Health
Robert Maxwell	-	Secretary and Chief Executive, King Edward's Hospital Fund for London
Dr Mollie McBride	-	Honorary Secretary, Royal College of General Practitioners
Virginia Morley	-	Project Officer, Primary Care Development, North West Thames Regional Health Authority
Professor D C Morrell	-	General Practice Teaching & Research Unit, United Medical & Dental Schools of Guy's and St Thomas's Hospitals
Sue Mowatt	-	Regional Director of Nursing, North West Thames Regional Health Authority
Duncan Nichol	-	Chairman, NHS Management Executive, Department of Health
David Pashley	-	Director of Primary and Community Services, North West Thames Regional Health Authority

King's Fund Institute London Conference: 21 September 1992

Participants

Dr Peter Pratt	-	Director of Community Services, Bassetlaw Hospital and Community Health Services NHS Trust
Antonia Roberts	-	Adult PSS Services and Community Care, Department of Health
Guy Robertson	-	Principal Officer, Social Services Association of Metropolitan Authorities
Janice Robinson	-	Programme Director, Carers' Unit, King's Fund Centre
Joyce Rowbottom	-	Policy Co-ordinator, Institute of Health Services Management
Ray Rowden	-	Unit General Manager, Priority Services Unit, Tooting Bec Hospital
Dr Zahra Sayed-Farshi	-	Primary Health Care Unit, Health Education Authority
Michael Scott	-	Director of Planning & Information, Priority Health Services, Rotherham Health Authority
Helen Shirley-Quirk	-	Health Care Directorate, NHS Management Executive, Department of Health
Joan Smaje	-	Director of Child & Family Services and Director of Nursing Services, Hillingdon Community Health NHS Trust
Chris Spry	-	General Manager, South West Thames Regional Health Authority
Jonathan Stopes-Roe	-	Secretary, London Enquiry Group, Department of Health
Robert J Strickland	-	General Manager, Greenwich & Bexley FHSA
John Tate	-	General Manager, Brent & Harrow FHSA
Caroline Taylor	-	General Manager, Camden & Islington FHSA
Barbie Vaughan	-	Programme Director, Nursing Unit, King's Fund Centre
Christina Victor	-	Director of Research, Department of Public Health, Parkside Health Authority

King's Fund Institute London Conference: 21 September 1992

Participants

Simon White	-	Director of Social Services, London Borough of Camden
Susan Williams	-	Joint Chief Executive, Lambeth, Southwark & Lewisham FHSA
Fedelma Winkler	-	Director of Planning, Barking, Havering & Brentwood FHSA

King's Fund Institute London Conference: 21 September 1992

Participants

Speakers

Virginia Beardshaw	-	Secretary, King's Fund London Commission
Sean Boyle	-	Health Information Analyst, King's Fund Institute
Pat Gordon	-	Programme Director, Primary Health Care Team, King's Fund Centre
Diane Plamping	-	Development Worker, Primary Health Care Team, King's Fund Centre
Chris Smaje	-	Research Officer, King's Fund Institute
Mike Solomon	-	Research Officer, King's Fund Institute

Discussants

Chris Gostick	-	Community Care Development Manager, North West Thames Regional Health Authority
Ros Levenson	-	Director, The Greater London Association of Community Health Councils
Richard Lewis	-	Primary Care Development Manager, South West Thames Regional Health Authority
Jill McDougall	-	Head of District Nursing, Southern Derbyshire DHA
David Taylor	-	Fellow in Health Policy Analysis, King's Fund Institute

Panel Members

Dr Stuart Carne	-	Consultant in Primary Care, North East Thames Regional Health Authority
Angela Coulter	-	Department of Public Health & Primary Care, University of Oxford
Norman Warner	-	Chair, City & East London FHSA

target payments — may be wrongly targeted anyway — ? relation with quality of care

prescribing patterns — ? effectiveness
they may be better off.

relationship between prescribing & referrals & / admissions ?
any information in outpatients?

→ list size + low level of support from DN

relationship between referral & admission

effect of GPFH

— what will the money be spent on — ? structural answers ?

— MUST EVALUATE NEW POLICIES & INITIATIVES
MANAGERS — CLINICIANS — RESEARCHERS

NEED TO UNDERSTAND DEMAND

increase intensity & activity in phc
more & better teams
nurses
administrative

? single-handed
? GPFH

INCENTIVES / CONSTRAINTS

interface between primary & secondary care
improve efficiency & outpatient services
follow-up
better communication
direct access

— GENERALIST / SPECIALIST RELATIONSHIP
GATEKEEPER

research into effectiveness in primary care
patients move through all sectors & back to phc
need

LOCALITY PURCHASING

relation between prescribing, referrals, admissions

Select Cttee on mat. services — NPEU — research & policy

COMPARATIVE ANALYSES OF LONDON

King's Fund Institute

It is essential to examine data about the capital in a comparative context. At one level, London can simply be compared with the rest of England. But for many purposes it would make much more sense to compare separate and distinct parts of the capital with parts of England which are in some senses similar to them. For this to be possible, a technique is required for classifying different areas into a number of relatively homogeneous groups.

The most well-regarded taxonomy in Britain was produced by making use of the 1971 and 1981 census data to classify administrative areas - including local and health authorities - into a number of clusters, families and sub-families (Craig, 1985). Unfortunately, this is not ideal for our purposes, but it does provide a very useful starting point because 'the groupings can be used as an aid for a more detailed investigation' (1985, p.1). The following section briefly summarises the essence of Craig's approach and explains why - where possible - it has to be modified for comparative analyses of health and health care in London. We then outline a modified approach.

Craig's Classification of British Areas

The main purpose of John Craig's socio-economic classification of local and health authorities in Great Britain is to 'provide groupings which help highlight some of the most general broad differences between areas' (1985, p.1). The statistical technique employed to do this is known as cluster analysis.

> *Basically this compares areas by calculating a measure of the overall difference between them on all the variables deemed to be relevant.*

> *Groups ... are formed by identifying areas between which the measure of overall differences is small* (1985, p.3).

It is important to note that there is no theoretical basis on which the selection of variables to perform the calculations can be made. It is generally advisable to make use of data which has a degree of face validity; it should be intuitively plausible to the intended audience. Nevertheless, there can be no getting away from the fact that:

> *the choice of variables is, in the last resort, a pragmatic one - that is the crucial test of the variables chosen is whether the resulting groupings are sensible and useful* (Craig, 1985, p.3).

For his analysis, Craig used 35 variables, derived from the 1981 Census, covering demographic and socio-economic structure, household composition, employment and housing. Data on each of the variables was analysed for 459 local authorities in Great Britain so as to produce a hierarchy of three kinds of groups. First, 28 'clusters' of areas were identified. These were then reduced to 10 larger 'families', and finally the 10 families were reduced to six 'groups' by amalgamating some of the families. This local authority based classification was then used to allocate health authorities to the same clusters, families and groups. Such an approach has the disadvantage that the classification of health authorities is almost certainly different from one which would emerge if they themselves were the primary focus of the analysis. On the other hand, Craig claims that his method:

> *has the considerable advantage that there is only one classification to interpret and that health areas and local authority areas can be interrelated* (1985, p.3).

TABLE 1

CRAIG'S CLASSIFICATION OF ENGLISH HEALTH AUTHORITIES*

Craig Family No	Name	London	Non-London	England
1A	Established High Status	12	23	35
1B	Higher Status Growth	0	17	17
2A	More Rural	0	25	25
2B	Resort and Retirement	0	11	11
3	Mixed, Town and Country	0	44	44
4A	Traditional Manufacturing	2	19	21
4B	Service Centres & Cities	1	19	20
5	LA Housing	1	3	4
6A	Inner London	10	0	10
6B	Central London	4	0	4
TOTAL		30	161	191

* Brent, Paddington and North Kensington, and Bloomsbury & Islington are included as separate authorities.

Table 1 shows the number of English health authorities - distinguishing between those in London and those in other parts of the country - in each of Craig's 10 families. A brief description of each of the families is provided in Box 1. Most of the London districts (26 out of 30) are categorised into three of the ten families. A simplified version of Craig's classification which highlights the distribution of London health districts is shown in Table 2.

Craig's taxonomy has certain useful features for anyone interested in undertaking comparative analyses of London. First, family 1A (established high status areas) provides a very useful framework for comparing the experiences of many of the outer London districts with similar authorities outside the capital. Second, by identifying some health districts in London which do not fit the conventional inner/outer dichotomy it draws attention to the need to think more carefully about the way in which London health districts themselves are classified.

BOX 1 DESCRIPTION OF CRAIG'S 10 FAMILY CLASSIFICATION

Family 1A Established High Status Areas
This family contains about 15 per cent of the population in the most desirable localities on the fringes of the major urban areas. It includes all of the outer London boroughs. It has the highest social class structure of all the families.

Family 1B Higher Status Growth Areas
This fairly distinctive and affluent family contains about 7 per cent of the population. It has the youngest age structure and the highest proportion of two-car households.

Family 2A More Rural Areas
A high proportion of the 13 per cent of the population in this family are employed in agriculture. It is the most mixed in terms of social structure with a relatively elderly age structure and the smallest proportion of ethnic minorities.

Family 2B Resort and Retirement Areas
This very distinctive family of coastal areas is one of the smallest with about 5 per cent of the population. It has the highest proportion of both over-65s and owner-occupiers. Nine of the thirteen areas are on the south coast.

Family 3 Mixed, Town and Country, Areas
This is the largest of the 10 families with nearly one-quarter of the population. The districts are among the most mixed in Great Britain and often include an older industrial centre with an area of adjacent countryside. The family is most strongly represented in the traditional industrial areas of the North, the Midlands and South Wales and it is the most typical of Great Britain as a whole. No London districts are included.

Family 4A Traditional Manufacturing Areas
Approximately 10 per cent of the population are represented in this family. This family includes the largest manufacturing textile areas of Lancashire. It is very much a traditional working-class area, and includes both Newham and Waltham Forest.

Family 4B Service Centres and Cities
This is a widespread family which contains about 14 per cent of the population. It is quite mixed. It has high proportions of unskilled workers and students and a considerable reliance on public transport. Public sector housing is more common than owner occupation. The only London district is Greenwich.

Family 5 Areas with much Local Authority Housing
This family contains 7 per cent of the population and is concentrated in Scotland. Twice as many households in this family live in local authority housing than the national average. It has the lowest social structure, and includes Tower Hamlets.

cont'd ...

Family 6A Parts of Inner London
This very distinctive family of 10 inner London districts contains a little more than 4 per cent of the GB population. It is particularly extreme in terms of social composition, age structure and the presence of ethnic minorities.

Family 6B Central London
This unique family centred on the fashionable areas of the west end of London contains just over 1 per cent of the population. It is very different to any of the other families. On most of the variables used in the analysis, this family is close to or at one of the extremes of the distribution.

Source: Craig, 1985

TABLE 2

CRAIG'S MODIFIED CLASSIFICATION OF ENGLISH HEALTH AUTHORITIES

Craig Family		London	Non-London	England
No	Name			
1A	Established High Status	12	23	35
1B	Higher Status Growth	0	17	17
2	Rural, Resort & Retirement	0	36	36
3	Mixed, Town and Country	0	44	44
4/5	Major Urban Areas	4	41	45
6	Inner London	13	0	13
TOTAL		29	161	190

* Bloomsbury & Islington are included as separate authorities.

Whatever its other merits, however, Craig's approach has serious limitations for the London-focused analyst seeking to make use of it for comparative purposes. The most important problem is that Craig identifies no other areas in Great Britain with which to compare the London districts in families 6A and 6B. An additional problem is that it is only possible to compare Tower Hamlets with areas in Scotland, whereas most of the easily available comparative data is for England only. Another difficulty is that the new

health districts of Parkside and Bloomsbury & Islington consist of combinations of authorities which in their former incarnations were split between families 6A and 6B. It is perhaps worthwhile emphasising why these difficulties represent such a problem for analytical purposes. The most convenient way of undertaking comparative analyses of health and health care in London is to classify the capital's health districts into meaningfully distinct categories which form part of larger groupings of homogeneous areas in the country as a whole. Given the way that administrative statistics are collected this usually means England rather than Great Britain.

It would be perfectly possible to analyse a selection of data for all English health districts and to produce a completely different classification to Craig's which would facilitate the kind of comparative analysis described above. We have taken the view, though, that there is some merit in retaining Craig's taxonomy where it is appropriate because it is so familiar, and that it makes sense to modify it only when that is essential for our purposes. In the vast majority of cases, Craig's classification of English health districts is perfectly adaptable for our purposes. Table 2 illustrates that families 1A to 3 - which account for almost 70 per cent of the total - are unproblematical. It is the remaining 58 (or so, depending on the time period to which the data relates) health districts in families 4 to 6 which do not easily lend themselves to facilitating the kinds of comparative analyses we want to conduct. It is in relation to this minority of health districts - 17 in London and 41 outside the capital - that we propose to modify Craig's taxonomy.

We can do this only in a very simple way for analysis of morbidity based on the *Health and Lifestyles Survey*. Here we simply aggregate Craig's categories 4-6 so as to facilitate some kind of comparative analysis. The small area analysis of the HALS data, therefore, compares two groups of Londoners with broadly similar groups in other parts of England. People living in the 12 districts in the capital classified as 'established high status' areas are

directly compared with those in the 23 similar non-London districts. Less satisfactorily, the people living in the 17 London districts spread across Craig's families 4-6 are compared with those in the 41 districts in families 4&5 which we refer to as 'metropolitan' areas. In the case of health service indicators and mortality data, however, we can adopt a more sophisticated form of modified approach.

A Modified Approach

Two key assumptions guide our development of a revised approach. First, that for health planning purposes there is a small group of hybrid authorities in the capital which straddle the conventional distinction between inner and outer London. Second, that in contrast to Craig we can identify reasonably homogeneous comparators for all London districts.

Our approach involves making use of the same statistical technique as Craig - cluster analysis - and similar kinds of census data. We have chosen to rely on a smaller range of variables, however, which are widely used for existing health planning purposes; the component parts of the deprivation indices developed by Carstairs, Jarman and Townsend. This set of data consists of 5 groups of 16 variables rather than Craig's total of 35 from the same groups, but the broad coverage is very similar.

Using the cluster facility available within SPSSX allowed us to vary the method of clustering as well as the array of variables. We were able to identify two new distinct groupings, each involving some of the London districts plus districts from other parts of England. This allows us to present an alternative classification of District Health Authorities (Table 3), which differs from Craig's classification in that the inner London districts are divided into two families, each of which contains non-London districts as well as London.

TABLE 3

KFI/CRAIG CLASSIFICATION OF ENGLISH
HEALTH AUTHORITIES

Craig Family No	Name	London	Non-London	England
1A	Established High Status	12	23	35
1B	Higher Status Growth	0	17	17
2	Rural, Resort & Retirement	0	36	36
3	Mixed, Town and Country	0	44	44
4	Major Urban Areas	4	34	38
5	Inner Deprived Areas	13	7	20
TOTAL		29	161	190

* Bloomsbury & Islington are included as separate authorities.

In the case of the new Family 5 - inner deprived areas - it was clear that these London districts are very different from most other health districts in the country. The seven similar non-London districts which we have identified are intuitively acceptable, and account for a population of 1.5 million, compared to the 2.5 million of the 13 London districts.

The London districts are divided between families 1A, 4 and 5, which we have termed established high status areas, urban areas and inner deprived areas. We have a set of non-London districts which we can use for the purpose of comparison in each case.

Although we have followed Craig's well established methodology, we would identify two advantages over Craig's taxonomy. First, we have taken a clear health perspective in clustering health districts rather than building those up from LA areas. Second, we have achieved a breakdown of what has essentially been regarded as inner London into two distinct families, which are no longer isolated, for comparative purposes, from the rest of England. At the same time we have retained one of the great advantages of Craig's

classifications; it produces groupings of areas which are broadly homogeneous. For example, the Craig classification correlates well with various census-based indices of deprivation which have been developed by such people as Carstairs, Jarman and Townsend and which can also be used to differentiate and categorise health authorities.

Summary

The method of comparing the health needs of Londoners with non-Londoners in this report varies slightly depending on whether we are investigating variations in health services and mortality or morbidity. In both cases, however, we have adopted a modified form of Craig's classification of health authorities. Table 5 summarises the differences between the two approaches. In each case, we remain faithful to Craig's original classification of families 1A, 1B, 2 and 3. The differences arise in our treatment of Craig's families 4, 5 & 6. In the case of health services and mortality, we have undertaken our own cluster analysis to reclassify these three families into two new ones which we refer to as 'urban' (4) and 'inner deprived' (5) areas. This means that there are three distinct families in London (1A, 4 & 5) which can be compared with broadly homogeneous areas in other parts of England. As far as morbidity is concerned, the data available only enables us to make the same comparisons for family 1A, the 'established high status' areas in outer London. What we have done, therefore, is to combine Craig's families 4, 5 & 6 and create a new category which we refer to as 'metropolitan' (4).

TABLE 5

CLASSIFYING ENGLISH HEALTH AUTHORITIES

Health Services and Mortality			Morbidity		
Family No.	Craig Nos.	Area Name	Family No.	Craig Nos.	Area Name
1A	1A	Established High Status	1A	1A	Established High Status
1B	1B	Higher Status Growth	1B	1B	Higher Status Growth
2	2	Rural, Resort & Retirement	2	2	Rural, Resort & Retirement
3	3	Mixed, Town & Country	3	3	Mixed, Town & Coutnry
4	)	Major Urban			
	) 4,5&6		4	4,5&6	Metropolitan
5	)	Inner Deprived			

King's Fund

London Health Care 2010
Changing the future of services in the capital

REVIEW

London Health Care 2010: Changing the future of services in the capital, the report of the King's Fund Commission, analyses the interlocking problems posed by health services, medical education and research in London. It warns that health services in the city may become unsustainable unless there is the political will to back a strategy of fundamental reform.

The report examines the demographic, technological and social changes that are combining to forge new patterns of health care. It recommends a radical programme of investment and restructuring to reshape services to meet the challenges of the new century.

1 The Context

1.1 In the hundred years since the first report on London's hospitals was published in 1892, there have been more than seventeen inquiries into the problems of health care in the capital. These are deep-seated, and pre-date the establishment of the NHS. There is longstanding agreement about their key elements, which are listed in Box 1.

1.2 From the late 1970s, efforts to change historic patterns of National Health Service (NHS) funding in order to balance resources more evenly across the country have contributed to a more rapid decline in hospital bed numbers in London than that experienced nationally as Figure 1 shows.

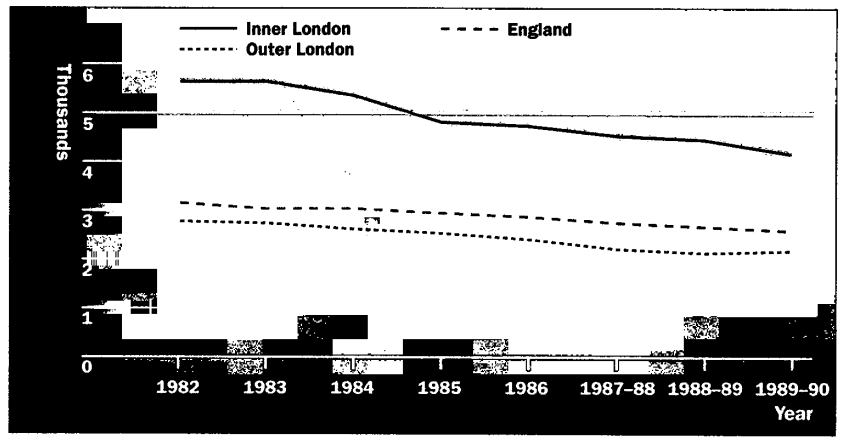
1.3 However, the concentration of specialist provision in the capital's NHS hospitals continued unchecked, as did levels of medical staffing.

2 London's Health Services

2.1 In 1989-90 some 2.9 billion, or around 20 per cent, of all English hospital and community health services expenditure was devoted to London, which contains 15 per cent of the English population. An additional £266 million was spent on London's Special Health Authorities (SHAs). These have a largely London-based caseload, while retaining national responsibilities for postgraduate education and research.

2.2 Health care in London costs an average of 20 per cent more than elsewhere in England, with services in outer-London close to the national average and care in the inner-city

Figure 1 Average available acute beds per 1,000 resident population, NHS hospitals, 1982–90



Box 1

KEY ISSUES

Over 100 years, official inquiries have identified persistent problems with health care in London. These are:

- **the concentration of acute hospitals in central London, with associated medical schools, research centres and postgraduate institutes all contributing to an expensive pattern of care.**
- **inadequate primary, community and continuing care across the capital;**
- **poor linkages between London's medical schools and the rest of London University, resulting in an 'apprenticeship' model of medical education which isolates medical students from their peers in other disciplines;**
- **fragmented and inadequately supported specialist and clinical research units across the capital;**
- **ageing buildings and equipment, with a lack of capital for new developments; and**
- **a management and planning structure that failed both to counteract the ingrained parochialism of London's health care providers and to give direction for the capital's health services overall.**

However, the effectiveness of past inquiries has been blunted by their failure to examine options for health services and medical education together. As a result, none has attempted a genuinely strategic approach for the future direction of the capital's health services.

costing 45 per cent more. In 1989–90, an episode of care in a London teaching hospital cost almost twice as much as one in a non-teaching hospital in the capital, at an average of £1052. This compared with a national average cost per case of £546.

2.3 Inner-London has maintained its historic role as a referral centre, with 30 per cent of people it treats originating from outside the inner city. This amounts to some 154,000 cases annually. 80,000 of these come from elsewhere in London.

2.4 London's role as a national referral centre is now very limited. Only some 3 per cent of London hospital cases and 17.3 per cent of special health authority (SHA) cases originate from outside the Thames regions.

2.5 Specialist expertise and equipment are fragmented across a number of competing institutions: in south-east London in 1991, for example, there were four cardiothoracic surgery services; three renal units; three plastic surgery centres and a three site radiotherapy service operating within three miles of each other.

3 Londoners and health care

3.1 Although Londoners' overall health status is as good or better than that of people living in comparable parts of England, and more is spent on their care, they express significantly greater dissatisfaction with health services.

3.2 Londoners receive a poor deal from services as they are presently organised. Inner city residents have difficulty obtaining standard hospital services because of the preponderance of specialist provision in the city's central hospitals. People in outer London travel long distances for specialist care.

3.3 Primary and community health services in the capital are poorly developed. Table 1 compares primary care in London with similar areas elsewhere using a variety of measures. In each case, London appears to be disadvantaged not just when compared with England as a whole, but also relative to comparable areas outside.

3.4 Spending on family health services in London's inner city is four per cent less than equivalent non-London areas. Drug related spending is 17 per cent lower in inner London than in comparable inner city areas. This pattern of lower spending is particularly surprising given London's higher costs.

3.5 London is also relatively undersupplied with continuing care for people with learning disabilities, mental health problems and frail elderly people.

4 Medical Education and Clinical Research

4.1 One third of all medical students in the UK are trained in London, which has only 12 per cent of the UK population. London medical schools also provide post graduate medical education, as do the University of London's post graduate institutes, which relate to the capital's SHA hospitals.

4.2 The medical schools spend £200 million and the institutes £98 million. In addition, service increment for teaching and research totalling £130 million a year is paid to London health authorities with teaching responsibilities.

4.3 The decline in bed numbers in London over the past decade has made it difficult to sustain traditional patterns of medical teaching. This has created significant problems with the quality of the educational opportunities offered to London medical students.

4.4 Formal postgraduate training opportunities are poorly developed throughout the UK, and are conspicuously absent in London, where they should be easiest to organise.

4.5 Research efforts are fragmented across eighteen institutions. With the possible exception of University College, no one London medical school or postgraduate institute has a sufficient foundation in basic biomedical science to ensure its future international status.

5 Impact of the NHS Reforms

5.1 The high cost of care in central London hospitals means that traditional flows of patients into inner London from

Table 1 A comparative profile of GP services in London, 1989–90

Type of area	% single-handed per 100 GPs	Practice nurses per 100 GPs	Ancillary staff per 100 GPs	% of GPs > 65 years	% of GPs' list size > 2,500
			London		
Inner deprived	20	15	121	9	20
Urban	19	13	127	8	19
High-status	17	16	135	6	17
Total	19	15	128	7	19
			Non-London comparators		
Inner deprived	20	12	140	6	11
Urban	12	16	144	3	9
High-status	9	19	159	2	9
Total	14	16	149	4	10
England	11	18	148	3	10

outer London and elsewhere will decline as purchasers move to lower-cost suppliers.

5.2 At the same time, the funds available to inner-London purchasers will fall as they come to be determined by the numbers of people living locally.

5.3 The introduction of charges for land and equipment will further increase London's costs relative to other NHS providers.

5.5 Accordingly, there is a real risk that services for Londoners will be adversely affected, especially if costs per case in inner London rise still further, as a result of carrying a higher proportion of fixed costs as volumes fall.

6 21st Century Health Care: Trends and directions

6.1 The social and economic context in which health care takes place is changing. Improvements in education, the increased information available on health care, and the changing position of women in society all mean that people are beginning to request improvements in the information they receive about their health, and involvement in choices made about their care.

6.2 A new emphasis on the rights and preferences of health service users means that waiting times for operations and for expert opinions – and the overall quality of care – are subject to new scrutiny.

6.3 Chronic degenerative diseases and cancers have replaced acute infectious diseases as the primary causes of disease and death in Britain. For many conditions, the management of disability has become as relevant as treatment.

6.4 Greatly increased possibilities for short-stay, day case and ambulatory care have been created by the rapid development of minimally invasive methods of diagnosis and treatment and less toxic anaesthesia. Developments in pharmaceuticals have shifted the management of certain conditions – for example peptic ulcer treatment – from surgery into primary care, and look set to do so for others.

6.5 These changes will continue to diminish the role of open surgery as we know it today, and blur the distinctions between surgery, medicine and radiology as well as between primary and secondary care.

6.6 Technological changes promise to make greatly enhanced diagnostic and monitoring capabilities available in primary care settings. Related developments in information technology and telecommunications could make expert opinions available in primary care settings, or to patients direct.

6.7 As a result of these changes, acute hospitals are likely to become smaller, more specialised and to focus on the care of people receiving complex, rare and/or expensive technologies and/or those suffering from trauma and multiple pathologies.

6.8 A considerable proportion of the dignostic and investigative work that currently takes place in outpatient and other acute hospital settings could be moved to primary and community care, or to patients' own homes. Certain specialities – for example psychiatry, dermatology and the clinical care of elderly people – may become almost entirely primary and community-based.

7 London Health Care 2010: A strategy for London

7.1 By 2010, the King's Fund Commission believes that the effects of these social and technological trends will have combined to reshape the health care system as we know it today. These changes pose particular challenges to centres like London where key building blocks of the new system – such as primary care – remain poorly developed.

7.2 Box 2 lists the principles which the Commission considers should underpin the reshaping of the service system in the capital.

7.3 The Commission considers that there needs to be a major shift of services and resources from hospital-based to primary care. The aim must be to locate many diagnostic and investigative procedures, and much treatment and care, in primary and community health settings close to where Londoners live, where this can be reconciled with quality and cost criteria.

7.4 Primary health care practitioners will need to draw on services which provide care for people with a wide range of needs for whom specialist acute hospital provision is inappropriate. This will include convalescence and respite care, rehabilitation, care for people who are dying and for people experiencing mental health problems.

7.5 Community-based treatment of this kind will often be provided in people's own homes through hospital-at-home schemes, or from nursing beds and care centres which are convenient and accessible to London communities. Nurses can manage much of the care at this level, with contributions from medical and therapy staff when required.

7.6 Acute care hospitals will provide diagnoses, investigations, treatment and care which require the use of expensive equipment and a range of highly skilled personnel.

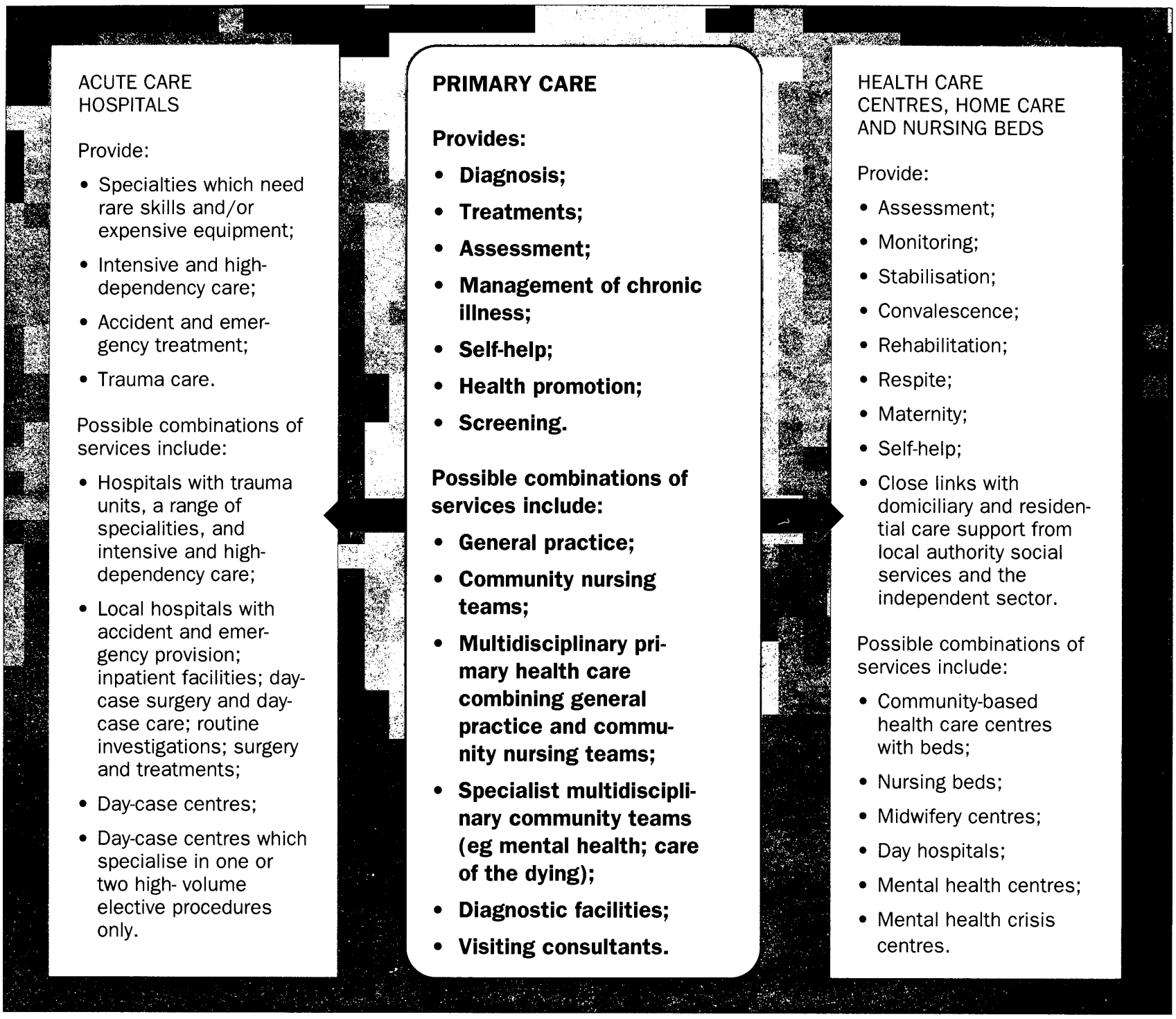
7.7 Dedicated day case facilities – which could be attached to acute care hospitals or freestanding – will handle a high proportion of all planned acute interventions.

Box 2

PRINCIPLES FOR CHANGE IN LONDON

- **London's health services must be planned and managed to serve the population rather than to perpetuate institutions.** This means staring from the health care requirements of the city's population, and the need to reduce health inequalities within the capital.
- **Londoners should be much more actively involved in their own health and health care.** Health services should recognise Londoners' autonomy and individuality. They should be designed to help them make informed choices about their health and treatment.
- **Health care in London must become primary health care led.** Secondary and tertiary care should become resources explicitly organised to enhance the capacity and support the work of primary health care practitioners.
- **Medical education and research in London should achieve international excellence, and a leading position within Europe.**

Figure 2 Health services 2010



7.8 Figure 2 shows the main elements of the 21st century service system, and indicates the range of services that they will need to provide.

7.9 The Commission does not believe that there is any one right way to array and house the services which will constitute London's health care system in the next century. The form that they take in different parts of London will be shaped by the requirements of particular localities and the communities that live within them, as well as by existing investment in buildings and equipment.

8 Costing the Vision

8.1 Calculations undertaken for the Commission by York University's Health Economics Consortium suggest that this major shift in the balance of provision between primary and secondary care can be accomplished in London within existing resources.

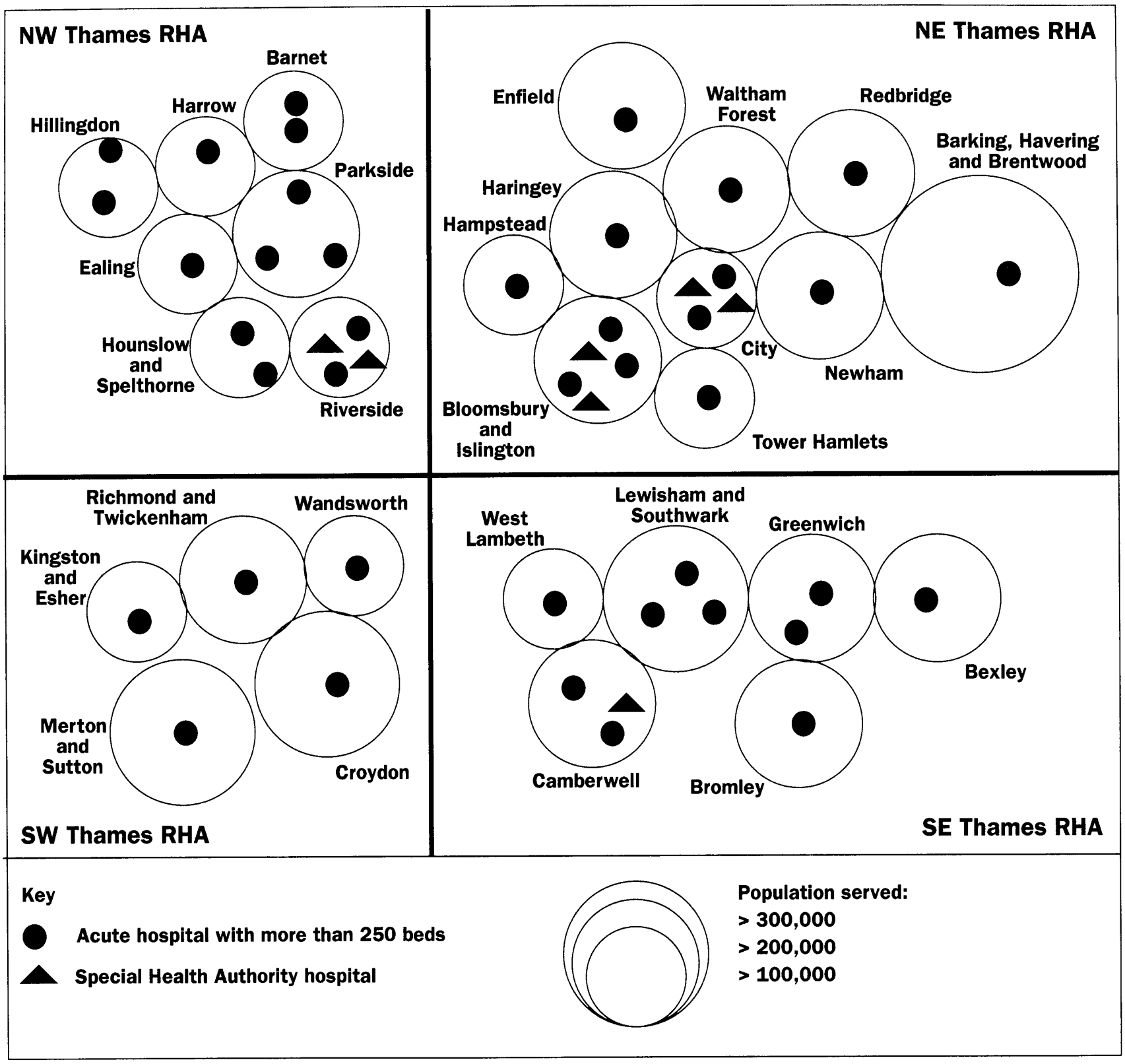
8.2 An estimated 12,000 beds in the core specialties of general medicine, general surgery, paediatrics, trauma and orthopedics, ear, nose and throat, ophthalmology and gynaecology will be needed to treat Londoners in the year 2010–11. This represents a 5,000 bed decline in the numbers currently available, or a reduction of some 25 per cent over eighteen years.

8.3 These estimated reductions – which are conservatively based – could release sufficient resources for a major community-based health care development programme, provided that they are linked to hospital closures and site sales.

8.4 Figure 3 gives the current disposition of major hospitals within London health districts in schematic form. Figure 4 gives an illustrative example of how local acute hospitals, specialty centres, and new community-based health care centres might be arranged in the London of 2010.

8.5 Currently, London has 41 acute hospitals with more than 250 beds. In our illustration, no more than thirty of these would be required. In addition, there would need to be a rationalisation of tertiary specialist units, resulting in the relocation of up to four of the existing SHA hospitals within retained units.

Figure 3 Current provision of major acute hospitals in London



8.6 Using conservative assumptions, £80 million in revenue resources could be released on a recurring basis if a restructuring programme of this order were implemented, and more than £900 million in capital. If the estimated £1.5 billion available under the NHS capital programme for developments to London's hospitals were added to this figure, there would be sufficient capital to implement the Commission's programme.

8.7 Some £1.2 billion would be needed to achieve the service rationalisation proposed, with an additional £220 million to develop community care premises. This is well within the sum potentially available, providing there is the initial investment to make it possible.

9 The Commission's Recommendations

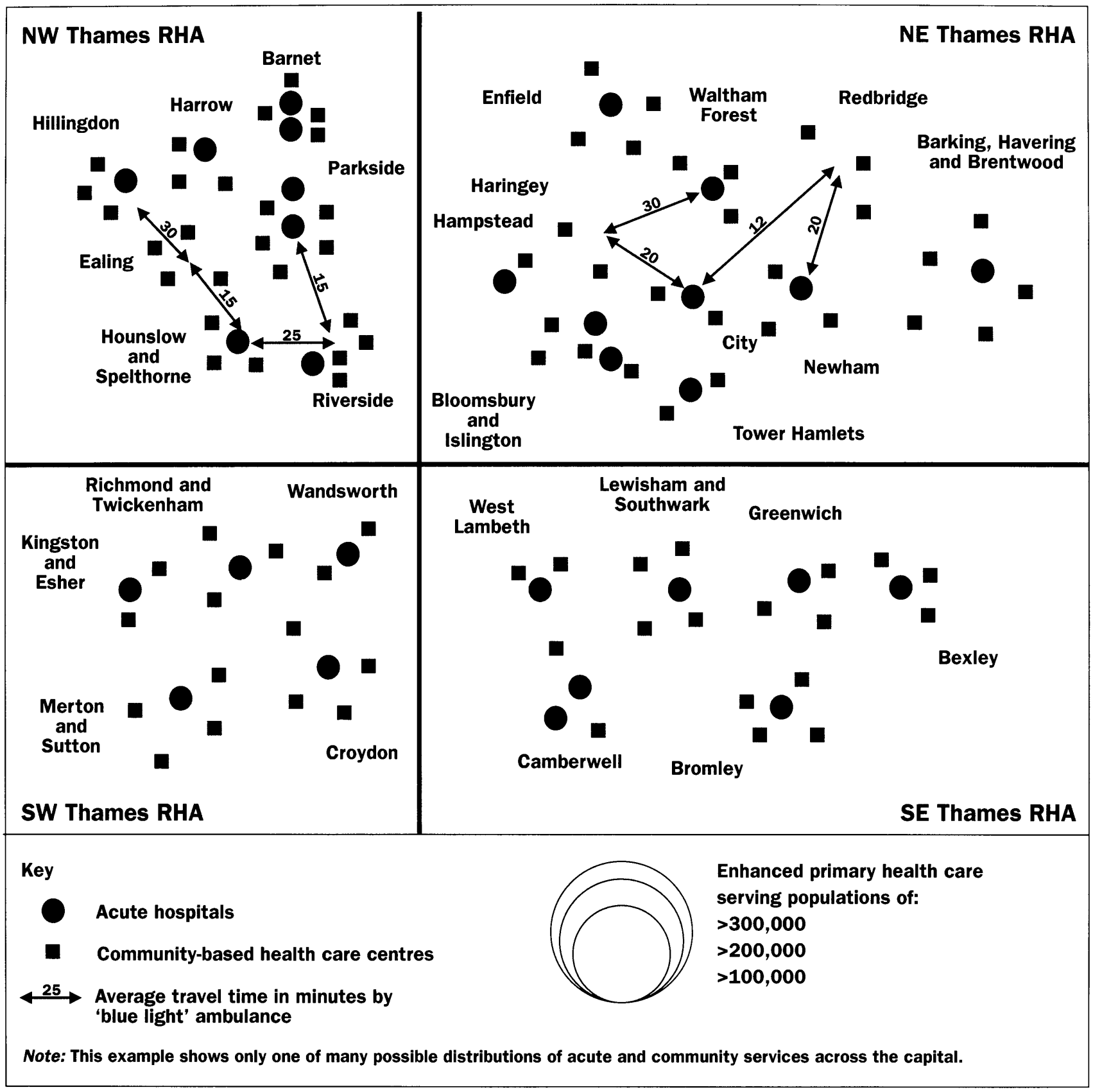
9.1 A Task Force accountable to the Secretary of State for Health and the Secretary of State for Education, and to the Chancellor for the Duchy of Lancaster on questions of research, should be established to undertake the reshaping of services in London, in conjunction with the established authorities. It should accomplish its work in 5 years.

9.2 The London Task Force should undertake a £250 million primary and community care development programme, in conjunction with London regional, district and family health service authorities.

9.3 This programme would have three goals: to address London's present deficit in primary and community services; to encourage primary health care practitioners to undertake aspects of treatment that currently take place within acute hospitals; and to involve Londoners in designing services to meet needs which they have helped identify.

9.4 The Task Force should work with London's regional, district and and special health authorities, commissioning consortia, local authorities and the University of London to

Figure 4 An illustrative example of a possible future pattern of health services in London



agree and implement a process of consolidation and modernisation for the city's health services.

9.5 This would involve the development of a plan for the more rational disposition of specialist services across the capital, improvements in efficiency and reductions in medical staffing levels.

9.5 The University of London should consolidate undergraduate and postgraduate medical teaching in four main centres in conjunction with the Task Force. These should be Imperial College, King's College, Queen Mary College/ Westfield and University College. To avoid academic isolation, St George's Medical School should become incorporated within the University of Surrey.

9.6 These new Faculties of Medicine would not be linked to particular teaching hospitals. Instead, they would contract with health care providers in primary, community-based and hospital-based care throughout the Thames regions to undertake different aspects of clinical medical education at undergraduate and postgraduate level.

9.7 As teaching centres are consolidated, there should be an overall reduction in the numbers of medical students trained in London.

If you want to know more about *London Health Care 2010: Changing the future of health services in the capital,* the report of the King's Fund Commission on London, copies of the full report are available from BEBC, 9 Albion Close, Poole, Dorset BH12 3LL at £14.00 plus £1.00 postage and packing (Telephone 0202 715555). ISBN 0 9518893 5 4.

Primary Healthcare in London

A Comparative Analysis

Sean Boyle & Chris Smaje

King's Fund Institute

PRIMARY SERVICES

Family Health Services FHSA

Community Health Services DHA

Social Services LA

King's Fund Institute

- Cost of services
- Quantity of services
- Quality of services

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The Breakdown of FHS Expenditure

Expenditure per capita resident population, 1990/91 (£)

	PS	GMS	GDS	GOS	FHSA Cash Allocation	Total FHS
London	51.4	33.2	15.3	2.2	10.1	112.2
Non-London Comparators	57.8	31.2	14.7	2.8	8.9	115.3
England	55.8	30.9	13.8	2.3	9.7	112.4

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- Practice Payments
- Premises Payments
- Medical Staff Payments
- Special Allowances
- Service Payments

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The Breakdown of GMS Expenditure

Expenditure per GP, 1990/91 (£)

	Practice	Premises	Medical Staff	Special Allowances	Services	TOTAL
London	36,198	4,065	6,312	3,122	9,217	58,914
Non-London Comparators	33,536	2,948	6,679	1,988	12,082	57,232
England	33,909	2,706	6,684	1,758	12,617	57,674

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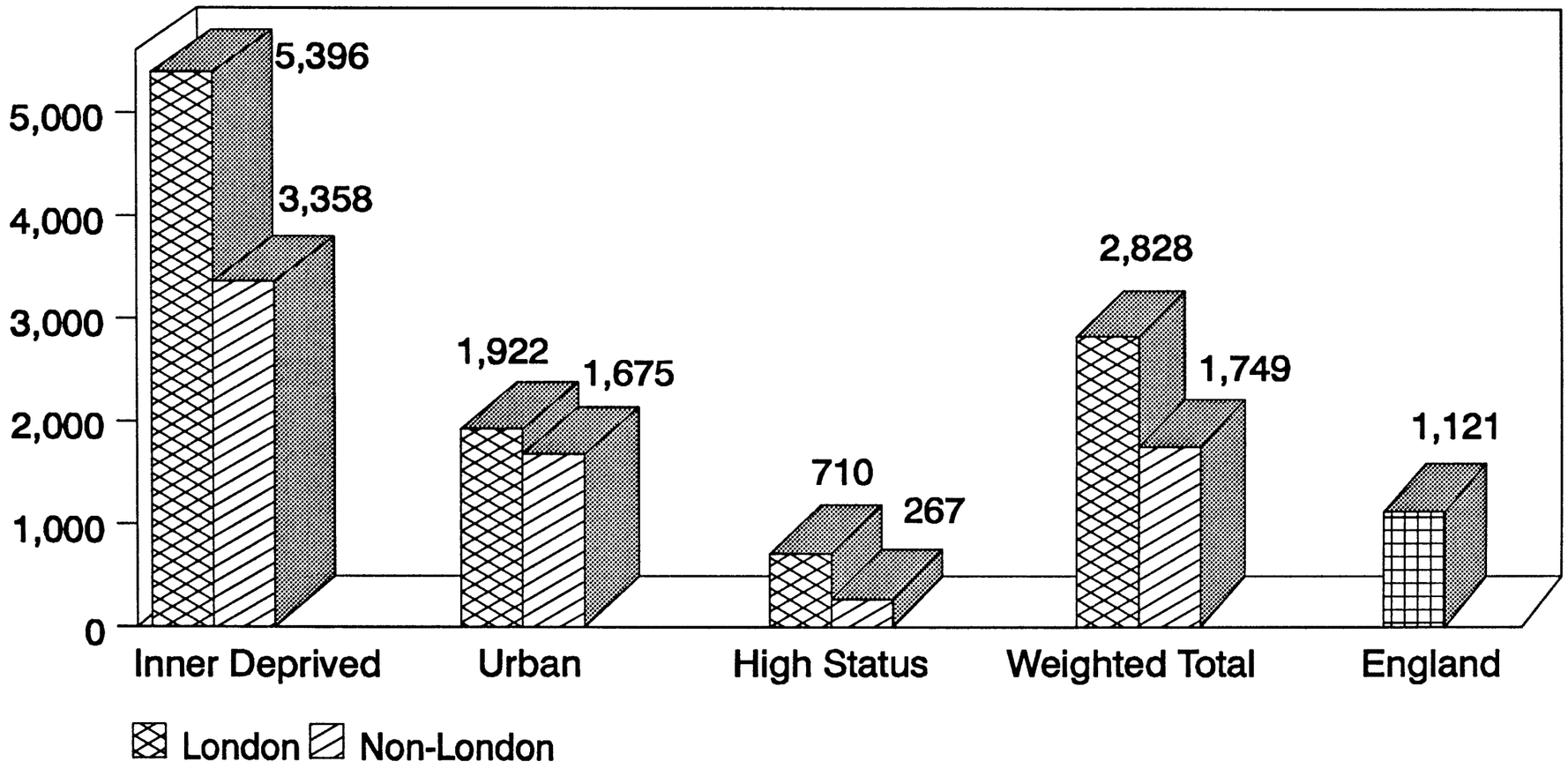
Total Deprivation Payments
per GP, 1990/91 (£)



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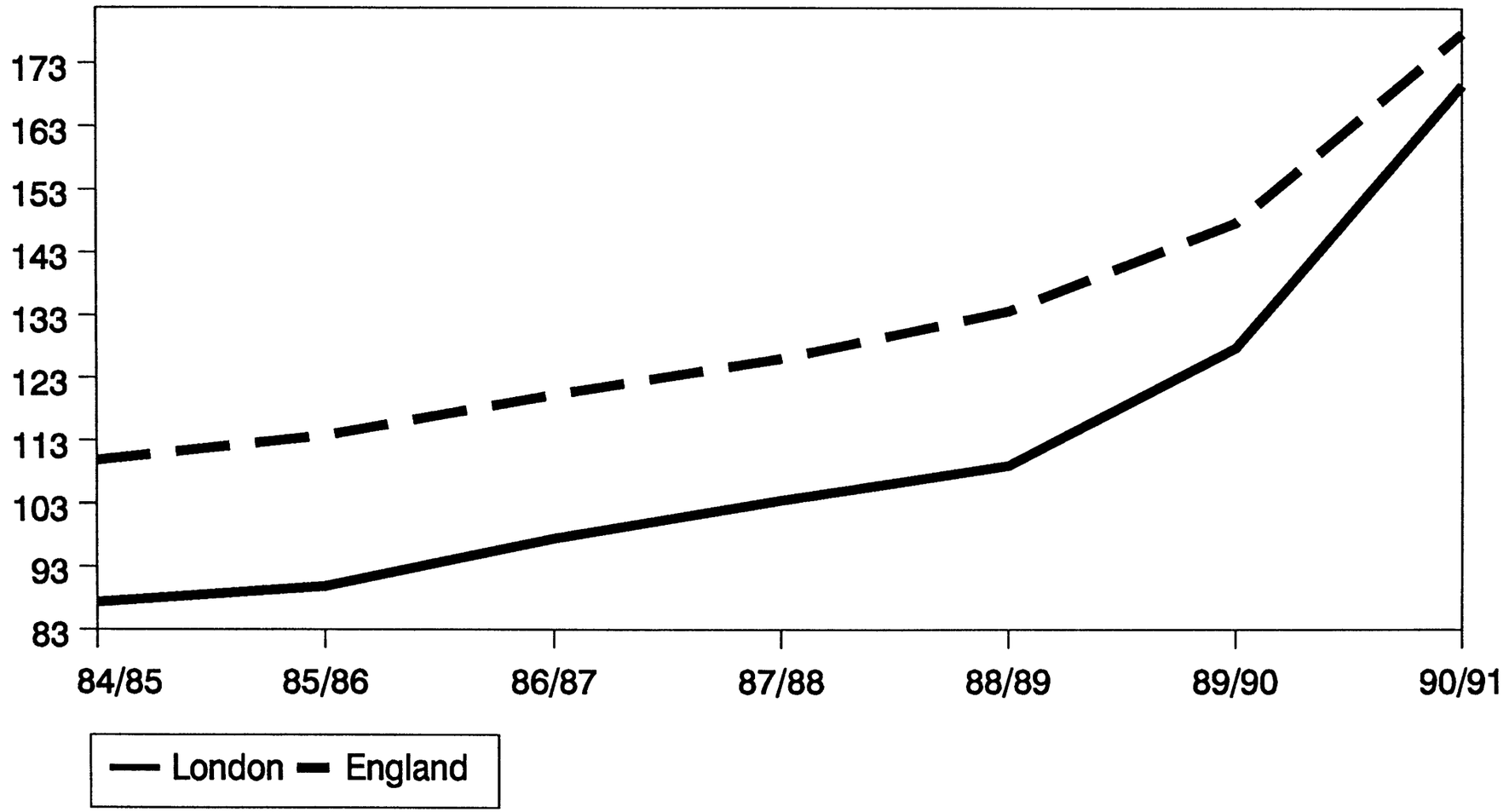
Whole Time Equivalent Practice Staff

(including nurses) per 100 GPs, 1984/5-1990/1



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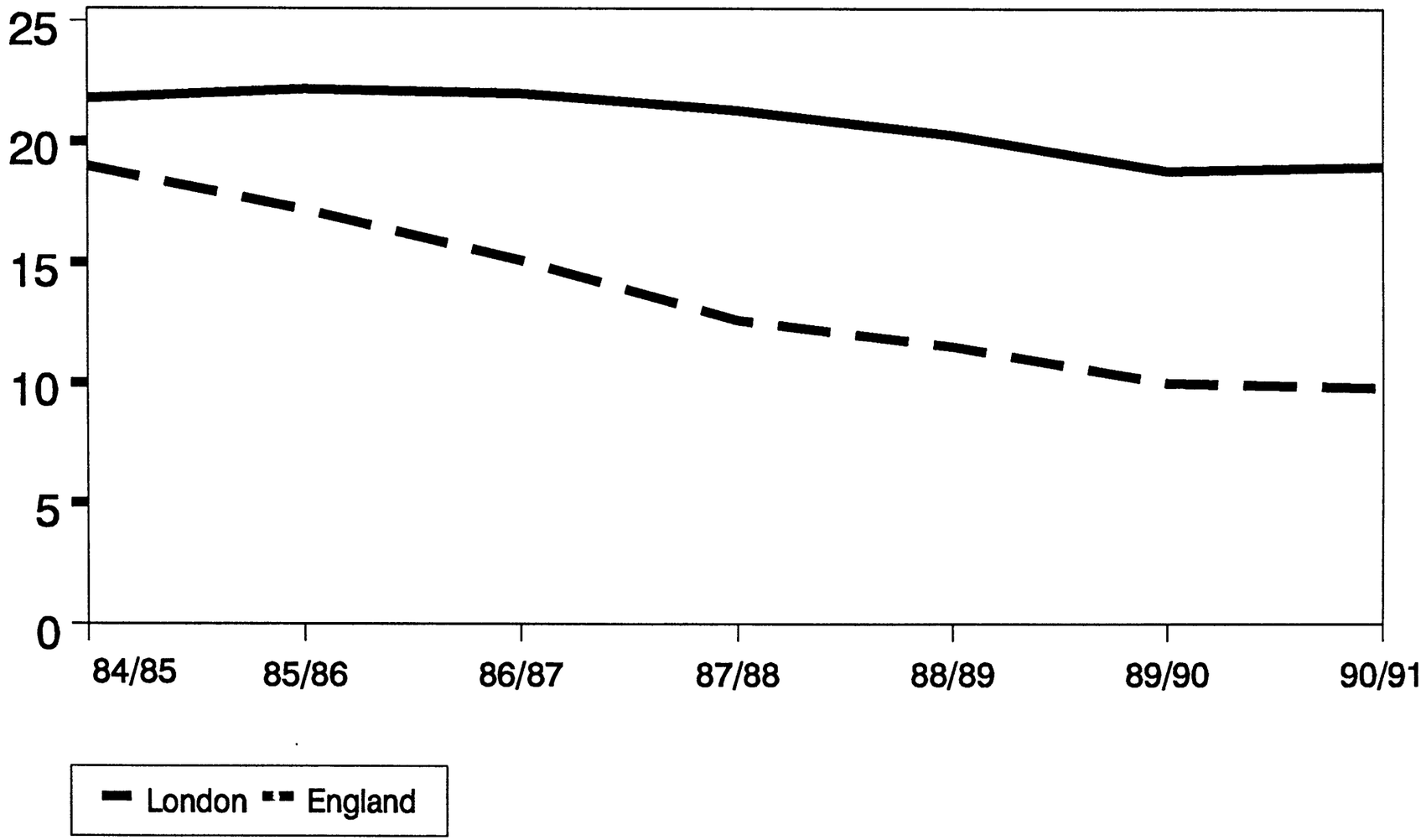
Proportion of GPs with List Size > 2500, 1984/5 -1990/1 (%)



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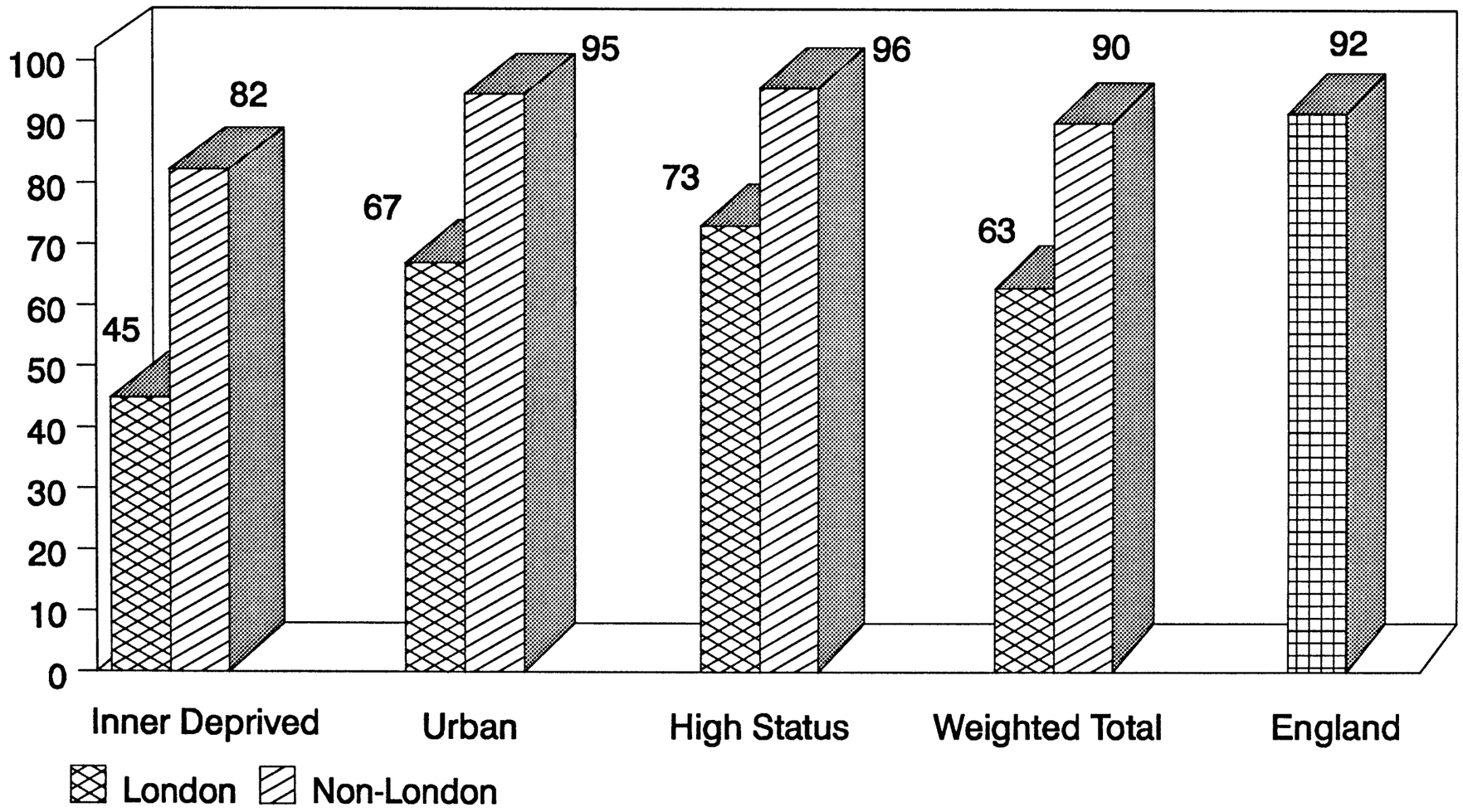
Proportion of GPs Reaching High or Low

Cervical Cytology target, 1990/91 (%)



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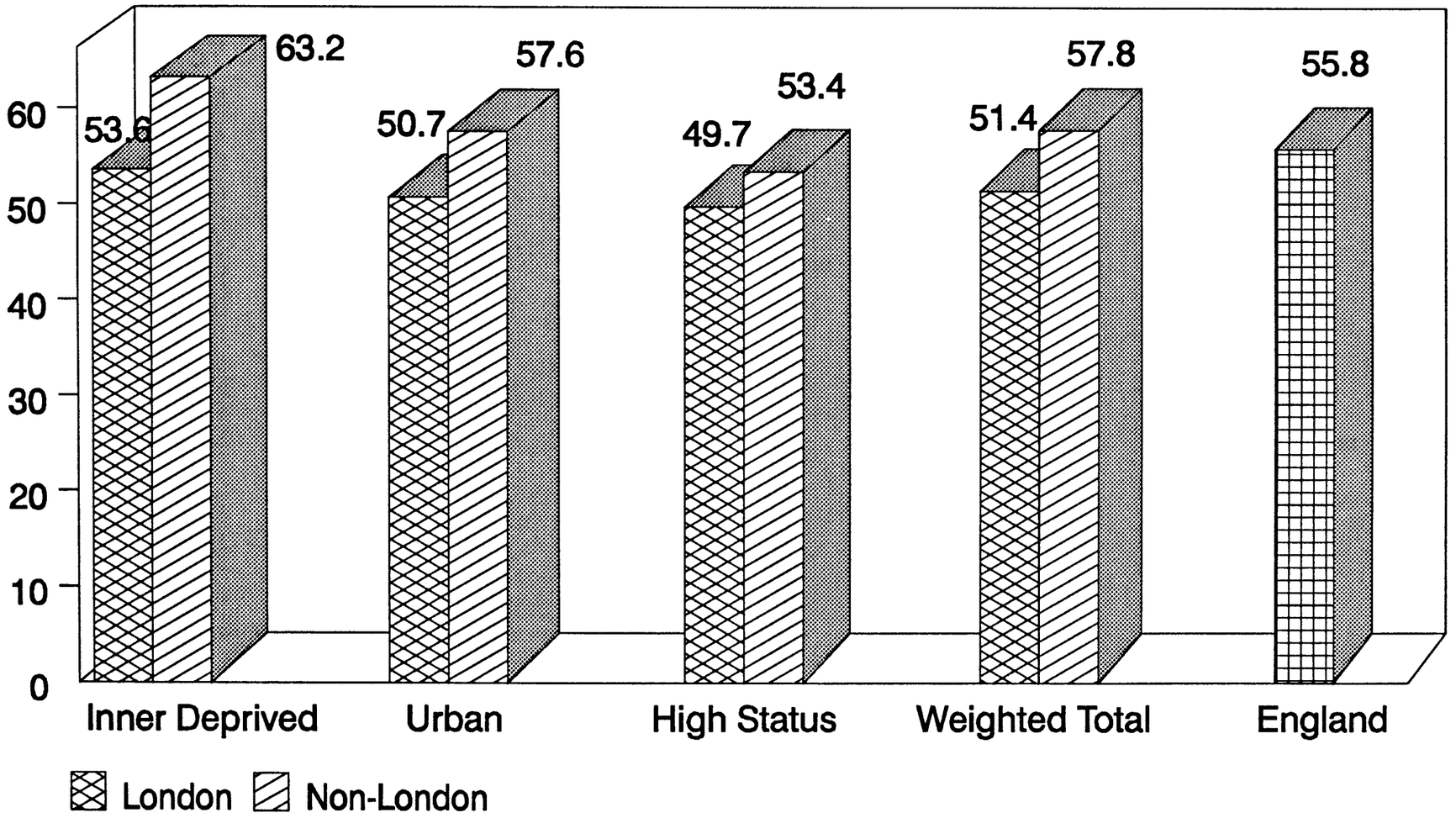
Pharmaceutical Services Expenditure

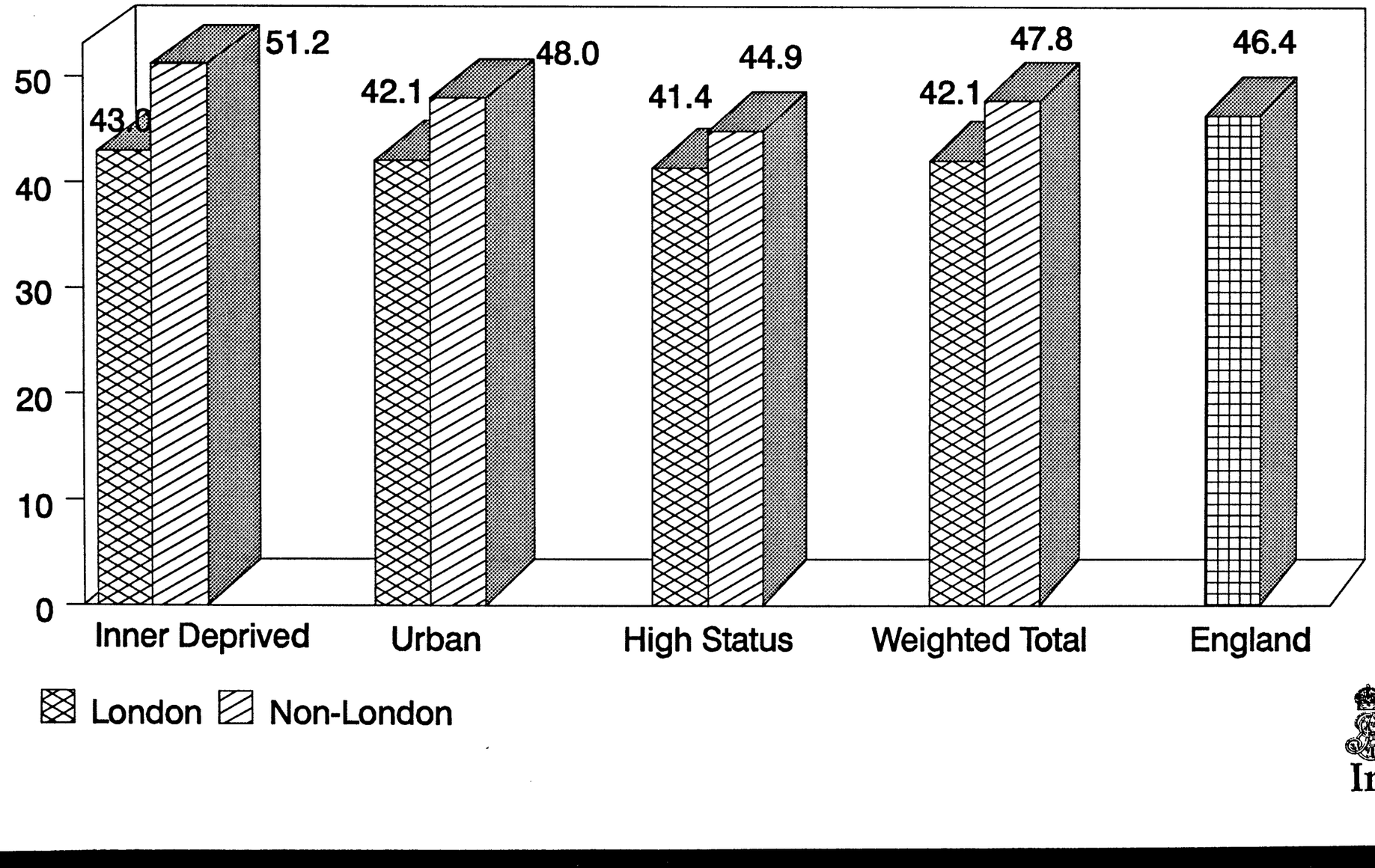
per Capita Resident Population, 1990/91 (£)



King's Fund Institute

Net Ingredient Cost

per Capita Resident Population, 1990/91 (£)



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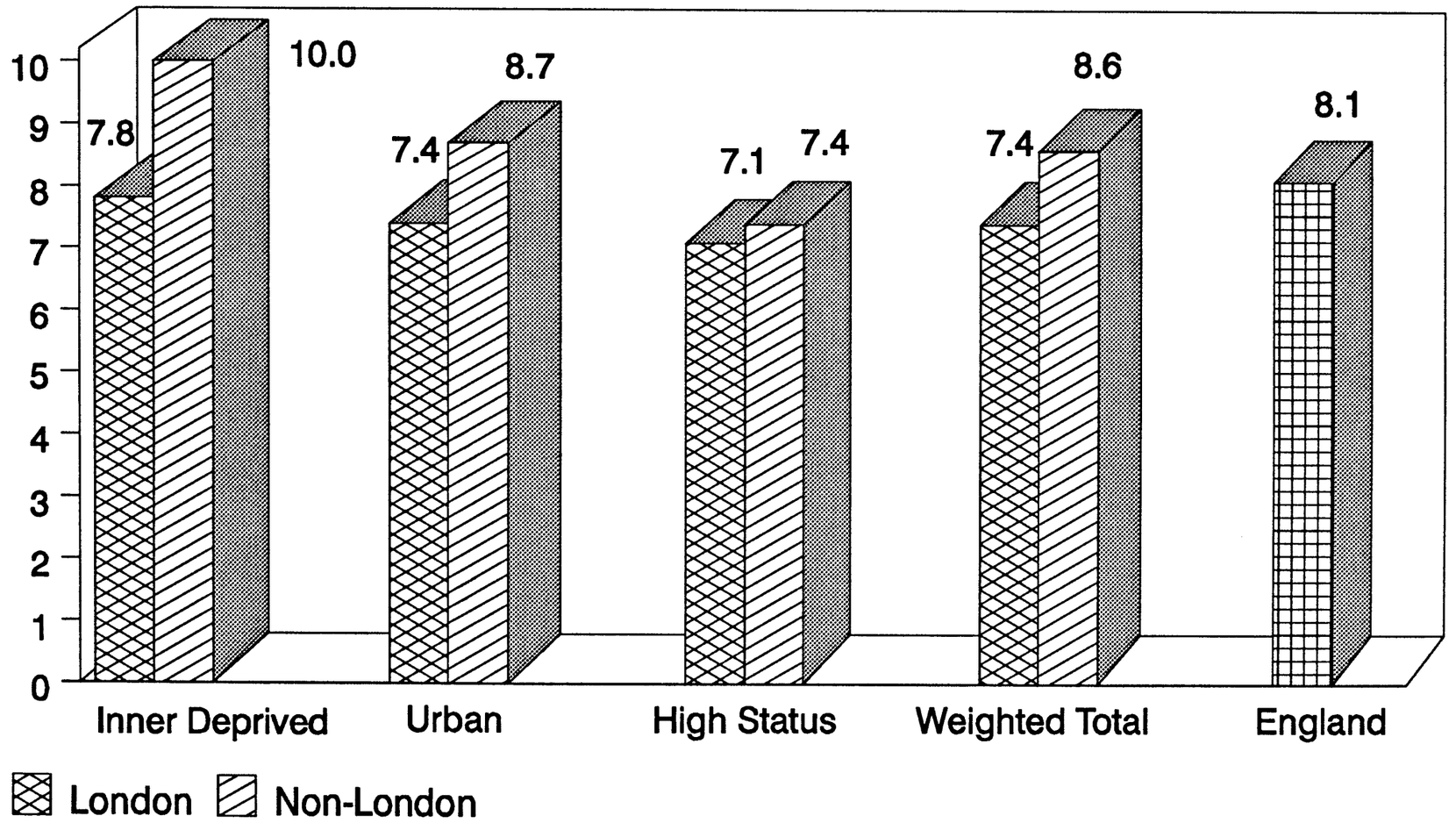
Prescriptions

per Capita Resident Population, 1990/91



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Supply and Demand Factors Causing Variation in Prescription Rate

SUPPLY FACTORS

- Other sources of prescribed pharmaceuticals
- Prevalence of GPs
- GP prescribing behaviour
- Access to GPs

DEMAND FACTORS

- Population age - sex structure
- Health status
- Socio-economic factors

PRESCRIPTION RATE

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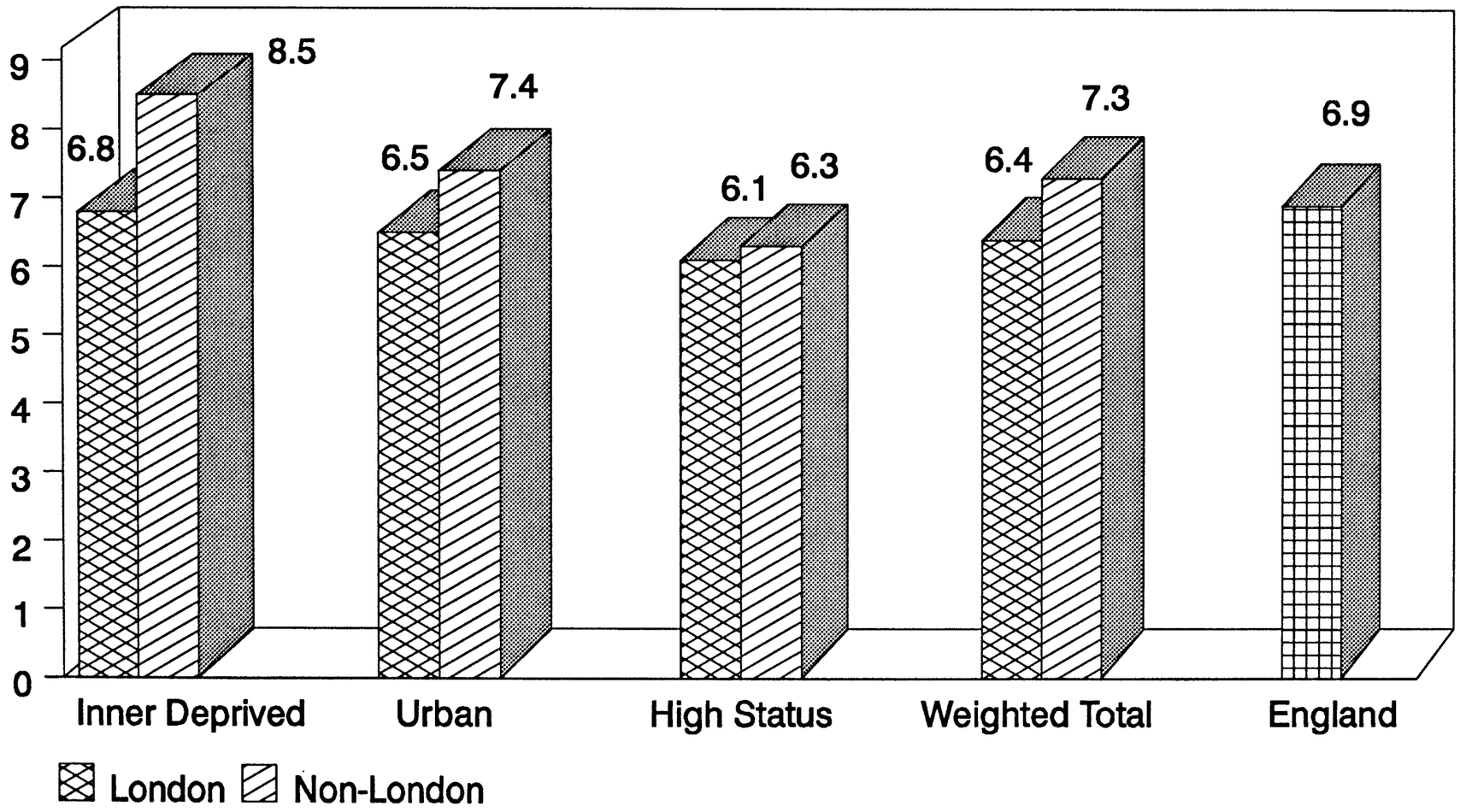
Prescriptions per Age-weighted Resident Population: IPA formula, 1990/91



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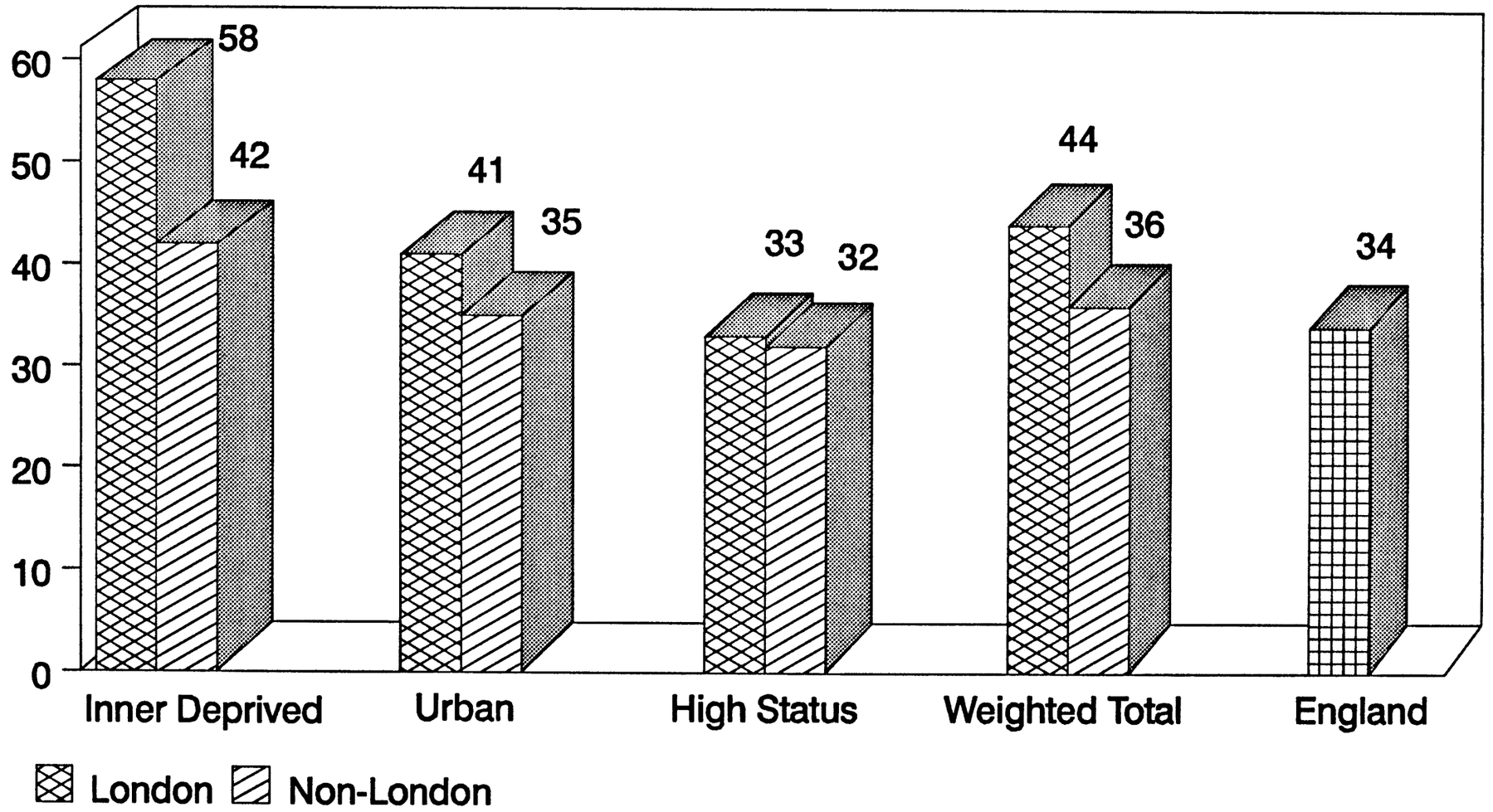
Total CHS Expenditure

Per Capita Resident Population, 1989/90



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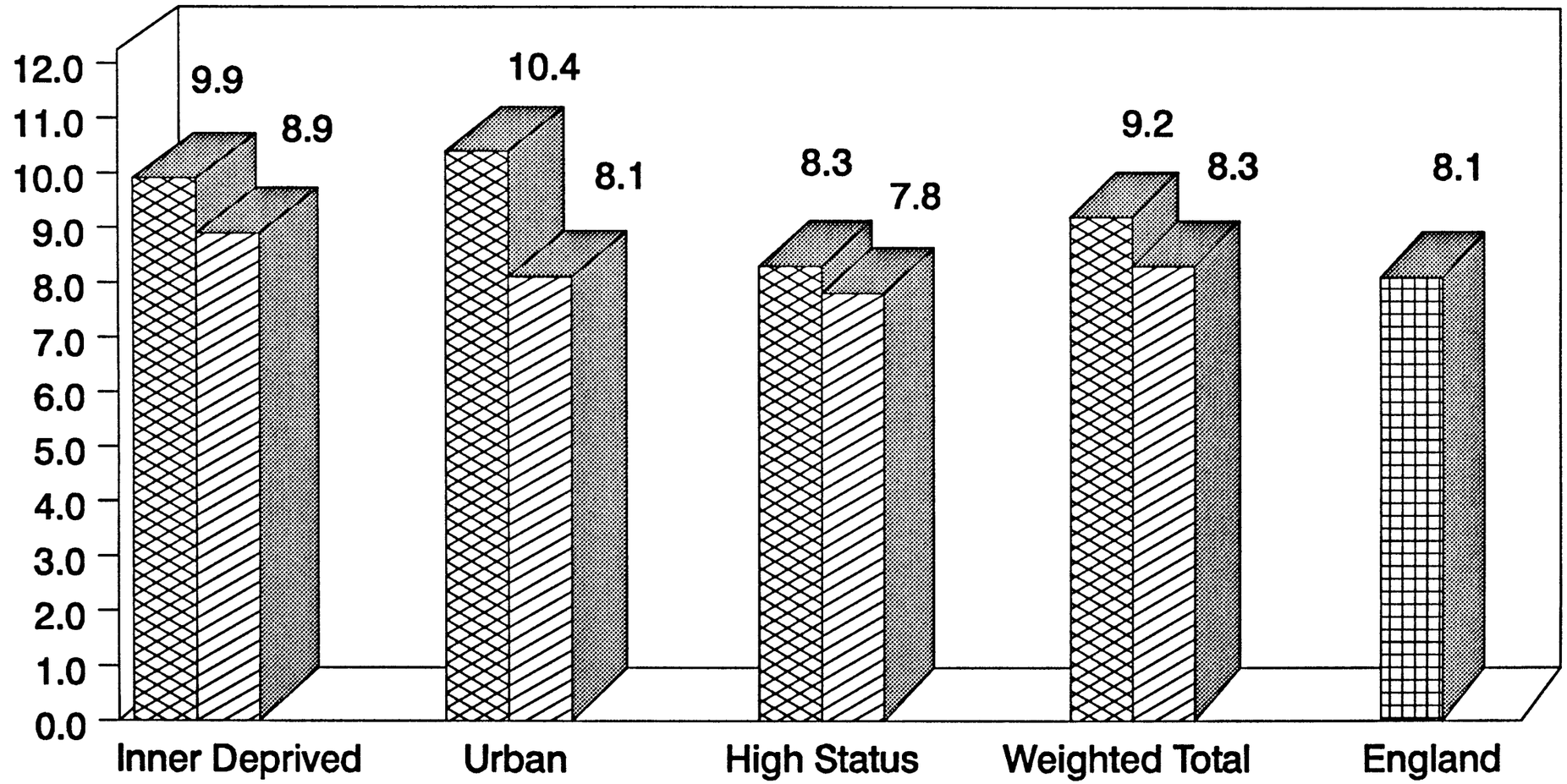
Total CHS Expenditure on District Nursing Services Per Capita Resident Population, 1989/90



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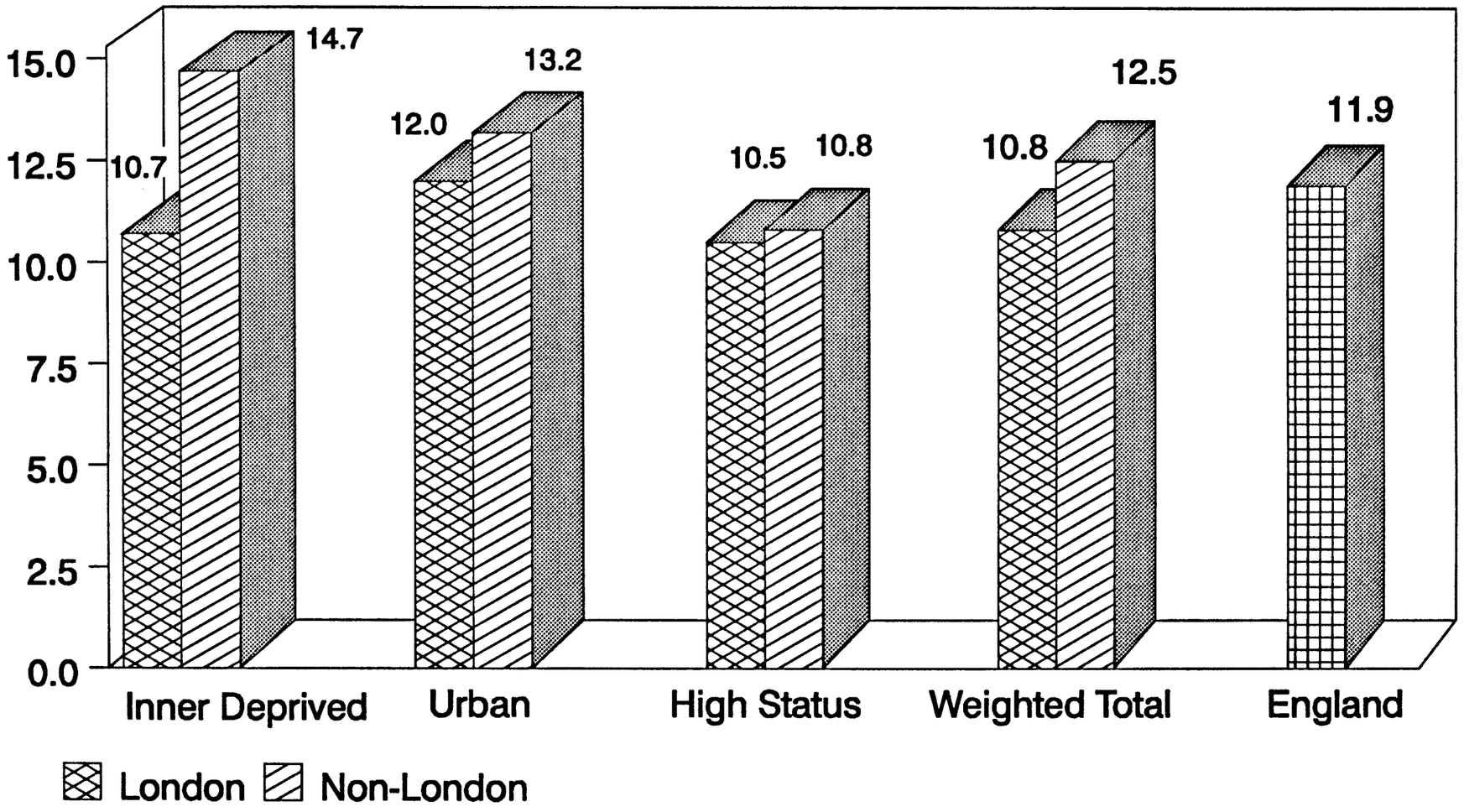
Average Number of District Nurse Contacts

Per Resident Aged 75+, 1989/90



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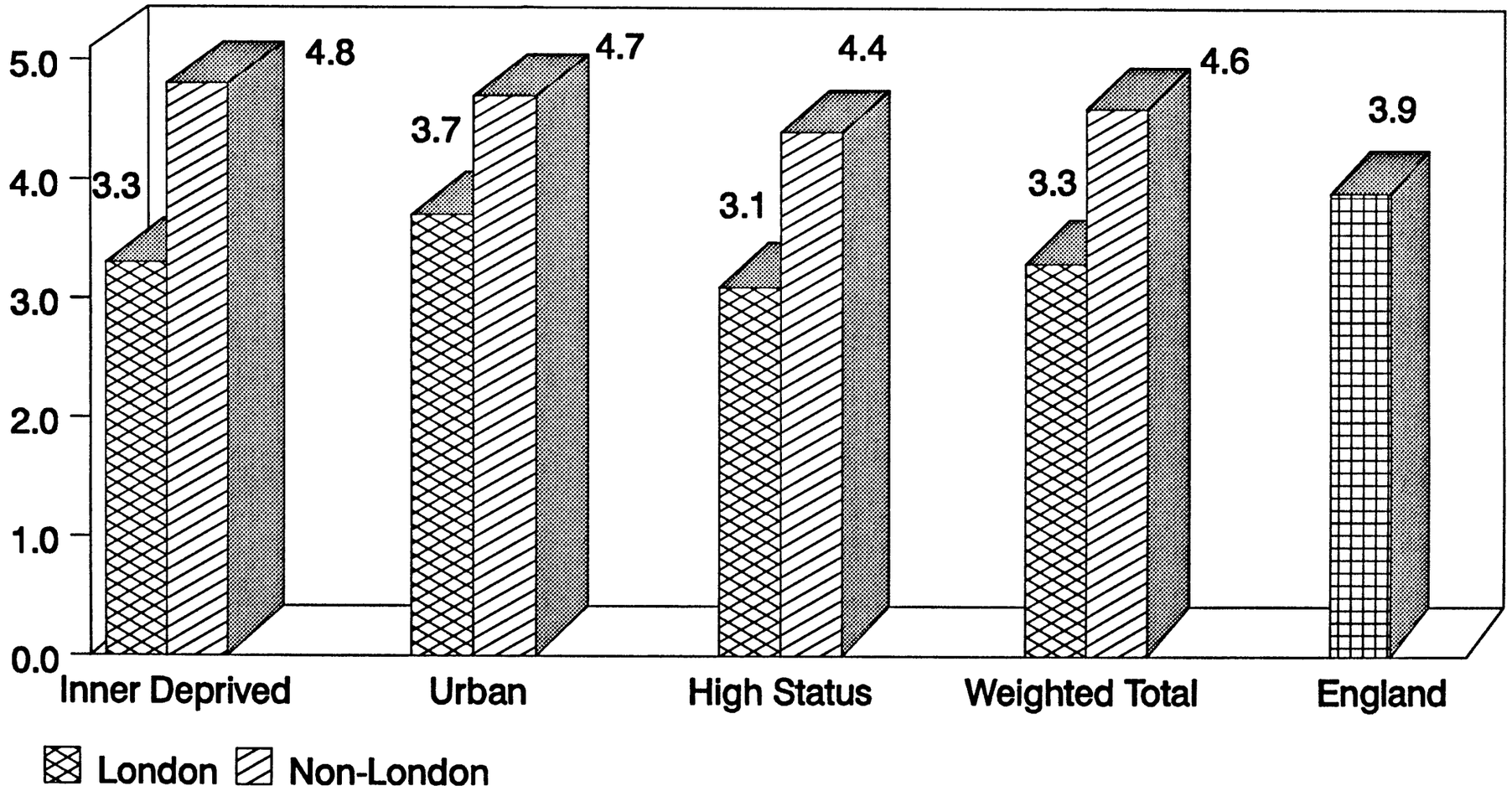
District Nurses Per 1,000 Residents

Aged 75+, 1989/90



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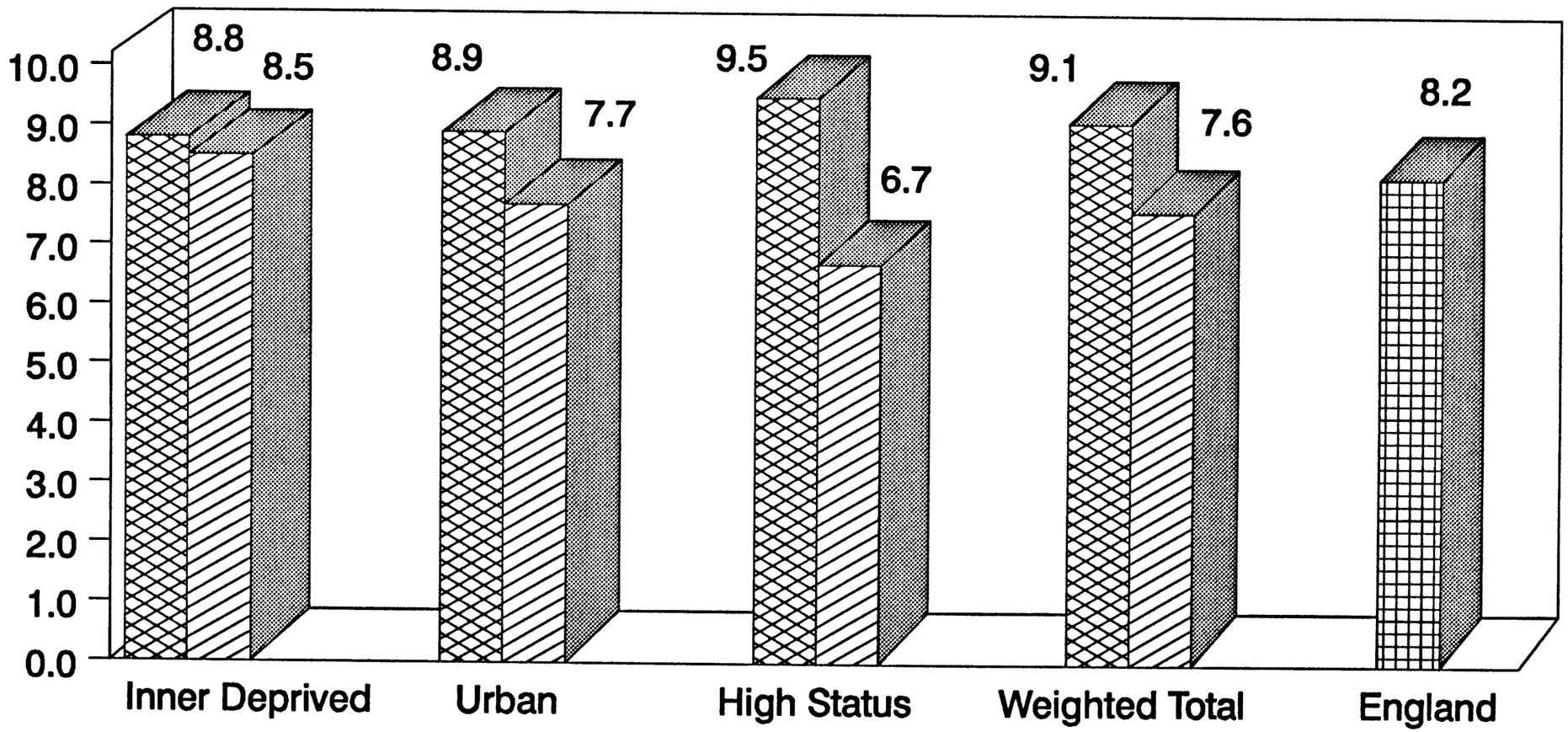
Average Daily Contact Rate
Per District Nurse, 1989/90



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Average Cost per District Nurse Contact, 1989/90

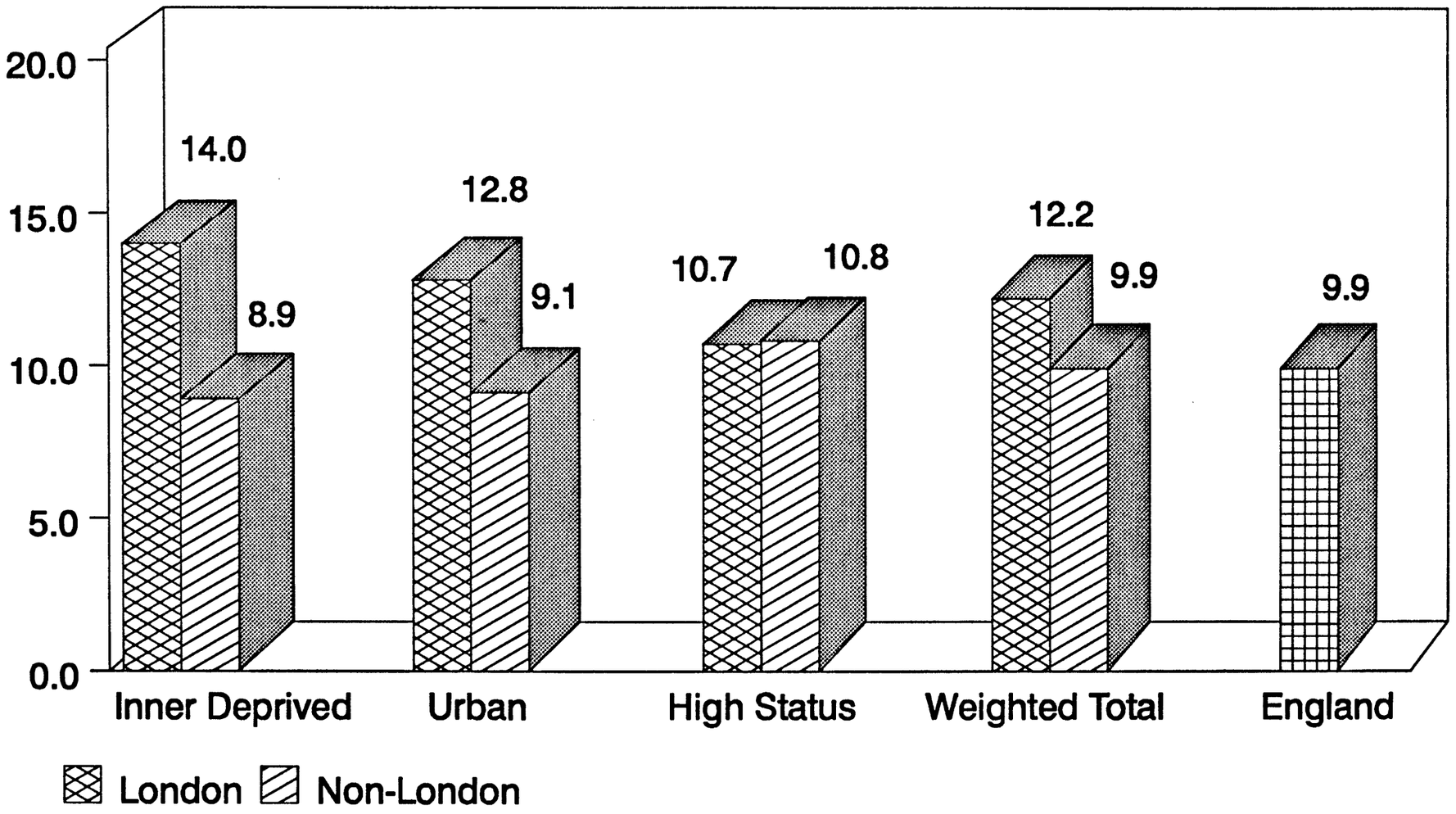

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TABLE 4.4: TOTAL CHS EXPENDITURE ON HEALTH VISITORS PER CAPITA RESIDENT POPULATION, 1989/90

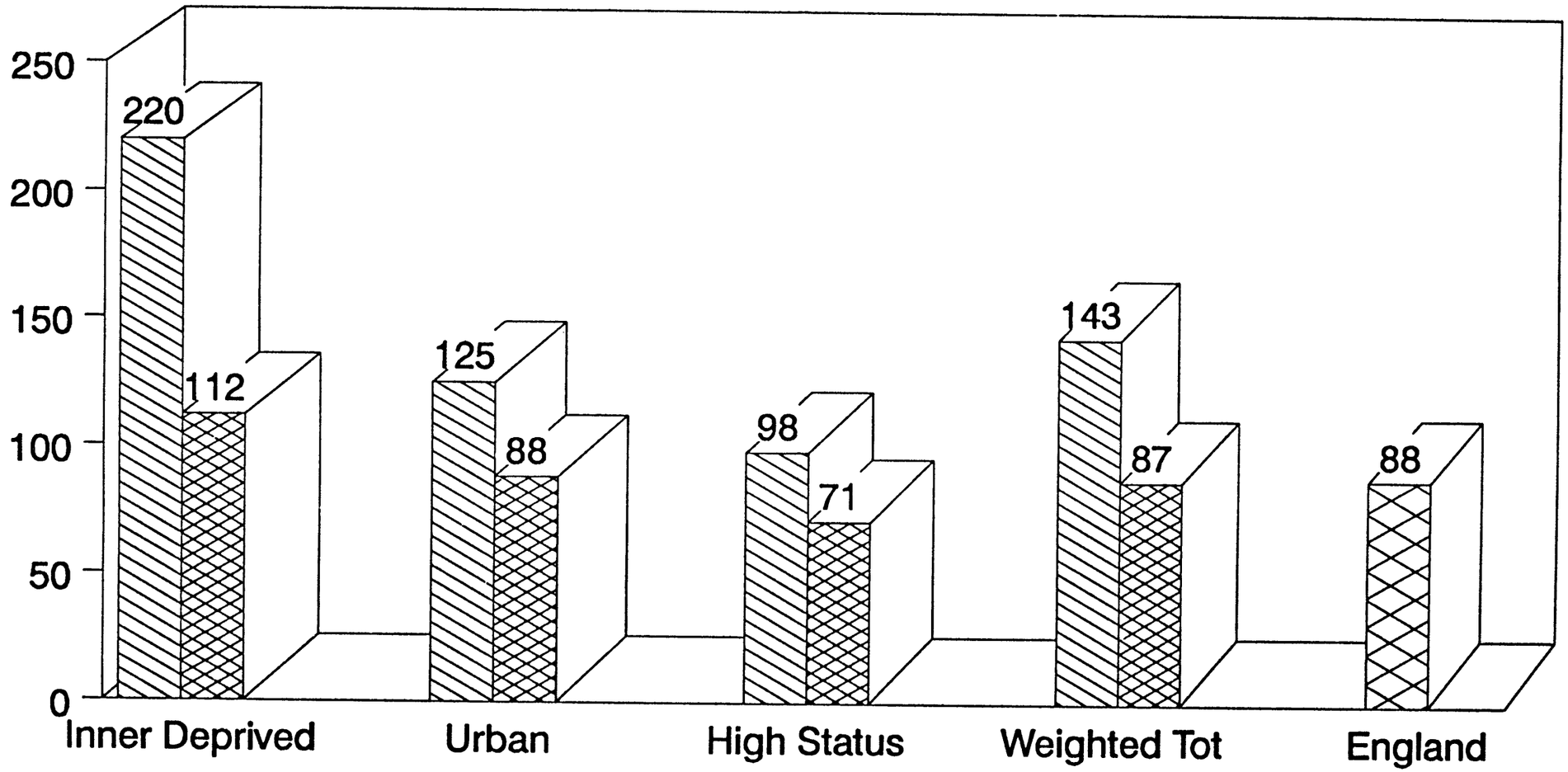
TYPE OF AREA	LONDON £	NON-LONDON £
Inner Deprived	6.9	5.0
Urban	6.5	4.9
High Status	4.5	4.7
Weighted Total	5.7	4.8
ENGLAND	4.7	

TABLE 4.5: A PROFILE OF HEALTH VISITING SERVICES, 1989/90

	COST PER CONTACT	CONTACTS PER 1000 RESIDENTS	HVs PER PER 100,000 RESIDENTS	DAILY CONTACT RATE PER HV
TYPE OF AREA	£	LONDON		
Inner Deprived	23.6	293	19.9	3.9
Urban	16.9	383	20.6	5.1
High Status	13.8	323	15.6	5.4
TOTAL	17.8	320	18.0	4.7
		NON-LONDON COMPARATORS		
Inner Deprived	12.2	404	19.4	5.7
Urban	13.2	382	20.8	5.0
High Status	12.6	366	18.4	5.5
TOTAL	12.7	383	19.1	5.5
ENGLAND	13.1	358	17.7	5.6

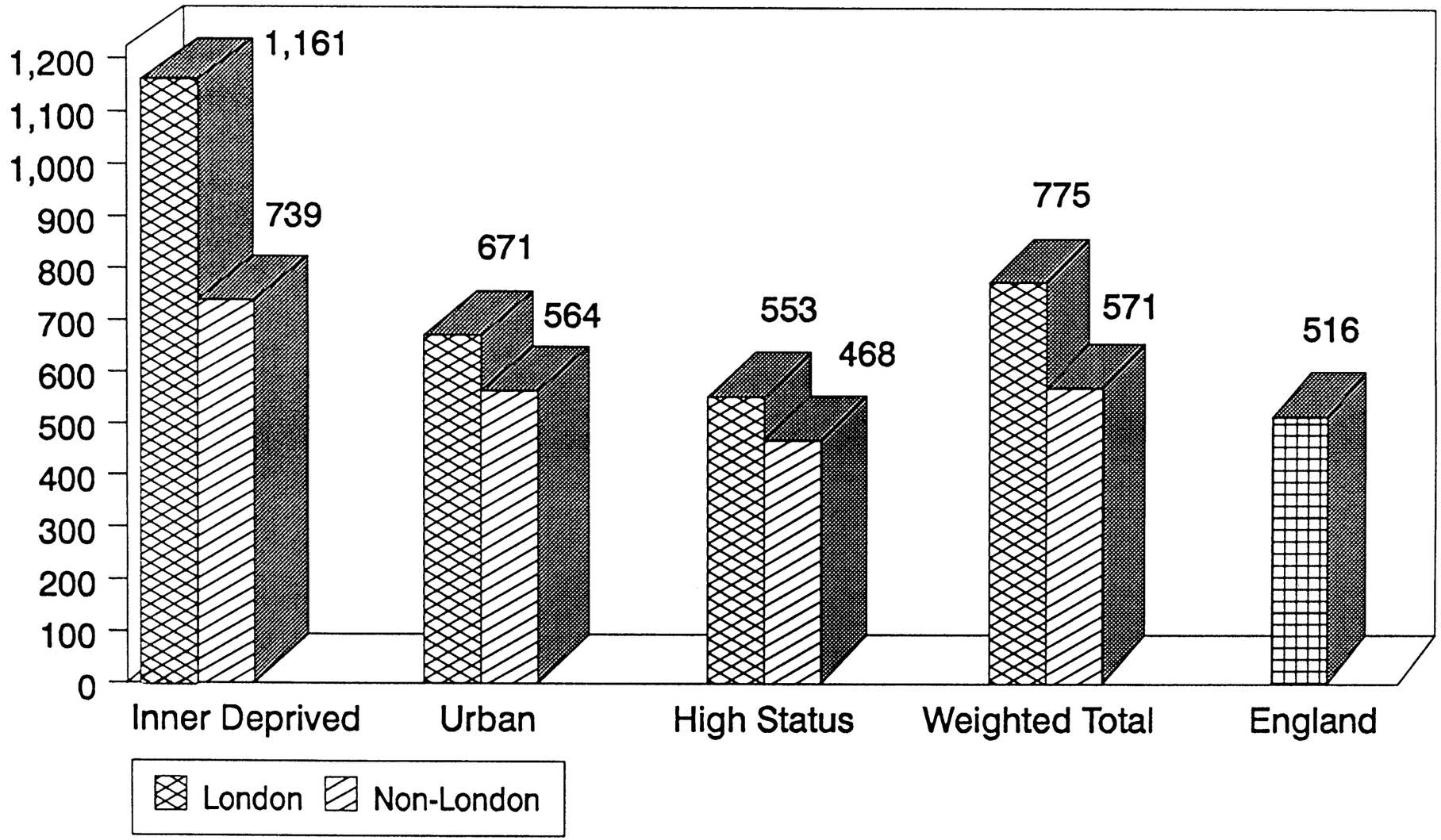
SSD Total Gross Current Expenditure

Per Capita Resident Population, 1989-90

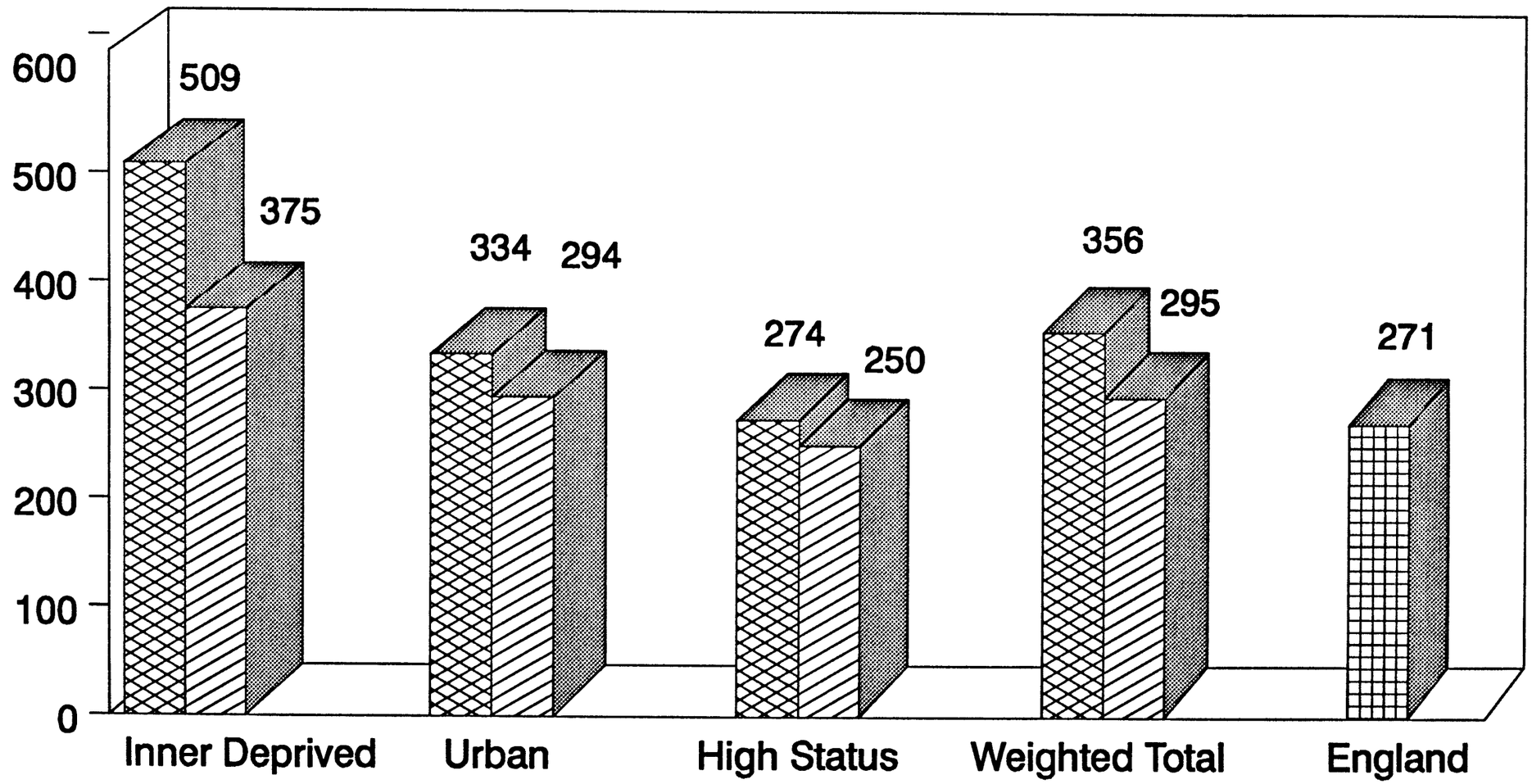


SSD Gross Current Expenditure on Elderly People

Per Capita Resident Population Aged 75+, 1989/90



SSD Expenditure on Residential Care For Elderly Per Head of Resident Population Aged 75+, 1989/90



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No of Places in Residential Homes

Per 1000 75+ Population, 1989-90

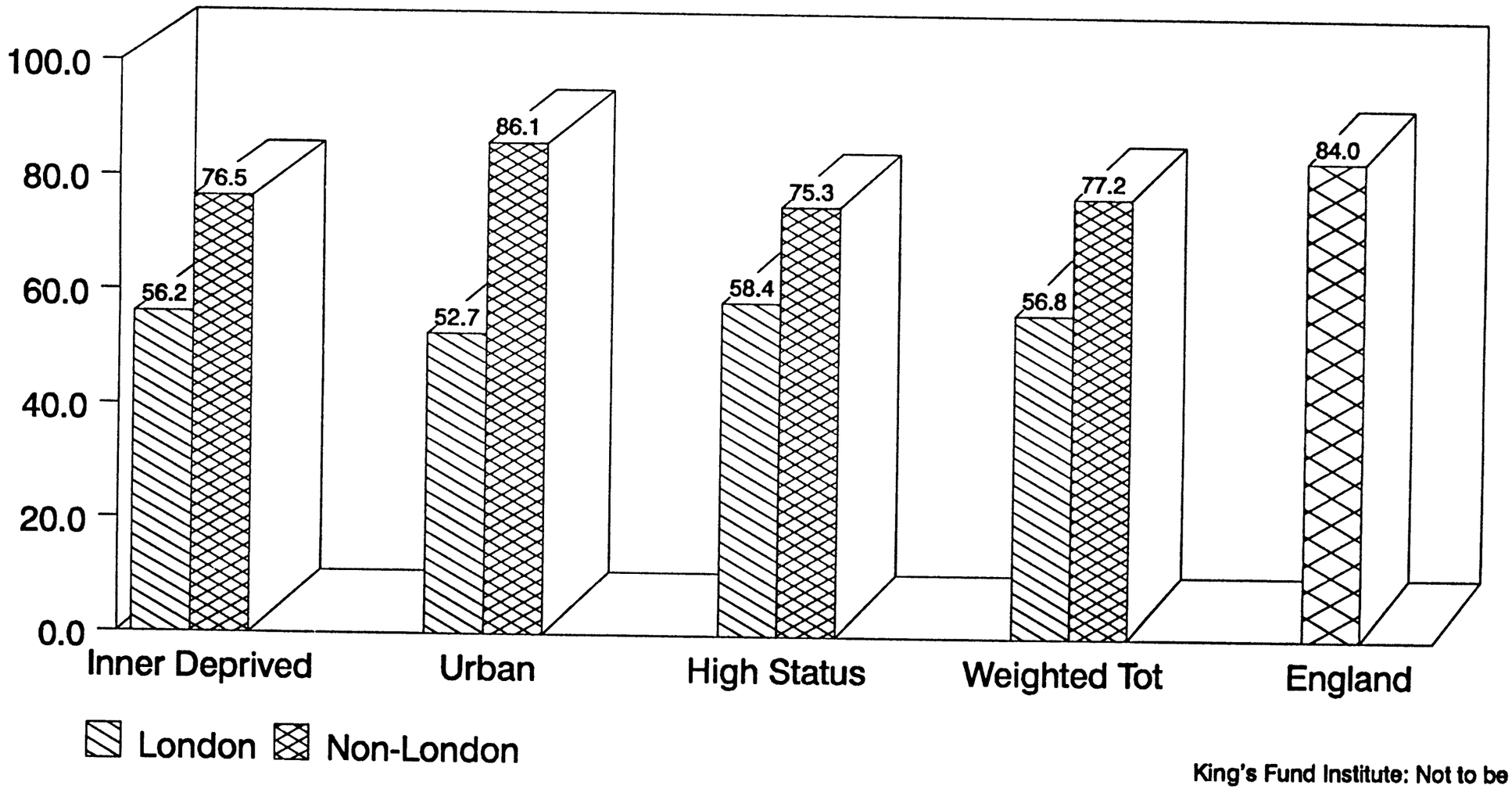
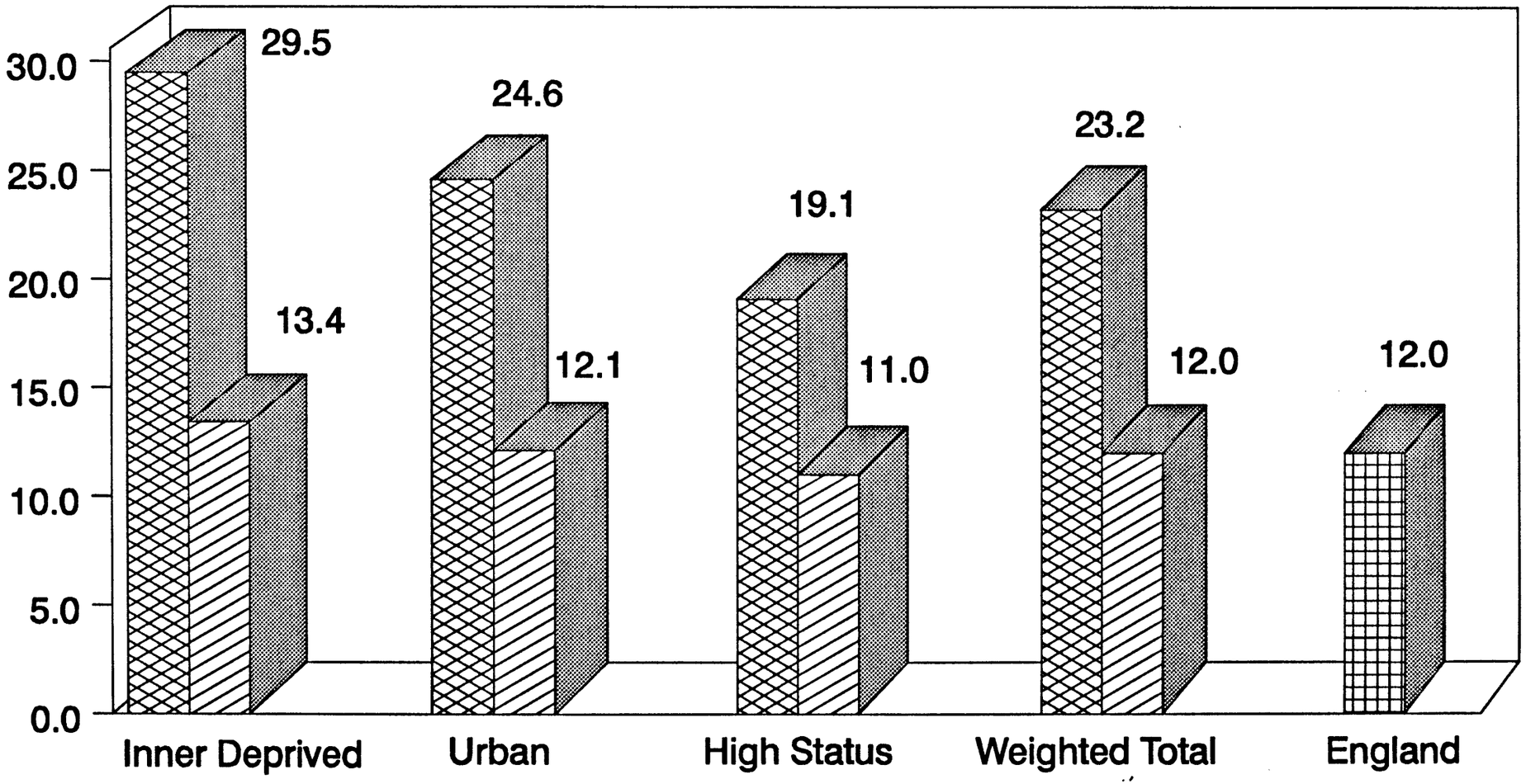


TABLE 5.4: A BREAKDOWN OF PLACES IN RESIDENTIAL HOMES FOR ELDERLY PEOPLE PER 1,000 POPULATION, AGED 75 AND OVER, 1989/90

TYPE OF AREA	LOCAL AUTHORITY	PRIVATE	VOLUNTARY	TOTAL
		LONDON		
Inner Deprived	34	7	15	56
Urban	31	13	8	52
High Status	24	20	14	58
TOTAL	30	13	14	57
		NON-LONDON COMPARATORS		
Inner Deprived	39	25	12	77
Urban	36	45	6	86
High Status	29	35	12	75
TOTAL	34	32	11	77
ENGLAND	31	44	9	84

Gross Current Spend on Day Centres

Per Capita Resident Population Aged 65+, 1989/90



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Number of Local Authority Daycare Places

Per 1,000 Population Aged 65+, 1989/90

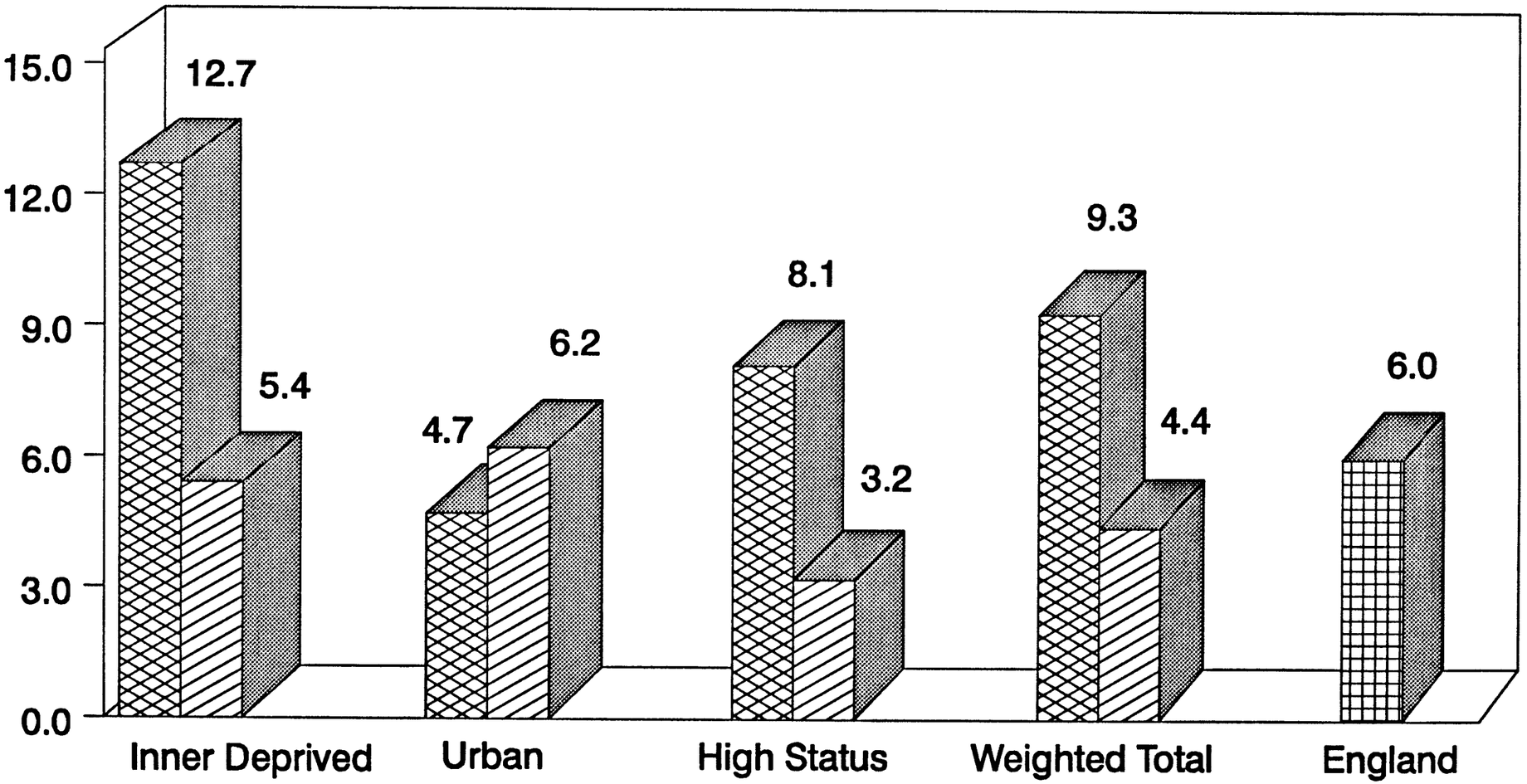

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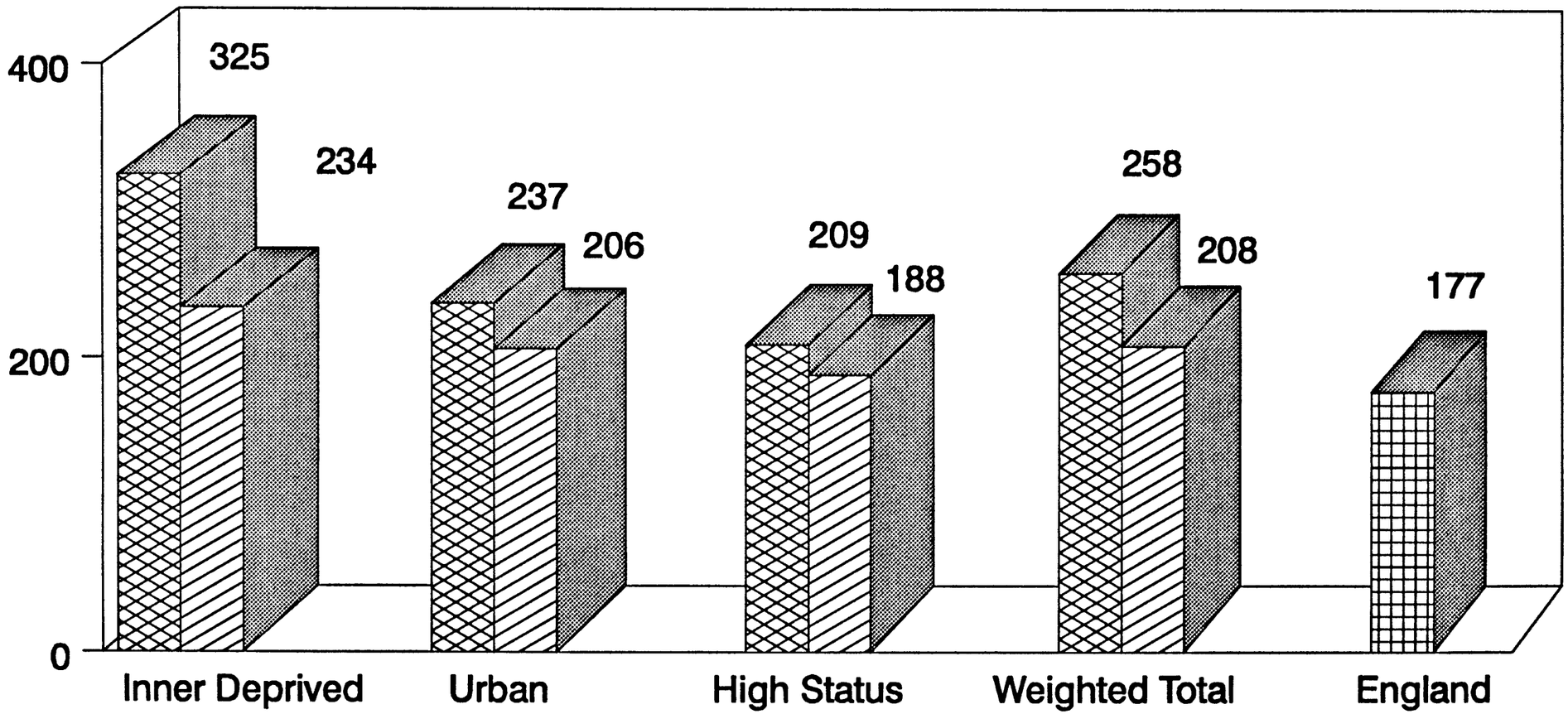
TABLE 5.13: A PROFILE OF DAY CARE SERVICES, 1989/90

TYPE OF AREA	GROSS CURRENT SPEND ON DAY CENTRES PER CAPITA POP. AGED 65+ £	NUMBER OF LA DAYCARE PLACES PER 1,000 POP. AGED 65+	WEEKLY GROSS SPEND ON DAY CARE PER PLACE PROVIDED £	NUMBER OF WTE DAYCARE STAFF PER 10,000 POPULATION
LONDON				
Inner Deprived	29.5	12.7	50.4	5.9
Urban	24.6	4.7	187.4	3.8
High Status	19.1	8.1	42.0	4.3
TOTAL	23.2	9.3	49.8	4.9
NON-LONDON COMPARATORS				
Inner Deprived	13.4	5.4	48.7	6.0
Urban	12.1	6.2	38.0	4.5
High Status	11.0	3.2	66.7	3.4
TOTAL	12.0	4.4	58.2	4.6
ENGLAND	12.0	6.0	40.9	4.1

Overall Expenditure on Primary Healthcare

Per Capita Resident Population, 1989/90



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F H S

- London is relatively under-resourced, taking account of higher input costs
- this translates into generally poorer services provision, both in terms of structural variables and service target variables
- London spends less on drugs because of lower prescribing levels

King's Fund Institute

CHS

- London spends relatively more on community health services, even when higher input costs are taken into account.
- There is a lesser provision of both district nurse and health visitor services in London.

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Social Services

- a high overall spend in London, especially in inner deprived London, even when the higher input costs are taken into account.

- a different balance of care between residential and non-residential services for the elderly in London.

- a lack of private provision of nursing and residential care in London.

King's Fund Institute

What do Londoners think of their services?

Mike Solomon

King's Fund Institute

OUTLINE

- Describe national context
- Compare London
- Assess the effect of living in London on satisfaction
- Suggest possible explanations

King's Fund Institute

PURPOSE

To investigate views about the NHS held by people in London and in Britain as a whole, using the OPCS Omnibus Survey four times over the year 1991-92

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Comparing Satisfaction

	NHS	GP	Inpatient	Outpatient	N=
			(% quite or very satisfied)		
London	56	81	54	51	927
Non-London	67	87	63	58	7569
National	67	87	62	57	8496

Source: OPCS, 1991-92

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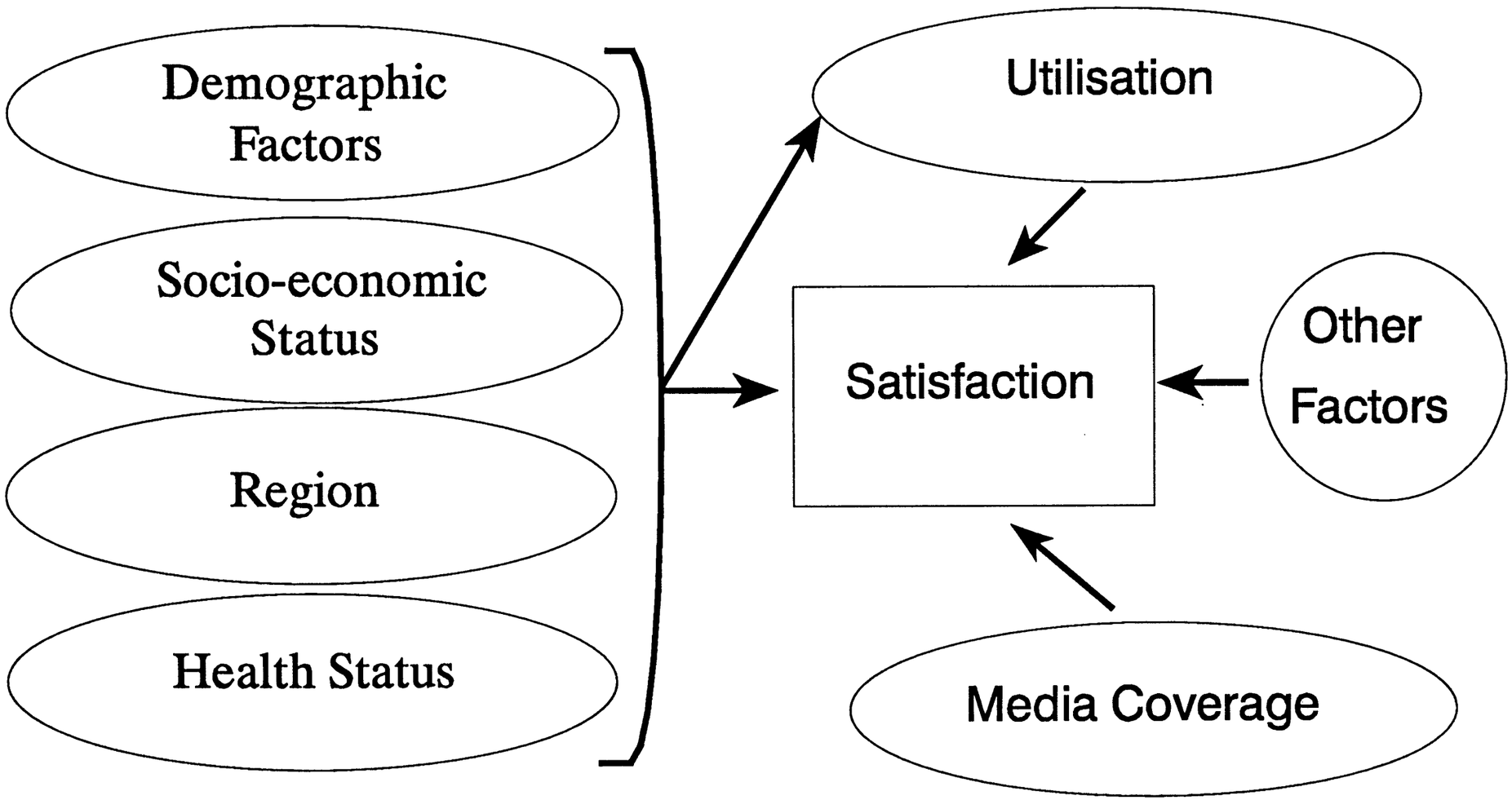
Determinants of Satisfaction with Health Services



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ILLUSTRATIVE CARICATURES

Mrs Satisfied

Married woman, aged 60,
recently seen GP.
Interviewed in 1992.

Mr Dissatisfied

Single man, aged 30,
with poor health,
recently seen GP.
Interviewed in 1992.

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Illustrative Probabilities of Being Satisfied With The NHS

	London	Non London
Mrs Satisfied	.63	.74
Mr Dissatisfied	.33	.45

National average = .67

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Illustrative Probabilities of Being Satisfied With GP Services

	London	Non London
Mrs Satisfied	.91	.94
Mr Dissatisfied	.69	.78

National average = .87

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Why Are Londoners Dissatisfied?

- Poorer services
- Higher expectations
- Life in London generally

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Possible areas for improvement in primary care

- GP's appointment systems
- Amount of time a GP gives to each patient
- Quality of medical treatment by GPs
- Choice of GP seen

Perceptions of the need for improvement in primary care

	London	Non-London
Appointments	55	46
Patient time	46	35
Quality	41	31
Choice of GP	37	29