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.

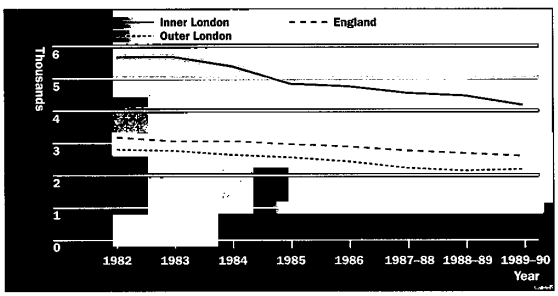
1.3 However, the concentration of specialist provision in the capital's NHS hospitals continued unchecked, as did levels of medical staffing.

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

	% 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
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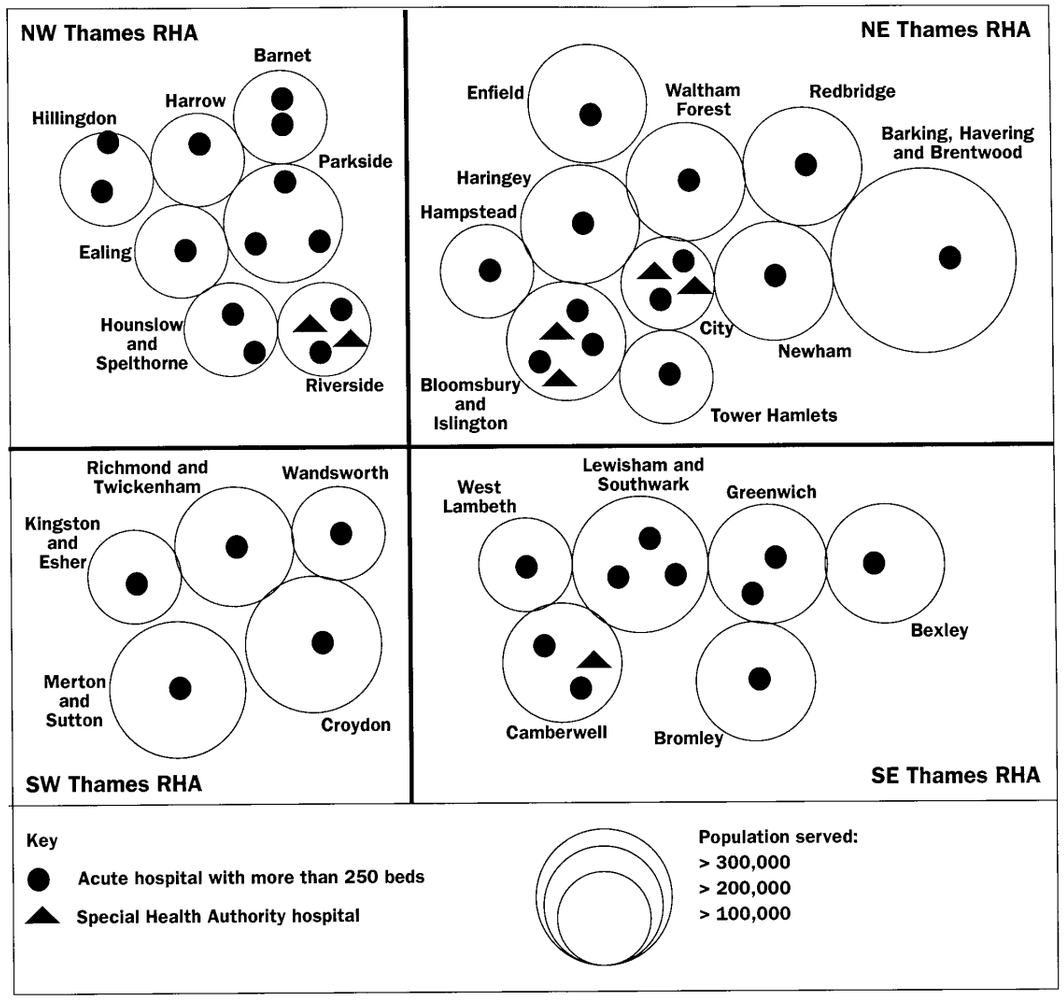
Figure 3 Current provision of major acute hospitals in London



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.

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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 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.

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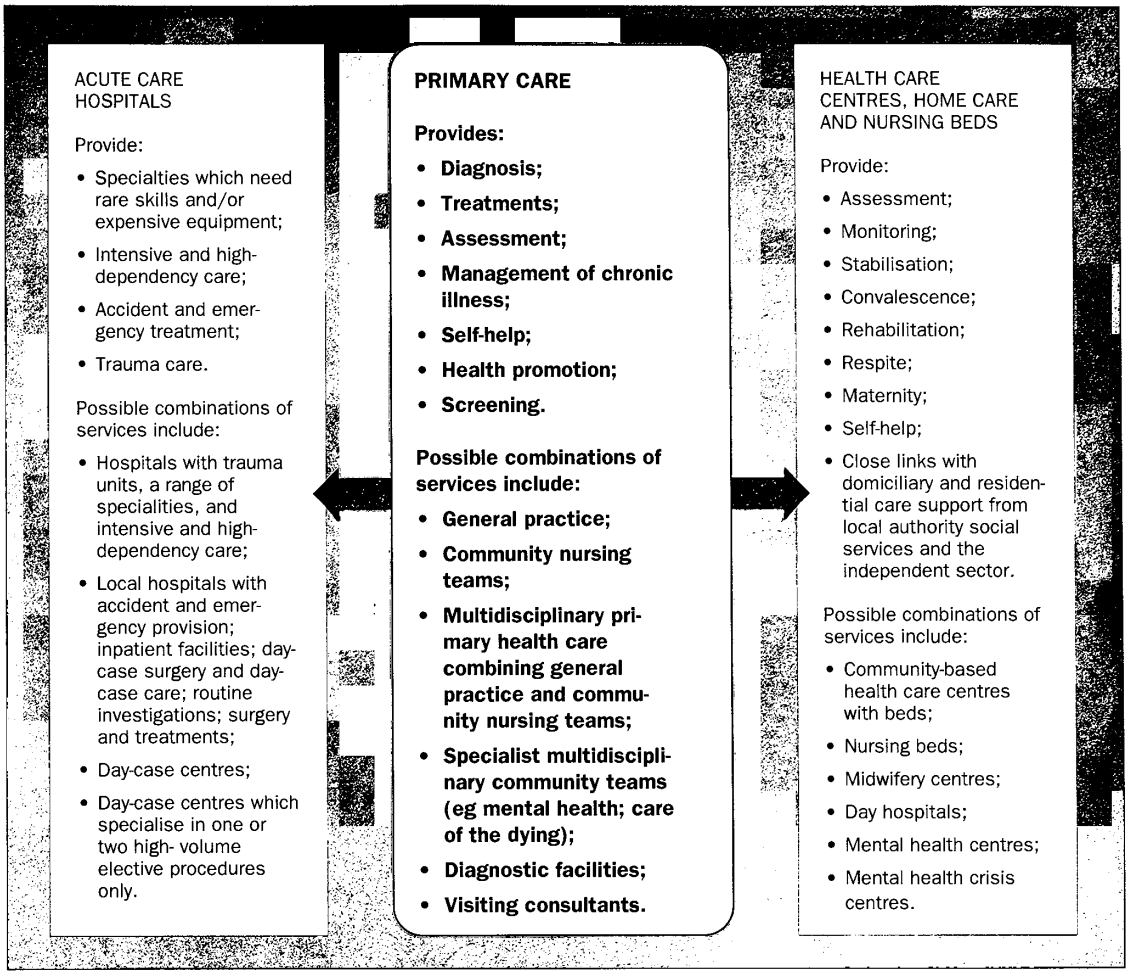
Box 2

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.

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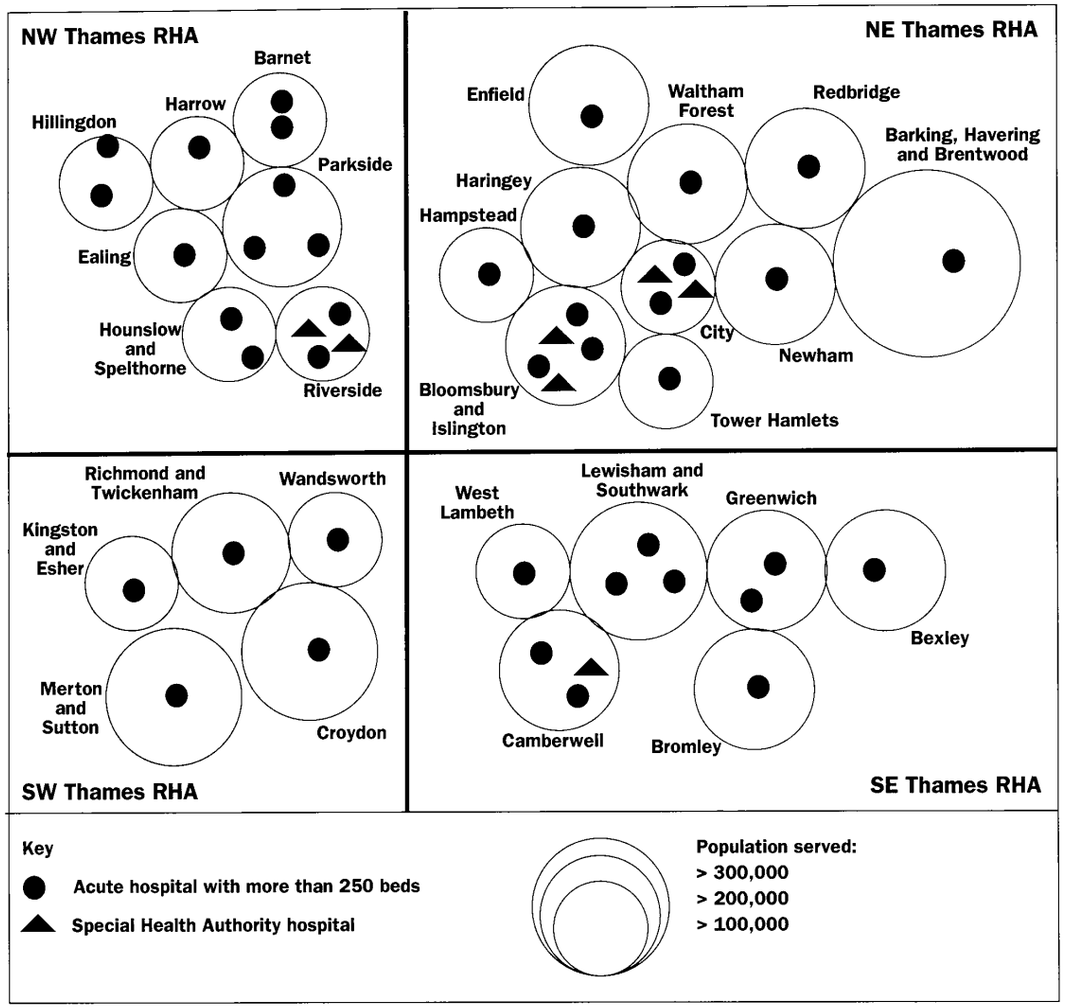

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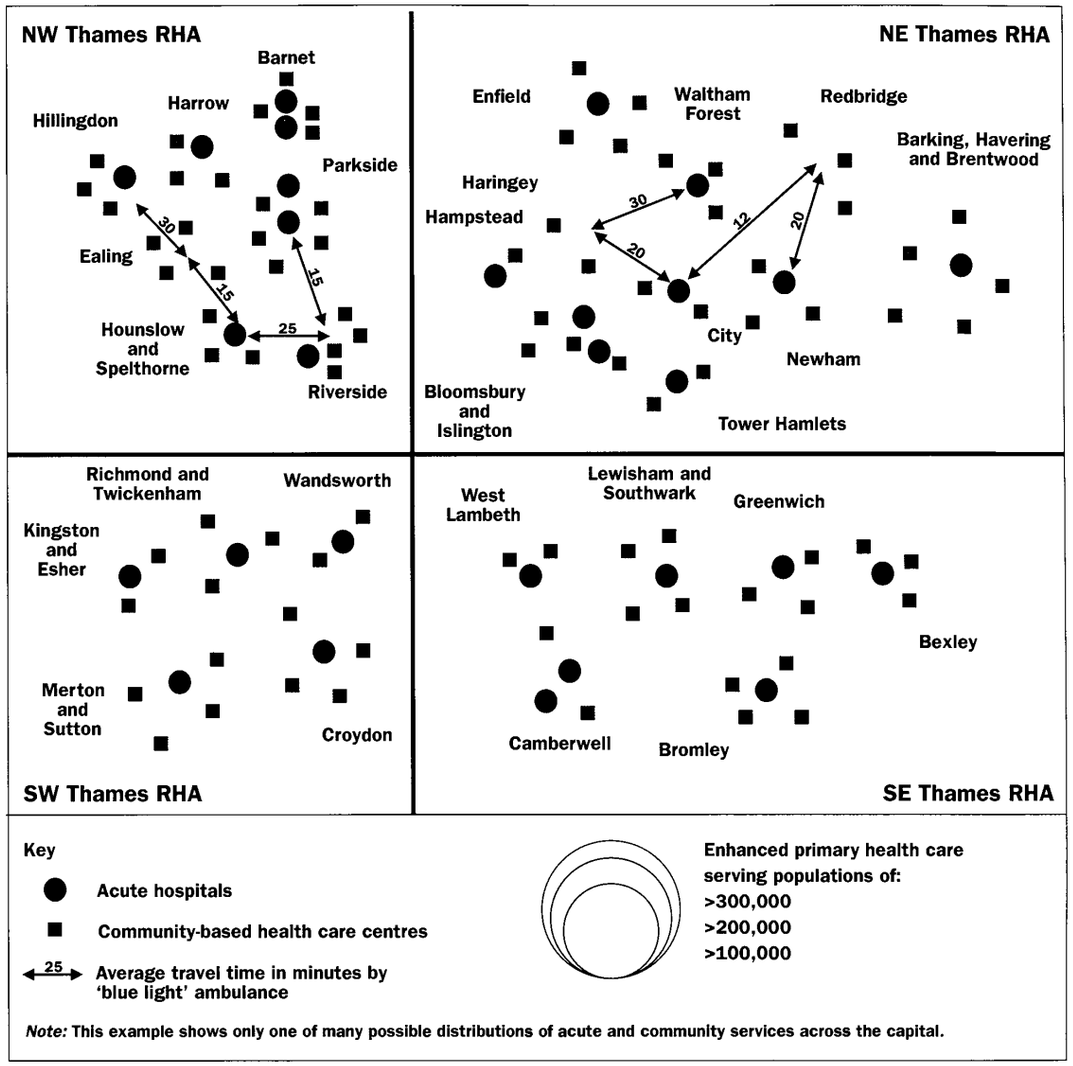
9.4 The Task Force should work with London's regional, district and and special health authorities, commissioning consortia, local authorities and the University of London to agree and implement a process of consolidation and modernisation for the city's health services.

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



Note: **This example shows only one of many possible distributions of acute and community services across the capital.**

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.

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