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n's health services in the 80s

LONDON'S HEALTH SERVICES IN THE 80s

Part 1

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FOREWORD

The problems associated with the provision of health care in London have exercised the minds of many generations of legislators and professionals – not to mention the general public. The complex interaction of social, economic and historical forces ensure that there are no single or simple solutions to be found. Rather does the situation call for a continual re-appraisal of current factors and an examination of these against the resources available and the priorities of the time.

The King's Fund has recently reviewed a number of its activities and has decided to build up a programme of work in the form of conferences, publications and projects, all of which bear upon "the London scene". The Fund has therefore welcomed the opportunity presented by the London Health Services Research Group to publish in the form of three Project Papers a series of papers originally given as lectures and which have been edited by Dr Mark McCarthy, honorary secretary of the Research Group. We are grateful to Dr McCarthy for making this possible and for the effort he has put into this production.

The papers cover a wide range of topics and are presented from several points of view. Taken as a whole they illustrate the fallacy that there are readily definable boundaries, neat and tidy classifications, to health and social care. If the Fund has a particular interest it is perhaps to try to expose the issues which, to use the jargon, lie at the interface between what is known as primary and secondary care; to look at the "grey areas" and perhaps to try to identify the good practices which have been created in tackling some of the dark, dirty and difficult problems.

For good practices and innovative ideas do abound and the discussion and exposure of these is perhaps something which has been neglected. And whilst many of London's problems are unique, it must not be forgotten that many of the difficulties of high density populations, scattered inadequate and unbalanced resources, and severe social deprivation, are common to many of our big cities.

We hope that this series of papers will make a contribution towards the improvement of health and social care in London and elsewhere. They are intended to complement the activities of many who share our concern, not least the Department of Health and Social Security, whose officers have joined with us in a number of the Fund's activities. If this series can open up the debate and can lead towards the identification of examples of better patient care, it will have served its purpose.

W G Cannon
Director, King's Fund Centre

The London Health Services Research Group was formed in 1976 to provide a forum for the exchange of information and ideas on research and development into health services in London. The majority of the group's members are working or researching broadly within the fields of health administration or community medicine. Meetings on a particular topic help to bring together people working in that field, who might not otherwise have had an opportunity for contact.

More details of the Group can be obtained from the secretary, c/o Department of Community Medicine, University College Medical School, University Street, London, WC1 (Tel 01-387 9300 ext 165).

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LONDON'S FUTURE POPULATION AND SOCIAL STRUCTURE:

DAVID EVERSLEY

The views put forward in this paper arise from three different, but in the event converging research programmes. First, during the author's terms of office as Chief Strategic Planner for the Greater London Council, work was commissioned to measure changes in the size and structure of the metropolitan population mainly in the period 1961—71, and to identify medium term trends which might have a bearing on various aspects of local government functions — housing, education, health and social services in particular. This work also included attempts to project levels of economic activity in London, with their implications for employment and earnings.[1] Secondly, a number of research projects in the middle seventies focused on the now fashionable problems of the Inner Areas, and much of the statistical material on which the generalisations in this paper are based was collected for an analysis commissioned by the Social Science Research Council's Inner Cities Working Party, designed to pinpoint how far the movements first observed in the 1960s had intensified, or slowed down, and how far the fears about the well-being of the population first expressed in 1972 had turned out to be well-founded.[2] Lastly, some recent research at the Policy Studies Institute, for the Department of the Environment and as yet unpublished,[3] focused on the process of household formation, and this work meshed very well with another longer-term investigation into the main trends in family formation (and dissolution).[4]

SOME AGREED TRENDS

A few generalisations can be made at this stage which would appear to be non-controversial. London's population has fallen quite dramatically from about 8.6 million in 1939 to under 7 million in 1979. There are a number of variant projections in existence; the highest and lowest values for 1991 are 6.8 million (on the assumption that fertility recovers from its very low 1977 levels and that out-migration is slowed down considerably), and 6.2 million (on the assumption that fertility continues at a low level and out-migration is maintained at the rates current in the early seventies).[5] The basis of these assumptions need not concern us very much here: it is sufficient to say that whatever characteristics we shall identify as

concomitants of the 'high' variant projections may apply even more strongly for the 'low' variant projections. Looking further ahead, there are OPCS and GLC projections now current which put London's population at round about the 6 million mark for the end of the century. [5,6]

INNER AND OUTER LONDON

This loss of population affects the Inner London Boroughs much more than the Outer Boroughs. (Very roughly, the Inner Boroughs correspond to the old LCC area – the definitions are not important because there are some outer boroughs with all the characteristics of the old inner ones, and some fairly affluent inner London areas.) Inner London still had 4½ million inhabitants in 1911; this had fallen to 2.7 million by 1971 and less than 2.5 million by 1977. Outer London increased from under 2 million in 1901 to a peak of 4.8 million in 1951 and then decreased very slowly to just under 4.5 million by 1977. So much of what we shall say about the characteristics of population change will be about the inner areas. Projections of future population show the inner areas to be very much more sensitive to the different assumptions we make about future population behaviour: the highest projection shows that the inner areas might actually gain a little population, but the lowest shows a further decline to 2.3 million, half the population at the beginning of the century.

THE CAUSES OF DECLINE

The decline of London's population can now be shown to have been the result of spontaneous changes in behaviour rather than planning policies: far more people moved out of the city making their own arrangements (mostly into owner-occupied housing) than in consequence of the planned growth of New and Expanded Towns, but of course the fall in fertility was no part of the government's policy. Nevertheless it is worth recording that all the official studies and plans for the metropolitan area (starting with the South East Study of 1964[7] and up to the finally approved Greater London Development Plan[8] confirmed by the Secretary of State in 1975)[9] considered this fall to be highly desirable. The 1964 Study stated that unless strong positive measures were taken, London's population by 1981 might rise to 9 million: 8 million was

the desired maximum. (In fact it will be little more than 6.5 million.) The object of this reduction was the elimination of the housing shortage, the easing of traffic problems, the improvement of access to leisure and outdoor recreation facilities especially for the inner London population, and better health and educational provision without the need to add massive infrastructure projects like schools and hospitals, given the high costs of land and construction. The projections of 15 years ago turned out to be very wide of the mark, and the reduction of population beyond the dreams of the regional planners has not apparently brought about all the desired benefits, if indeed any. It is as well, however, to show how wrong we all were, because we may well be wrong again with our current projections, despite the additional insights we think we have gained.[10]

LONDON'S ECONOMY

The next reasonably uncontroversial set of statements about London's development in the last 15 years, and its future prospects, concerns its economic condition. Compared with the mid-sixties, London has lost nearly half the jobs it then had in manufacturing industry, whereas those in the service sector (in administration, commerce and personal services) have increased. This change has meant some additional unemployment for semi-skilled and unskilled workers, and especially unqualified school-leavers, but the opportunities for white collar workers have remained good.[11] Had it not been for the fact that many offices also moved out of London into the rest of the south-east region, there could have been a great increase in the inflow of commuters. This has not happened. Manufacturing plants have closed down, rather than moved; a great many new offices have been built, as well as hotels, restaurants and shopping centres but a good deal of growth has also accrued to the small and medium size towns within a 50 mile radius of London where there has been a great increase of residents, as well as workplaces.[12] This is a movement which has generally been welcomed on all grounds – health, efficiency, and 'the quality of life'. So London has not really become poorer in any significant way (as was feared at one time because of the decline in industry), but there are serious pockets of unemployment and low wages, and there are obviously great inequalities.[13] (Not always in the way we might expect: thus some of the lowest-earnings are found in outer London boroughs where there are concentrations of lower grade clerical workers.) Not all the better-off have left the city;

indeed there has been something of a reflux amongst the managerial and professional groups which have colonised what are sometimes known as areas of gentrification, especially in some favoured inner boroughs, like Islington and Lambeth.[14]

Many more people depend on tourism and entertainment and shopping facilities which serve the region as much as the capital. Some people consider this to be a somewhat unstable base for London's economy, but this is a controversial point;[15] London's traditional industries, like the docks, have performed so badly that there is perhaps less of a threat to employment in new trades like catering, conferences, and research.[16]

LONDON'S DISADVANTAGED POPULATION

Lastly, there is widespread agreement on the fact that London has a relatively, and probably absolutely, larger number of people living there who for one reason or another are disadvantaged, compared with the rest of the south east region and the UK.[2] Foremost amongst these groups are the immigrants and their descendants. In 1978, 9% of London's population was estimated to be of West Indian, African or Asian origin. In inner London boroughs it was much higher (21.5% in Lambeth) and three outer boroughs also had more than 15% of the population of NCWP origin. By 1976, 23% of all births in inner London, and 19% of those in outer London, compared with 7% in England and Wales, occurred to mothers born in the New Commonwealth and Pakistan. Taking all countries of birth outside the UK, 41% of all inner London births, compared to 12% nationally, fell into the categories: Ireland (Republic), New Commonwealth (including Pakistan) and 'Other'. These figures are neither new nor alarming; they do not mean that London is about to be swamped by the black population, nor that the fertility of the immigrants is very much greater than that of the natives. What it does mean is that London contains a high proportion of fairly recently arrived women of NCWP origin who have joined their husbands; and conversely, that Londoners thinking of starting families have a high propensity to move into the rest of the south east region, or East Anglia. It does mean that many boroughs have up to a third of their school children coming from immigrant homes. If the difficulties these immigrants encounter when trying to find work and housing outside certain boroughs continue, then we might well expect long-term ethnic composition to reflect the present birth figures.[17]

SOCIAL COMPOSITION

We now turn to changes which are rather more difficult to analyse, on which there is some disagreement as to past movements, and even more about future trends. We have already pointed out that out-migration from London has been largely in the owner-occupier section of the population. By and large, out-migrants have been young families, in the reproductive age groups, and including a high proportion of skilled manual workers, as well as professional and managerial groups. They have been largely native British born people. Elderly people have also moved; but mostly from amongst the more affluent groups able to afford privately arranged retirement, e.g. to the southern 'geriatric belt'.[18] In-migrants to London have predominantly been young people from elsewhere in the British Isles, and slightly older ones, at first mostly male, from overseas. When they arrived, they probably possessed few skills, and earned low incomes, whatever their colour. If that had been all, the socio-economic composition of London would have changed quite drastically: there would have occurred what has become known as 'social polarization', with a higher proportion of the population belonging either to the lowest socio-economic strata, with low incomes, high unemployment, few skills, and uncertain prospects, or to the highest groups — the affluent inhabitants of the inner West End and the smarter suburbs.[19] The 'middle mass' would have furnished most of the out-migrants. Though there is probably a good deal of truth in this view, it omits the fact that people who come to London young, work their way up: many of them are students, apprentices, or trainees. So they may move upwards on the social ladder and when they have reached a certain point, move out again. If this analysis covered the whole spectrum, the social composition of London would be quite stable. However, this is inherently unlikely. We only have detailed figures from 1961—71: during this period London's 'top' groups (S.C. 1 and 11) increased faster than the national average, and the bottom groups (IV and V) decreased more slowly, whilst the middle groups (III N and III M) decreased faster.[20] This is consistent with what we have said about immigrants, and about people moving out to become house-owners (whilst those finding standard housing in London mostly obtained it in the publicly-owned rented sector). It also accords with what we know about incomes: whereas non-manual incomes in London are considerably higher than those in the rest of the country, manual wages are only slightly higher. This would point to the presence in London, on one hand, of a relatively

high number of very well-paid jobs (in the higher echelons of administration and commerce), and on the other hand, rather more ill-paid service trade jobs (e.g. in catering, local authority manual staffs).[21]

INDIVIDUALS AND HOUSEHOLDS

If we look at this problem from the point of view of the individual and the household, we also have some signs that the composition of London's population is changing in a way which could give rise to anxiety. The proportion of pensioners in the population of the inner boroughs is rising faster than in the country as a whole, probably because the older tenants in particular find it less easy to make the move out of London. Without having detailed evidence on this point, it seems plausible to suppose that as the younger generation finds work and housing opportunities outside the metropolitan area, the elderly may be left behind.[22] Using age-adjusted mortality figures (with the help of an area comparability factor), we find that inner London death rates are higher than those of outer London. Certain causes of death (e.g. pneumonia) require more detailed analysis (because of a nationally rising trend), but again inner London shows a higher rise of incidence.[2] Though both infant and perinatal mortality rates are falling, they are still higher in the inner than in the outer boroughs, and in some cases much higher.

These matters are the province of the community physician. However, it is worth stating them here because on every indicator we can produce from other sources – on housing conditions, sharing, overcrowding—we find that the differential remains: inner boroughs fare worse than outer boroughs, and London as a whole is worse off than the country as a whole.[2] Given the fact that unemployment as a whole is not high in London, and earnings at least somewhat above national average, why then this persistence of adverse conditions? Our statistics do not throw a great deal of light on these problems. We know that London has more Lone Parent Households than the rest of the country, and that the proportion has been growing.[23] It is highest, again, in inner London. There is a much higher incidence of one-person households, most of them consisting of old people living alone. There is a high proportion of households consisting of unrelated persons living together. There are no moral overtones to this statement, but it means there are many more people living in households which are not families, and we know nothing about what happens to these individuals

when they are sick, unemployed, or handicapped. In some London boroughs only just over half the households are 'married couple' households — i.e. of a type which is considered standard elsewhere. And the trend, over time, is for more and more households in London to fall into these higher-risk categories. We say 'higher risk' without having detailed information about them, because we must assume that the potential strain on the social welfare and health services is greater when we are dealing with old people living alone, lone-parent households, and young people separated from their families. Unfortunately there is very little detailed survey work available that deals with casualties in this sort of situation. We know that it is good professional practice to discharge people from institutions as rapidly as possible — the elderly, the mentally ill, offenders, and to return them to family and community care.[24] But our analysis of London's population trends makes us doubtful about the future. Will this sort of care still be freely available if present movements continue? We have only fragments of information. Indicators of social pathology are notoriously unreliable.[24,25] The proportion of children in care per thousand of the young population appears to be much higher in inner than in outer London, and rising faster.[2] On the other hand registered handicapped people are no more frequent in the inner boroughs than in the outer areas. Practically all indicators show London as a whole to be worse off than the rest of the south east region (though no worse than metropolitan counties in the country as a whole).

THE SOCIAL BALANCE SHEET

What can one conclude from this fragmented evidence that is of value in assessing the problems of the future? In the early seventies, it was recognised that the faster London's population fell, the higher would be the proportion of the population who were relatively handicapped. This conclusion was based on the fact that families with more than two children, immigrants, unskilled people, the handicapped and chronic sick, and the non-property owning elderly find it very difficult to move out of London, either under the assisted schemes, or by buying homes elsewhere. Whilst some of the newcomers would be professional and managerial workers posted to London on promotion, there would always be a demand for young and unskilled workers recruited to undertake the more menial tasks, in public services, in catering and in the transport industries, from London airport cleaners to railway porters, and in the past London has looked to this workforce amongst recently arrived overseas immigrants.

Some commentators, however, assumed that though this long term trend posed problems, there were other factors to consider. Many of the inner London boroughs were wealthy and could afford a high standard of social services. London was well served with hospitals, the proportion of patients per doctor seemed satisfactory. The public authorities were beginning to recognise the special housing problems of underprivileged groups and schemes were launched to enable some of them to move to new and expanded towns. The central government altered its rate support grant formula so as to strengthen the financial position of the boroughs which had the greatest burdens to bear.[26,27,28] There was some complacency, therefore, about the way London was coping with its changing population structure.

THE MOST RECENT TRENDS

Looked at from the standpoint of 1980, however, and with such newly gathered information like that of the 1978 National Dwellings and Housing Survey,[29] this complacency seems misplaced. Since the early seventies, the national economic situation has worsened. Unemployment has risen. The rate of house building in both the public and the private sector has slowed down considerably and house prices have risen much faster than incomes.[30] New employment opportunities for the unskilled and semi-skilled are practically non-existent, and recent surveys have shown that some of the vacancies which apparently call for no particular skills cannot be filled because the conditions of work are too unattractive to tempt the theoretically available unemployed workforce—wages are too low, distances from home are too great, working hours unsocial. The net result of this is that out-migration from London has slowed down considerably (from 110 000 p.a. in the late sixties to 71 000 in 1975/6). On the other hand, rather surprisingly, the number of births has risen steadily over the last two years, and this, with a smaller and still ageing population, means higher age-specific fertility rates. (Table 1.1 shows some provisional computations based on the 1971 census age structure of the female population). There are many possible explanations for this: the greater immobility of the immigrant population has already been quoted. A higher proportion of these increased births are illegitimate.[31] And at the same time abortions are also rising again, though these are not accurately analysed by usual residence of mother.[32] Both illegitimacy and abortions suggest that the

TABLE 1.1

POPULATION PROJECTIONS
for Inner London

Females — thousands

		1971 census	1991 proj 1	proj 2	proj 3	proj 4
Inner London	0-14	299.4	245.1	223.3	230.9	210.6
	15-24	256.1	241.0	229.0	241.0	229.0
	25-34	205.6	268.1	243.7	268.0	243.6
	35+	820.8	611.8	578.4	611.7	578.3
	45+	651.6	430.0	410.7	429.9	410.6
Outer London	0-14	470.5	450.4	438.2	425.6	414.3
	15-24	323.4	316.6	312.6	316.7	312.6
	25-34	279.7	360.0	349.9	359.7	349.7
	35+	1229.3	1074.0	1055.7	1073.8	1055.5
	45+	965.9	751.2	738.9	751.0	738.8
Greater London	0-14	769.9	695.4	661.5	656.6	625.0
	15-24	579.5	557.7	541.6	557.5	541.5
	25-34	485.3	628.1	593.6	627.9	593.3
	35+	2050.1	1685.8	1634.2	1685.4	1633.8
	45+	1617.5	1181.2	1149.7	1180.9	1149.4

Source: Greater London Council Research Memorandum 563, The 1979 Round of Demographic Projections for Greater London: Part II: Population Projections by P Congdon, J Hollis and S Strachan.

Notes:

1 Proj 1 Fertility high migration low
Proj 2 Fertility high migration high
Proj 3 Fertility low migration low
Proj 4 Fertility low migration high

2 The groups printed in bold figures accounted nationally for 93% of all births.

3 By 1991, only the 0-14 age-group is affected by differences in fertility projections although all age-groups are affected by migration. However by the year 2000 some of this age-group will themselves be in the fertile 15-34 age-group.

population at risk in various respects is still growing. Infant mortality amongst illegitimate children is persistently higher than for those born to married mothers.[33] This alone would account for the higher infant mortality rates of the inner boroughs where most of the illegitimacy occurs, e.g. Lambeth.

THE PROSPECTS

If one therefore re-examines the variant projections produced by the Greater London Council,[5] one might now take a different view of London's prospects from those of the early seventies. Instinctively one might have said that the trend would be towards a higher rate of out-migration, and steadily falling fertility. Hence the low variant projections we have quoted. And this fall would have been an indication of the possibility, at least, that London's housing and social problem would be eased.

But if the recent trends in housing costs, the slow-down in house building, and rising fertility are taken together, we could well imagine that they might mean a further deterioration in the situation. This, in a way, is an odd sequel to the planning debates of ten years ago. Then, it was feared that too rapid a rundown of London (meaning mostly in jobs for skilled workers) would lead to high unemployment and an increase in the relative disadvantage of the remaining population.

It was therefore recommended that something should be done to slow down the reduction, especially in manufacturing employment, and to plan to bring the out-migration of people and jobs into phase with each other.[8] In the event, neither national nor local authorities had any control over the matter at all. The new outflow of jobs (or rather the extinction of existing industrial firms) has continued, but at a slower pace, and thus unemployment has not risen much, though the earnings of manual workers have not kept pace with the rest of the country, and there are more fulfilled vacancies in the service sector suitable for workers and normally found in the redundant manufacturing labour force.

Instead, it is the failure of the population to fall at the maximum rate of about 1972–75 (highest out-migration and lowest number

of births) which now seems to be the most important pointer to the future. Certainly the reduction of the total population of more than one and a half millon since the peak has not brought a proportionate improvement in the housing position. Apart from the failure of the house-building programme, we can quote the high rate of stock erosion as a cause—dwellings in the rented sector especially being taken over by the tourist industry, and in some cases by students (because student numbers rose without additional residental accommodation being provided for them). Business firms have acquired houses and flats, and an unknown number of dwellings have become second or holiday residences by people living elsewhere — abroad, or in the country round London. Nobody knows exactly why, in a period when London's fit housing stock has risen by more than 20% (though more slowly than in the country as a whole), and resident population has fallen by 20%, housing conditions should still be as bad as they are, with all the implications this has for health, for domestic life, and for the welfare of children.

However, taking all the trends outlined in this paper together, one is driven to the conclusion that in several important respects the remaining population of inner London in particular (but also some outer boroughs like Brent, Ealing and Haringey) is relatively more at risk than it was in the past. Recent severe cut-backs in public spending (but especially housing, health and education) will fall hardest on a population which is already vulnerable on several counts.

CONCLUSIONS

It must be stressed that this tentative interpretation of trends has to be hedged about with every kind of caution. It is not a prophecy of doom. We have seen trends changed abruptly, and have then spent years trying to explain what happened. House prices may stabilise and more young people may be able to set up house outside London. The younger generation of immigrant-descended population may find it easier to obtain work and housing away from the crowded centres. Their educational achievements are already rising.[34] Economic growth may be resumed. Educational and training facilities may, by concentrating their reduced resources, improve the prospects of young people

in the labour market. And as more middle-aged people who are already owner-occupiers, come up to retirement they may be able to exchange their London house for some other location with fewer problems.

On the other hand some commentators will reply to this: Pigs may fly. Before one allows oneself more optimism, one has to see at least some indications that official policies are moving in the right direction. In 1979, they seemed to move the opposite way. A great deal depends, therefore, on what the community itself can do. One reads of a great many worthwhile experiments in the fields of care (often by voluntary groups) for the vulnerable sections of the population. Great progress has been made in de-institutionalising people in the last ten years, despite the fact that the rise in total health and welfare resources has not been spectacular.[35] Perhaps more can be done by the internal reallocation of scarce accommodation and manpower.

On this conflicting evidence, it would be easy to finish by saying that we just do not know. However, this, I feel, would be over-cautious on the evidence before us. It would be better to say that unless counter-measures are taken fairly rapidly, the relative disadvantages of London's population will get worse, and especially so in the high risk inner areas. If one says that these are mainly boroughs with a high proportion of immigrants, one is not making a racialist remark: rather, this is a reflection of the fact that the housing and workplaces, which we have provided for the immigrants of the sixties, were of such a poor standard that problems were bound to get worse. It may be suggested that if some immigrants had fewer children than apparently they do have at present, they might have fewer problems. However, there is no evidence for this. Some very low paid native born groups have low fertility, and are still at or just above supplementary benefit level, i.e. living in poverty. We cannot rid ourselves of the problem by pretending that universal family limitation provides an answer. In the early seventies, the age specific fertility of London women overall was considerably below the national average, mostly, as we now know, because those couples intending to produce families migrated out to a much greater extent than those who were not yet reproducing. But those low fertility rates resulted in no visible easing of London's social problems.

In any case, this is only a small part of the total picture. As we have

pointed out, it is the rising proportion of the elderly living alone, of one-parent households, and of young people living in multi-adult households, that are likely to pose particular problems of health and welfare. The population analyst can do no more than show the trends in the size and distribution of such high risk households, and to guess what further changed might occur as the result of economic developments, of changed in the housing stock, and of changed in the distribution of incomes. It is up to social workers, educationists and health workers to say how they propose to cope with this situation.[24,36,37]

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POPULATION BOUNDARIES FOR HEALTH SERVICES

HUGH SANDERSON

The problem can be taken in three sections. Firstly, what is meant by a population boundary for services? Secondly, can they be defined in London? And thirdly, do population boundaries effect anybody?

WHAT ARE POPULATION BOUNDARIES?

Population boundaries exist when populations looking to one centre for services can be divided from other populations looking to other centres for services. They can exist as actual geographic lines for services which are organised on a strict area basis, as in Figure 2.1 where primary care is provided for discrete populations and a group of primary care areas look to a district hospital for secondary care. Several of these groups may then look to a regional hospital for tertiary specialist services. Community services in this country are organised on this basis and in some countries, e.g. Finland, most of the health care system is arranged in this way.[1]

An alternative type of population boundary can be seen (Figure 2.2) where two centres of services are available. Equivalence zones may exist where people are as likely to go to one centre as another, and if information on use is available in fine enough detail, then a fairly precise watershed, or population boundary, can be mapped.[2] In practice information is not usually sufficiently accurate to achieve this but estimates of the population using facility A and facility B can be derived.

Relatively simple geographically organised services can exist when there are only two centres of service and the numbers of people looking to more than one centre are relatively small. However, life may be much more complicated, the simple models can break down and it then becomes impossible to define population boundaries.

FIGURE 2.1

GEOGRAPHICALLY DEFINED SERVICES

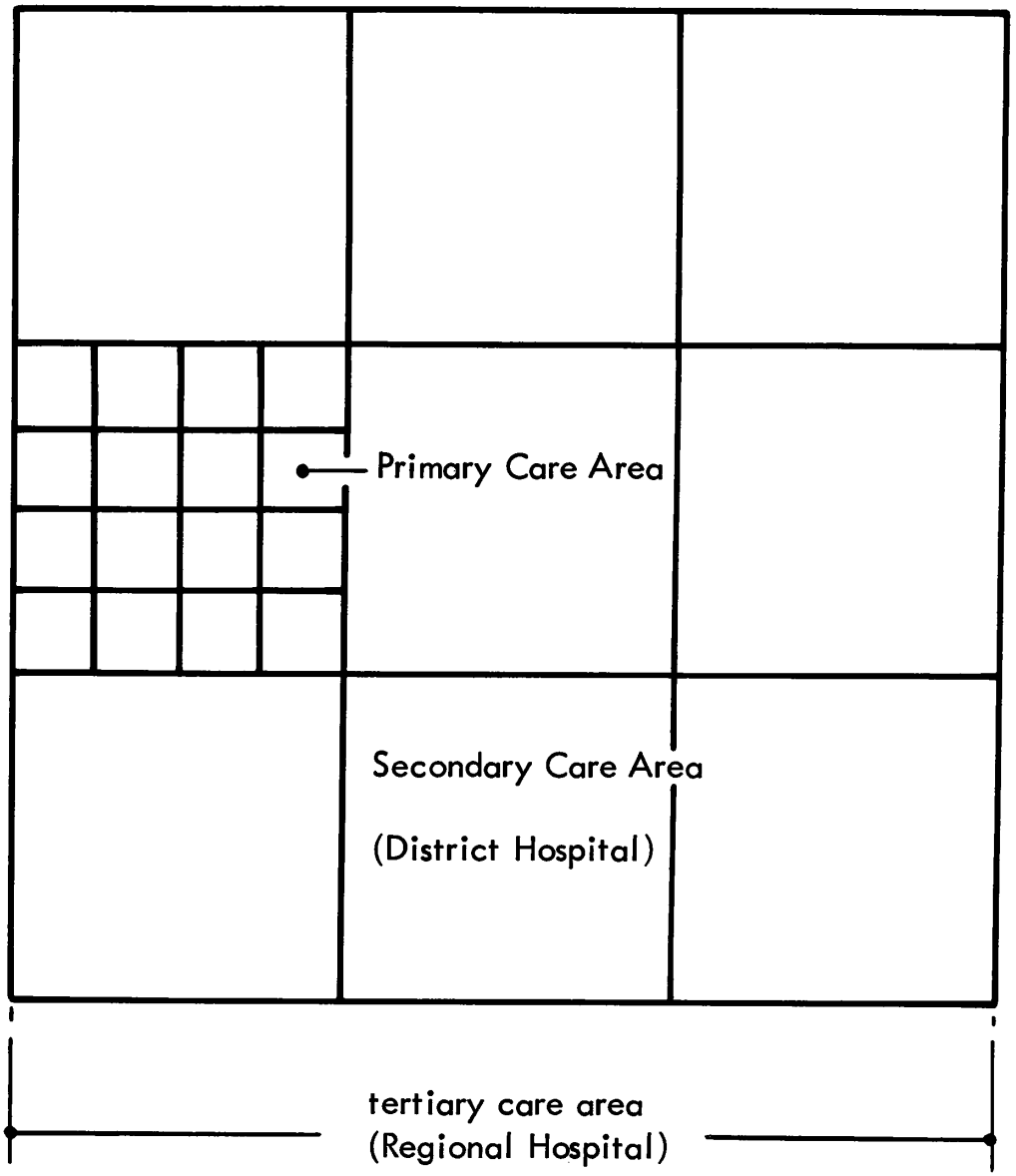
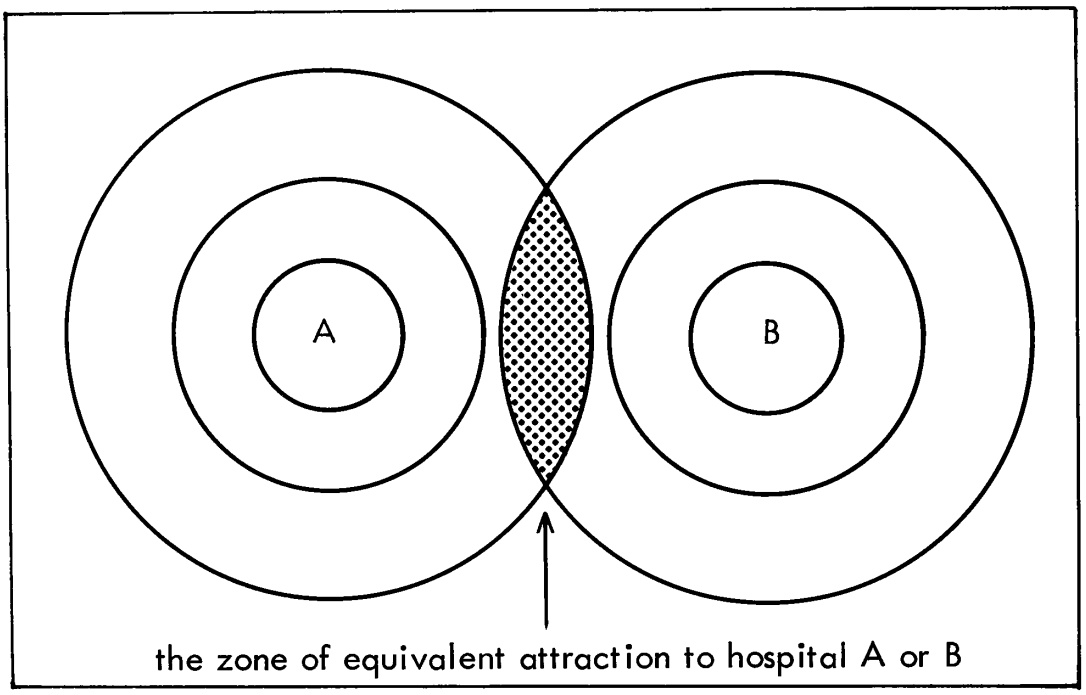


FIGURE 2.2

POPULATION BOUNDARY FOR SERVICES
BETWEEN TWO COMPETING HOSPITALS



CAN POPULATION BOUNDARIES BE DEFINED IN LONDON?

It is helpful to look at health services systematically as primary care — the point of first contact and community care, secondary care — acute and longstay, and tertiary care — specialist services available only by referral from secondary care.

General practitioner services are provided by doctors in contract to the Family Practitioner Committees. Each FPC covers the population of an Area Health Authority, thus several hundred GPs can hold a contract with one FPC. The geographical boundaries of the FPC are strictly defined but there are flows across the boundaries for GPs can hold contracts with more than one FPC. These flows are however relatively small. Within the area of the FPC there is no geographical arrangement for primary care services although GPs may not accept patients who live a long way from the surgery. Services are therefore relatively local but not necessarily so; although

roughly geoqraphically based at a macro level, this disappears at the micro level.

Community services include health visiting and district or home nursing and these are organised on a health district basis with only exceptional overlaps and cross boundary flows. These services may be organised within the district in one of two main ways. Either the nurse of health visitor is attached to a particular general practice or number of practices, and is responsible for providing services to the patients of this practice; or she has a strictly defined 'patch' and total responsibility for patients living in that geographical locality.

Both kinds of organisation are found in London – sometimes, especially in Inner London, within the same district. Population boundaries at a micro level can be defined for the latter organisation and not for the former. However, even when the patients of one practice come from more than one district, the district boundaries still exist for community nursing services unless there are special reciprocal arrangements between districts. In Inner London, the pattern is for community nurses to work on a 'patch' basis and in outer London on an attachment basis, but the pattern is variable and adjacent districts may have different organisations.

Secondary services may be divided into acute hospital and longstay. The acute hospitals in London can be sub-divided into teaching and non-teaching and in general the teaching hospitals are found in central London and draw in large numbers of patients from outer London and the Thames counties (Figure 2.3). Non-teaching hospitals are also found in the central area but tend to supply the local services to inner London exclusively.

Flows of patients occur on a local basis to non-teaching hospitals and local population boundaries can be defined (Figure 2.4). In Redbridge and Waltham Forest, 28% of Redbridge admissions flow to Waltham Forest and a watershed line could be drawn. However this picture is confused by 24% of the admissions flowing to the teaching hospitals and another 8.5% flowing to other non-teaching districts, which makes it difficult to define population boundaries for the services. The pattern for a teaching district is even more complex (Figure 2.5) and all that can be done here is to calculate the population which is being served by a hospital, even though this may be made up of small numbers of people scattered over a wide area.

FIGURE 2.3

THE LONDON UNDERGRADUATE TEACHING HOSPITALS

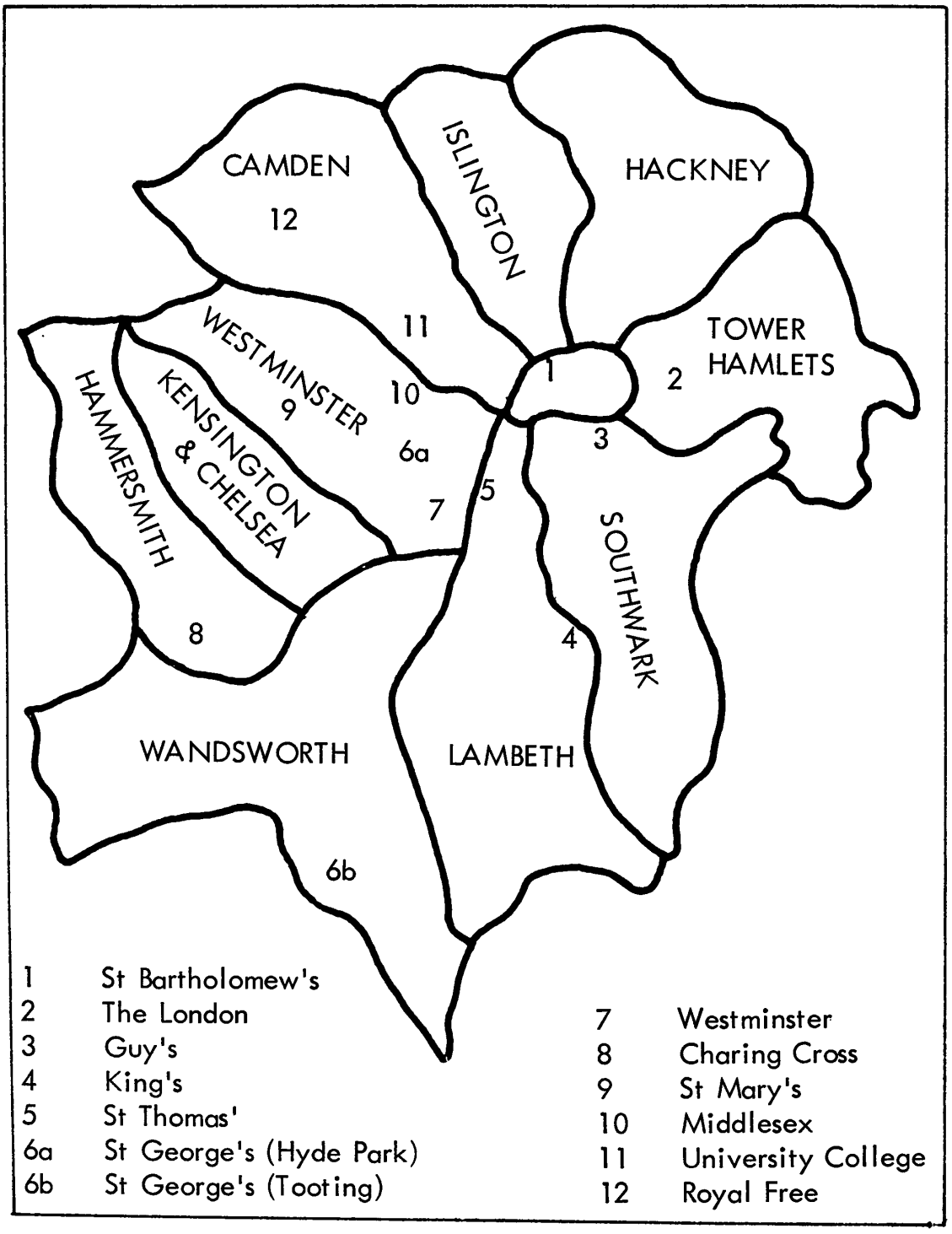


FIGURE 2.4

FLOWS FOR ACUTE SPECIALTIES
in Redbridge and Waltham Forest AHA 1977

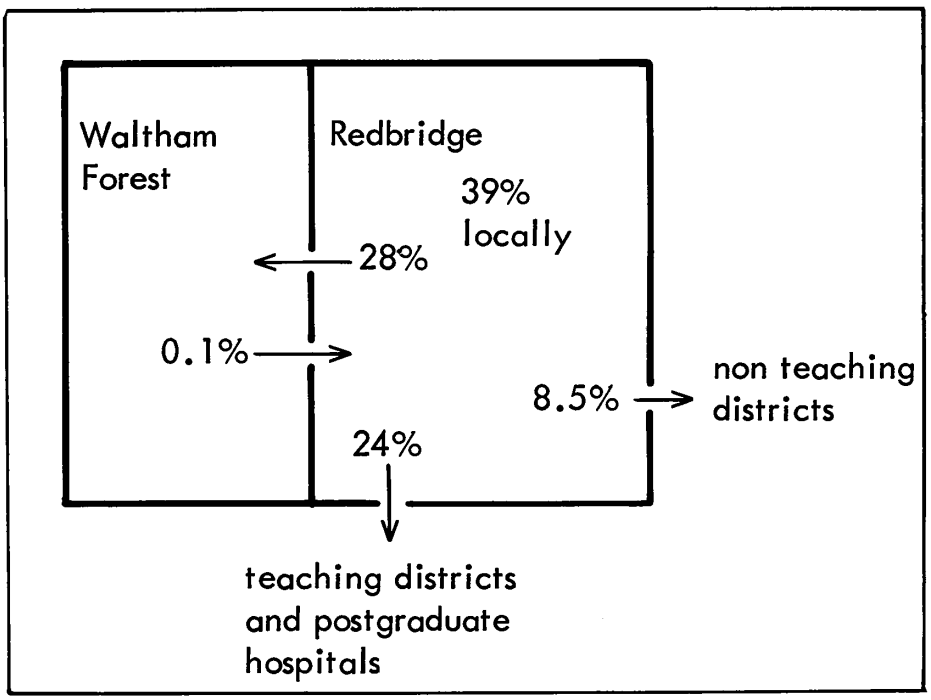
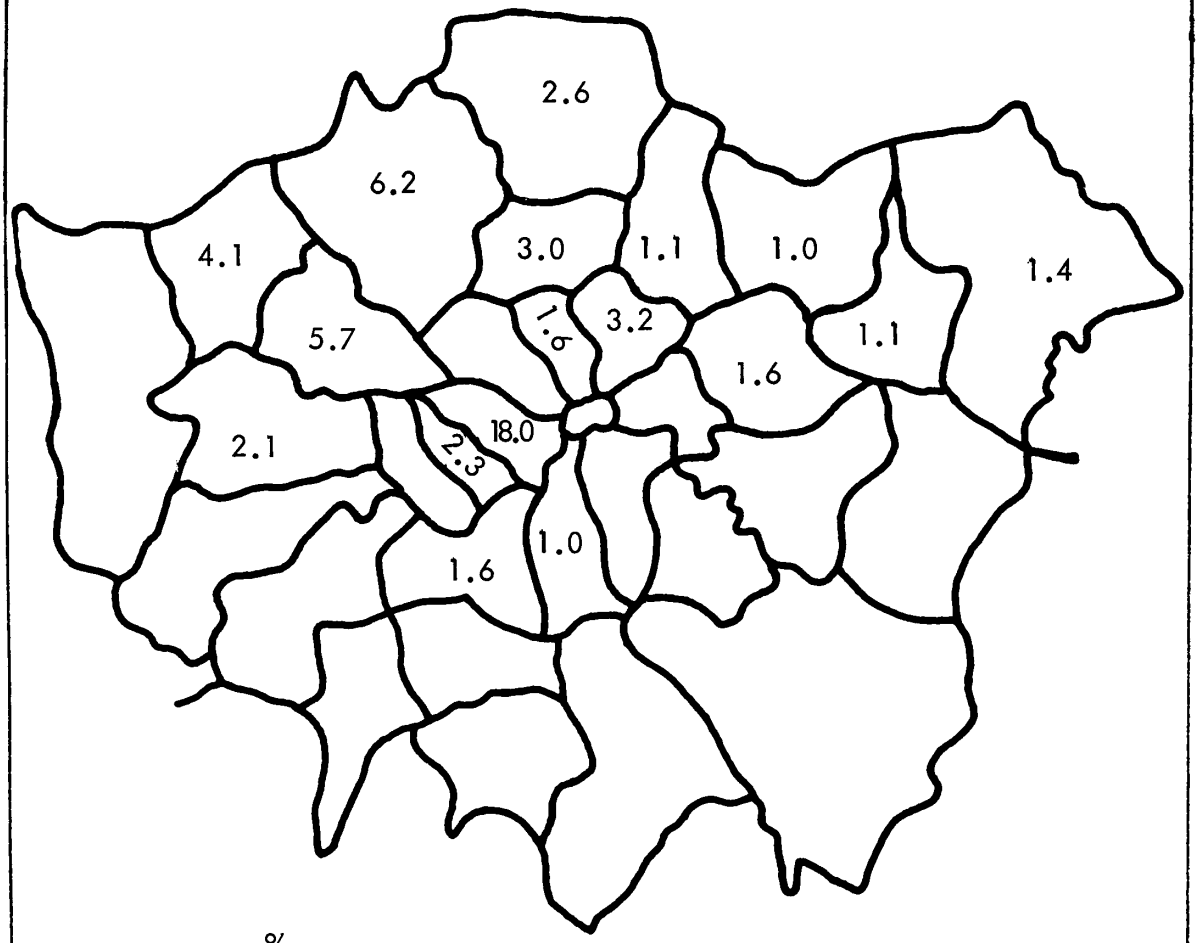


FIGURE 2.5

ORIGIN OF PATIENTS ADMITTED TO HOSPITAL
in N E District, Kensington Chelsea and Westminster AHA(T)
for acute specialties, percentage of admissions 1977

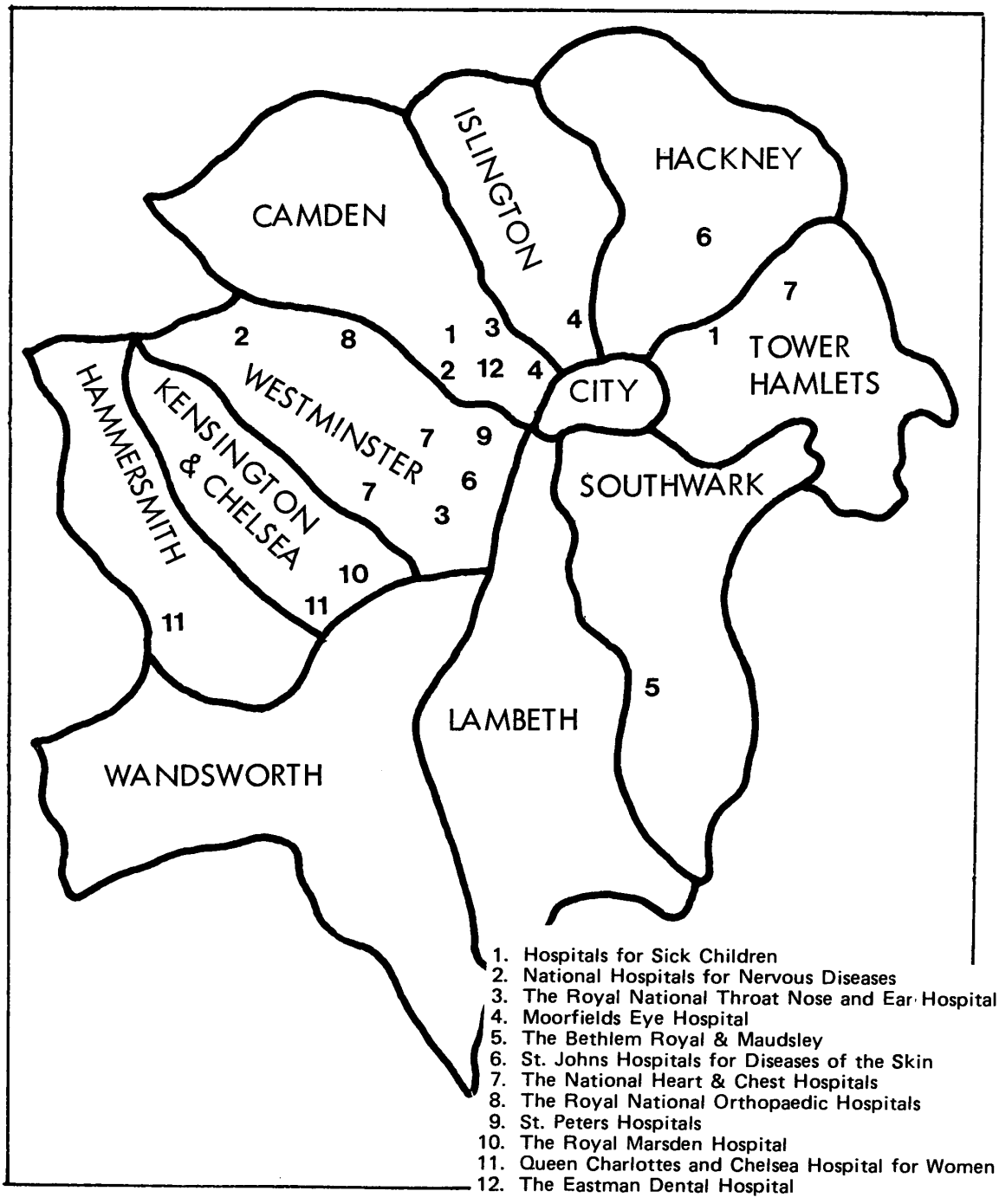


	%
Bedfordshire	1.5
Hertfordshire	5.6
Essex	4.0
Kent	2.8
Surrey	2.6

Source: London Health Planning Consortium[9].
Note: numbers are given only for areas or districts contributing one per cent or more of admissions.

FIGURE 2.6

THE POSTGRADUATE HOSPITALS IN LONDON



The reasons for these flows from long distances are varied but are partly related to the health care requirements of commuters, the presence of 'hidden specialties' in teaching hospitals, and the seeking of a better quality of care.[4,5]

For geriatric, mental illness and mental handicap services, there are quite strict geographic boundaries for services which determine the eligibility for service in a particular district. However, although the patients are local, for several of the inner London districts mental handicap and mental illness facilities are sited in outer London or in the Thames counties. In addition the picture may be confused by de facto geriatric, long term, care being provided in 'acute' beds which do not have geographic criteria of eligibility.[6]

Tertiary or specialty referral services are provided partly by teaching hospitals, partly by the postgraduate hospitals and also by some non-teaching regional specialty services (Figure 2.6). The profusion of specialty services leads to duplicating and blurring of catchment population for specialty services, for although the postgraduate hospitals each provide one specialty and each teaching hospital may not have the full range of specialty units, there are several options available for a patient requiring any specialty service. In addition, postgraduate hospitals may not have a purely tertiary function. Analysis of the patient flows shows that some hospitals (especially Queen Elizabeth's Hospital, Hackney, and the London Chest Hospital, Bethnal Green) serve as acute secondary hospitals and provide services for local residents (Table 2.1)

In summary, it can be seen that only some parts of the health services in London are organised on defined population boundaries, other parts have wide and over-lapping catchments. The important question is does this matter – and to whom does it matter?

DO POPULATION BOUNDARIES (OR THEIR ABSENCE) AFFECT ANYBODY?

Health services impinge upon and employ large numbers of people with a wide range of problems and priorities. It is difficult to analyse the consequences of the structure of the health service on all these groups

TABLE 2.1

SOURCE OF INPATIENTS FOR SELECTED POSTGRADUATE HOSPITALS

	percentage		
	within AHA	within rest of GLC	within rest of UK
Great Ormond Street	6	34	55
Queen Elizabeth, Hackney	68	17	9
Brompton	19	38	31
London Chest	47	33	18
National Heart	5	36	55
Queen Charlotte's	66	24	6

Source: Hospital Inpatient Enquiry 1971

of people, but four groups can be selected who represent a number of different view points. These are health service workers, administrators, planners, and patients.

This selection of four groups does not include all the sectional interests in the health service; nor does it imply that each of these four groups has completely different objectives and interests; nor does it imply that administrators and planners are not health service workers or sometimes even patients. Most health service workers are concerned that patients get the best service possible and aspects of the organisation that make efficient working difficult are resented by patients and staff alike. There are large areas of specific interest for each group where the structure and organisation of London's health services may have an effect.

Health service workers cover a wide range of professional, technical and ancillary staff and for many of these it matters little whether the services are organised on a population basis or not. Particularly for hospital workers, patients appear at the front door, are treated and discharged and it makes little difference where they come from. However, for some health workers the interface of geographically organised services with those without geographical boundaries can be extremely difficult.

In the primary care sector the relationship between non-geographic GPs and geographically deployed community nurses can be difficult because discontinuities in care and communication can create difficulties for team work. It appears that health workers in central London participate more in case conferences with a combination of health and social services staff than with GPs alone, compared with their colleagues in outer London (Table 2.2). This may be due to the lack of attachments to general practice in inner London. However, direct attachment may not be ideal since not all GPs wish to have attachments, nor all persons registered with GPs. Some geographic organisation is therefore essential to provide total community coverage. Many nurses also feel that geographic organisation allows more economical working and a better knowledge of the local community, so that the disadvantage of the mismatch at the doctor/nurse interface is less than the disadvantage of a mismatch at the nurse/community interface.

TABLE 2.2

CASE CONFERENCES (LASTING MORE THAN 30 MINUTES) ATTENDED BY HEALTH VISITORS IN 1977

	percentage attended with:				
	social workers	hospital staff	GPs	a combination of staff	others not specified
Camden & Islington	33	8	3	48	8
City & East London	28	22	9	33	8
Enfield & Haringey	12	22	39	17	9
Redbridge & Waltham Forest	22	7	22	25	23
Barking & Havering	18	20	31	13	18
Essex	42	10	12	26	8
NET RHA	26	15	20	26	12
England	16	12	39	11	21

Source: Hughes[3] Computed from Form LHS 27/3

Relationships between GPs and hospital doctors may be difficult if patients are admitted via a central bed service to one of several hospitals. This makes it more difficult for GPs to visit patients in hospital, be kept aware of progress and discuss future treatment with the consultant.

Patients discharged from hospital often require continuing care from geographically organised services like community nursing, social services (meals on wheels, home helps etc), geriatric care or local authority residential accommodation. The number of contacts required of ward sisters and hospital social workers is greatly increased for central London hospitals and this reduces the quality of professional relationships and makes satisfactory arrangements of services for discharged patients much more difficult.

For the medical profession there are a few disadvantages to the lack of geographic organisation of hospital services in inner London. As noted before, it is difficult for GPs to build up a working relationship with consultants. Teaching and postgraduate hospitals are however concentrated in a relatively small area of inner London, which would not occur if secondary and tertiary services were evenly distributed throughout Greater London and the home counties. The concentration of research, teaching and expertise creates an environment which is a powerful attraction and may allow consultants in teaching hospitals to have better qualified staff than elsewhere. This may allow more time for private practice or research but only anecdotal evidence is available on this point.

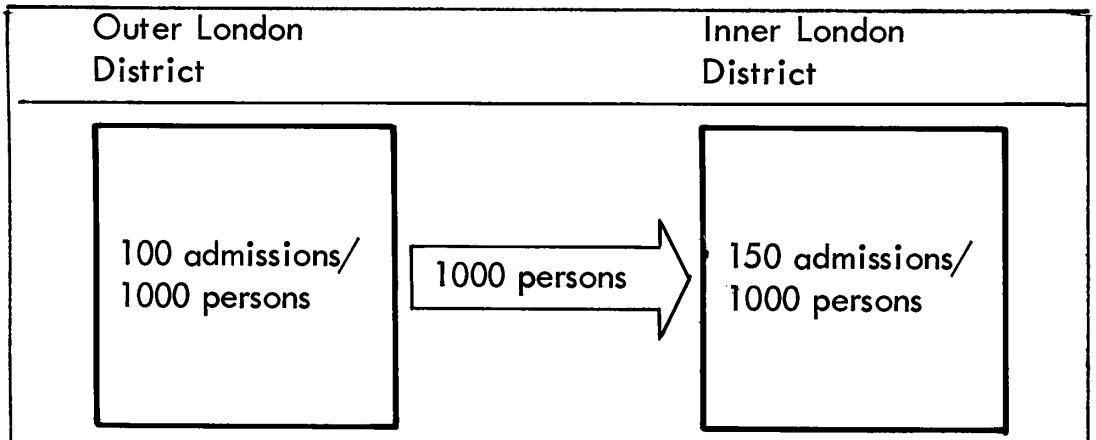
For administrators there are a number of problems caused by the present organisation of services. One of the major ones is the question of resource allocation. Teaching hospitals are expensive institutions and their costs per case are higher than in general hospitals. Although some allowance is made for this in the increment for teaching allowance, the calculation of catchment population has become very important and there are three ways of doing this.

The proportion can be calculated on the basis of the utilisation rate in the exporting area, that of the importing area or the average of the region. These different methods only make some difference if the utilisation rates differ between districts, but if we take an example an inner London district importing patients from an outer London district,

the utilisation rate in the inner London district might be 50% higher than that in the outer London district. Use of the exporting district rate would then ascribe a 50% greater catchment population than if the importing district rate was used (Figure 2.7). In addition imported patients may be high resource consumers because they are using hidden specialist services.[7]

FIGURE 2.7

THREE WAYS TO CALCULATE CATCHMENT POPULATIONS



Regional admission rate = 125/1000 persons

$$\text{Catchment population} = \frac{\text{imports}}{\text{admission rate}}$$

Catchment population:

a) using the exporting district admission rate

$$= \frac{1000 \times 1000}{100} = 10\,000 \text{ persons}$$

b) using the importing district admission rate

$$= \frac{1000 \times 1000}{150} = 6\,666 \text{ persons}$$

c) using the regional admission rate

$$= \frac{1000 \times 1000}{125} = 8\,000 \text{ persons}$$

Other administrative problems include the high turnover rate of community nurses in inner London, which may be due to geographic organisation, lack of nurse attachment to general practices and difficult relationships with the hospitals. Hospitals in central London also have difficulties in recruiting ancillary and hotel staff because of the competition from hotels and offices. This problem would be greatly reduced if geographic organisation of services dispersed the central London hospital concentration and gave an even distribution of health services.

Problems for planners have been created by this mixture of types of geographic and non-geographic services. One of these problems is the difficulty of getting reliable statistics of use and the need to gather information from a very wide geographic area. This is related to the fact that London is divided into four Thames regions and leads to difficulties in the monitoring of how changes in one part of the service effect other parts of the system.

Another problem arises from the varied sources of patients and the mixture of patterns of organisation, which makes it very difficult to plan comprehensive services for the community of a district. Not only is the task difficult but because of this planners tend to see their task as developing particular services rather than providing comprehensively for the health needs of the population.

Planning in other sectors such as housing, social services, or transport policy is geographic and health planners find it difficult to coordinate with these activities if, despite apparent coterminosity, there are substantial differences in the population being planned for. It may be however that coterminosity is not particularly relevant to the problem of coordination between local authorities and health services, since evidence to the Royal Commission suggested that differing priorities and methods of funding were more important causes of problems in coordinating planning.[8]

Specific problems are also posed by the postgraduate hospitals which receive funding directly from the Department of Health and exist outside the main planning system. One of the effects of this is to reduplicate facilities — especially in secondary care — so that extra facilities may exist in places where they are not necessarily most needed, and cause inappropriate use.

The problems already described all have an effect upon the quality of the service provided for patients but there are other specific problems for certain groups of patients. The non-geographic organisation of services in central London has allowed an imbalance of acute hospital beds in the centre of London. This has resulted in stretching of the services at the periphery, fewer beds per head of population, larger waiting lists and a higher threshold for admission.[9]

Conversely, certain groups of central London patients have suffered because of the predominance of acute curative facilities. These are patients requiring continuing care, the elderly, the chronic sick, the mentally ill and the mentally handicapped. Examination of the trends in mortality and morbidity statistics show that the needs for health care are changing from acute curative medicine to preventive and caring services. No longer are infectious and acute diseases important causes of death and disability, but cancer, cardiovasular disease, degenerative joint diseases and accidents are major burdens of illness.[10] For this we need preventive services and long term caring services. The disruption of continuity which the teaching hospital/primary care mismatch has created is ill-fitted to cope with this evolutionary change.

In summary, there are disadvantages for a number of groups arising from this mixture of geographic and non-geographic services. Those who could be said to gain from present pattern are the medical profession, the residents of the inner city requiring acute curative services and those requiring tertiary services. Although it may be difficult to establish relative priorities between these groups, on balance it is likely that the problems caused by this lack of organisation are greater than the benefits.

ACKNOWLEDGEMENTS

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38

LONDON'S HEALTH SERVICES: AN OVERVIEW

QUENTIN THOMPSON and MARGARET LALLY*

INTRODUCTION

Few would deny that there are some aspects of London's health services which leave something to be desired; in particular the administration and planning of the services seems to attract much of the critical attention. The Greater London Council has fairly recently added its voice to those expressing concern about this aspect of the health service. Not all the agencies expressing concern have a direct, or even an indirect, responsibility for health services, but health is not altogether a new topic for the GLC. Prior to 1948, the London County Council was the municipal hospital authority for its area, and from 1948 to 1966 it was the local health authority responsible for providing the community and school health services. On the creation of the present structure of London government in 1966 these health authority functions were transferred to the London boroughs at the same time as the setting up the GLC in its current form. The 1974 reorganisation took these functions away from the boroughs to be taken over by the Area Health Authorities.

Local authorities have never resigned themselves to the divorce, as they see it, of the health service functions from the remaining locally planned and delivered services for which they are responsible. They tend to be particularly concerned about the lack of local democratic control in the health services in general. Indeed, the GLC evidence to the Royal Commission was that London's health service should be unified at regional level and under the democratic control of the GLC.

There is a further, and more general, reason which could be put forward to explain the GLC's interest. The GLC is the strategic authority for London and as such could be said to be concerned about any set of policies or actions on a London-wide scale that are likely to have an impact on the well-being of Londoners. The GLC sees its role, in part, as acting as an advocate or spokesman for London in the national form. Clearly matters of particular interest in this context are the problems of

resources, and the resource allocation process, as they do, or might, affect the services provided for Londoners.

Perhaps the single event which brought this underlying current of concern to the surface was the publication and acceptance by the government of the Resource Allocation Working Party report. The implications of the principles of RAWP for London were that, at least in relative terms, resources were to be channelled away from the inner areas. This clearly conflicted with the GLC's own priorities, and indeed those of another government department, the Department of the Environment. The apparent conflict led to more general questioning about the adequacy of the planning and resource allocation processes for London.

The remainder of this paper briefly outlines some of the matters of concern in this area, some of which are already under investigation by, for example, the London Health Planning Consortium; some of them are discussed in more detail in other papers in this series. There are eight such issues raised in the paper, the first five of which relate specifically to aspects of the resource allocation process.

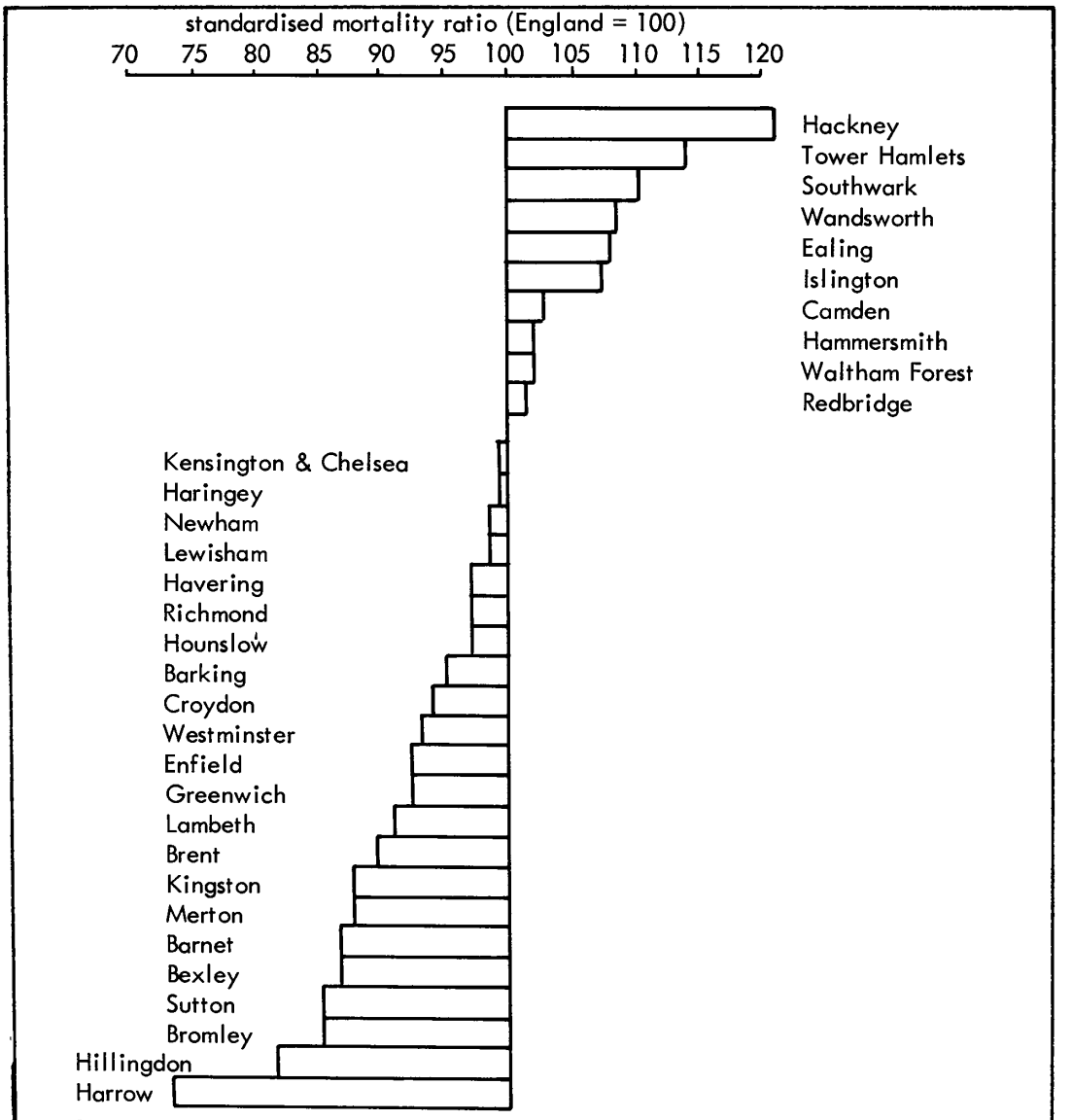
* The views expressed in this paper are the personal ones of the authors and do not necessarily reflect those of the GLC.

MEASURES OF NEED IN RAWP

RAWP aimed to secure equal opportunity of access to health care for people at equal rick of disease (morbidity) — a principle which could not be faulted but which can be interpreted in various ways. The formula used Standardised Mortality Ratios as the proxy for measuring geographical risk. The main reason for using SMRs is that they are the only widely available and fairly up-to-date set of statistics that do have some clear relevance to health. However the implied links between mortality, morbidity, need for health care and need for resources of health care have not been firmly established. More specifically there is no conclusive evidence that the SMR is a reliable measure of the relative geographical risk of contracting a condition and of needing health care. Mortality appears to correlate with some types of morbidity, such as chronic sickness, but not with others; where there is a positive relationship between mortality and morbidity it is not necessarily a linear

FIGURE 3.1

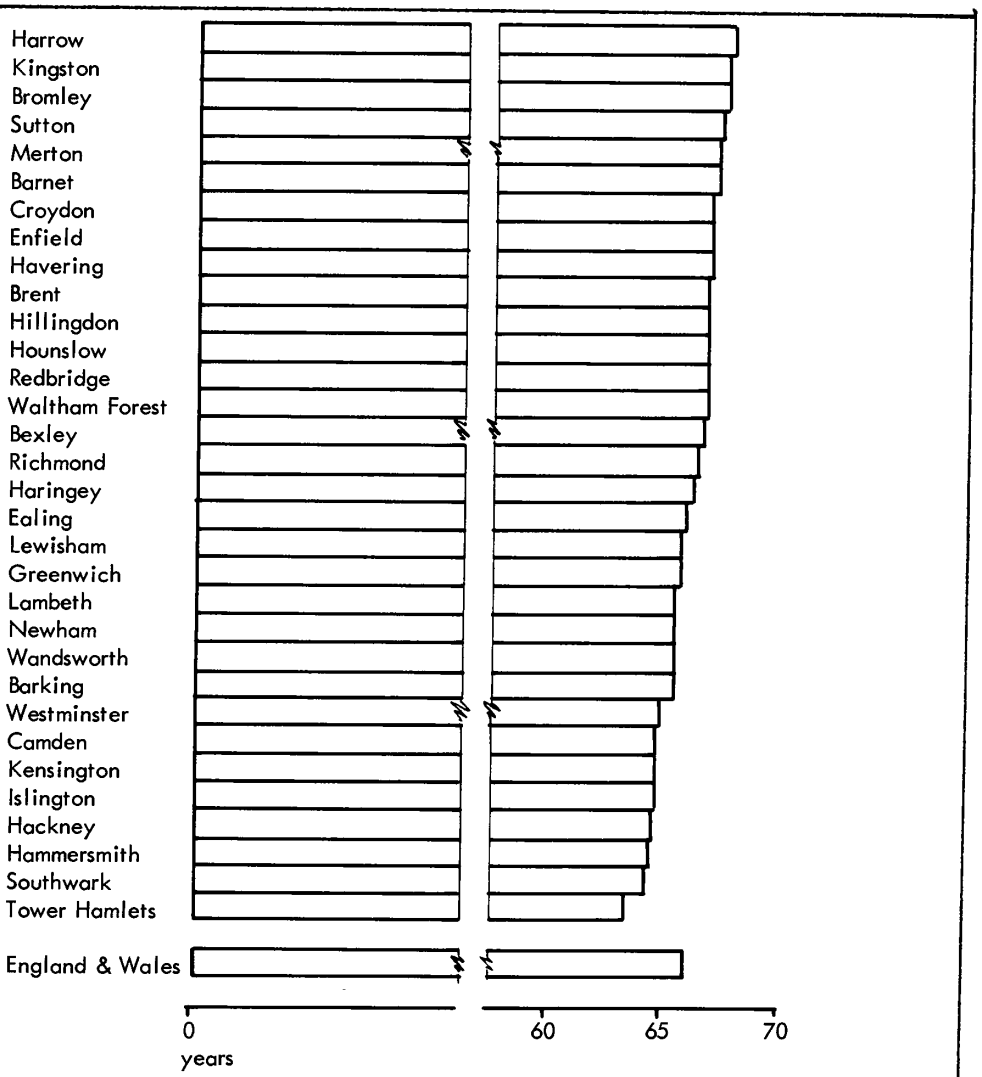
COMPARISON OF AGGREGATED SMRs 1974-76
of London Boroughs



Source: London Health Planning Consortium's London Profile.
Note: The SMRs used are the ratios of the numbers of deaths from each condition group in a particular area to those which would be expected on the basis of national mortality rates. These are then aggregated in proportion to the use made nationally of hospital facilities by the different conditions.

FIGURE 3.2

LIFE EXPECTANCY OF MALES
aged five in each of the London Boroughs
with national comparison 1971 (based on 1970-72 data)



Source: London Borough figures - GLC unpublished data
England & Wales figure - Life Tables 1970-72, OPCS Series DS No 2

Note: This is a hypothetical picture in that it assumes that the population is 'closed' against migration, in or out, so that there are no changes in membership except the losses through death, and it also assumes that people die at each age from the experience of three years around a census point.

one. The present formula for allocating resources is of questionable relevance to morbidity and the need for health care. Even if morbidity itself were used as an indicator, it might show a need for primary care more than secondary care, but the resources being allocated are for secondary care. Figure 3.1 shows the values for SMRs for the London boroughs in 1975–7. For comparison, Figure 3.2 gives a picture of 'life expectancy' by borough based on 1970–2 data (see footnote on figure).

While the choice of indicator is a matter of national concern it does have a significant London dimension in that the choice of SMRs as the main indicator of need leads to a bias in the figures that is unfavourable to London. It creates further distortions if used for a sub-regional RAWP. However if SMRs are to be used at all it is important that they are used consistently and that all the Thames RHAs use SMRs calculated on the same basis.

It would also seem desirable that the jump in logic from need for health care (via SMRs) to need for resources should be backed by cost-effectiveness studies, especially for the very expensive end of high technology medicine if the resources to it are to be allocated by this process. It would be interesting to see such studies set alongside similar ones on preventative medicine. On a slightly more philosophical note, to what extent should it be the case in the field of health services that the 'need' indicator underlying the allocation of resources should be effected by the deployment of resources? Is there any evidence to show that it has been so affected?

ALLOWANCES FOR SOCIAL DEPRIVATION

Social deprivation can increase levels of clinical morbidity and to an extent this will be reflected in the SMRs. However deprivation can also generate extra demands on the health service over and above that required by a given level of morbidity. For example, on a day-to-day basis, hospital staff will take into account the housing conditions of a patient before deciding whether to discharge; longer hospital stays may be needed for patients for unsatisfactory housing conditions. RAWP was based on the principle that it should not be the function of the Health Services to correct for the deficiencies of other services, but the fact remains that the day-to-day decisions do try to so correct to a certain

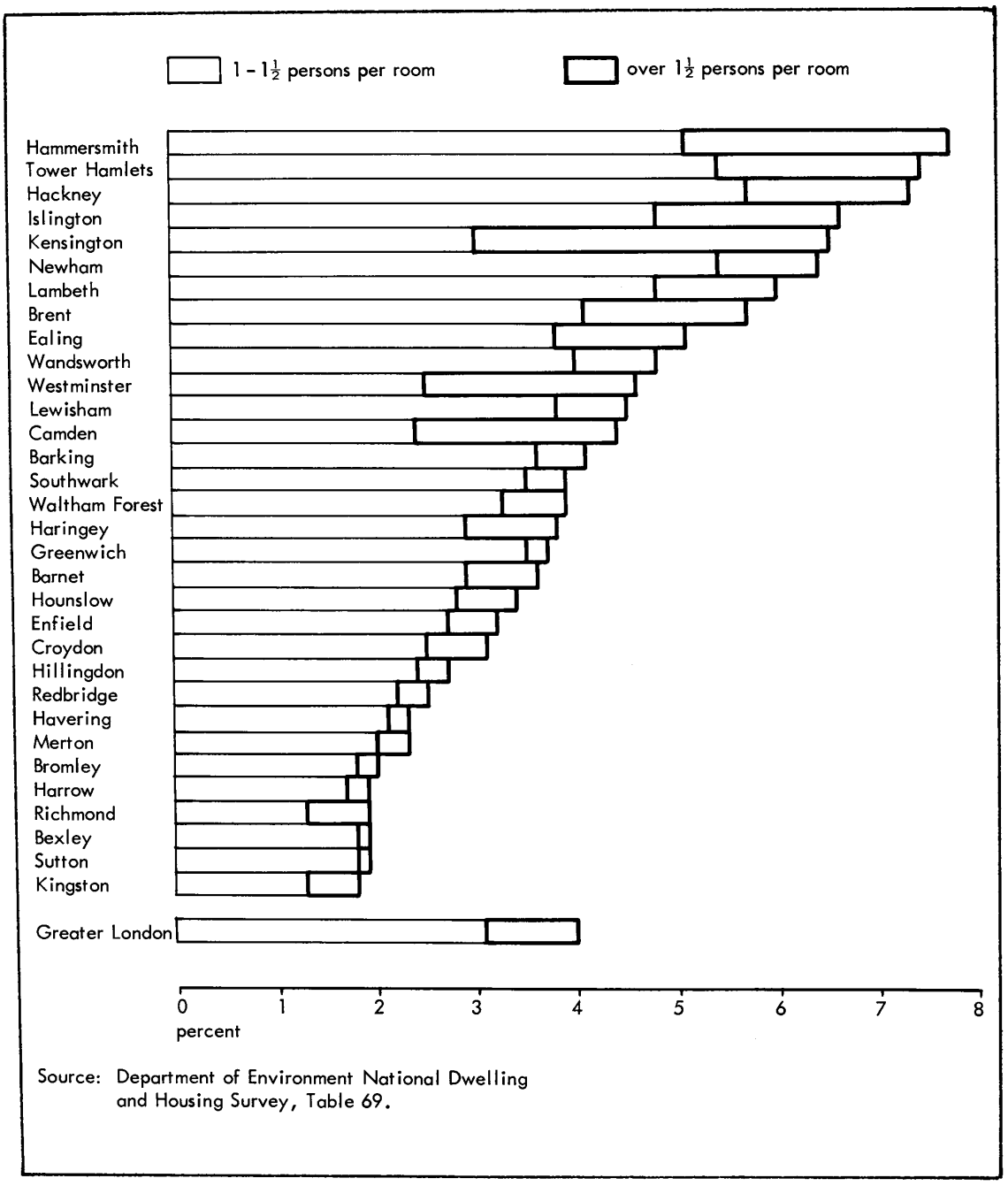
extent. If this is the case at the ground level should it not also be taken into account in the resource allocation formula in some way? LHPC suggested some modification to the assumptions on length of stay to allow for poorer community services.

Furthermore in places where the historical pattern of health services has de facto made allowances for other deficiencies, a withdrawal should only be made if some compensating allocation is channelled to the deficient services (e.g. in the Rate Support Grant process). There is, of course, evidence that deprived groups do not use the health service effectively and in proportion to their need. This suggests that resources should be deployed in developing more appropriate patterns of care and that these new patterns should be evaluated.

The LHPC has briefly examined some indicators of social deprivation in their profile of acute hospital services in London. Four 'relevant' indicators were examined (i) percentage of households with more than one person per room; (ii) percentage of households lacking exclusive use of basic amenities; (iii) percentage of pensioners living alone; (iv) percentage of New Commonwealth immigrants. The borough figures for these for 1978 are given in Figures 3.3 to 3.6 respectively. LHPC concluded that inner London was clearly a very 'deprived' area, and noted that it also had relatively high SMRs. Another working party of the DHSS and Thames regional officers conducted a similar exercise. Both concluded that some extra weighting is needed for social deprivation, over and above using SMRs for sub-regional allocation. While such a factor is clearly more important the smaller the geographical area being considered, it would be unrealistic to assume that such weighting would even out over each of the Thames regions as a whole. More work is also needed on which factors to take into account and with what weighting.

FIGURE 3.3

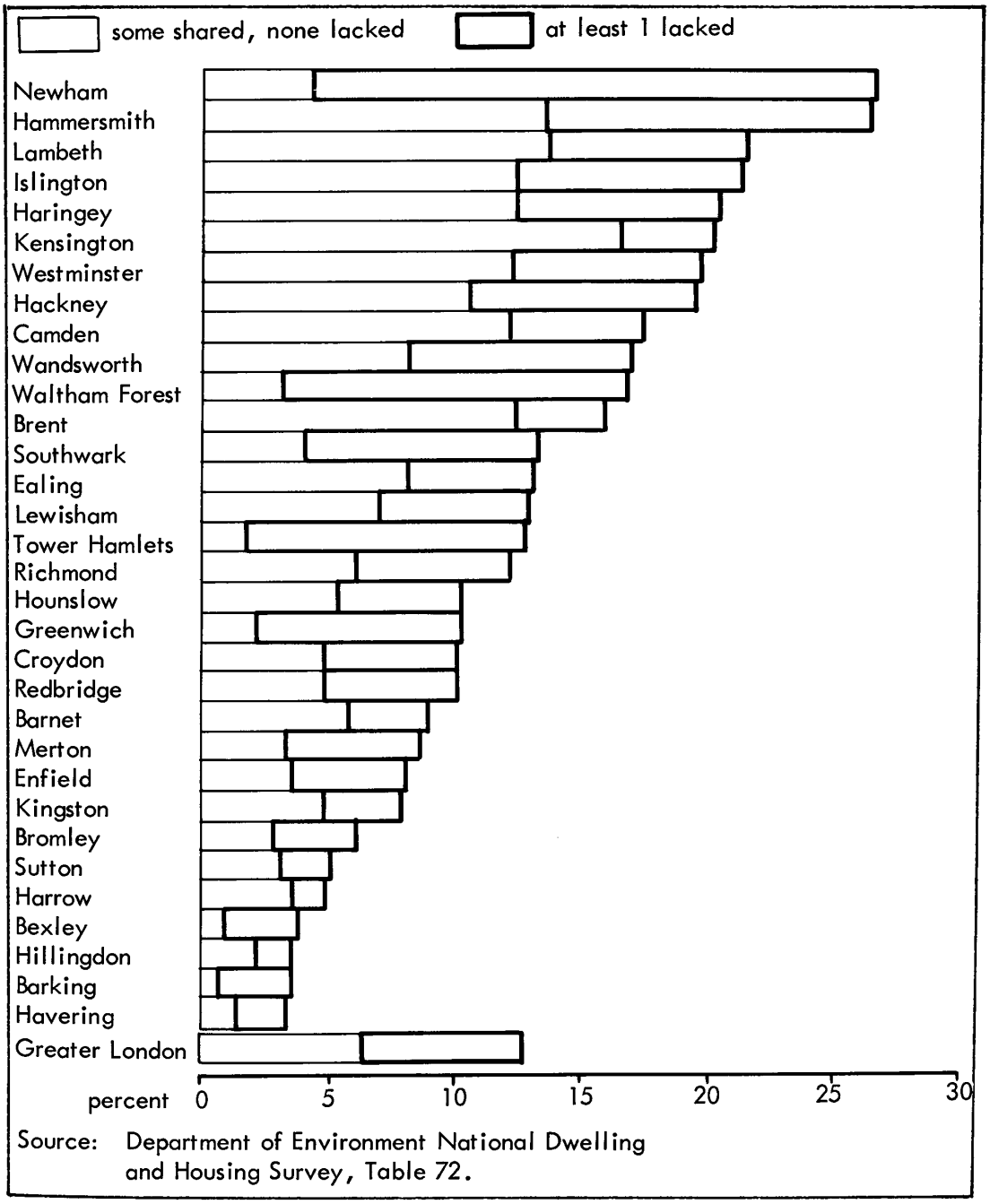
DENSITY OF OCCUPATION 1978
percentage of households living at:



Source: Department of Environment National Dwelling and Housing Survey, Table 69.

FIGURE 3.4

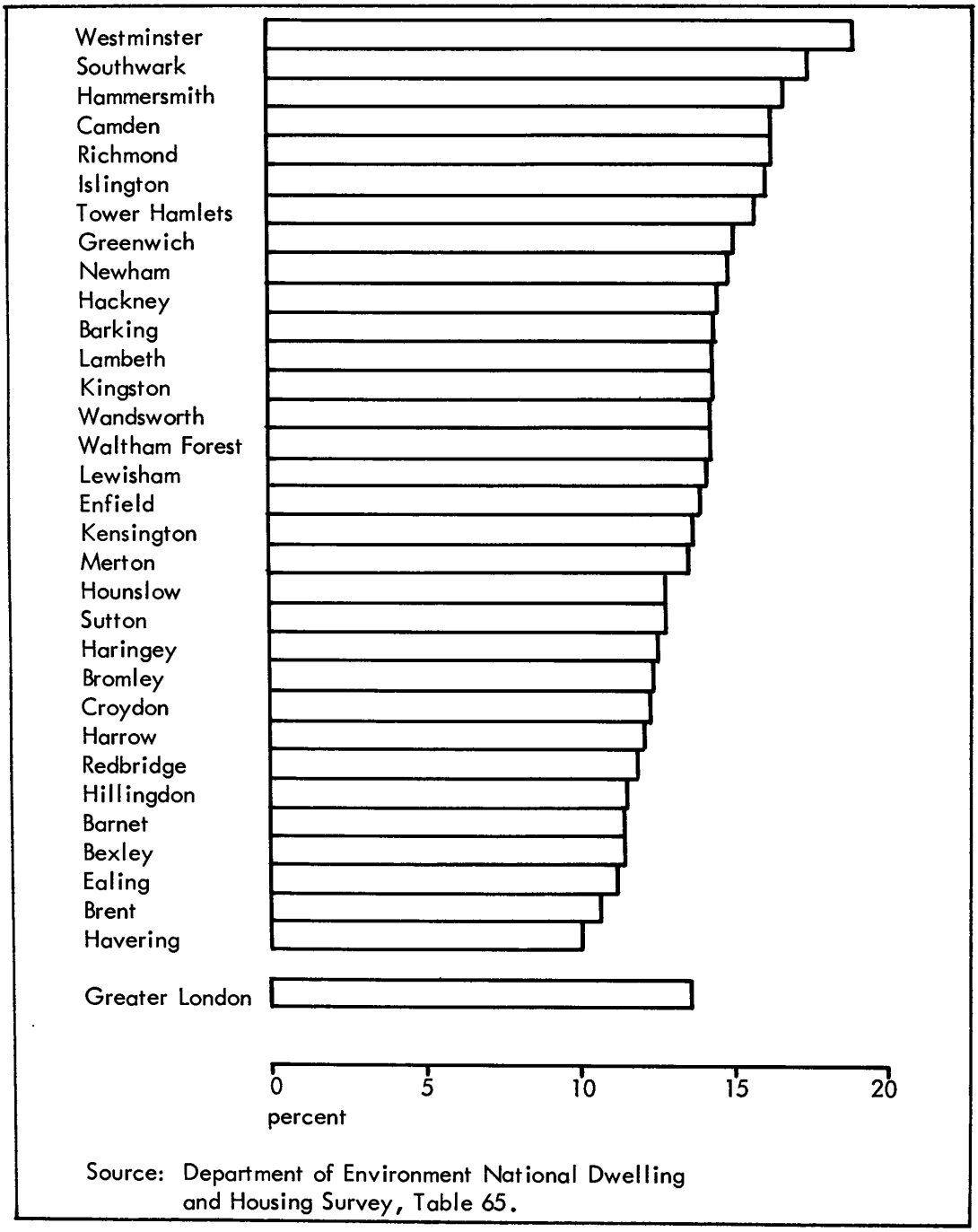
USE OF BASIC AMENITIES 1978
percentage of households lacking or sharing basic amenities
(inside wc, fixed bath or shower, hot water supply)



Source: Department of Environment National Dwelling and Housing Survey, Table 72.

FIGURE 3.5

PEOPLE AGED 60 OR OVER LIVING ALONE 1978
percentage of households in each Borough

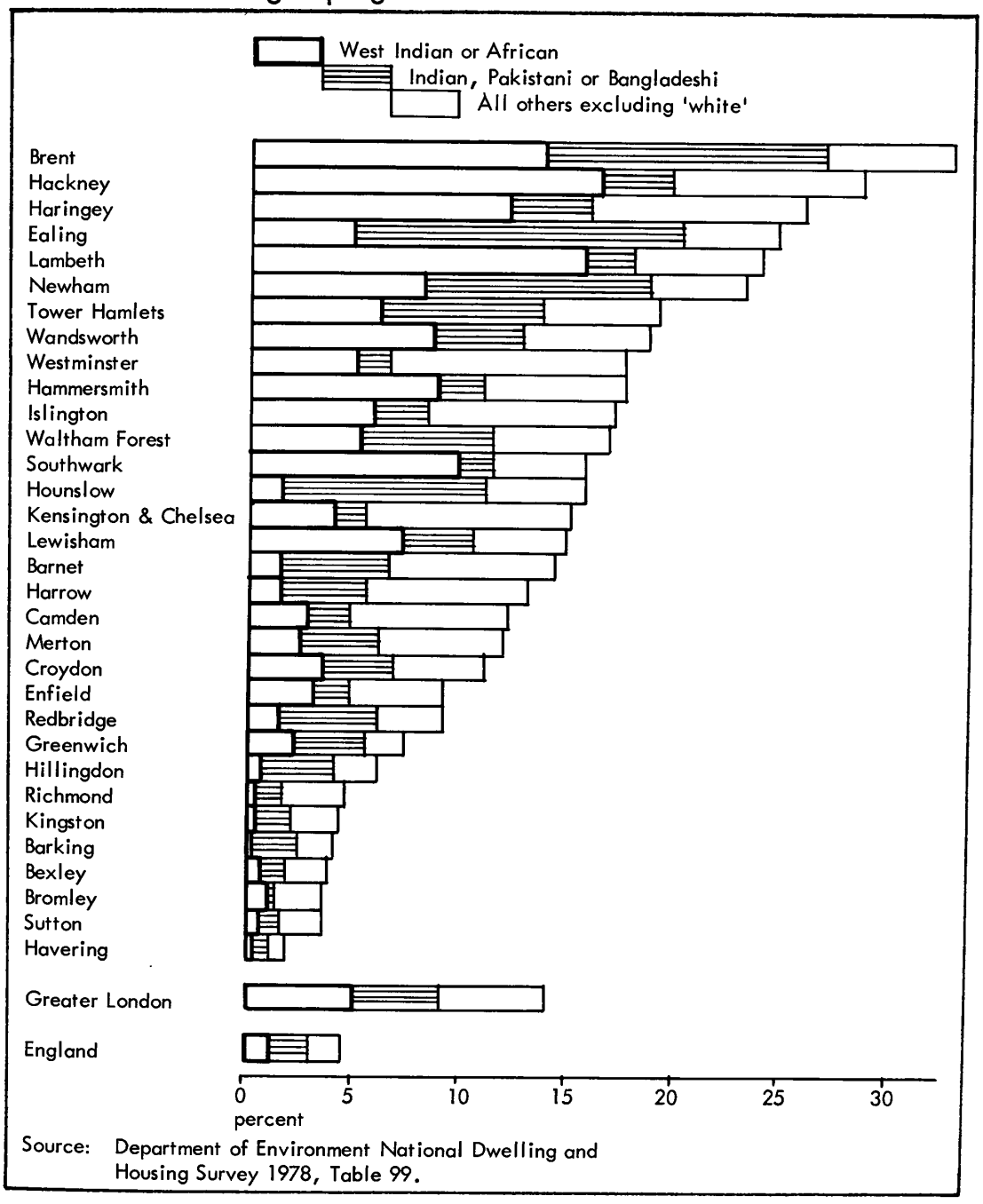


Source: Department of Environment National Dwelling and Housing Survey, Table 65.

FIGURE 3.6

ETHNIC ORIGINS

Percentages of Borough populations giving their ethnic grouping as other than 'white' 1978



Source: Department of Environment National Dwelling and Housing Survey 1978, Table 99.

CROSS BOUNDARY FLOWS

The allowance made in the resource allocation process for cross boundary flows at the regional level is the actual extent of the flows at present; this seems to stem primarily from an inability to forecast change. It might be appropriate to consider whether such an assumption should more properly be based on a decision of policy. The costs of treatment for patients crossing boundaries are assumed to be the national average for each specialty. Due to the special position of many of the London hospitals it is unlikely that the case costs would be as low as the national average; there will be a tendency for the more difficult, and hence more expensive, cases to be the ones sent to London, and not least the secondary referrals will fall into this category. A more accurate estimate of the true costs would seem to be called for — or at least the average Thames regional costs for those flowing into Thames regions. Within the Thames regions nearly 8% of patients flow across regional boundaries (see Table 3.1), and so it is particularly important that they should be consistent in the assumptions they use. The plans so far produced are not consistent.

TABLE 3.1
CROSS-BOUNDARY FLOWS
in the Thames Regions

	NW Thames	NE Thames	SE Thames	SW Thames	All Thames
a Total imports	50 140	23 044	31 108	26 927	131 219
b Imports from Thames Regions	36 226	15 348	27 258	22 161	100 993
c Exports to Provincial Regions	6 974	3 584	1 551	4 503	16 612
d Net Provincial Imports ie a - (b + c)	6 940	4 112	2 299	263	13 614
e Total discharges and deaths	341 390	376 914	350 623	247 420	1 316 347
f Total provincial net imports as a percentage of total discharges and deaths	2.03	1.09	0.66	0.11	1.03

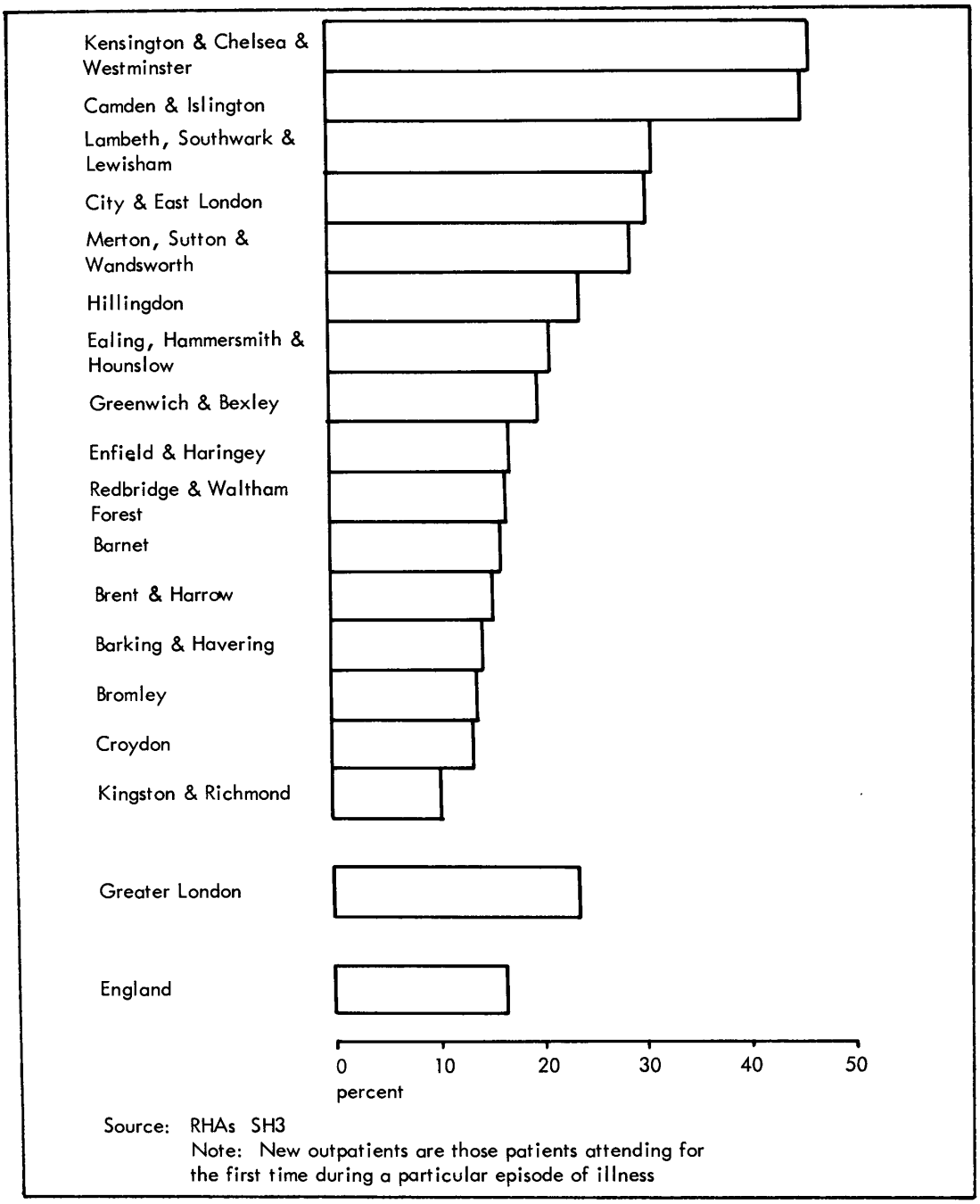
Source: Table C9 (p104) Report of the Working Party on Resource Allocation 1976

FIGURE 3.7

ATTENDANCES OF NEW OUTPATIENTS
per 100 resident population by Area Health Authority 1977

Source: RHAs SH3
Note: New patients are those attending for the first time during a particular episode of illness

FIGURE 3.8
NEW ACCIDENT & EMERGENCY ATTENDANCES at A & E departments in the London Area Health Authorities per 100 resident population 1977



Source: RHAs SH3
Note: New outpatients are those patients attending for the first time during a particular episode of illness

RAWP made no allowance for the cross boundary flow of out-patients. This is of particular concern for London as the rate of attendance of out-patient departments per 1,000 resident population is very much higher for London than the national average (see Figure 3.7). Unfortunately there are no statistics which show how much this is due to non-residents, but it is likely to be a significant element. A further factor may be a compensating element for the poor primary health care in parts of Inner London (see below). Similar reasoning extends to the use of Accident and Emergency departments (see Figure 3.8).

TEACHING HOSPITALS

The RAWP calculations included a Service Increment for Teaching (SIFT), an attempt to take account of the extra cost to teaching hospitals of their teaching responsibilities, over and above their service costs. A baseline of service costs was estimated from a sample of hospitals and adjustments made for the specialty mix and workload of each teaching hospital — though not for the particular complexity of cases within specialties with which some London hospitals have to deal, nor for the higher cost of inputs in London compared with the rest of the country. The excess cost of teaching hospitals above the service baseline was derived from the actual cost of a representative teaching hospital (at the median) and 75% attributed to teaching. The decision to finance only 75% of the excess costs was taken because that was all that could be explained by the teaching load but some of the further costs not funded by SIFT are certainly attributable to the research and development activities associated with good teaching. It is a matter of concern that these supplementary functions of the teaching hospitals are not included in the calculations. Either the teaching suffers if these functions are inadequately funded, or resources have to be channelled away from other services — often non-hospital based ones which are often already under-provided in teaching areas. The method of calculating those costs directly associated with teaching is likely to result in underestimates for London. The service innovations that are achieved through the research associated with teaching benefit not only the patients in the teaching hospitals but those throughout the country. The teaching and the supplementary functions are part of a package: how realistic is it to try to separate them from resource allocation purposes?

The needs for teaching purposes in terms of beds – or perhaps more appropriately patients – has been under discussion since the publication of norms in the Goodenough report of 1944. The UGC issued a similar set of norms (still in terms of beds) in 1976, as the throughput of patients increased significantly between 1944 and 1976, perhaps it is the beds that are being treated rather than the patients! The report of Lord Flowers' working party on medical education is likely to recommend significant changes in London, it is hoped that all the various reports and varying methods of calculations can be brought together to find a way of balancing servicing with teaching needs. There is also clearly scope for rationalisation of a number of regional specisIties, a task that is not assisted by having London divided into four regions.

LONDON COSTS

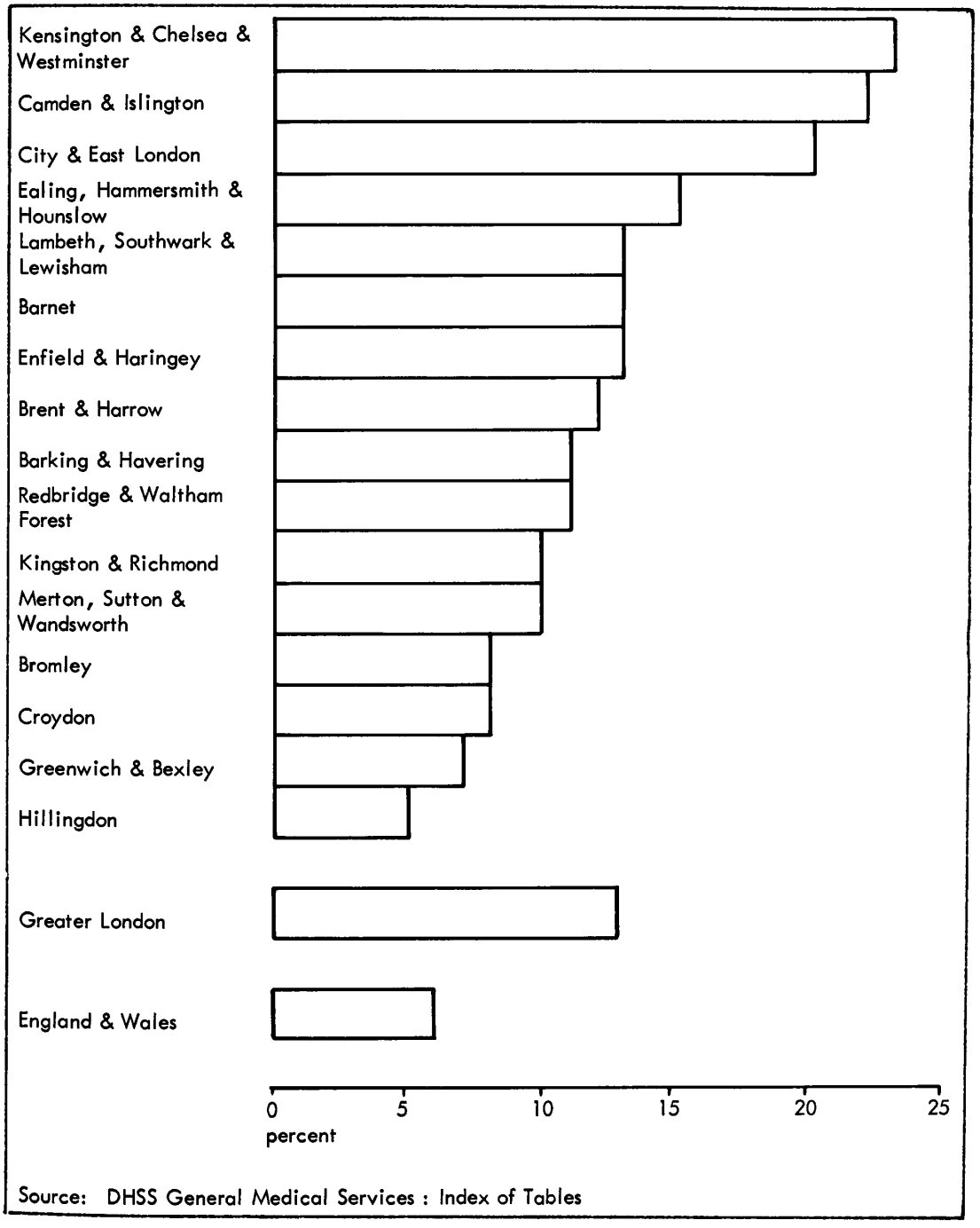
RAWP recognised the need for an urgent study into the extra costs associated with London. In addition to London Weighting there are other direct costs which are higher in London, e.g., rents and the need to classify posts in higher grades to attract staff. There are further significant indirect costs for teaching hospitals which have been estimated by DHSS as being more than twice the amount of London Weighting with a further list of unquantifiable factors. Until it is established to what extent these higher costs are unavoidable, it would seem appropriate for the national formula to allow for them; to use London Weighting as the only factor clearly underestimates the position. The Working Party of the DHSS and Thames regional officers recommended that such additional costs be accounted for in the sub-regional allocation and attempted to calculate the extra market cost variation factor. This seems preferable to the RAWP suggestion of a 'subjective' allowance.

PRIMARY CARE: FAMILY PRACTITIONER SERVICES

It is widely acknowledged that there are a number of problems with primary care in inner London especially with regard to the general practitioner service. Whilst in crude statistical terms London appears well provided with GPs it is a cause of concern that many of these doctors are elderly with small lists, operating single handed from lock-up or otherwise inadequate premises (see Figures 3.9 to 3.11). This can lead to some patients experiencing difficulty obtaining a GP and to a

FIGURE 3.9

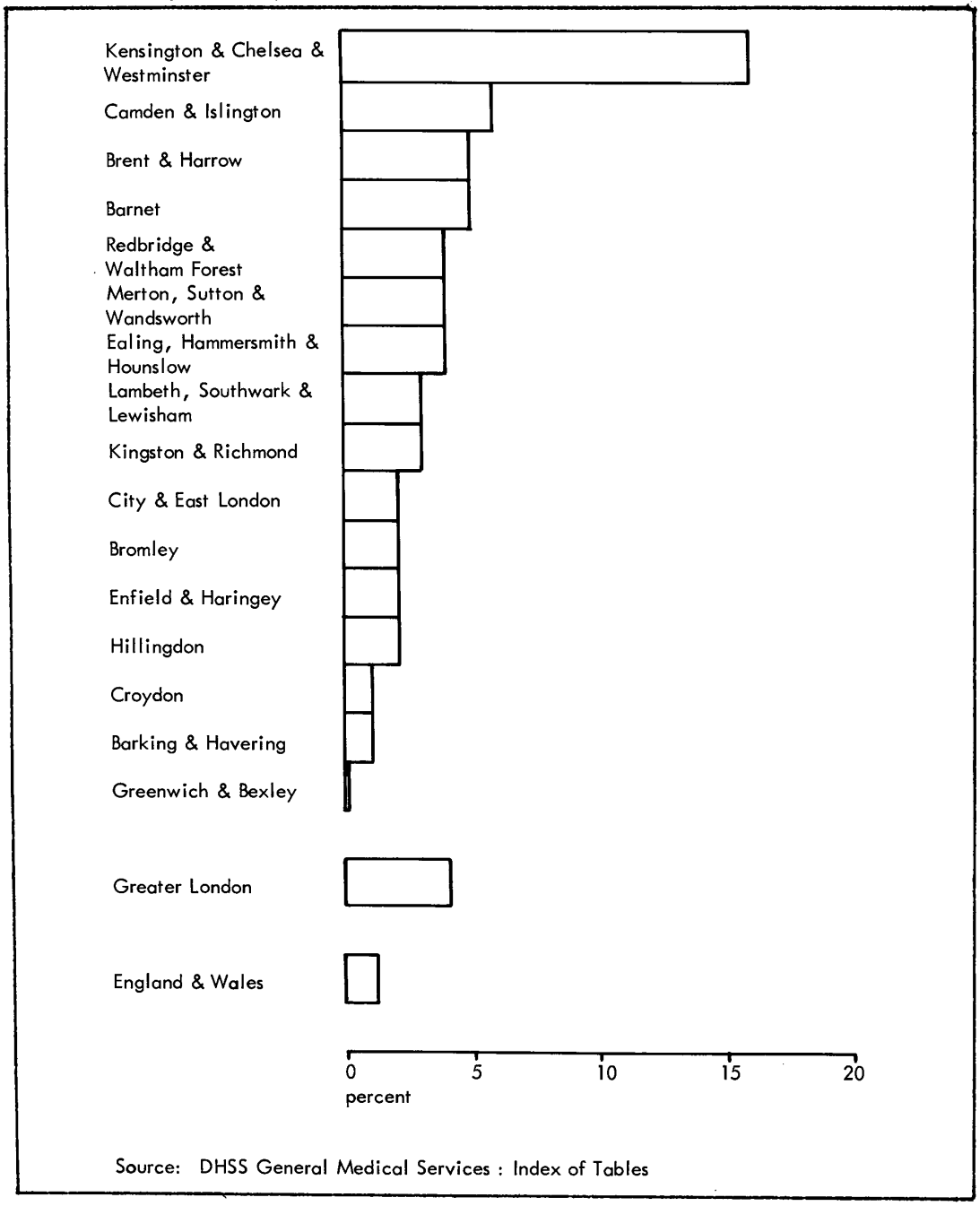
GENERAL PRACTITIONERS
aged over 65 by Family Practitioner Committee 1978



Source: DHSS General Medical Services : Index of Tables

FIGURE 3.10

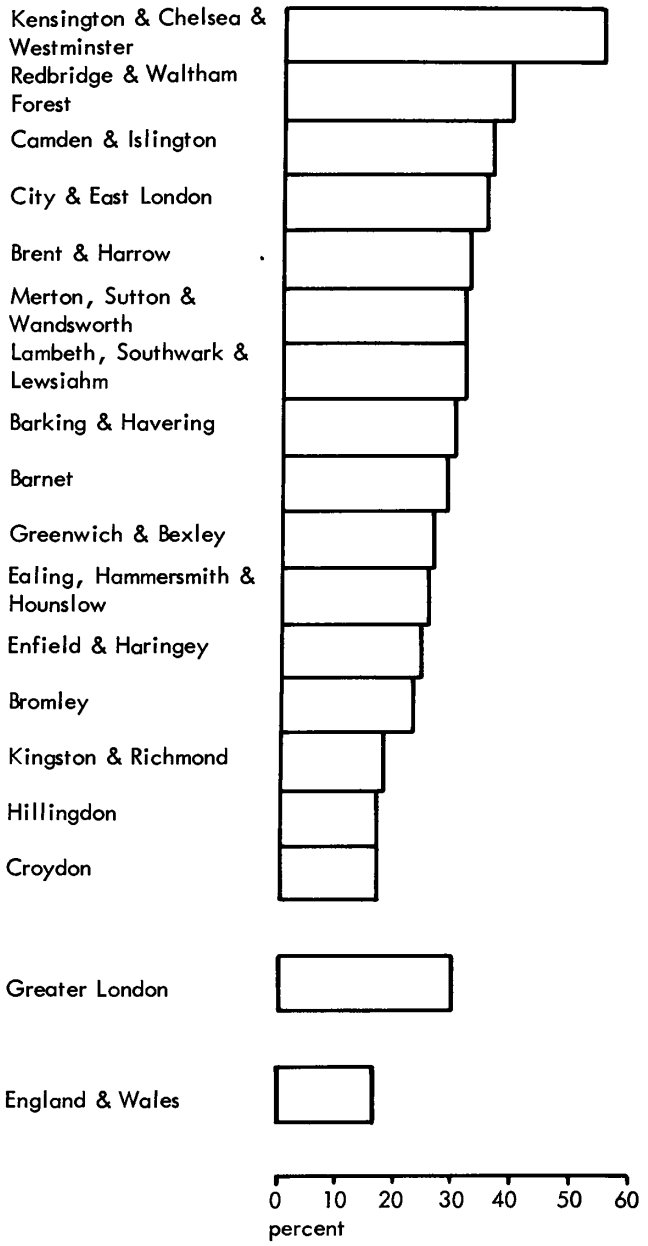
GENERAL PRACTITIONERS
with average list size of less than 1000 patients
by Family Practitioner Committee 1978



Source: DHSS General Medical Services : Index of Tables

FIGURE 3.11

GENERAL PRACTITIONERS
working in single handed practices
by Family Practitioner Committee 1978



Source: DHSS General Medical Services : Index of Tables

greater use of the commercial deputising service and accident and emergency departments. It is widely accepted that the quality of care must be improved and that inner London needs an injection of young enthusiastic GPs with new ideas and approaches.

The Medical Practices Committee operates a set of guidelines based on the average list size of GPs in an area to determine the degree of encouragement or discouragement they will adopt to suggestions for a new GP to practise in the area. The assumption underlying is that areas in which the average list size is small are well provided with GPs. If the list size is less than 1,800 the MPC will not usually allow a new GP in. Yet it is clear that list sizes are small in London for a variety of reasons including the desire of some elderly GPs not to take on more than they can handle, and 'other professional commitments' of some of the GPs, particularly in Central London.

It is apparent that the current operation of the MPC guidelines is inappropriate for London. This point is echoed by the working party on under-doctored areas which emphasises the need to take criteria other than list size into account when assessing GP manpower requirements. Financial incentives are one means of influencing the pattern of general practice, help in funding premises is another and one in which Local Authorities could be closely involved. However it is also important that general practice in London is made more challenging and stimulating through the introduction of innovations in primary care, closer liaison with the teaching hospitals and greater inter-professional contact.

London attracts to it clientele who make extraordinary demands on the health and social services. For instance, ethnic minorities may experience different patterns of morbidity to the indigenous population and have different expectations of the health service. There is also the problem of the more transient elements of London's population such as the homeless and drug addicts who may be unable or unwilling to register with a GP and have difficulty in obtaining treatment when needed.

There are also problems with the other family practitioner services. For instance, it can be difficult to obtain certain dental treatments under the NHS, particularly for the handicapped. The method of remunerating

dentists militates against preventative dentistry. There is also concern that the closure of certain pharmacies in London may result in problems of access to this valuable service. Emergency cover both at night and at weekends for GPs, dental and pharmaceutical services is often very unsatisfactory; for GPs this often stems from the problems mentioned above.

Perhaps of most concern is the inadequate attention that is paid to these services in the preparation of plans on the setting of priorities for the health service as a whole. For example, at regional level only the North East Thames Region paid any significant attention to the state of primary care in its regional strategic plan, and then it said:

> "The most important and challenging problem facing the Region is the state of primary care in inner city Areas". [It] " will not improve until the pattern of general practice is substantially altered, the quality of practice is improved, the numbers of community services increased and wastage rates reduced, and a co-ordinated research strategy into the problems of primary care in the inner cities established. Though the Region . . . has a major interest in the improvement in the quality of primary care, it has only very limited and indirect control of . . . . . the pattern of general practice."

At a national level, even if the principle stated by RAWP is accepted, that the health services should not make up for the deficiencies of others, it is totally unacceptable to adopt the principle between elements of the health service. It is the case that some hospital functions (e.g. accident & emergency, out-patients) compensate to a degree for the inadequacies of the primary care services. If the planning and resource allocation process is not to allow for that, it is essential that ways be devised to insist on better services being provided at the primary care level.

COMMUNITY CARE SERVICES

The other community care services, both health services and social services based ones, are also facing problems in London. There is known, for example, to be particular difficulty recruiting and retaining health

visitors in many inner London areas. It is stated government policy that priority should be given to the development of the community based services rather than the institutional based ones. Even within the health services there is no very effective mechanism for giving expression to such a policy in terms of the allocation of resources. As mentioned earlier the demands on some of the hospital based services, for example, an accident and emergency or out-patient departments, is felt to stem in part from the poor service available from the primary and community care based services. It would seem to be disingenuous to cut back on hospital care in London without having a clear, strategy to improve the non-hospital services.

The implementation of the government priorities also has a significant impact on services provided by local authorities, personal social services in particular. However no adjustment is made to the Rate Support Grant formula to try to take account of the government policy, and further, the government is expecting the social services budget of local authorities to be cut along with all the others. In London where the burden on social services is often already high, such a conflict of policies causes particular problems.

LINKS BETWEEN PLANNING AND RESOURCE ALLOCATION

A local authority is used to determining its need for resources as the basis of its future intentions in terms of its plans. While it is understood that this is not the only possible model, it is not unreasonable to expect some tie up between plans produced and the process of allocating resources. The current system in the health service affords little opportunity for such links. Comments have already been made about the lack of a mechanism for expressing policy priorities in terms of resource allocation, and about the consequences of underestimating the true costs, e.g., of the London teaching hospitals, by using a theoretical approach, in terms of the resulting drain on resources from other services. The weaker the link between the planning and the resource allocation proccesses, the more important it is to ensure that the plans are designed to meet the same objectives as the resources are allocated to achieve. If the overall objective is able to be expressed in terms of the health of the community in some measurable way (SMRs?) then the current resource allocation process would reward those areas which adopted less effective plans. This

is not to say that Regions would deliberately design ineffective plans, but that the system does not encourage a rigorous search for effectiveness.

CONCLUSION

This brief outline covers some of the major problems facing London's health services. Some of them are being addressed (e.g. teaching hospitals), some of them may be intractable (e.g. measures of need) and others still need a significant amount of research (e.g. social deprivation). 'Patients First' is concerned primarily with the administrative structure of the health service: the removal of the area tier and subsequent redrawing of boundaries. It is to be hoped that the proposed London Advisory Group will provide a forum for considering some of the above issues. The removal of one tier should at least simplify the planning and resource allocation processes, while that should make it easier to address the substantive problems, it will not, by itself, make them disappear.

Through its wide membership of health services researchers, perhaps the LHSRG has a role to play too. The group is in a unique position to gather information on the current state of research into the major London issues – and indeed perhaps to define properly what these issues are. Would it then be possible, and if so, desirable, to devise a co-ordinated research strategy to tackle these problems for the benefit of London's future health services as a whole?

BED NEEDS AND RESOURCES

JOHN KNIGHT

One of the major responsibilities of a Regional Health Authority is to issue guidance to its Areas, so that they may draw up plans for the future provision of health care resources. South East Thames RHA has issed and updated guidelines to its AHAs since 1974 and one of the first issues to be covered by these guidelines was the recommended level of inpatient bed provision. Bed provision was selected as a priority because it was recognised that this facility absorbed most of the available capital and two thirds of the annual revenue allocation.

In very broad terms, the RHA's approach has been to:

1 identify present levels of health care utilisation

2 project forward past trends in these levels

3 make assumptions on future pattern for health care and future levels of utilisation.

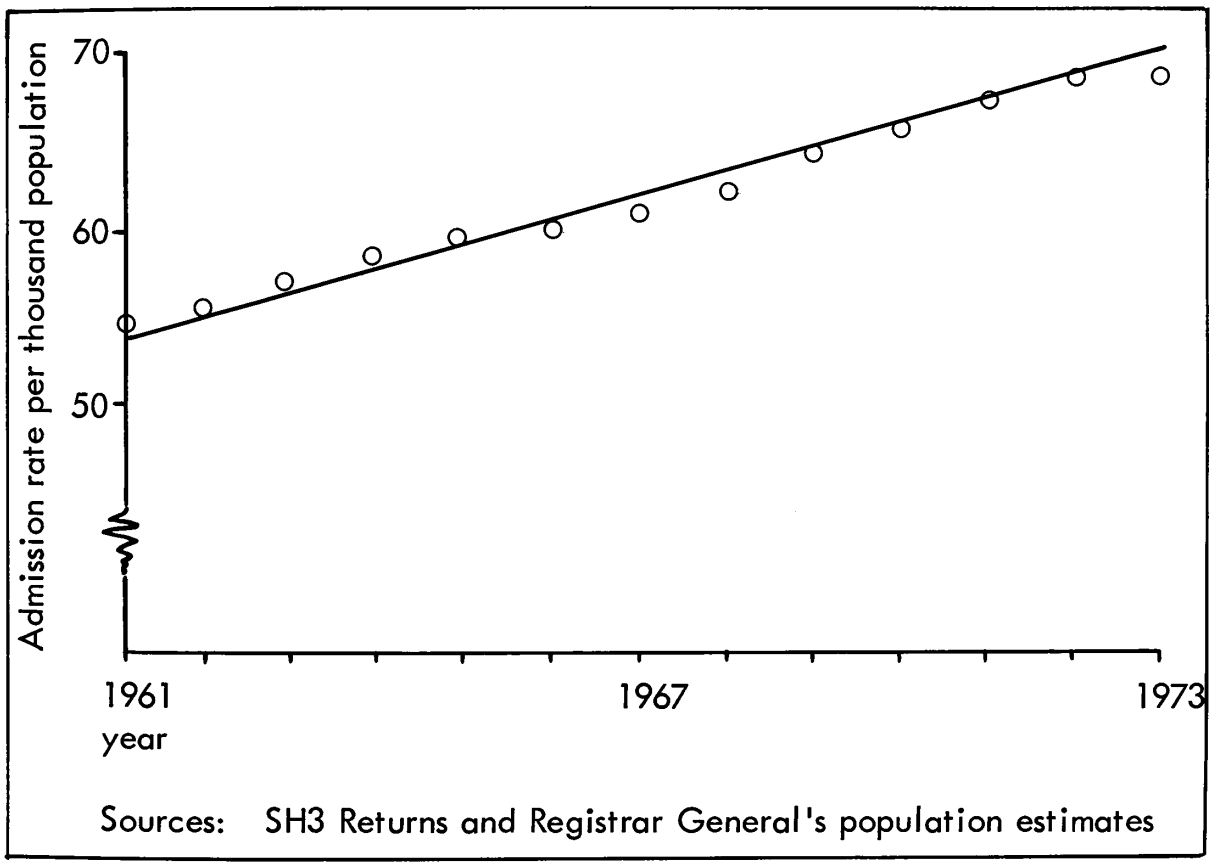
4 identify significant factors in the community which effect the demand for the particular resource.

The first task in tackling the problem of bed provision was to sub-divide the beds into related groups. The largest group in terms of revenue and manpower requirements was the district acute specialties, that is those acute specialties which are common enough to be present in every health district, such as general medicine and general surgery. Other categories of beds included mental illness, geriatrics, etc. and all available beds were assigned to one category or another.

The next stage was to look at past trends in admission rates and mean duration of stay in each of the specialties and aggregate them into their specialty groups. In recent years the tendency in all specialties has been for the admission rates either to increase or to stay reasonably constant, while at the same time the mean duration of stay in hospital has decreased.

FIGURE 4.1

HOSPITAL ADMISSION RATES FOR ACUTE SPECIALTIES,
South East Metropolitan RHB 1961-73



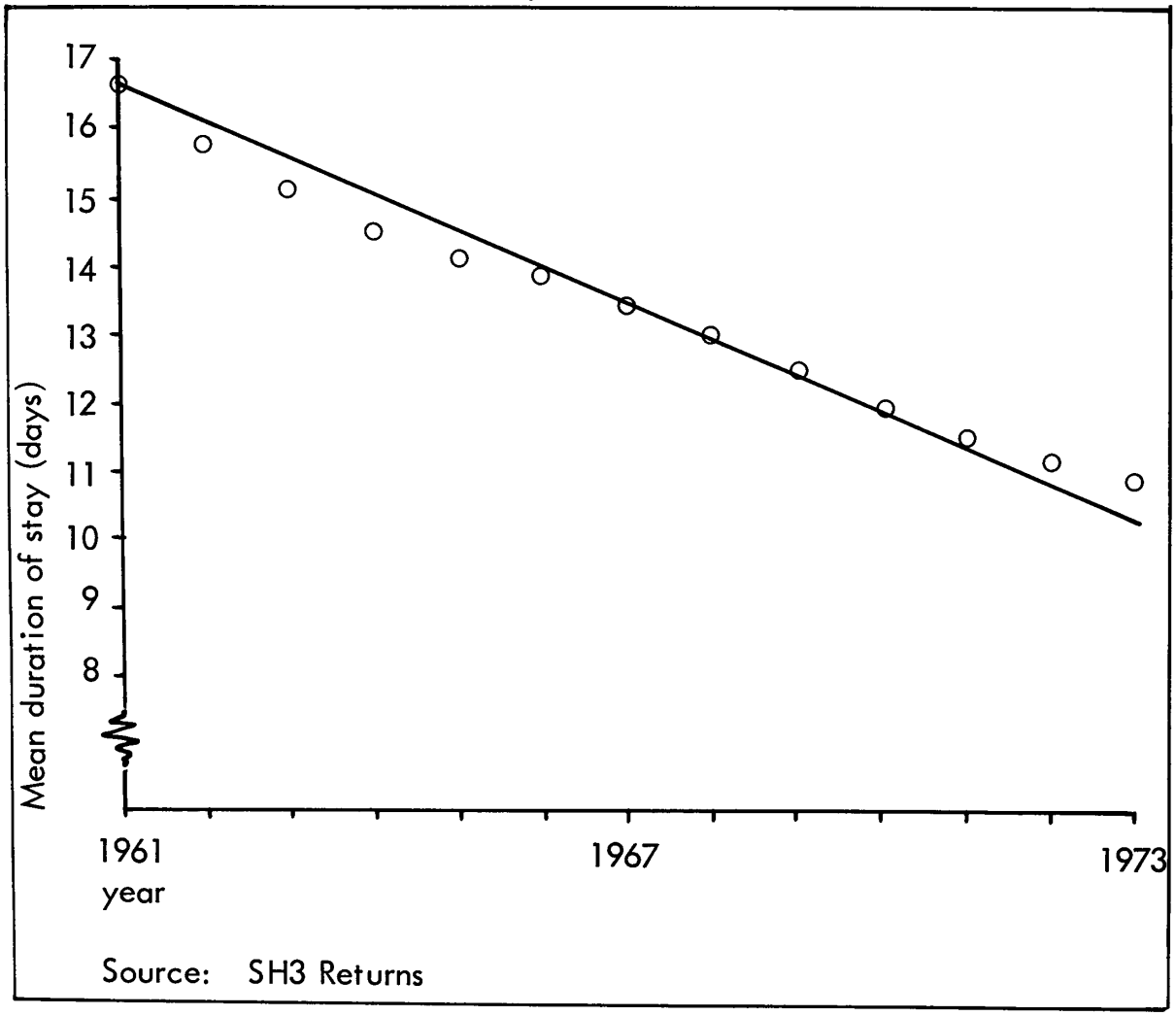
Sources: SH3 Returns and Registrar General's population estimates

Figure 4.1. shows that admission rates for all district acute specialties together over the last decade have increased steadily. Similar trends have occurred in geriatric medicine, while psychiatric admissions have stayed more or less constant. Admissions to obstetric beds have reflected the decline in the birth rate.

Figure 4.2. shows the mean duration of stay, again for district acute specialties, and it will be seen that the trend has been steadily downwards. This pattern of reducing mean duration of stay has applied to almost every specialty and type of bed.

FIGURE 4.2

MEAN DURATION OF HOSPITAL STAY
for district acute specialties,
South East Metropolitan RHB 1961-73



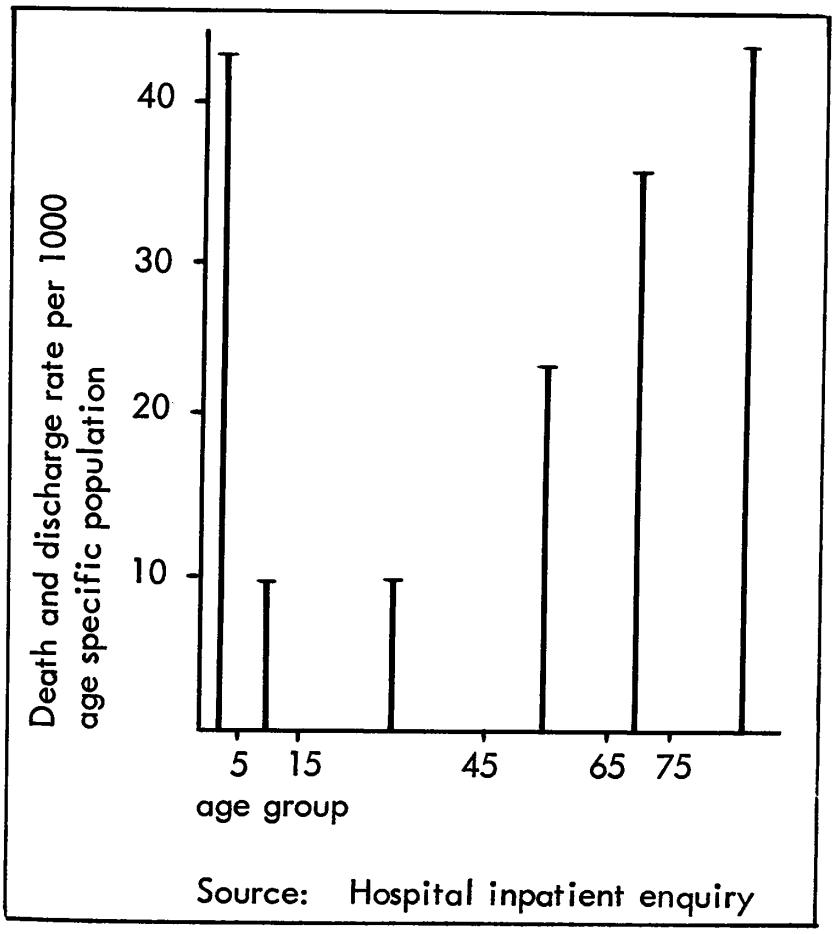
Source: SH3 Returns

The bed guidelines which the RHA adopted were based on national utilisation rates and were weighted to allow for the current trends. There is a problem, of course, in detecting when the falling bed provision will begin to level off, and a danger that projections of this kind can become a self-fulfilling prophecy.

In addition to looking at the national trends, we also examined the factors which had an effect upon the utilisation rates: the most significant of these is age. Figures 4.3 and 4.4 show the dealth and discharge rate and the mean duration of stay by age for general medicine and paediatric beds. The very young and the very old are admitted to hospital far more frequently than other age groups and the mean duration of stay increases with age. Clearly, any guideline related to inpatient beds must be weighted to reflect the impact of age.

FIGURE 4.3

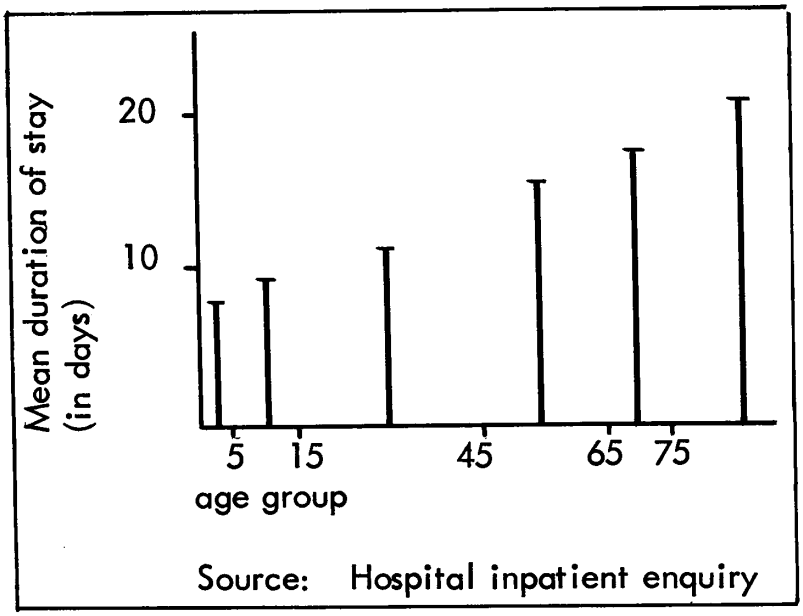
HOSPITAL DEATHS AND DISCHARGES
for general medicine and paediatrics,
England and Wales 1973



Source: Hospital inpatient enquiry

FIGURE 4.4

HOSPITAL STAY
for general medicine and paediatrics,
England and Wales 1973



Source: Hospital inpatient enquiry

Similar techniques have been used to establish the level of bed provision required by a given population for all specialties and these levels of provision have then been related to the population served by the various health districts to the Region. Catchment populations have been used rather than resident populations and the calculations have all been based on current HAA data.

The real problem for the South East Thames Region relates to the very significant population shifts which have occured over the last decade or so. Since the early 1920s the population of central London has been declining steadily and the population of the Home Counties growing. The significance of this change is not always fully realised. For example, between 1961 and 1971 the population of the area covered by the present Medway Health District increased from 254 000 to 305 000 (+20%). During the same decade the resident population of the King's Health District fell from 309 000 to 265 000 (-14%). While population move-

ments are notoriously difficult to forecast accurately, there are strong indications that the population movement from central London will continue for the foreseeable future, although maybe on a smaller scale.

The past failure of health service resource distribution to match population movement has resulted in significant variations in the level of health service provision to the various localities in the South East Thames Region. Taking as a roughly comparable yardstick the national average rate of provision per thousand population served adjusted for age and sex, we find that the East Sussex Area is currently 450 District acute beds (23%) below this national average level, for the Lambeth, Southwark and Lewisham Area is 700 District acute beds (31.8%) above the level. The effect of the predicted population movement will be to increase the excess of general acute beds in the Lambeth, Southwark and Lewisham Teaching Area to more than 1000 and East Sussex AHA will find itself a further 100 beds below the national level of provision. It is these past and predicted population movements which are causing the current mis-match between levels of health service provision between the various Areas.

This maldistribution of resources has led to considerable variations in the utilisation rate of acute beds. Figure 4.5 shows the number of District acute beds (those specialties which occur in every health district) per thousand catchment population and the annual occupied District acute bed days per thousand resident population.

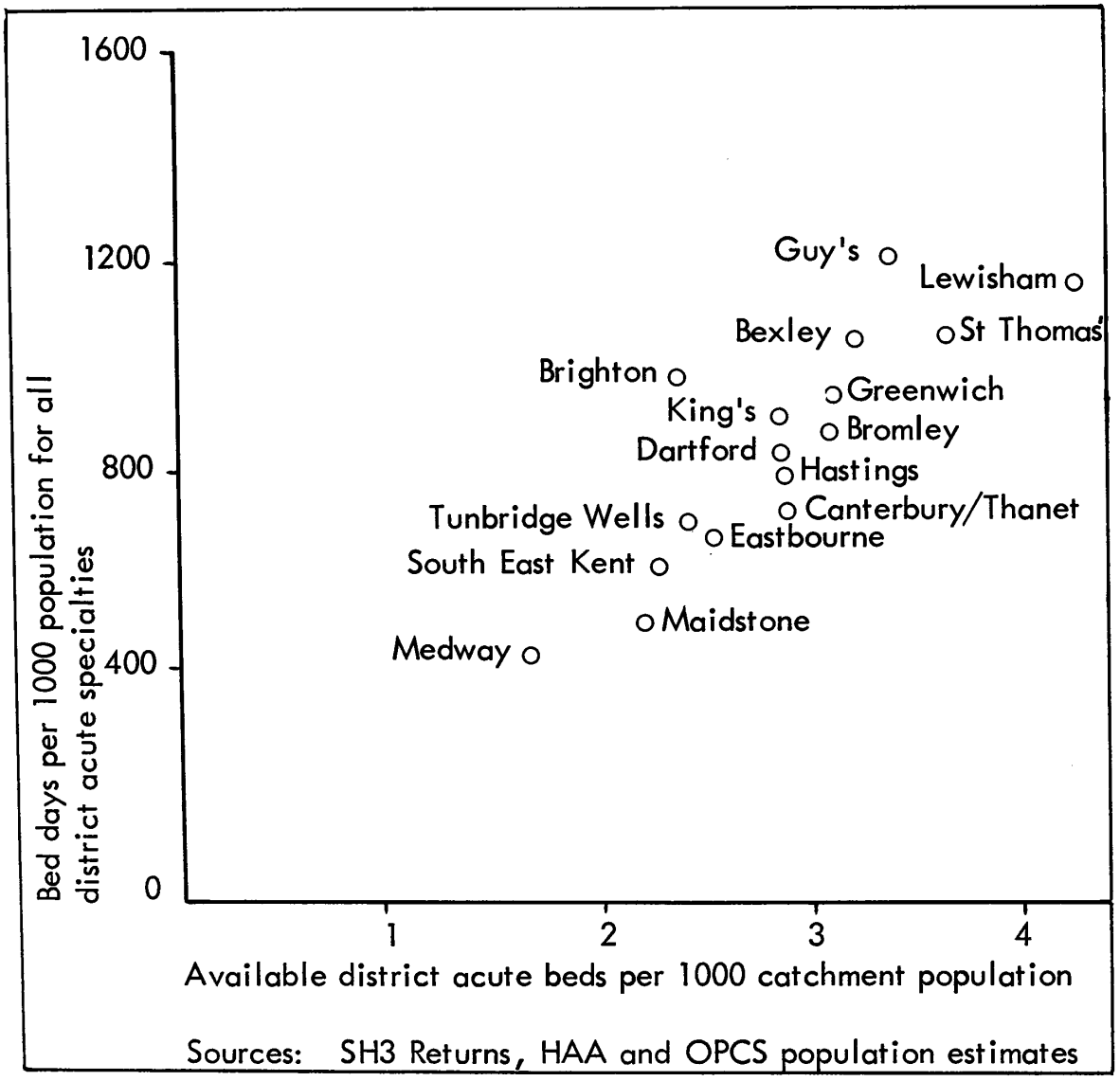
It is necessary to compare levels of provision on the basis of catchment population (estimated population served by the District) with the levels of use based on resident population. A direct comparison between the level of beds sited in the District and the level of use would ignore the fact that the patients regularly cross district boundaries to receive their health care, and will continie to do so. High levels of provision appear to lead to high levels of utilisation. For example, comparing one of the health districts with the highest level of provision with the lowest, the following figures emerge (Table 4.1).

Before leaving the subject of patient flows, it is important to consider whether these flows will continue in future and whether allowance should continue to be made for them. Historically, the most significant patient flows have been from the home counties to the famous undergraduate and

postgraduate teaching hospitals sited in or near the centre of London. A careful library search has revealed a catchment area survey carried out as long ago as 1938 and this has been compared with data obtained from the Hospital Inpatient Enquiry for 1958, and with Hospital Activity Analysis data for 1976.

FIGURE 4.5

THE RELATIONSHIP OF BED USE
with provision in districts of South East Thames Region 1976



Sources: SH3 Returns, HAA and OPCS population estimates

TABLE 4.1

COMPARATIVE USE OF BEDS IN TWO DISTRICTS OF SOUTH EAST THAMES REGION 1976

Health districts	number of district acute beds per 1000 catchment population	annual number of occupied district acute bed days per 1000 population
St Thomas'	3.59	1040
Medway	1.65	463

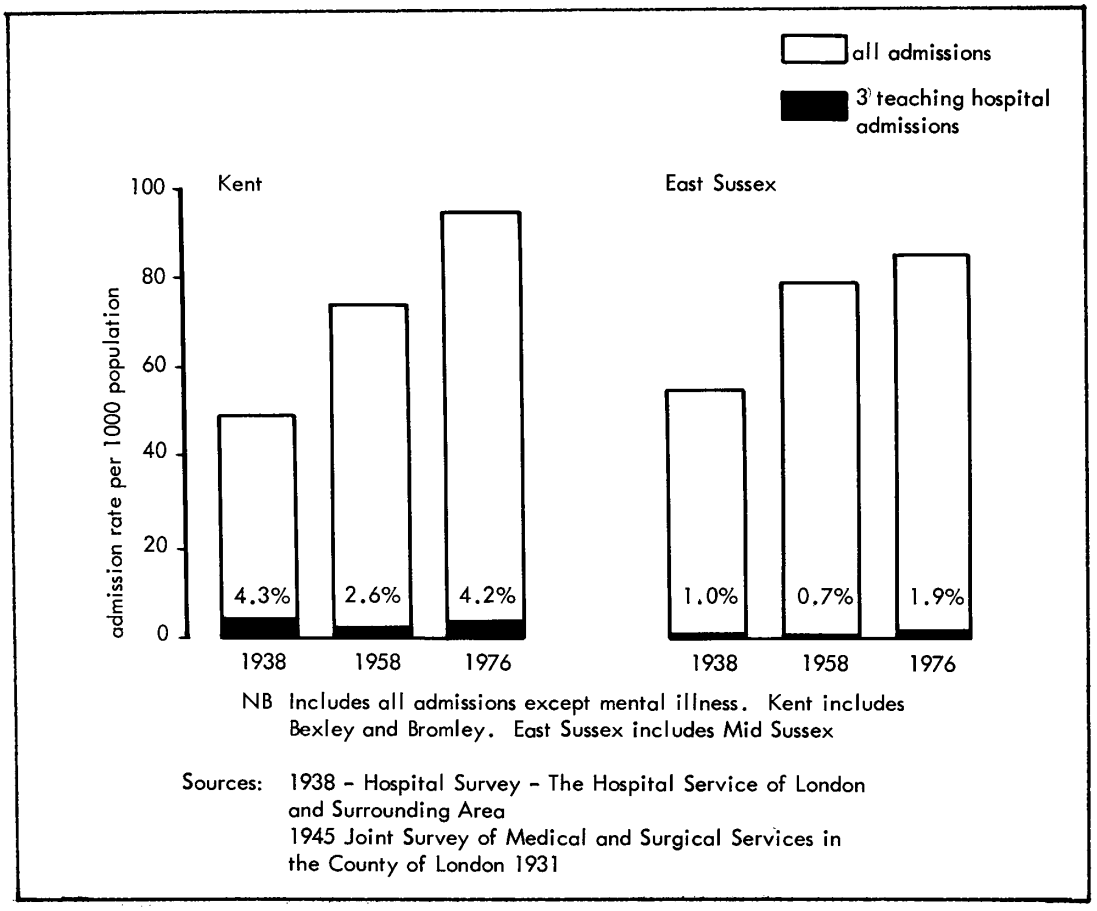
Figure 4.6 uses these data and shows the hospital admission rate per 1000 population of the residents of Kent and East Sussex over a period of almost forty years. It also demonstrates which proportion of those admissions went to the three undergraduate teaching hospitals sited in this Region. Although only a small proportion of the residents of Kent and East Sussex cross boundaries to be admitted to the Region's three undergraduate teaching hospitals, the flow has existed for many years and it is not unreasonable to expect it to continue for the foreseeable future.

Lambeth, Southwark and Lewisham teaching Area is overprovided with general acute beds compared with the average level of provision in the rest of the country. The beds are used intensively and, although the admission rate per thousand among the population of the Area is higher than the rest of the Region and nationally, it is naturally extremely difficult for the staff working in the Area, or the local residents, to accept that they are "over-provided".

Problems of the teaching Area are further exacerbated by the need to provide clinical experience for the three undergraduate medical and two undergraduate dental schools sited within its boundary. The University Grants Committee recommends certain levels of acute bed provision for the given intake of medical students and any reduction of beds below this level is thought to impair the teaching school's ability to provide an adequate level of education.

FIGURE 4.6

ADMISSION RATES FOR KENT AND EAST SUSSEX
showing proportions admitted to
St Thomas', King's and Guy's Hospitals 1938, 1958, 1976



NB Includes all admissions except mental illness. Kent includes Bexley and Bromley. East Sussex includes Mid Sussex

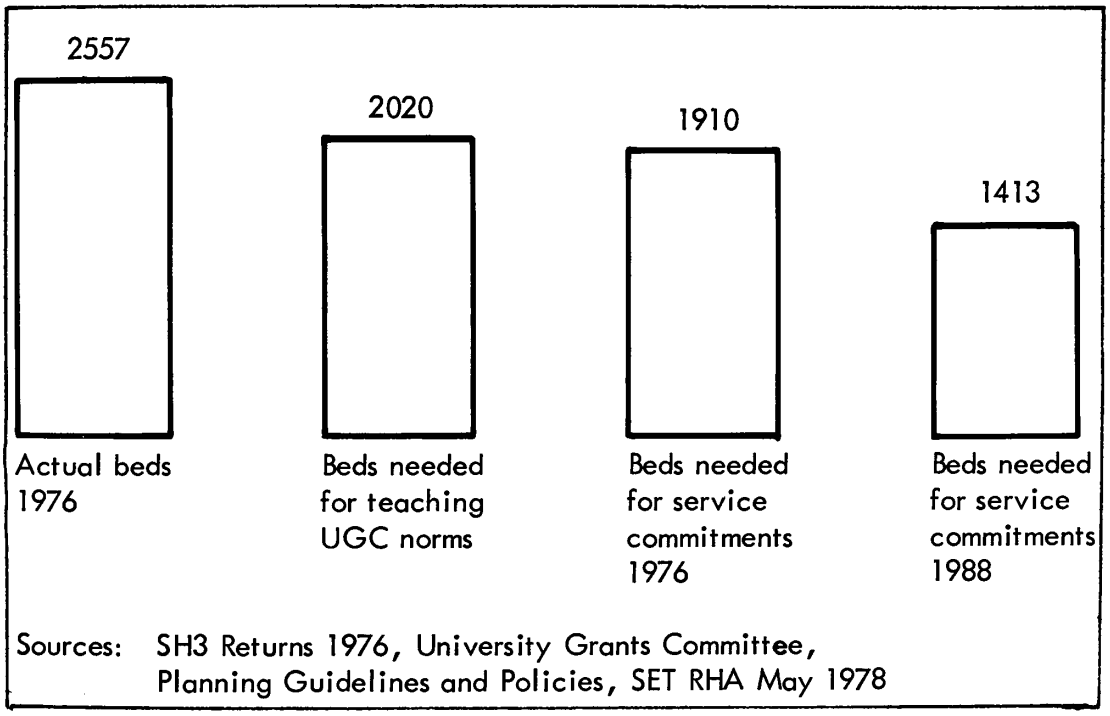
Sources: 1938 - Hospital Survey - The Hospital Service of London and Surrounding Area
1945 Joint Survey of Medical and Surgical Services in the County of London 1931

Figure 4.7 demonstrates that the acute bed provision in the teaching Area is only some 20% above the recommended UGC level and there is little room to make reductions in the acute beds to move towards greater conformity with the rest of the country. If the population drift continues in the future, this imbalance will worsen significantly.

It must be appreciated that the UGC expresses service workload required for teaching purposes in the terms of beds. If the teaching requirements were expressed in terms of patients the position would be much less serious. Between 1950 and 1977 the inpatient caseload in the five main

FIGURE 4.7

ACTUAL PROVISION AND ESTIMATED NEEDED BEDS
in Lambeth, Lewisham and Southwark AHA (T)



Sources: SH3 Returns 1976, University Grants Committee, Planning Guidelines and Policies, SET RHA May 1978

teaching specialties in the AHA(T) rose from 41 000 to 68 000, an increase of almost 70%. During the same period, the annual intake of medical and dental undergraduates into the three teaching hospitals increased from 337 to 439 students, an increase of about 30%.

These figures indicate there are more patients available per student today than there were in the past. Patients with very short stay, say less than two days, are not always suitable for teaching purposes. But even if these patients are eliminated, the percentage increase in cases between 1950 and 1977 is still in the region of 50%.

For geriatric services the South East Thames RHA has adopted a norm of 7.8 beds per thousand population over 65. Because the RHA believes that it should concentrate on developing community services to deal with the problem of the elderly sick, this norm is significantly less than the DHSS recommended level of provision, and taking account of the fore-

cast increased proportion of the elderly among future populations, only two Areas in the Region will be up the recommended level of provision in 1988, and each of Kent and East Sussex Areas will be some 350 beds short of the minimum requirement proposed by the RHA.

In common with many Regions, psychiatric services in South East Thames are still mainly provided in large Victorian institutions. There are seven such mental illness hospitals in the Region, providing some 80% of the available beds in this specialty. Although considerable upgrading has taken place over the years, these hospitals still cannot be considered as adequate to provide an up-to-date treatment for the mentally ill. The Region has stated that its objective is for mentally ill people to be cared for within the main stream of medicine, and also to be accommodated as close to their homes as possible, but the present location of mental illness hospitals and beds prevents either of these objectives being obtained. Doubtless there are sufficient numbers of mental illness beds in total in the Region, but they are in the wrong place. Massive injections of capital would be required to correct this maldistribution. By national standards, not one of the health districts in the Region has an adequate number of mental illness day places: four health districs have no mental illness day place accommodation at all and three have no mental illness beds. Again, significant capital expenditure would be required to solve this problem.

Like the mental illness services, the mental handicap patients in the Region are housed for the most part in two isolated large institutions. It is the policy of the RHA to house mentally handicapped people in homes within the community as far as possible, so as to reduce the isolation of the patients and the staff who care for them. The Region has enough mental handicap beds and the need for the beds is falling as the social service and local education colleagues take an increasing share in provision. However, to provide the right type of bed in the right place will again require massive capital outlay.