PRIMARY HEALTH CARE IN LONDON

Quantifying the challenge

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King's Fund Institute

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Any errors of fact or interpretation are ours alone.

EXECUTIVE SUMMARY

The imbalance in London between primary health care and hospital services has long been recognised. Attempts are now being made to address this issue by strengthening community-based services. This paper quantifies the nature of the challenge facing primary health care in the capital relative to the rest of the country.

The paper concentrates on two major elements of primary care provision: GP services and the social care of the elderly. Some of the issues affecting the delivery of pharmaceutical and community nursing services are also examined. A complex picture is painted but a common theme emerges; more is spent per capita on primary health care in London than in England as a whole but relatively less services are provided.

The main results of the paper are summarised under two headings: Family Health Services, and social and community care.

Family Health Services

- Expenditure on Family Health Services per capita resident population in London is equal to the England average and slightly less than that in comparable areas of the country, but the balance of expenditure between General Medical Services (GMS) and Pharmaceutical Services (PS) is very different. Seven per cent more is spent in London on GMS than is the case nationally whereas eight per cent less is spent on PS.
- The differential in expenditure on GMS between London and England is lower than might be expected in view of the typically higher input costs associated with the provision of goods and services in the capital. The structure of payments to GPs, set within the framework of a national contract, is the main factor underlying this.
- The element of a GP's salary deriving from the number of patients on his or her list - which might be thought of as 'automatic' payments - is greater in London than elsewhere: direct payments for services on the other hand are less. List inflation and deprivation payments are the chief source of differences in automatic payments, which in London constitute 68 per cent of the average GP salary compared to 62 per cent nationally. The average GP's earnings from service payments on the other hand is 16 per cent in London compared with 22 per cent in England as a whole.
- List inflation in London is nearly 20 per cent compared to six per cent in England as a whole. GPs in London receive capitation payments for 1.3 million more patients than the estimated size of the resident population.

- Expenditure on services for which direct payments are made is 24 per cent less in London per capita resident population compared to the England figure. This is reflected in poorer provision in London over a range of services which the 1990 GP contract attempted to foster, including health promotion clinics, childhood immunisation, cervical cytology, child health surveillance and minor surgery.
- A number of indicators of the quality of the structural framework within which GMS in London operate suggest it is inferior both to England as a whole and to similar areas in the rest of the country. The underdevelopment of GMS in London is typically characterised by single-handed, older GPs operating from poor quality premises.
- Less is spent on pharmaceutical services in London due to a lower prescribing rate: 11 per cent fewer drugs are prescribed to Londoners than is the case in England as a whole. Factors underlying national variations in prescribing rates can account for only a relatively small part of this difference.

Social and community care

- Local authority expenditure on social care for elderly people per capita is 50 per cent greater in London than is the case in England as a whole. In addition, London is characterised by a different pattern of care for elderly people. There is substantially less residential provision, but a greater level of services such as home helps and day care centres.
- There is a shortage of private residential provision in London for care of elderly people. There are six times as many private residential care places per capita in England as a whole as there are in inner deprived London. Public provision is unable to compensate for this shortage.
- More is spent on residential provision in London than elsewhere in the country at a greater cost, both per capita resident population and per available place. For example, local authorities in the capital's inner city spend almost twice the national average on residential care, but obtain just 10 per cent more places.
- There is substantially greater expenditure on non-residential provision for elderly people in London than is the case nationally. This results in more provision of services such as home helps and meals but at a much greater average unit cost.
- London spends 40 per cent more on community health services than is the case in England as a whole. However, there is substantially less provision in terms of contacts with district nurses or health visitors, and at a higher cost per contact.

Policy Implications

Both the Tomlinson Report and *Making London Better* have suggested ways of addressing the underdevelopment of primary care in London. The findings reported in this paper clearly support the need for a number of key initiatives. These include:

- The introduction of more flexibility into GP contracts at the local level.
- A programme of investment in the physical infrastructure of primary health care providers.
- The closer integration of health and social services to meet the long-term care needs of elderly people.
- A re-examination of the funding and provision of private nursing and residential care.
- The development of new approaches to joint commissioning that overcome the problems posed by historic boundaries of care.
- A more comprehensive approach to the equitable allocation of financial resources across all services, which recognises the extra costs associated with provision in London.

CHAPTER 1

Introduction

It is a common belief that primary and community health services in London are underdeveloped. This is often contrasted with the apparently excessive provision of acute hospital services in the capital relative to population size. Until recently, there has been little systematic effort to deal with this persistent issue. However, the crisis in London's acute hospitals which was triggered by the reforms of the 1990 NHS and Community Care Act has caused the Government to take a fresh look at the overall provision of services in London.

In October 1991 Sir Bernard Tomlinson was appointed as special adviser to the Departments of Health and Education on London's health services, with a remit to address the provision of health care in inner London within the context of the reformed NHS. His report was published a year later (Department of Health, 1992a). Much of the subsequent debate focused around recommendations for the rationalisation of the acute sector. However, arguably one of the key contentions of the report was the need for a transfer of resources from the acute to the primary sector, which was justified in terms of the substitutability of primary for acute care.

With specific reference to primary care, the main recommendations of the report were:

- development of General Medical Services in London through premises improvements and more flexible local contracting;
- enhancement of co-ordination between the agencies responsible for the delivery of primary care; and,
- improvement of the level of nursing and residential home provision in London, particularly for the elderly, to help ease the pressure on acute beds.

Making London Better (Department of Health, 1993), the Secretary of State's response to the Tomlinson Report, broadly welcomed its main elements and established a London Implementation Group (LIG) to ensure that its key structural recommendations for improving London's health services were implemented. A 'Primary Health Care Forum' was established to oversee the implementation of primary care development within a 'London Initiative Zone' (LIZ) covering those parts of London thought to have high levels of need, weak existing primary care services, and where acute sector rationalisation poses further challenges. A list of FHSAs in LIZ is included in the Appendix. In addition to these developments, the Secretary of State committed some extra money for capital projects over a six year period.

The Tomlinson Report and *Making London Better* both assume that primary care in the capital is underdeveloped and needs considerable investment if it is to function adequately. The publication of both of these, therefore, marks the beginning rather than the end of public debate about the future of primary and acute care in London. Indeed, the specific remit of the Primary Health Care Forum is to develop an agenda for change over the next two years. Against this background, it is important that the implementation of primary care development is informed by a detailed knowledge of the nature of current provision in London. The aim of this paper is to provide such a picture.

The paper has two complementary functions. One is to describe the current provision of key aspects of primary care in London. The other is to consider whether the level and nature of this provision is adequate. To do so, we adopt a comparative framework which is outlined in the following chapter.

One problem which must be faced in pursuing such aims is the diversity of primary health care services. Although many of the key issues in London are well known, it is notoriously difficult to offer a widely accepted and comprehensive definition of precisely what primary care entails. Hughes and Gordon made a valuable attempt to capture its essence by suggesting that:

> *Primary care is a network of services that covers the whole spectrum of health and social care: prevention for the young and well, treatment of acute and chronic illness, rehabilitation, respite care, residential care, support at home for patients who are frail, elderly, disabled or acutely or chronically ill, and terminal care.*
>
> (1992, p.15)

For analytic purposes, however, the problem remains of whether to track the provision of particular forms of care, wherever they are offered, or simply to follow the administrative divisions of health and social care provision.

In this paper broadly we adopt the latter approach. Chapter 2 provides the context for this in outlining the financial framework within which primary health care services are provided in London. The analysis is divided between the provision of family health services (FHS) and community health services (CHS), as well as the provision of social care for elderly people, both through Personal Social Services (PSS) and independent providers. By following the structure of the data which is available – essentially a provider-focused approach – a clear exposition of the current level and nature of provision is possible.

The need to develop better General Medical Services and better social care for the elderly in London has been highlighted by the Tomlinson Report and *Making London Better*. However, few recent analyses have provided a detailed account of the current state of provision in these areas. The aim of Chapters 3 and 4 is to provide such an account for GMS and services for the elderly respectively, so that future needs can be judged against the level of current services.

Chapter 5 examines two areas which have been relatively neglected in the debate about the future of primary care in London. These

are the provision of community nursing services and the level of expenditure on pharmaceuticals. Both have significant implications for the efficiency and effectiveness of primary care in London.

In Chapter 6 the major themes are brought together. First, an analysis of the overall provision of primary health care services in London is provided in terms of the availability and use of financial and human resources relative to the rest of England. Some of the key aspects of the paper are then summarised. Finally, options for the development of primary and community services in London are considered.

CHAPTER 2

Financial framework

Introduction

Primary health care services are organised administratively under three separate agencies. Within the NHS, Family Health Services Authorities (FHSAs) are responsible for the provision of a range of family health services, and District Health Authorities (DHAs) are responsible for community health services. The Social Services Departments (SSDs) of local authorities are responsible for the provision of Personal Social Services (PSS), although, as Chapter 4 indicates, independent agencies also constitute a significant component of social care provision.

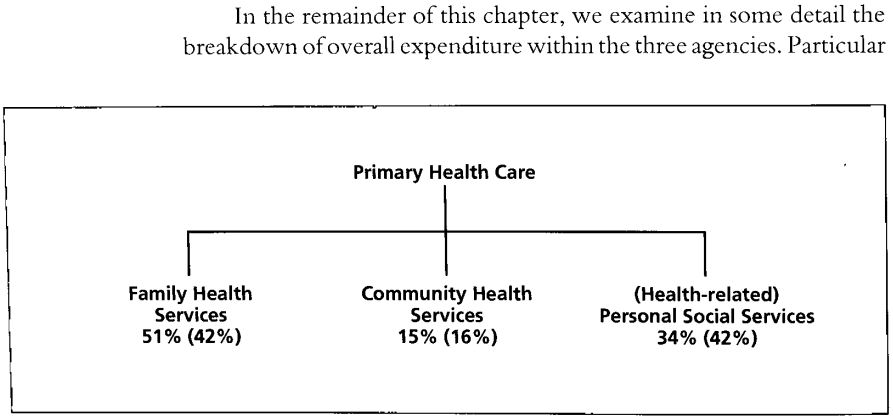
Increasingly, community health services are being provided by separate community trusts, and DHAs are consolidating their function as purchasers or commissioners rather than providers of care, often in collaboration with FHSAs. At the same time, with the full implementation of the NHS and Community Care Act in April 1993 SSDs are developing a clearer responsibility for purchasing social care. At present, however, such developments remain fragmented. Accordingly, at a national level, it makes more sense to analyse primary care provision in terms of the previous administrative structure.

Overall, in 1990–91 in England, some £10.5 billion was spent on primary care, of which £7 billion was spent within the NHS. In London, on the other hand, of £1.9 billion spent on primary care, just £1.1 billion was spent within the NHS. Total expenditure on primary care is looked at in more detail in the final chapter. Figure 2.1 shows the different balance of expenditure between the relevant agencies when London is compared with England. London spent an equal proportion – 42 per cent – on both PSS and FHS whereas nationally 51 per cent was spent on FHS compared to just 34 per cent on PSS.

In the remainder of this chapter, we examine in some detail the breakdown of overall expenditure within the three agencies. Particular

Figure 2.1

Primary health care expenditure, England (London), 1990–91



regard is paid to the relative level of expenditure in London in comparison to the rest of the country. To do so, a tripartite classification of the English health authorities is employed.

The classification divides London into areas of separate and distinct socio-economic and demographic character, and provides comparator areas of a similar character from outside the capital. This allows more meaningful judgments to be made about the performance of London's services than simple comparisons with a crude national figure. It also offers a consistent geographical basis with which to consider the services provided by each of the relevant agencies, since these often have different geographical boundaries. Details of the comparative methodology and sources of the data are described in Box 2.1. In accordance with the classification, London is divided into:

- Inner deprived areas;
- Urban areas; and,
- High-status areas,

with corresponding comparator areas outside London. A list of the health authorities in each of the status areas is provided in the Appendix.

Family Health Services

Family Health Services comprise general medical, pharmaceutical, dental and ophthalmic services. The general medical practitioner (GP) is the initial contact for most individuals who have a health concern, and may be thought of both as a gateway to the most appropriate form of care, and as the actual point of delivery for a particular set of services. Dental and ophthalmic practitioners are essentially concerned with service delivery, although they may also refer on in some circumstances.

Expenditure on Family Health Services in 1990–91 in England amounted to £5.4 billion. In London, £785 million was spent on FHS. This constituted a little under 15 per cent of FHS expenditure in

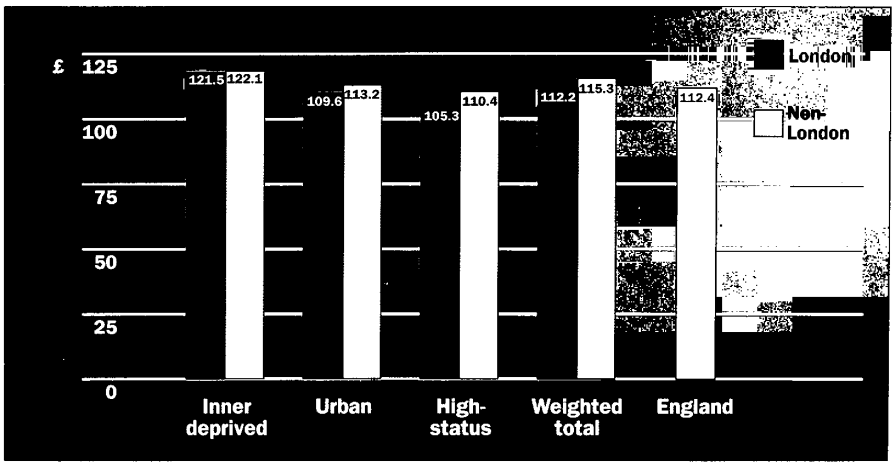


Figure 2.2

Total FHS expenditure per capita resident population, 1990–91

Box 2.1

SOME METHODOLOGICAL ISSUES

The Comparative Methodology
The comparative approach adopted in this paper is a modified version of Craig's (1985) classification of local authority and DHA areas. Craig used the statistical technique of cluster analysis to identify areas of similar demographic and socio-economic character throughout England, based on 1981 census data. Unfortunately, for our purposes, he identified no areas which were comparable to many of the inner London districts. For this reason we have modified his approach to provide comparator areas for the relevant London districts, but have otherwise retained the classification as far as possible.

A more detailed discussion of the modification can be found in earlier papers (Boyle and Smaje, 1992a; Benzeval *et al,* 1992). In essence, the cluster analysis was repeated using a number of variables which are typically found in established deprivation indices. Central to this approach was the contention that a small group of 'hybrid' authorities could be identified, straddling the conventional inner/outer London split, and that major urban areas of similar character could be found elsewhere in the country. This enabled a tripartite taxonomy of London DHAs to be constructed and, crucially, comparators outside the capital to be found for them. A list of the DHAs which constitute the classification is provided in the Appendix; about 90 of the 190 English DHAs (as at 1989–90) are included.

The approach is relatively unproblematic when service provision is organised only at the DHA level. However, in the case of primary care the matter is complicated by multi-agency provision, which, despite the recent reforms, effectively still occurs in many cases across different geographical boundaries. To resolve this problem, the FHSA and local authority data have been transformed so that they can be analysed at the DHA level. This was achieved by allocating the appropriate proportion of the resident populations of these authorities to the relevant status category on the basis of the classification of the constituent DHA or DHAs.

For example, Birmingham FHSA incorporates the areas of five DHAs: three are in inner deprived areas, one in an urban area and one in a high-status area. The proportions of the FHSA population in these areas are 59, 25 and 16 per cent respectively. When presenting data for a given variable, the numerator and denominator values for Birmingham FHSA are therefore allocated out between status categories according to these proportions. The summary figures found in the text are simply aggregations of this process across all the clustered DHA areas. For this purpose, transformation matrices were developed which were consistently applied to the raw authority-level data.

Presenting the data in this way provides a clear and consistent basis for looking at otherwise incommensurable data sets, and has the major advantage that comparisons can be made across the spectrum of primary care provision. However, such an approach rests upon the assumption that resources, activity and so forth are distributed between areas in the same proportions as the resident population. This may not in reality occur. In general it is therefore wise to interpret the status category-specific data as approximate rather than actual. However, at the aggregate level with which we are principally concerned the assumption is unlikely to introduce any systematic distortion.

Presenting the Data
Where data are presented in this paper, figures are generally provided for each of the status categories and for England. Weighted totals are also provided for London and its comparator areas.

The weighted totals are 'averages' which represent an overall value for both London and its comparator areas as a whole. They are weighted to take account of the relative composition of London's population in terms of residence by status area. The details of this technique are set out elsewhere (Boyle and Smaje, 1992a).

The key point, however, is that the non-London values are weighted according to the same proportions as the London values. This is because, as can be seen from the Appendix, the relative proportion of the population in each status category differs significantly between London and the comparator areas. Thus, a non-London total, weighted according to its own composition would not provide a meaningful comparison with the situation in London. It should therefore be borne in mind that the London-based weighting for non-London areas adopted is not an average for the actual situation in those areas. Rather, it provides a comparative context within which the situation in London can be judged.

Sources of Data
Except where otherwise stated, the figures upon which this analysis is based are derived from the health service indicator data set (Department of Health, 1991c, 1992b) in the case of FHS and CHS provision, and the key indicators of local authority social services (Department of Health, 1991a, 1992d) in the case of PSS provision.

England, slightly less than the proportion of the national population resident in London, and certainly less than the 20 per cent of Hospital and Community Health Services (HCHS) expenditure which takes place in London.

Figure 2.2 shows that FHS expenditure per capita resident population in London in each status group is not only less than in comparable areas elsewhere but also that the overall figure for London is marginally less than the national average. This is rather surprising in view of London's typically higher input costs: goods and services are generally more expensive to provide in the capital than elsewhere in the country.

No summary figures for regional differentials in input costs for health care are available. However, other evidence suggests that costs are higher in the capital than average. For example, the Revenue Support Grant Distribution Report (1991) for local government has suggested a mark-up of around 20 per cent for Personal Social Services in inner London. Similarly, the New Earnings Survey (Department of Employment, 1991) shows still greater discrepancies between London and England as a whole for various sectors of the labour market. On the face of it, therefore, FHS spending in London is lower than might be expected. But the comparative picture is complicated by the existence of a national contract for the remuneration of GPs. We return to this point in Chapter 3.

Total FHS expenditure can be divided into the four separate service components mentioned above:

- Pharmaceutical Services (PS), principally comprising payments for drugs prescribed by GPs and dispensed by community pharmacists;
- General Medical Services (GMS), comprising payments to GPs;
- General Dental Services (GDS), comprising payments to NHS dental practitioners; and,
- General Ophthalmic Services (GOS), comprising payments to NHS opticians.

Figure 2.3

Family health services expenditure, England, 1990–91

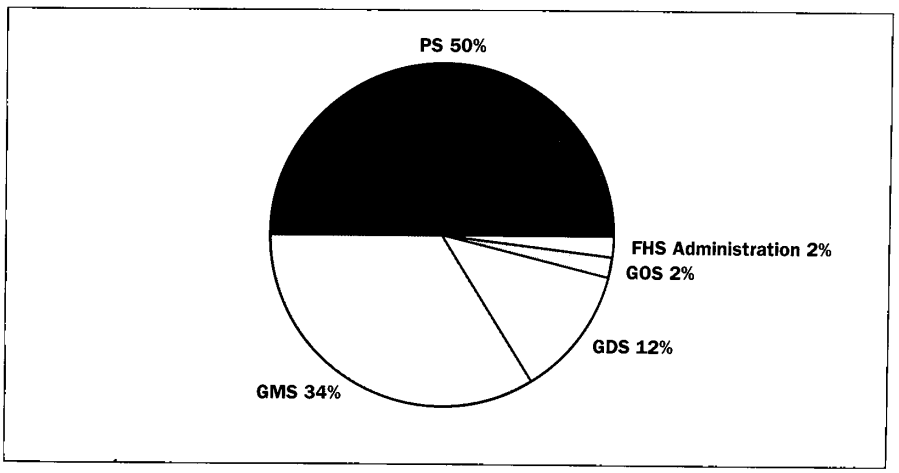


Table 2.1

A breakdown of FHS expenditure per capita resident population, 1990–91

	PS	GMS Practice staff	GDS	GOS	FHSA cash allocation	Total FHS
	£	£	£	£	£	£
London	51.4	33.2	8.1	15.3	2.2	2.0	112.2
Non-London comparators	57.8	31.2	7.1	14.7	2.8	1.8	115.3
England	55.8	30.9	7.4	13.8	2.3	2.3	112.4

Figure 2.3 indicates the proportion of overall FHS expenditure accounted for by each of these components in England as a whole in 1990–91. FHSA administrative costs are also included. GMS expenditure includes the cost of practice staff and premises development, which is paid for out of a separate cash-limited budget. Clearly, the PS and GMS components are the most significant elements of overall FHS expenditure.

The level of expenditure per capita resident population on each of these components is shown in Table 2.1 for London, its comparators and England. It can be seen that the principal factor underlying lower overall FHS spending in London is PS expenditure. The other components are in general higher than both the comparator areas and the national figure.

Against this background, and concentrating on the two largest components of overall FHS expenditure, we consider the nature of service development and provision in the capital. General Medical Services are examined in Chapter 3. The adequacy of GMS provision is addressed by considering some of the fundamental indicators likely to affect most aspects of service provision. Chapter 5 returns to the issue of low PS expenditure, looking in some detail at the factors underlying it. In view of the relatively smaller levels of expenditure on General Dental Services and General Ophthalmic Services, and the increasing importance of the private sector in these areas, we do not consider them further.

Social services

The aim of social services is to provide forms of care which allow individuals who might otherwise face some difficulty in their everyday existence – whether through infirmity, a lack of particular life skills, or emotional turbulence – to live reasonably well and safely, and with a minimum probability of suffering unnecessary illness. A precise definition of what part of the expenditure of Social Services Departments (SSDs) constitutes a contribution to the delivery of health care is probably as unwelcome as it is intractable. However, the importance of social services to the delivery of health care has long been recognised. For example, the Acheson Report stated:

> *... in an area like inner London where traditional neighbourhood and family networks have often broken down... efforts to secure improvements in the delivery of primary health care were likely to fail, unless the social and home support services were sustained at least at their present level and better co-ordinated with the health services.*
>
> (LHPC, 1981, p.96)

Effectively, public provision of social services is aimed at five groups:

- elderly people;
- physically handicapped people;
- people with learning difficulties, both children and adults;
- people with mental health problems; and,
- children and their families.

Chapter 4 concentrates on the provision of care for elderly people, which constitutes over 50 per cent of all social services expenditure nationally. However, data on the amount spent by social services on provision for the other priority needs groups are provided in Box 2.2.

The independent sector plays an important role in the provision of social care to elderly people, as a provider of services funded both publically – including income support paid from the Department of Social Security (DSS) budget – and privately. In Chapter 4, therefore, while the focus is on local authority provision, some analysis of independent provision of social care is included.

In England in 1990–91, some £4.7 billion was spent on Personal Social Services, of which the health-related portion was some £3.5 billion. This last figure excludes that element which is spent on services for children, except for a small part on the provision of care to those children with learning difficulties.

Figure 2.4 presents total gross current expenditure by SSDs per capita resident population. Across all status groups, London spent more than its non-London comparators. This is particularly striking in inner

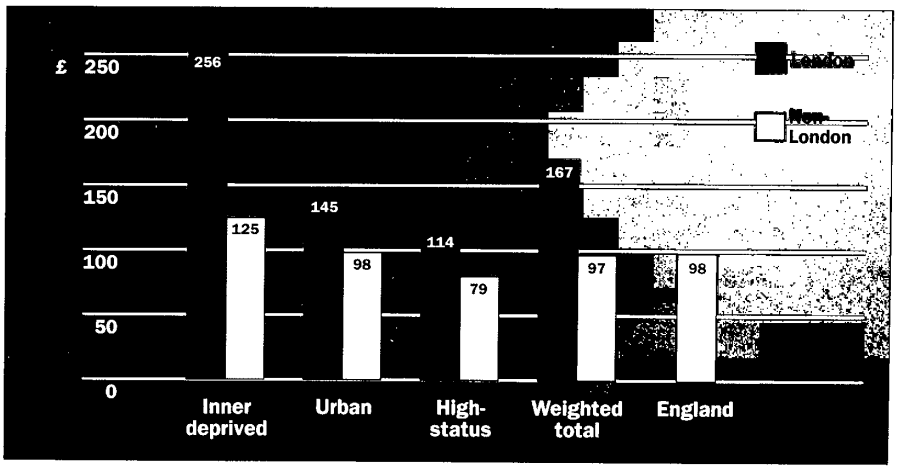


Figure 2.4

Total SSD gross expenditure per capita resident population, 1990–91

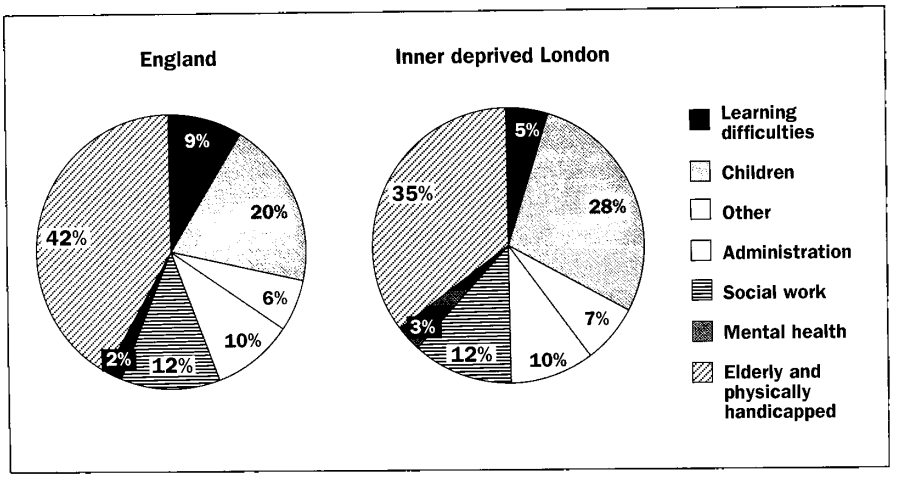
Box 2.2

SOCIAL SERVICES EXPENDITURE

Figure 2.5 examines the breakdown of current expenditure according to client group. Expenditure on two groups – children, and elderly and physically handicapped people – make up over 60 per cent of the total, both nationally and in most London authorities, although as the figure shows, this tends to be weighted less towards elderly people in inner deprived London than is the case nationally.

Figure 2.5

A breakdown of SSD gross current expenditure, 1989-90



The other major client groups are adults with learning difficulties and people with mental health problems. Expenditure on these groups is a relatively small part of the overall budget, both nationally and in London, amounting to some 10 per cent, most of which is spent on the first group. We identify the health-related element of SSDs' budgets as excluding that part which is spent on services for children – except for a small part on the provision of care to children with learning difficulties.

A large part of social services expenditure relates to what are commonly known as support services: these include social work, administration and other areas such as training. Unfortunately, for our purposes, local authorities behave differently in the way in which they provide data on the breakdown of their expenditure on social services. While, on the whole, most authorities include, as separate items, expenditure on these support services, there is a minority which re-allocate some or all of them to specific client groups.

The figures presented in the text are based on recharging support services on a proportionate basis according to that part of the budget already identified to a particular client group, thus allowing most authorities to be included in the averages.

Social work is a large area of expenditure which crosses all of the above client group boundaries. It is a moot point whether it should be regarded as a support service as such, but clearly to maintain the client group framework requires some recharging of that part of the budget spent on social work.

Over 10 per cent of the Social Services budget is spent on social work, slightly less on administration and about five per cent on other items (which includes training). Figure 2.5 shows the relative proportions spent on each category in England as a whole, compared to the situation in inner deprived London. Figure 2.6 shows that nearly three times as much is spent on social work in inner deprived London, per capita population, as is the case nationally; for London as a whole the figure is nearly 80 per cent higher. Even comparing like with like London spends considerably more than similar areas in the rest of the country. For example, inner deprived London areas spend nearly twice as much as that in similar non-London areas.

Figure 2.7 shows expenditure on administration and again London spends a lot more per capita population than is the case nationally. Inner deprived London spends over two and a half times the national average and London as a whole spends nearly 80 per cent more than the national figure. This raises the question of the optimal size of administrative body for social services.

It is certainly the case that the average size of population served by a London local authority is much less than that nationally: this is also the case for other bodies involved in the provision of health care services. A high negative correlation was found between the total administrative expenditure of a local authority, per capita resident population, and its overall population size. This matter is returned to more generally in Chapter 6, in the context of the optimal size and structure for the administration of all health-related services.

Figure 2.6

SSD gross current expenditure on social work per capita resident population, 1989–90

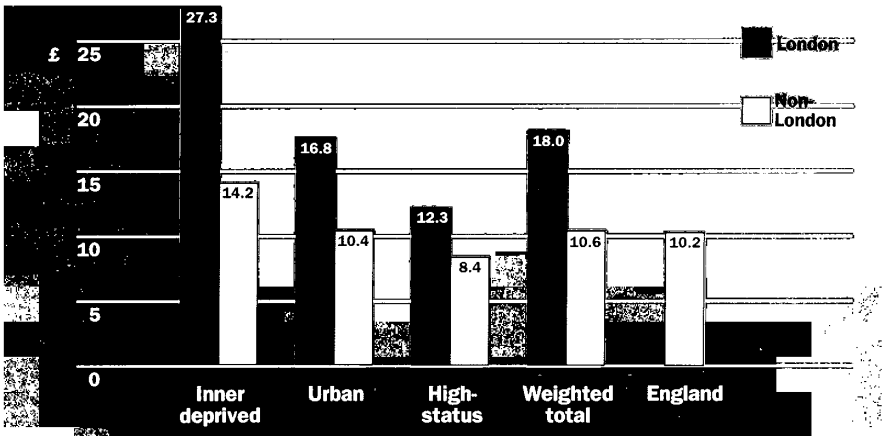
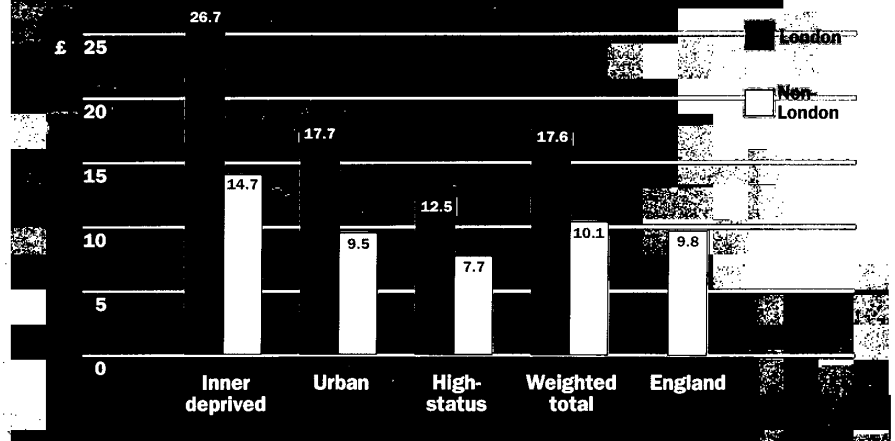


Figure 2.7

SSD gross current expenditure on administration per capita resident population, 1989–90



deprived London, where expenditure was twice that of similar areas in the rest of the country, and approaching three times the national average. London overall spent over 70 per cent more per capita resident population than similar areas elsewhere in the country.

Community health services

Community health services provide a wide range of community and home-based care to patients and their carers. The majority of professional employees are community nurses, who principally provide care for children and the elderly, as well as people with learning difficulties. CHS provision also involves community medical and dental staff, and a number of other professional services, such as speech therapy, chiropody and physiotherapy.

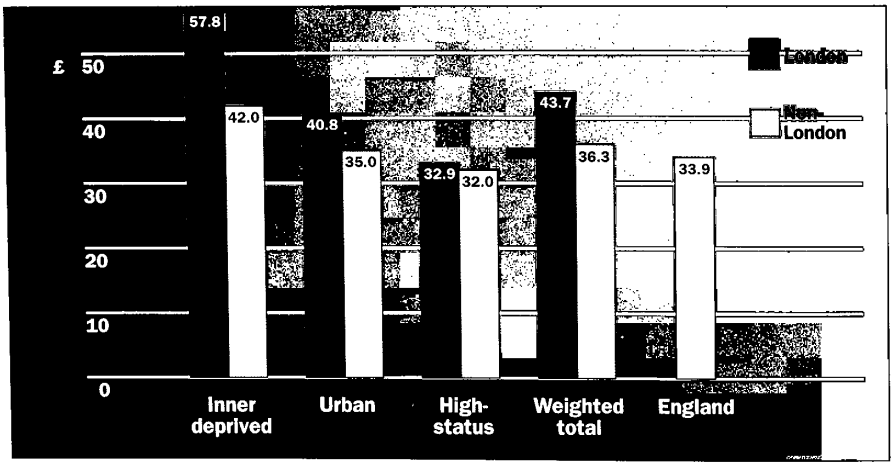
In 1990–91, CHS spending in England amounted, at £1.6 billion, to some 12 per cent of the overall HCHS budget, and 23 per cent of the NHS budget devoted to primary care. Figure 2.8 shows the comparative pattern of expenditure on CHS. In each status category, expenditure per capita resident population in London is greater than in the comparator groups. Overall, expenditure in London exceeds comparable districts by 20 per cent and the national value by 29 per cent. This is examined in more detail in Chapter 5, in which it is shown that the figures conceal a number of differences in the composition of overall CHS expenditure and in the services provided.

The figure highlights variations across the status categories in CHS spending, from relatively less in the high status areas to more in the inner deprived ones. For example, inner deprived London spends over 70 per cent more on CHS than the national average, and inner deprived non-London almost 25 per cent more, whereas high-status London areas spend slightly less than average, and approximately the same as that in high-status non-London areas.

This pattern mirrors the relative levels of expenditure on acute hospital services, tending to confirm the notion that historically high levels of HCHS funding are shared between both hospital and

Figure 2.8

Total CHS expenditure per capita resident population, 1990–91



community health services. The Audit Commission (1992) identified a positive correlation between DHA spending on hospital services and community services. Underlying this, it claimed, is the fact that:

> *... the activities of community health services have changed very little in recent years, with the majority of districts 'rolling over' resource levels from one year to the next ... an illogical pattern of services – inherited by health authorities – has persisted.*
>
> (Audit Commission, 1992, p.11)

In Chapter 5, we concentrate upon community nursing services and their significant role in the evolution of effective patterns of care for individuals in the community. Although CHS involve a wide range of activities and considerable interaction with other agencies, in resource terms it is the community nurses who form the most distinctive component of CHS provision accounting for some 55 per cent of overall expenditure nationally.

CHAPTER 3

General medical services

Introduction

This chapter compares the provision of health care services by London's GPs with that offered elsewhere in the country. The first section sets out the financial context of GMS provision through a detailed analysis of the GP remuneration structure. The following sections discuss respectively the quantity of care – in terms of the availability of human resources – and the quality of care, in terms of a number of indicators of practice structure and activity. The impact of the new 1990 GP contract on key areas of specific service provision is then examined. The chapter concludes by pointing briefly to some of the areas which the analysis suggests merit particular attention.

Perhaps the most important feature of GMS is simply the availability of GPs for consultation. However, the quality and effectiveness of GP consultations are notoriously difficult to measure. Many of the conventional indicators of general practice quality are at best only proxy measures. Nevertheless, a thorough comparative picture of GMS expenditure, general practice structure and the delivery of specific services can at least provide an indication of whether general practice in the capital is able to meet Londoners' needs adequately. The weight of the evidence presented in this chapter generally confirms the common perception that GMS in London are less well developed than is the case elsewhere in the country.

Financial framework

GPs are not salaried employees of the NHS; they are independent contractors, obliged by their terms of service to provide general medical care to their patients. For this reason, GMS expenditure is composed of a rather bewildering array of payments which are detailed in the *Statement of Fees and Allowances* (Department of Health and Welsh Office, 1990). In addition to these direct payments, FHSAs also assume considerable responsibility for paying GPs' premises and practice staff costs, a commitment which was enhanced under the 1990 contract. The direct payments are conventionally broken down into three main components:

- a salaried element (the Basic Practice Allowance);
- capitation-based fees (including 'deprivation' payments); and,
- item of service fees.

The 1990 contract shifted the emphasis towards the capitation element; in 1990–91 standard capitation fees were set at £11.95 for each registered patient below the age of 65 – an increase of some 30 per cent over the previous year. There were bigger increases for patients in the 65-74 and 75+ age ranges – the payments were £15.75 and £30.35 respectively. Payments for GPs who reached list coverage targets for certain preventive services were also introduced. Conversely, the basic practice allowance was reduced by nearly 40 per cent.

In Chapter 2 expenditure per capita on GMS in London in 1990–91 was shown to be slightly higher than elsewhere. Table 3.1 relates GMS expenditure to the number of GPs, and breaks it down into five components. By choosing the GP as the base measure, it is possible to examine directly the average composition of payments to GPs in London in comparison with elsewhere. This allows a clearer assessment of the incentives implicit in the remuneration structure than if the normal resident population denominator is used.

Table 3.1

A breakdown of GMS expenditure per GP, 1990–91

Source: based on Department of Health (1992c)

	Practice	**Premises**	**Medical staff**	**Special area**	**Services**	**Total**
	£	£	£	£	£	£
London	36,196	4,065	6,312	3,124	9,217	58,914
Non-London comparators	33,536	2,948	6,679	1,988	12,082	57,232
England	33,907	2,706	6,684	1,761	12,617	57,674

Inevitably, the aggregation of payments under GMS is to a certain extent arbitrary. In Table 3.1 five categories are chosen to encompass GP remuneration which emphasise the broad aim of different types of payment. These are:

- *Practice*, covering assured payments to GPs for medical practice, such as the Basic Practice Allowance and capitation fees;
- *Premises*, covering payment for renting premises and other outlay on physical stock;
- *Medical staff*, covering GP superannuation, assistant allowances and a range of educational payments;
- *Special area*, including deprivation payments, rural practice payments, and payments which are designed to encourage GPs to practice in under-doctored areas; and,
- *Services*, covering payments to GPs for the range of specific services they provide directly to patients.

Table 3.1 shows that the total difference in expenditure per GP between the London and non-London status areas is just three per cent.

However, there are large differences between the sub-categories outlined above: practice payments to London GPs exceed the comparator areas by 8 per cent, premises payments by 38 per cent, and 'special area' payments by 57 per cent. Conversely, medical staff payments are 5 per cent less in London, and service payments 24 per cent less.

The Basic Practice Allowance is essentially constant across the country. Practice payments differ because average list size in London is larger, so capitation payments are higher. In fact, a breakdown of the figure reveals that it is payment for patients under the age of 65 which principally underlies the difference. However, the payments do not necessarily correspond to the true level of the population, due to list inflation. In 1990–91 London GPs received payments for 1.3 million more people than were actually resident in the capital. List inflation and its implications for the remuneration of GPs are discussed later in this chapter.

Turning to the other categories, it is not surprising that premises payments in London are greater, given the effect of costs in the capital and the greater number of single-handed GPs, a factor which is examined below. The lower level of medical staff payments can be accounted for largely by lower postgraduate educational payments and payments to GP trainers, indicating a generally poorer uptake and provision of educational opportunities in London.

It is in the area of service and special area payments that the most interesting differences occur. The greater payments in London for the latter compensate to some extent for lesser payments for the former. The nature of service provision is examined in some detail below: the 24 per cent difference in payments is certainly reflected in the level of provision. Moreover, this figure conceals wider discrepancies in provision between different types of service.

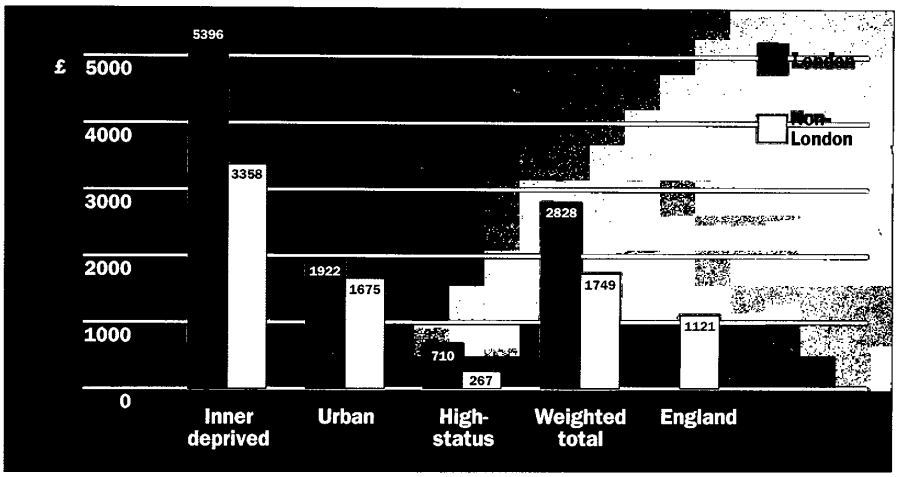
The large differential in special area payments is due principally to much higher levels of deprivation payment in London. The intention of this new payment, introduced in 1990, was apparently both to encourage GPs to practice in areas where, *ceteris paribus,* GP workloads are high, and also to support or reward those GPs who work in such areas (Secretary of State for Social Services, 1987). The payment is based on the Jarman under-privileged area (UPA) index, which was originally developed as a measure of the factors causing an increased workload for GPs. Payments are made at three levels of 'high', 'medium' and 'low' deprivation, as measured by arbitrary cut-off points on the UPA index. For areas falling into none of these categories of deprivation, there is no payment.

Figure 3.1 displays the overall level of deprivation payments in the first year of the scheme's operation. Not unexpectedly, there is a very strong status group gradient. Moreover, without exception, payments in London exceed those for the comparator areas, with an aggregate difference of some 62 per cent.

Two main criticisms have been levelled at the form of the deprivation payment. First, it has been argued that the UPA index is deficient, both in its measurement of deprivation and in its tendency to favour London at the expense of other parts of the country

Figure 3.1

Total deprivation payments per GP, 1990–91



Source: based on Department of Health (1992c)

(Townsend and Davidson, 1992). Second, the payments may seem unfair to those GPs whose patients live in areas with UPA scores which fall just short of a cut-off point, since they receive significantly less money for an ostensibly similar practice population (Senior, 1991).

The high level of deprivation payments in London occurs not only because of the 'London bias' of the UPA index, but also because of the nature of the stepped payments. Relative to the rest of the country, a large part of London's population lives in areas which are defined as being of medium or low deprivation. Other systems of deprivation payment have been suggested which are not so favourable for London, even though they are still based on the UPA index. For example, the system suggested by Senior (1991) of payment on a continuous rather than a discrete scale would reduce overall deprivation payments in London by about £1,000 per GP. Clearly, the choice of payment associated with a given level of deprivation is a key factor in determining the national distribution of deprivation payments.

In fact, the current structure of deprivation payments acts as a form of 'London weighting', with nearly 40 per cent of total remuneration from this source going to London's 15 per cent of the national workforce. On average, a GP in inner deprived London received about £5,400 from deprivation payments in 1990–91, some 16 per cent of the intended average net remuneration recommended for GPs in 1990 (Review Body on Doctors' and Dentists' Remuneration, 1990). To illustrate the significance of this component it is worth putting service payment figures alongside it. The maximum sum which a GP with an average list could have earned from new payments such as the cervical cytology, childhood immunisation, pre-school booster and minor surgery fees barely exceeds the £5,400 figure (Department of Health and Welsh Office, 1990).

The scale of deprivation payments in London may act as a disincentive for GPs to achieve higher income levels through service-related payments, since, *ceteris paribus*, the greater the fixed element of the remuneration structure, the less incentive there is to do extra work in order to achieve a higher income. Indeed, Carr-Hill and Sheldon

(1992) have suggested that the existence of special payments in deprived areas undermines in principle the goal of service targets. It has been argued (Jarman *et al*, 1988), in the case of immunisation, that GPs in inner deprived areas face difficulties in providing services which relate to the characteristics of inner city populations. Be that as it may, in general the level of service payments clearly indicates substantially less provision.

Overall, then, remuneration for GPs in London – in contrast to other occupations – differs little from the national picture. It would appear that the existence of a national contract for GPs, which makes no special provision for higher costs in London, is reflected in remuneration levels.

However, there are major differences in the composition of overall remuneration between London GPs and those elsewhere. In particular, capitation payments and deprivation payments operate very much to the advantage of London GPs. Considering only 'baseline' remuneration, such as practice, premises and special area payments, which – in contrast to item of service fees – are assured regardless of the work undertaken, London GPs in fact earn some 10 per cent more than the national figure. It is the low level of payment for items like services which brings the two figures close together.

It is difficult to determine the extent to which the low level of service provision in London relates to the incentives implicit in the remuneration structure on the one hand, or to the special problems of providing GMS in London on the other. Yet it is doubtful that the overall level of payment is sufficient to offer appropriate incentives for GPs to practice in the capital or, indeed, to deliver an equivalent service. Certainly, if the goal is to improve the level and quality of GMS, a thorough appraisal of the impact of the national remuneration structure on service provision in London is required.

The quantity of GMS

This section examines the comparative level of staff in London, in terms of GPs, practice nurses and other practice staff. It shows that in general the capital has similar staffing levels to the rest of the country. This has been achieved through a significant increase in the numbers of ancillary and nursing staff in the capital as a consequence of the 1990 contract.

Table 3.2 displays the number of GPs (unrestricted principals) per resident population for each status area, and also the number of practice nurses and non-nursing practice staff corresponding to the GPs. Some additional discussion is provided in Box 3.1 on list inflation and the merits of resident or registered population as base measures for indicator variables. It also outlines the implications of using absolute numbers of GPs rather than whole-time equivalents (WTEs).

Taking GPs first, a general trend can be discerned towards an increasing concentration from the high-status to the inner deprived areas. Inner deprived London has 13 per cent more GPs per resident population than the national figure. However, the overall London

Table 3.2

GMS staff, 1990–91

Type of area	GPs per 10,000 resident population	WTE practice nurses per 100 GPs	WTE practice staff per 100 GPs
LONDON			
Inner deprived	6.1	30.3	132.2
Urban	5.4	28.7	134.0
High-status	5.3	23.7	157.0
Weighted total	5.6	27.2	143.5
NON-LONDON			
Inner deprived	5.6	22.7	151.0
Urban	5.3	28.1	146.2
High-status	5.4	30.6	152.2
Weighted total	5.4	27.0	150.8
ENGLAND	5.4	30.0	147.8

Note: Practice staff figures exclude practice nurses

value differs from comparable districts elsewhere by only 4 per cent, and all the figures are broadly similar. The pattern exhibited in the table has in fact been relatively consistent over the last eight years, although the number of GPs relative to population has increased somewhat, both nationally and in London.

Clearly, then, GP numbers per resident population do not vary significantly across the country, with the exception of inner deprived London. This lack of variation is perhaps not surprising in view of the work of the Medical Practices Committee (MPC), which regulates the national distribution of GPs through control of practice vacancy procedures. Nevertheless, it would be a mistake to infer on the basis of these figures that there is a fair distribution of GPs in London, since there may be variation at the sub-FHSA level. For example, Taylor (1991) cites evidence that the most deprived areas in Haringey – one of the inner deprived London status areas – are less well provided with GPs than the more affluent parts of the district.

Table 3.2 also displays practice staff levels. The desirability of efficient administrative support through the employment of ancillary and managerial staff is generally recognised. In addition, GPs are increasingly employing their own practice nurses. WTE practice staff increased by a striking 86 per cent between 1979 and 1989 (Department of Health, 1991b).

The 1990 contract gave FHSAs increased discretion in the reimbursement of GPs for practice staff. Restrictions on the type of staff and the level of remuneration were removed, and cash-limited budgets were awarded for premises development and practice staff. It is still too early to assess the full impact of this change. However, the data shown

Box 3.1

MEASURING POPULATION AND STAFF

The population

In comparing GMS provision against the population base to give some measure of supply relative to potential demand, it is possible to choose one of two population measures:

- *Resident population:* a measure of the number of people who live in a given area, based on OPCS estimates from census returns; and,
- *Registered population:* the number of people who are registered with GPs in a given area, based on GPs' records of their personal lists.

It could be argued that in an analysis of GMS provision the more valid measure in many cases would be GPs per registered population, since – theoretically at any rate – this more accurately represents the real workload of the GP.

However, we do not present such data here for two reasons. First, there is the well known problem of list inflation, whereby there is a lag both between the recording of newly registered patients on GPs' lists and the removal of ones who are no longer registered, if indeed they are removed at all.

Although efforts are frequently made to 'clean' GPs' lists, in practice registered population figures always exceed resident population, regardless of catchment area considerations. Inflation is particularly acute in London; overall, registered population exceeds resident population by 19 per cent. The national figure is just 6 per cent. Thus any comparative analysis of London using registered population would be seriously distorted.

Second, our comparative methodology is based upon the proportions of FHSA resident populations who live in the various types of DHA area. Although such an approach cannot yield completely accurate data, at the aggregate level with which we are concerned, it constitutes the least controversial basis for comparison across a variety of GMS data. Clearly, where population base data is required, it is sensible to choose the same data which was used in formulating the comparative methodology.

The number of GPs

The measure for the number of GPs employed in Table 3.2 refers to the absolute number of unrestricted principals, rather than the number of WTEs, which are generally used to express staffing levels in the NHS. The nature of GPs' contracts makes it impossible to quantify them in terms of WTEs. Data is, however, available on the number of GPs who have part-time commitments, as measured by their stated hours of availability to patients. In fact, the proportions are universally quite small; in London about 3 per cent work half or three-quarter time, in the non-London comparator group the proportion is about 5 per cent, and the national figure is roughly in between the two.

The proportions of GPs with small list sizes – which might be thought to relate to the prevalence of part-time GPs – are also low. Using the Department of Health's cut-off point of 1,000 patients, the corresponding figures for small list size are 3 per cent for London and 2.6 per cent for both the comparator areas and England. Even in inner deprived London, the figure is only a little over 3 per cent. Bearing these figures in mind, the absolute number of GPs seems an acceptable base measure for the availability of General Medical Services.

in Figures 3.2 and 3.3 indicate that there have already been dramatic increases. Nationally, the number of practice nurses per GP increased by 67 per cent in a single year. Other types of practice staff increased by 14 per cent. The figures for London are even more striking: 80 and 27 per cent respectively.

The data suggest that the new arrangements have had a profound effect on staff levels, both in London and nationally. FHSAs have placed great emphasis on the importance of practices recruiting new staff, particularly nurses. In this respect they have developed further the impetus of GPs themselves in the year preceding the introduction of the new contract, when GPs retained discretion in the employment of practice staff whose contracts FHSAs subsequently had to honour. In 1989–90 the number of WTE practice nurses per GP nationally

Figure 3.2

WTE practice nurses per 100 GPs, 1984/5–1990/1

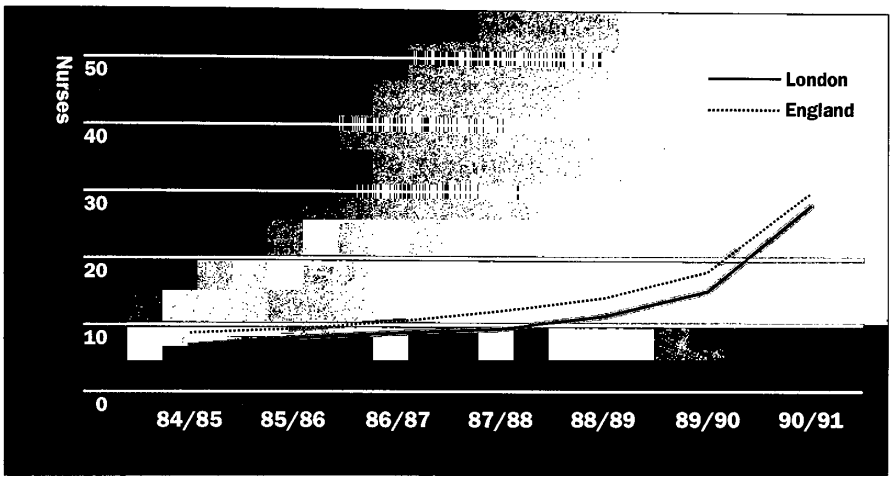
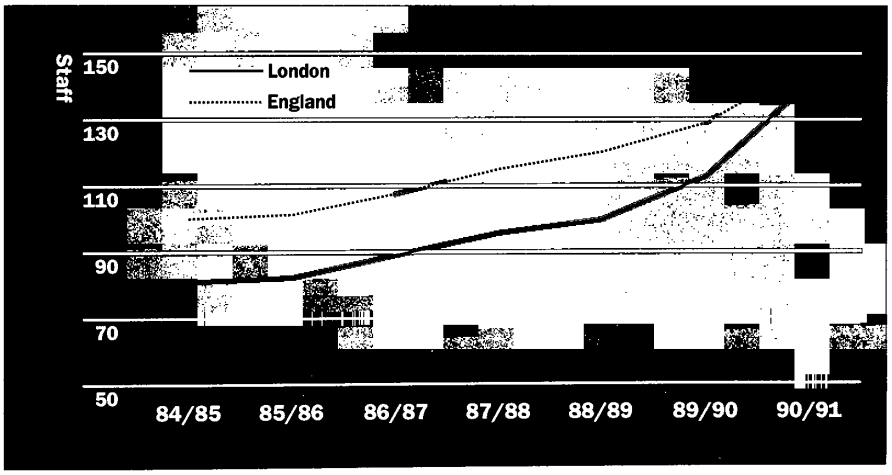


Figure 3.3

WTE practice staff per 100 GPs, 1984/5–1990/1



Note: Practice staff figures exclude practice nurses

increased by 32 per cent from the previous year.

Table 3.2 shows the distribution of practice nurses and other practice staff in 1990–91. It can be seen that London has rather fewer practice staff per GP than comparable areas elsewhere. Overall, however, these non-London areas employ just 5 per cent more staff per GP than London. There is also a general trend across the status categories, from a greater number of staff employed in high-status areas to fewer in the inner deprived areas. By contrast, the number of practice nurses in London is if anything higher than in the comparator areas, although 10 per cent less than the national figure. Surprisingly perhaps, the trend across the status categories noted above for practice staff is reversed: inner deprived London has considerably more practice nurses per GP than the high-status London areas, and as much as 33 per cent more than in the inner deprived comparator areas.

Since the introduction of the new contract with its additional flexibility, London has been catching up with other areas in terms of the employment of practice staff and nurses per GP. In 1989–90 the non-London comparator areas as a whole employed 18 per cent more

practice staff and seven per cent more nurses. By 1990–91 the gap in practice staff had narrowed to just five per cent and in the case of practice nurses, London employed slightly more.

The quality of general medical services

London appears to be comparatively well-provided with GPs and, to a lesser extent, practice staff. However, it does not follow that ease of access for patients to GPs and their services – nor, indeed, the quality of care – is equally uniform across the country. This section examines contemporary data to establish the structure of general practice in the capital. The data do not allow measurement of quality in clinical or outcome terms. It is possible, however, to examine the situation in London relative to the rest of the country using a series of accepted indicators of practice quality. The key data presented in this section relate to:

- list size;
- out-of-hours provision;
- the extent of single-handed practice;
- the age profile of the GP workforce; and,
- the quality of premises.

List size

GPs with large lists are less likely than colleagues with fewer patients to be able to deliver care which is both adequate and timely. For this reason, list size would appear to be a useful indicator of practice quality. In practice, however, average list size data – based essentially upon the registered population – are misleading because of the problem of differential inflation, which was outlined in Box 3.1.

A commonly used indicator of list size is the proportion of GPs with more than 2,500 patients. Although the data show that there is a greater proportion of such GPs in London, considerably higher list inflation in the capital again precludes any definitive conclusion. However, if it is assumed that list inflation is independent of list size, it can be shown that most of the apparent excess is explicable in terms of higher inflation in London. Until the level of inflation is addressed in quantitative terms at the individual GP level, it remains difficult to determine precisely the relative proportion of GPs with large lists. As the previous section showed, however, the number of GPs measured against resident population is certainly not out of step with national patterns. The existing data therefore suggest that actual list size is not a significant problem in the delivery of GMS in London.

Out-of-hours provision

GPs are contracted to provide 24-hour cover to their registered patients. To discharge this responsibility at night, they often work together on a rota system either within the practice or amongst local

Table 3.3

Night visits per 1,000 resident population, 1990–91

Type of area	Higher rate	Lower rate	Total
LONDON			
Inner deprived	8.9	2.5	11.3
Urban	9.4	9.2	18.6
High-status	10.2	7.0	17.2
Weighted total	9.6	5.6	15.2
NON-LONDON			
Inner deprived	18.0	10.4	28.4
Urban	15.8	14.5	30.2
High-status	19.1	4.7	23.9
Weighted total	18.2	8.3	26.5
ENGLAND	18.7	7.3	26.0

Source: based on Department of Health (1992c)

practices. Sometimes, however, they employ deputising services; these are commercial agencies which provide locum GP cover.

Although some use of deputising services is inevitable, particularly for single-handed GPs, it is generally acknowledged that such services are an inferior substitute for the patient's own GP, or a local rota. In recognition of this, considerably higher remuneration is made for night visits where a deputising service is not used.

GPs' 24-hour responsibility has been subject to some dispute, and the profession has recently indicated that it no longer wishes to provide out-of-hours cover. Various alternatives, such as the creation of primary care emergency centres, have been suggested. Nevertheless, while the current system is still in place, it is appropriate to consider the nature of deputising service use, particularly since it is a useful indicator of practice quality.

In order to use deputising services, GPs must seek FHSA consent. The proportion of GPs in London with such consent is high. In fact, a greater proportion of practices have consent in inner London now than was the case in 1978, the year for which the Acheson Report cited figures (LHPC, 1981). The most reliable recent data indicate that, for all London status areas in 1989–90, about 90 per cent of practices had consent (Department of Health, 1991c). Personal communications from inner London FHSAs suggest that this is still an accurate representation of the current picture. By contrast, the overall value for the comparator areas in 1989–90 was just 65 per cent, although consents in inner deprived non-London areas were also very high. Consents in high-status non-London areas were under 40 per cent.

In view of the above, the figures in Table 3.3 are startling. The table shows the number of visits per resident population actually

claimed for by GPs for night visits, at both the higher and lower rates, in 1990–91. Taken together, the figures act as a proxy for total GMS utilisation out of surgery hours, whilst the lower rate figure alone acts essentially as a proxy for the use of deputising services.

Despite very high levels of consent to use deputising services, actual use in London would seem relatively low. Moreover, the same pattern holds for visits undertaken by GPs themselves. Assuming that the need of Londoners for night visits does not differ inordinately from elsewhere, these figures would imply that the capital's residents seek primary care from other sources outside GP surgery hours, if at all. It is commonly suggested that hospital Accident and Emergency (A&E) departments are important providers of primary care in London. In attempting to establish the cause of low out-of-hours utilisation of GMS in London, it is therefore worth considering the role of A&E departments.

Although figures for the number of 'primary care' attendances are not routinely available, the total number of A&E attendances per capita in London – particularly inner deprived London – is very much greater than the national figure. This could, however, relate to utilisation by non-resident populations such as commuters, or to the particular characteristics of the resident population. One such characteristic may be a greater propensity for 'primary care' attendance, although other factors may also lead to a greater need for A&E services.

There is, however, some direct, if local, evidence that Londoners do use A&E departments at night as an alternative to general medical care. For example, in a survey conducted at King's College Hospital, Dale (1992) found that half of the evening and weekend 'primary care' attenders who were registered with a GP had come because of perceived difficulties of access to their GP's services, and that a considerable proportion of primary care attenders more generally expressed dissatisfaction with GP services as a reason for attendance.

Similarly, research by Bedford *et al* (1992) has shown that most infants brought to the A&E department of a London hospital had conditions which would have been better dealt with by community-based primary care professionals. Over a fifth of parents attending had no use of a telephone, and many were registered with practices which used deputising services. Lack of timely access to advice was one of the major reasons given for A&E attendance.

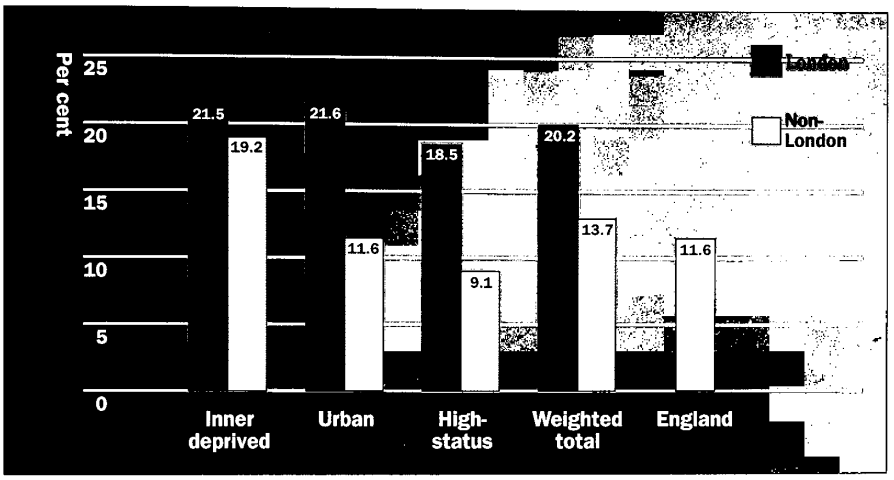
It is not possible to establish whether patient dissatisfaction with GP services and poor access to GMS can entirely explain the lower use of deputising services and the relatively high use of A&E departments in inner deprived London. It is clear, however, that this pattern of service use is markedly different from anywhere else in the country. For example, in non-London inner deprived areas high use of A&E departments is combined with greater utilisation of deputising services.

Single-handed practice

The extent of single-handed practice is the key indicator chosen by the Department of Health to characterise practice type. Figure 3.4 shows the proportion of all GPs in each of the status categories who are in

Figure 3.4

Proportion of single-handed GPs, 1990–91



single-handed practice.

The Figure illustrates that there is a metropolitan dimension to the phenomenon; in each London status area, roughly one in five GPs are single-handed. Inner deprived non-London is typified by a similar figure, but the proportion drops away markedly in the other non-London comparator groups. Overall, there are nearly twice as many single-handed GPs in London as there are nationally.

In recent years, there has been a trend away from general practice in single-handed practices towards larger groups or partnerships of GPs working from single premises. This is generally thought to provide a better model for the delivery of primary health care. Between 1979 and 1989 the number of single-handed GPs nationally fell by 8 per cent, from 3,332 to 3,062, whilst the number of partnerships comprising six or more GPs more than doubled (Department of Health, 1991b). Although the proportion of single-handed GPs in London has fallen even more rapidly over this period (Jarman and Bosanquet, 1992), as Figure 3.4 shows, it remains nearly double the national value.

GP age profile

Historically, London has had a more elderly GP workforce than elsewhere in the country. Concern about the quality of care delivered by elderly GPs in London led the Acheson Report to advocate compulsory retirement for GPs at the age of 70; the recommendation was later implemented nationally with the introduction of the 1990 contract.

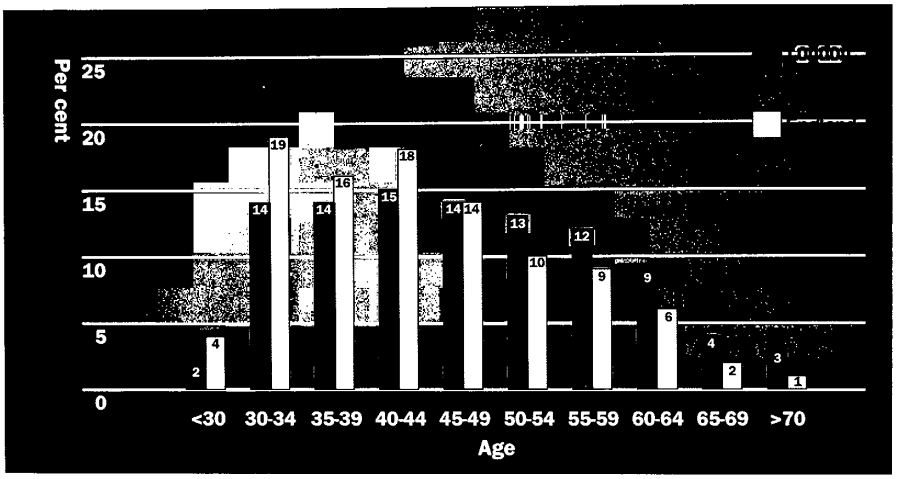
In Figure 3.5 the age structure of GPs in London in 1989 is compared with the national picture (Department of Health, 1991d). In this case, it is not possible to employ the usual comparative framework.

The figure indicates that the age profile of GPs in London still tends to be weighted towards the older end of the distribution. In London, 30 per cent of GPs were aged under 40, compared to 39 per cent nationally. Conversely, 28 per cent of London GPs were aged over 55, compared to 18 per cent in England as a whole.

More recent figures from 1990–91 confirm this general picture for GPs aged over 65. Despite the introduction of compulsory

Figure 3.5

Age structure of GPs in London and England, 1989



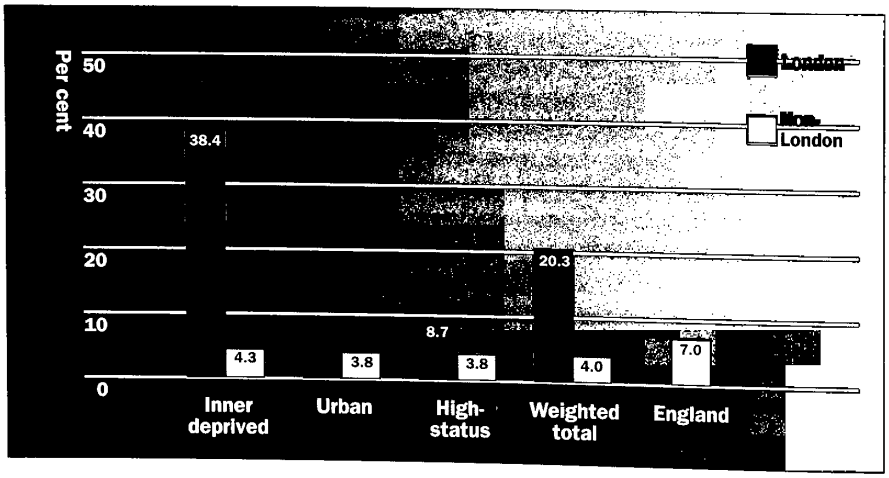
retirement, more than eight per cent of GPs in inner deprived London were over the age of 65 in 1990–91, compared to less than three per cent both in the comparator groups and England as a whole. In fact, over at least the last eight years there has been a trend towards a decreasing proportion of elderly GPs both nationally and in London. However, the proportion in London relative to the national figure has increased.

Premises

Data on the proportion of practices whose premises meet the minimum standards allowed under the rent and rates scheme give some idea of the relative quality of premises in terms of issues such as access for elderly and disabled people, practice facilities, and arrangements for patient and medical record confidentiality (Department of Health and Welsh Office, 1990). Quality of premises can have major implications not only for service development and patient convenience, but also – in the case of some patients – for access itself. The data are displayed in Figure 3.6.

Figure 3.6

Proportion of practices below minimum standards, 1990–91



The figure shows a considerable range of values. The non-London comparator groups have relatively small proportions of practices beneath minimum standards. Urban and high-status London also have quite small proportions. However, in inner deprived London over a third of practices are reckoned to be below standard. Indeed, in three of the four inner London FHSAs, the figure exceeds one half. Clearly, the manifestly poor quality of premises in inner deprived London represents a major issue which needs to be tackled in developing better GMS in the capital.

Summary

The structure of GMS provision in London, particularly inner deprived London, does not compare favourably with elsewhere in the country. Although the distribution of GPs and associated staff in the capital is adequate, factors such as the apparently poor availability of GPs out-of-hours, the proportion of single-handed GPs and the age structure of the GP workforce are not conducive to high quality care for Londoners. More important, perhaps, is the quality of premises, which the Tomlinson Report identified as a key issue. The difficulties of securing adequate premises in London certainly underlie many of the structural problems outlined above, although this is less true outside the inner deprived area.

Service provision and the 1990 Contract

The new GP contract, introduced in April 1990, made considerable changes in the arrangements governing the provision of a number of key GP services. This section examines levels of provision in the main areas affected by the contract, and compares the experience of London with equivalent parts of the country. The analysis concentrates on the following services:

- Cervical cytology and childhood immunisations (both now subject to target payments);
- Health promotion clinics;
- Child health surveillance; and,
- Minor surgery.

These four items represent some 40 per cent of national expenditure on services for which separate payments are made. The main services not covered here are maternity and contraceptive services, night visits – which were examined earlier – and adult immunisations.

Although the services examined in this section constitute slightly under 10 per cent of total GMS expenditure, they nevertheless provide an important pointer to the overall quality of general practice. Adequate provision of such services is not only a major policy objective made explicit by the 1990 contract, but also an indicator of the ability of general practice to assume direct responsibility for the delivery of care and preventive services as a key part of the primary health care

team. In fact, as this section shows, the response in London has been poorer than elsewhere in the country.

Cervical cytology and childhood immunisation

The 1990 contract replaced item of service payments for cervical cytology and childhood immunisation with a system of targets for the proportion of the GP's patients which must be covered. Thus, GPs receive a payment for cervical cytology services only if at least 50 per cent of registered women in the appropriate age range have had an adequate cervical smear test within the last five and a half years. Similarly, to receive payment for immunisation and pre-school boosters, 70 per cent of registered children in the appropriate age range must be covered. Higher levels of payment are made if 80 per cent coverage is achieved in the case of cervical cytology, and 90 per cent in the case of childhood immunisation.

Table 3.4 displays the proportion of GPs reaching either the higher or the lower target payment for both cervical cytology and childhood immunisation, as well as providing a population coverage figure in the case of cervical cytology. For both cytology and immunisation, the pattern is remarkably similar, the most striking feature being the extremely low figures for inner deprived London. In fact, there is a generally high level of performance on targets nationally. For most areas, the figure varies between 70 and 95 per cent, although in general the cytology targets appear slightly easier to reach than those for immunisation. For inner deprived London, however, in both cases

Table 3.4

Cervical cytology and childhood immunisation, 1990–91

Type of area	GPs reaching high or low cytology target %	GPs reaching high or low immunisation target %	Women (20-64) with adequate smear in last 5.5 years %
LONDON			
Inner deprived	44.8	44.7	47.9
Urban	67.0	69.7	57.1
High-status	73.1	76.1	59.3
Weighted total	62.9	62.2	54.4
NON-LONDON			
Inner deprived	82.2	70.7	72.7
Urban	94.6	86.6	75.7
High-status	95.6	93.0	72.1
Weighted total	89.9	82.8	72.9
ENGLAND	91.6	87.2	70.5

considerably less than half of the GPs have reached even the lower payment. A similar pattern obtains for pre-school booster target payments, although the figures are slightly lower, and in inner deprived London they are as low as 28 per cent. In all cases, there is a noticeable trend across the status categories.

When the figures are broken down further, it can be seen not only that the proportion of GPs reaching the targets in London – particularly inner deprived London – are lower, but also that a smaller proportion reach the higher level target. For example, in England as a whole four times as many GPs reach the higher immunisation target than the lower one. In inner deprived London, less than double the number of GPs reach the higher rather than the lower target. Broadly similar patterns are found in the case of cervical cytology.

Such figures suggest a poorer level of population coverage in London. The third column of Table 3.4 provides a direct measure of this for cervical cytology, indicating that both nationally and in the comparator groups nearly three-quarters of women have had an adequate smear; in London the figure nowhere exceeds 60 per cent, and in inner deprived London it is less than half. Clearly, women resident in London are not being screened as effectively as elsewhere.

This may well be due in part to population mobility in the capital; the call and recall system through which women are invited to have a cervical smear operates over a time period in excess of five years, by which time many will have changed address. Moreover, since the system is dependent upon GP registration, women who do not have a GP will be missed. Whatever the reason, assuming some degree of effectiveness in the screening programme, there are clearly grounds for concern that potentially avoidable mortality and morbidity is not being effectively averted in London.

No similar national figures can easily be presented for childhood immunisation. Records are generally kept by the community health units of DHAs, who contact parents for their children's immunisations. National figures on child population coverage are not available in a format comparable to GP activity. Although immunisations carried out in DHA clinics count towards GPs' targets, though not their remuneration, it may be that a greater proportion of London GPs rely on these clinics to provide immunisations, and do not themselves submit claims for payment to their FHSA. They would then be recorded as failing to meet the target, even if their patients have in fact been immunised. The extent of this is, however, impossible to determine.

Clearly, then, data concerning GP performance on targets may not be good indicators of relative population coverage, but rather of the financial implications of the target system to FHSAs. Yet, if this is the case, the data presented above show the failure of the target system in encouraging many London GPs to take active responsibility for their patients in these areas. The reasons for this are undoubtedly complex, and involve both demographic factors (see, for example, Jarman *et al,* 1988), and factors which relate to the nature of general practice in London. It would appear nonetheless that the changes introduced in

the new contract have done little to improve or rationalise the provision of cervical cytology or childhood immunisation services under GMS in the capital.

Health promotion clinics

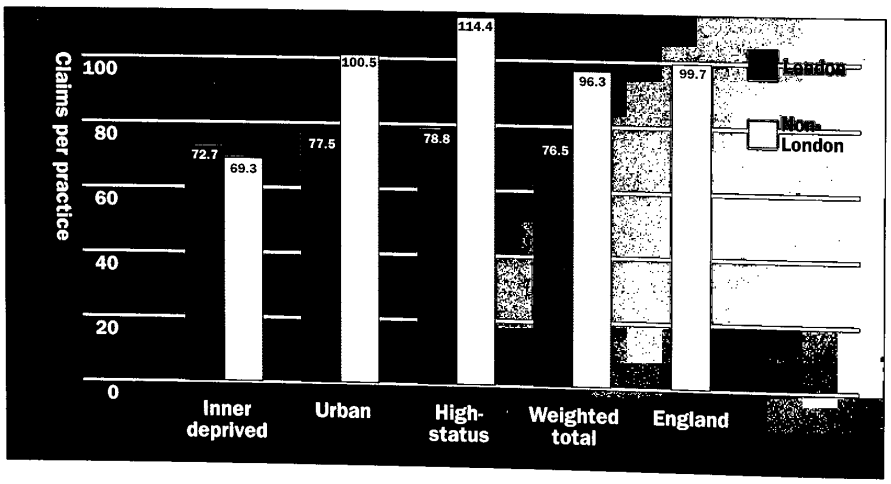
A new payment for health promotion activities was introduced by the 1990 contract. The idea was to separate some part of the GP's health promotion activities from the more opportunistic approach taken in normal surgery hours. To qualify for payment, GPs had to initiate separate clinics, in agreement with their FHSA, for areas such as diabetes, asthma, smoking or alcohol control and heart disease prevention, and ensure that a certain minimum number of patients attended.

This aspect of the new contract has proved to be short lived. In May 1992 the Department of Health announced that health promotion clinics would be replaced by a more flexible system arranged around locally agreed and validated health promotion targets. Certainly, the existing system was unpopular with health professionals. It was felt that a centrally defined national system was too unwieldy to yield adequate results at a local level. Moreover, the system was open to abuse since it was difficult to monitor and there was no upper limit on claims. In addition, some commentators have argued that separate clinics are counter-productive since they discourage GPs from offering opportunistic advice in normal surgery sessions, where it is more likely that patients most in need of health promotion advice will be encountered (Scott and Maynard, 1991).

A new system has recently been negotiated which addresses some of these criticisms. It is nevertheless worth looking at the extent to which practices have provided health promotion clinics, since it is unlikely that the level of provision under the new arrangements will be very different. Nationally, some 83 per cent of practices held such clinics in 1990–91. In London, however, the figure was just 63 per cent, whilst the non-London comparator groups had a figure slightly in excess of the national average. Only about half of the practices in inner deprived London held clinics.

Figure 3.7

Number of annual claims for health promotion clinics per practice holding clinics, 1990–91



In Figure 3.7, the number of claims in 1990–91 for health promotion clinics per practice offering such clinics is displayed in the familiar manner. It is immediately noticeable that, even amongst those practices in London offering clinics, claims were generally lower than in the non-London comparator group. Overall, at nearly two clinics per week, non-London practices claimed for about a quarter as many clinics again as London practices. There does not appear to be any logical reason why London practices which did offer clinics should run fewer than elsewhere. Arguably, it is in the deprived metropolitan areas that the need for health promotion activities is greatest.

In fact, the data presented here indicate that the high-status areas outside London have provided the most clinics, despite the fact that, following the same logic, there is less need for them in these areas. Moreover, it should be remembered that the figures in Figure 3.7 refer only to practices which held health promotion clinics. If all practices are considered, there have been more than twice as many health promotion clinics held per practice nationally than in inner deprived London.

These figures, of course, tell us nothing of the type of activities undertaken and the number of patients attending. The claim differentials highlighted in the table may be indicative of variation in policy between FHSAs which is likely to persist under the new arrangements. On the basis of the figures presented above, it is doubtful that practices in London will prove to be as capable as elsewhere in the country at providing specific health promotion sessions.

Child health surveillance

Another innovation of the 1990 contract in the area of health promotion was the introduction of a separate payment for child health surveillance to those GPs who applied for eligibility on the basis of their own competence and their practice arrangements.

Considerably fewer GPs in London are included on child health surveillance lists than is the case nationally – some 36 per cent in the capital, against 52 per cent nationally. However, this discrepancy is

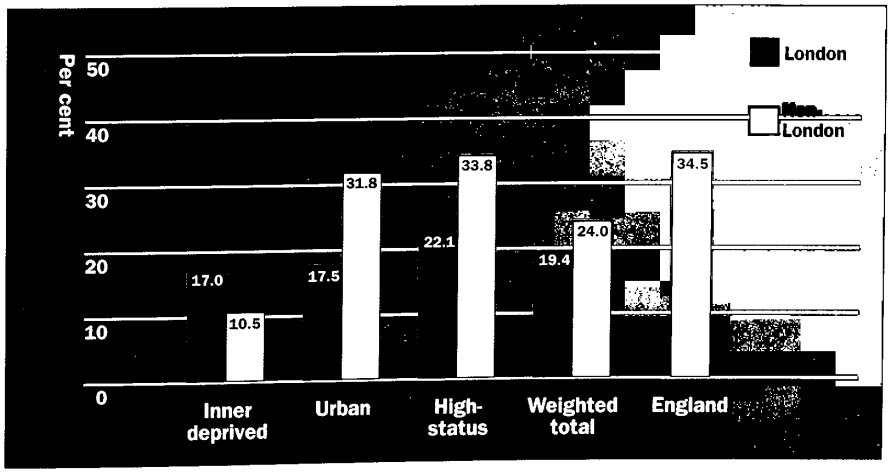


Figure 3.8

Children aged 0–5 receiving child health surveillance from GP as a proportion of total 0–5 resident population, 1990–91

rather smaller than that for several other services. Despite some variation between the comparator areas, the overall London value of 36 per cent is quite similar to the total figure for the comparator groups.

Figure 3.8 shows the number of children receiving child health surveillance by GPs as a proportion of the total child population: the figures are calculated from GP claims for remuneration (Department of Health, 1992c). It can be seen that there is a universally low level of coverage. Nationally, GPs have claimed for just 35 per cent of children and in London the figure is less than 20 per cent. Unfortunately, it is not possible to assess the overall level of coverage since DHA figures are not available. Nevertheless, in terms of GMS provision, coverage in London is markedly inferior to the national picture and, with the exception of the inner deprived areas, to the comparator groups as well. The pattern is similar to that for the extent of inclusion in the list, but the disparity is in fact rather greater, suggesting that relatively fewer London GPs who are on the child health surveillance list have actually provided the service.

In one sense the low proportion of GPs offering child health surveillance in London may not matter greatly since DHAs have retained their responsibility to provide such services. However, it was clearly the intention of the 1987 White Paper *Promoting Better Health* to involve GPs more closely in this area. Although subsequently the Hall Report (1992) concentrated on recommending an appropriate content for child health surveillance programmes, rather than the appropriate personnel, its suggestion that routine monitoring be replaced by a more flexible, sustained and interactive form of surveillance clearly indicates an important role for the family doctor. On the evidence presented above, this has substantially failed to materialise, particularly in London.

Minor surgery

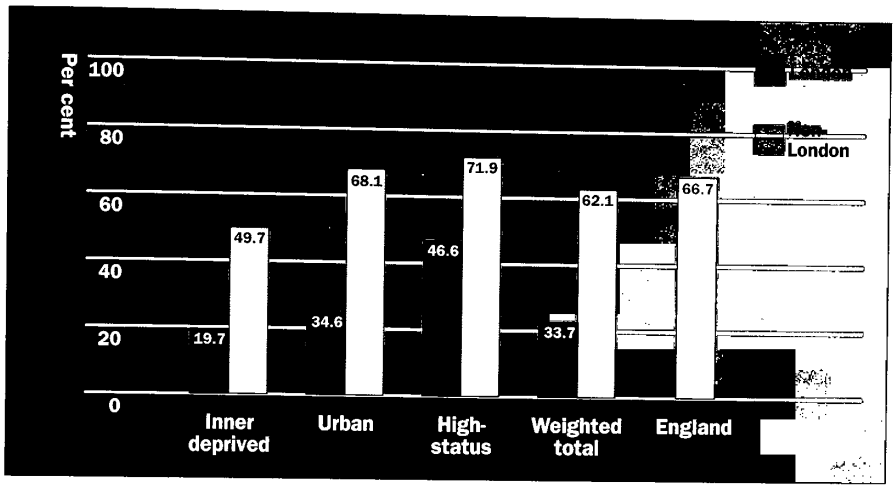
Following the suggestion in *Promoting Better Health* that minor surgical procedures undertaken by GPs could reduce waiting times and improve patient convenience, the 1990 contract introduced a payment for minor surgery. As with child health surveillance, GPs are required to apply for eligibility on the basis of their skills and experience and the adequacy of their premises. They are then able to receive payment for a limited range of approved procedures such as articular injection and the excision of skin lesions.

Figure 3.9 shows the proportion of GPs on the minor surgery list in each status category. The figures for London are exceptionally low, at approximately half that of both the national figure and the total figure for the comparator areas. There is also a strong trend across the status categories. Although these data alone do not indicate practice level minor surgery provision or, indeed, levels of activity, more detailed work confirms them as an adequate proxy for activity (Boyle and Smaje, 1992b).

While it is difficult to adduce any firm evidence to account for the low level of provision in London, the poor standard of premises is a likely candidate. Perhaps more than in any other area of service

Figure 3.9

Proportion of GPs on minor surgery list, 1990–91



provision, the need for a separate and well-equipped treatment room prevents many GPs from undertaking minor surgery. In view of the staffing implications of a minor surgery service, the greater proportion of single-handed GPs in London is also a factor (Smaje *et al.* 1991).

Summary

Overall expenditure on services per resident population is considerably lower in London than elsewhere, despite the fact that GMS expenditure is a little higher. On the basis of the evidence in this section, it appears that lower expenditure is mirrored by poorer service provision in the case of the services which the 1990 contract attempted to foster.

Expenditure per GP on all services for which separate payments are made was 24 per cent lower in London in 1990–91 than in the comparator areas. A further breakdown reveals that expenditure on the services examined in this section was 37 per cent lower, whilst expenditure on remaining services such as maternity and contraception was 15 per cent lower. This indicates either that the arrangements introduced by the new contract have been received more conservatively by London GPs, or that, despite their efforts, greater difficulties have been encountered in delivering these services to Londoners. In either case, the result is poorer coverage of the population in London.

Conclusion

The overall quality and nature of GMS provision in London relative to the rest of the country is substantially similar to that described by the Acheson Report in 1981. Despite the fact that many of the Report's recommendations have now been implemented, improvements in London have merely matched national developments, without reducing the disparity between the capital and elsewhere (Jarman and Bosanquet, 1992).

Clearly, general practice in the capital is typified by great diversity, with very high and very poor quality practices existing almost side by side (Hughes and Gordon, 1992). In addition, it is possible that demand side

factors such as population mobility may render the delivery of GMS particularly problematic in London. Nevertheless, in several important respects London is not as well served by GMS as is the case both nationally and in the comparator areas. Although this applies principally to inner deprived London, in many cases the relatively poor development of GMS is a feature of the whole city.

GMS expenditure per capita in London in 1990–91 was marginally higher than elsewhere, but the level of provision of specific services was generally very much lower. The GP contract sets remuneration levels nationally with no special provision for areas where living costs are high. However, as we have seen, the relative composition of GP remuneration in London does to some extent act as a compensatory factor. Nevertheless, it is unlikely that national levels of provision will be attained without changes in the system of GP remuneration which not only compensate the GP for working in London, but also give clearer incentives to achieve adequate levels of service provision. As well as problems with the delivery of specific services, more general indicators of practice quality point to the need to develop the infrastructure of general practice in London if it is to reach the standards found elsewhere in the country.

An obvious conclusion is that more resources should be devoted to GMS in London, and more flexibility allowed for in developing services. Such thinking informs both the Tomlinson Report and *Making London Better*. However, even with the provision of extra resources, it is important to ensure that they are used to target the causes of underdevelopment directly. Some thought therefore needs to be devoted to the best means of establishing a younger GP workforce, organised into larger groups and practising from generally improved premises. Such a workforce would be in a better position to develop the kind of services and community-based care which is increasingly demanded of a modern health care system.

CHAPTER 4

The provision of social care for the elderly

Introduction

The purpose of this chapter is to examine the provision of services for elderly people provided by the Social Services Departments (SSDs) of Local Authorities. It is useful in looking at the provision of long-term care for elderly people to draw two distinctions: one is between residential and non-residential forms of care; the other is between public and independent provision and financing of care. The private and voluntary sectors are jointly known as the independent sector.

Long-term care should be designed so that, with the minimum of intervention, the individual can lead a normal healthy life. An appropriate balance between residential and non-residential forms must be achieved. This chapter is concerned mainly with care which is not hospital-based, notwithstanding that in some areas NHS beds are the only substitute for a lack of nursing home places. Often, long-term inpatient stays in acute hospitals by elderly patients are an example of the most interventionist form of residential or nursing care for elderly people.

The second important distinction is between public and independent provision: first in terms of who provides the service – the public, private or voluntary sector; and second who funds the service – the public through the Department of Environment (DoE), council tax payers and the Department of Social Security (DSS), or the private individual, either directly or through an insurance scheme. Social Services Departments (SSDs) are funded by the DoE and local government taxation; the DSS provides income support to individuals with insufficient funds to pay for the provision which they require.

In Box 4.1 the distinction between residential and nursing care is explained and a more detailed breakdown of the division between public and independent provision and financing is provided, though the data only allows this at a national level.

The next section considers the level and composition of expenditure by local authorities on services for elderly people. This is followed by analyses, first of the level of residential provision, and then of non-residential services in London. The important role played by the independent sector in the provision of residential services has already been noted and some discussion of independent provision is also included. Finally, some distinguishing features of social care provision in London are highlighted.

Box 4.1

THE PATTERN OF LONG-TERM CARE FOR ELDERLY PEOPLE

It is useful to distinguish between two types of care, nursing care, and general assistance with personal care and conditions, which is usually regarded as the function of residential and non-residential care. Nursing care is generally offered either in NHS long-stay wards or in independent registered nursing homes, residential care in public (LA Part III) or independent residential homes, both registered and non-registered. DHAs are responsible for the registration of nursing homes, both voluntary and private, whereas residential homes must be registered with the SSDs of local authorities, if they offer accommodation to more than four people. In a minority of cases, homes are dually registered as both nursing and residential.

Both nursing and residential care are provided by the independent sector, with the source of funding being either public, private, or a mixture of both. Public provision of nursing care generally occurs in NHS long-stay beds, both for elderly people and the elderly mentally ill (EMI), and is paid for almost always publicly. The overall provision of nursing and residential care in 1991 was provided at a cost of £6.5 billion (Laing and Buisson, 1992).

Table 4.1 The distribution of residential and nursing care between the public and independent sectors in the UK, March 1991

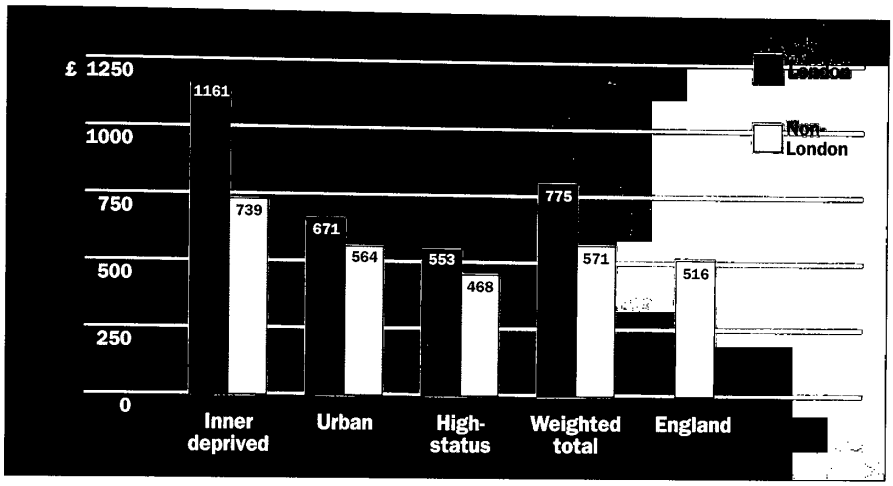
Type of provision	Number of places	Cost (£ million)	Source of finance (£ million)	
			Public	Independent
Public				
NHS long-stay elderly	45,000	879		
NHS EMI	31,000	606		
LA Part III	120,000	1181		
Total public	196,000	2666	2270	396
Private				
nursing	135,200	1861		
residential	161,200	1448		
Total private	296,400	3309		
Voluntary				
nursing	12,100	168		
residential	41,900	343		
Total voluntary	54,000	511		
Private and voluntary	350,400	3820	1691	2129
All sectors	546,400	6486	3961	2525

Using Laing and Buisson's *Review of Private Healthcare* (1992), we constructed Table 4.1 which reveals both the breakdown of this supply between the public, private and voluntary sectors, and the source of finance. The independent sector provided 64 per cent of care overall. Some 60 per cent of this care was residential in nature, and of this residential care some 63 per cent was provided by the independent sector. 66 per cent of nursing care was provided by the independent sector. However, the text reveals a very different position in London from that in the rest of the country with considerably less private provision.

Examining the source of finance of this care, overall the position was reversed with 61 per cent of funding coming from the public sector. 44 per cent of care provided in the independent sector was funded publicly and 85 per cent of public care. Thus, of the £3820 million spent in the independent sector, £1691 million was paid personally, £1552 million was DSS income support, £71 million was local authority support of people in independent homes and £68 million was NHS contracts. The cost of public supply was estimated to be £2666 million, of which £1485 million was the cost of hospital stays, £785 million was local authority net revenue expenditure, and £396 million was local authority charges to residents (Laing and Buisson, 1992).

Figure 4.1

SSD gross current expenditure on elderly and physically handicapped people per capita elderly resident population aged 75+, 1989–90



The composition of expenditure

Figure 4.1 presents gross current expenditure on elderly people per capita resident population aged 75 years and over. This 'old elderly' population is generally regarded as the client group for elderly services even though some of these are provided to the physically handicapped and people under 75. The data does not allow expenditure on physically handicapped and elderly people to be separated out.

Figure 4.1 shows that London as a whole spends some 50 per cent above the national average and 36 per cent more than comparable areas elsewhere. This pattern is maintained across the status groups. Similar differences emerge when expenditure is related to the total resident population.

Table 4.2, based on gross current expenditure by local authorities on services to the elderly and physically handicapped, compares the proportion spent on different forms of care in London with similar areas in the rest of the country. In inner deprived London, 44 per cent is spent on residential services, compared with 51 per cent in comparable non-London areas, and 53 per cent nationally. On the other hand, London spends a comparatively larger proportion on all forms of non-residential care except home helps. Yet, as is shown later, London still spends more per head of population on each form of care than is the case nationally.

Local authorities have a statutory duty, under the National Assistance Act, 1948 to:

> *... provide residential accommodation for people who by reason of age or infirmity are in need of care and attention not otherwise available.*

Nationally, over the period 1980 to 1987, there was a 38 per cent increase in the total number of places available in all types of residential home, from 185,000 to 255,000. However, the number of local authority supported places declined from 130,000 to 110,000, whereas there was a substantial increase in the quantity of care funded from other sources, from 55,000 places in 1980 to 145,000 in 1987. The

Table 4.2

A breakdown of gross current expenditure on services to elderly and physically handicapped people, 1989–90

Type of area	Residential care %	Day care %	Home helps %	Meals %	Other %
LONDON					
Inner deprived	43.8	8.7	29.9	8.2	9.4
Urban	49.7	9.2	28.3	6.4	6.4
High-status	49.6	10.1	28.0	6.5	5.8
Weighted total	46.8	9.3	29.0	7.3	7.6
NON-LONDON					
Inner deprived	50.8	7.6	31.2	3.9	6.5
Urban	52.2	6.9	32.1	3.1	5.7
High-status	53.3	6.9	30.6	4.0	5.2
Weighted total	52.0	7.2	31.0	3.8	6.0
ENGLAND	52.5	7.0	31.0	4.0	5.5

decline in the number of local authority supported places has continued: in 1991 just 90,000 remained.

Nevertheless, expenditure on residential accommodation is still by far the biggest single element in spending on elderly services. This includes services for which SSDs cover part or all of the costs, whether in local authority, voluntary or privately managed homes. In 1991 over 92 per cent of residents supported by local authorities nationally were in local authority homes. The figure is probably higher in London, where there are fewer independent homes. In 1990, just under seven per cent of such residents were under 65 and 18 per cent were under 75. The great majority are 'old elderly' people, who constitute a smaller proportion of the population in London than elsewhere in the country.

The impact of the age structure of the elderly population on demand for services is discussed in more detail in Box 4.2. The total number of elderly people is not the only factor determining the need for such resources. There is some evidence of flows of elderly Londoners away from the capital at the time when they make demands on continuing care services. It remains difficult to evaluate whether flows occur because there is less residential care available in London or vice versa.

Residential services

Table 4.3 shows the level of residential provision in London in terms of the total number of available places in residential homes for elderly people, per capita resident population over 75, broken down by local authority, private and voluntary places.

Box 4.2

THE DEMAND FOR ELDERLY CARE IN LONDON

Examining the demography of the elderly population in London may point to characteristics which would cause a different level of demand on services for the care of elderly people than is the case elsewhere in England. An elderly person is usually defined as someone aged 65 years or over, although it is generally accepted that it is the 75+ age group which makes the biggest call on social services.

In 1991 some 7.8 per cent of London's population were between 65 and 75, 5.2 per cent between 75 and 85, and 1.4 per cent over 85, compared with national figures of 9.0, 5.6 and 1.5 per cent respectively. The population in London then is certainly less elderly than that of England as a whole. Since 1981 the proportion of the population aged over 75 in London has fallen relative to the same proportion for England as a whole. This trend will continue over the next ten years so that by 2001 it is estimated that the population structure in London will be younger still, relative to England.

Taking the standardised mortality ratio (SMR) as a proxy for health status, elderly Londoners appear healthier. Thus, for the 65+ age group in London the SMR is 93: the mortality ratio of elderly Londoners is seven per cent less than the national average. In inner deprived London the SMR is 95: elderly inner-city Londoners still seem to be healthier than average, and are certainly healthier than their non-London inner deprived counterparts whose SMR, at 109, is 15 per cent higher than that in inner-city London. So, on the basis of both number of elderly and their relative health status, the evidence suggests that the inherent demand for elderly services in London would be less than that elsewhere in the country.

Another factor which may be instrumental in reducing the demand for care in London below that suggested simply by reference to the total elderly population figure, is the substantial migration of elderly Londoners at a time when their demand for services is likely to be highest. There is no direct evidence to support the proposition that the demand for continuing care among such elderly migrants is high relative to those who remain. However, there is indirect evidence. Recent figures released by the Department of Health show that, of people claiming income support for residential and nursing home care, only 6.7 per cent live in London although London has some 13 per cent of the elderly population of England (AMA, 1992a).

It is claimed that the 85+ age group is a better proxy for cross-boundary flow into residential care than any of the other age-groups. If this is the case, then figures for the period 1989 to 1991 show that most areas of London are substantial net exporters of this age-group (AMA, 1992a). The shortage of provision highlighted in both the text and Box 4.3 may result in the demand for care by elderly Londoners manifesting itself in these flows out of the city.

London overall is considerably under-resourced, relative to comparable areas elsewhere, in terms of the total number of residential places available to its local elderly population. In England as a whole there are 84 places per 1,000 elderly population. This compares with 56 places in inner deprived London and 57 in London as a whole – some 32 per cent less than the national average. Comparing like with like, similar non-London areas have 77 places, some 35 per cent more than the London average.

The dominant factor is the shortage of private residential care homes in the capital. In inner deprived London, there are only seven places in private residential homes per 1,000 resident elderly population compared with 44 in England as a whole, over six times as many. This effect is reinforced by the number of places in local authority homes in London which is some 12 per cent less than that in comparable areas elsewhere in the country. Only in the case of voluntary homes are there more places in London than elsewhere.

The cost of local authority provision in the capital is markedly

Table 4.3

A breakdown of places in residential homes for elderly people per 1,000 population aged 75+, 1989–90

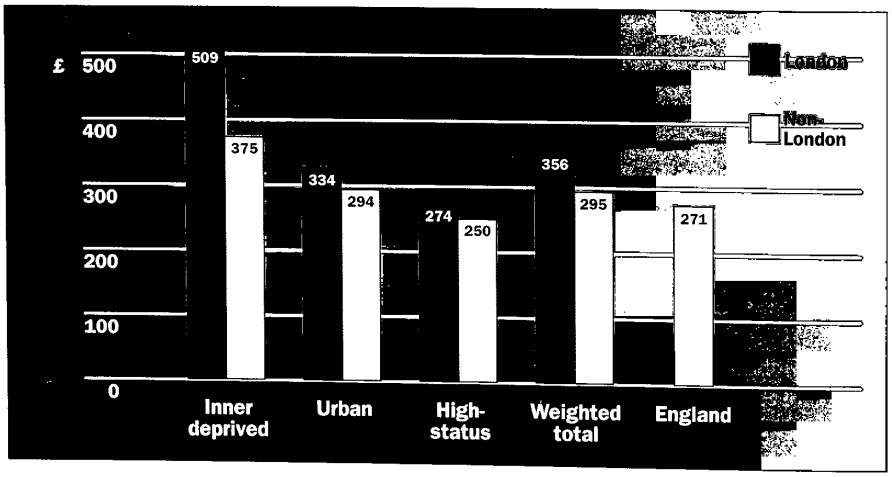
Type of area	Local authority	Private	Voluntary	Total
LONDON				
Inner deprived	34	7	15	56
Urban	31	13	8	52
High-status	24	20	14	58
Weighted total	30	13	14	57
NON-LONDON				
Inner deprived	39	25	12	77
Urban	36	45	6	86
High-status	29	35	12	75
Weighted total	34	32	11	77
ENGLAND	31	44	9	84

higher than elsewhere, with the result that less places can be provided for a given level of expenditure. Figure 4.2, which expresses expenditure in terms of the number of people aged over 75 in the population, shows that over 31 per cent more is spent per capita on elderly residential accommodation in London compared with the national average: in inner deprived London the difference is even more striking at 88 per cent above the national figure. London overall spends some 21 per cent more on residential care for elderly people, per capita resident over the age of 75 years, than similar areas elsewhere in the country.

There is a sharp contrast between the lower level of local authority provision in London and the extra expenditure per capita. For

Figure 4.2

SSD expenditure on residential care for elderly people per capita resident population aged 75+, 1989–90



example, in inner deprived London just 10 per cent more local authority places are provided at a cost per capita which is almost twice that of England as a whole.

Differentials in the level of expenditure can be partially explained by examining the relative cost of providing a place. Most local authority expenditure on elderly residential accommodation goes towards meeting the cost of providing accommodation in local authority homes within their own area. However, there may be some partial or complete support for residents in private and voluntary homes, both within and outside the area. Two measures of cost are considered so as to take account of differences which may arise from this source. In the event, London is relatively expensive whichever measure is chosen.

Figure 4.3 expresses expenditure in terms of the number of available places in local authority homes. A small proportion of this expenditure relates to places in independent homes, but this is more commonly the case outside of London. So, if anything the figures over-estimate the average cost outside London. Yet London as a whole still spends 45 per cent more per place provided than that spent nationally; inner deprived London spends 68 per cent more. When expenditure is related to comparable areas elsewhere, London overall spends nearly 40 per cent more, and inner deprived London nearly 50 per cent.

Figure 4.3 relates to available places, but occupancy rates may vary from area to area. In fact the overall London and England occupancy rates are almost identical at 88 per cent. An alternative formulation considers expenditure on residential care for elderly people per supported resident in the local authority's own homes.

Data are only available in terms of the traditional inner/outer London split. These show that annual expenditure, at approximately £13,150 per supported resident in inner London, is 47 per cent more than the England average of £8,950; outer London, at £11,000, is some 23 per cent higher. Figures available on the price of care in private residential homes in 1990 suggest an average price in London overall some 28 per cent higher for shared rooms and 34 per cent for single, than is the case in England as a whole – £11,800 and £13,260

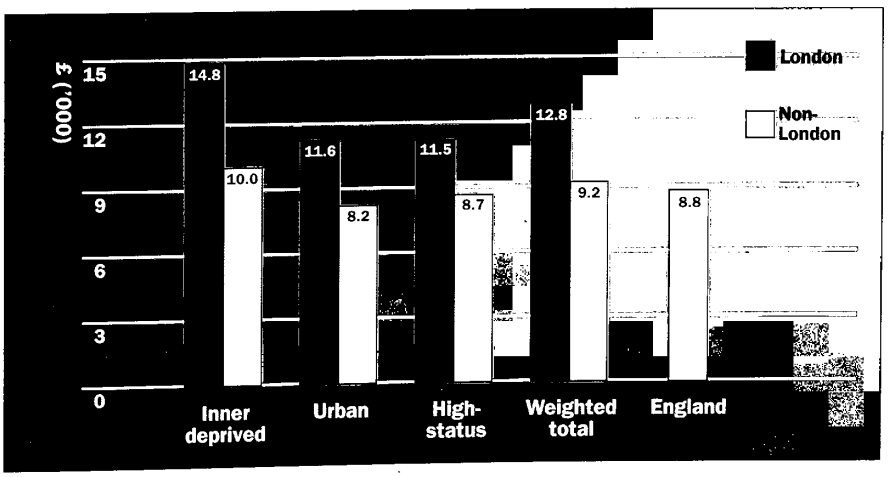
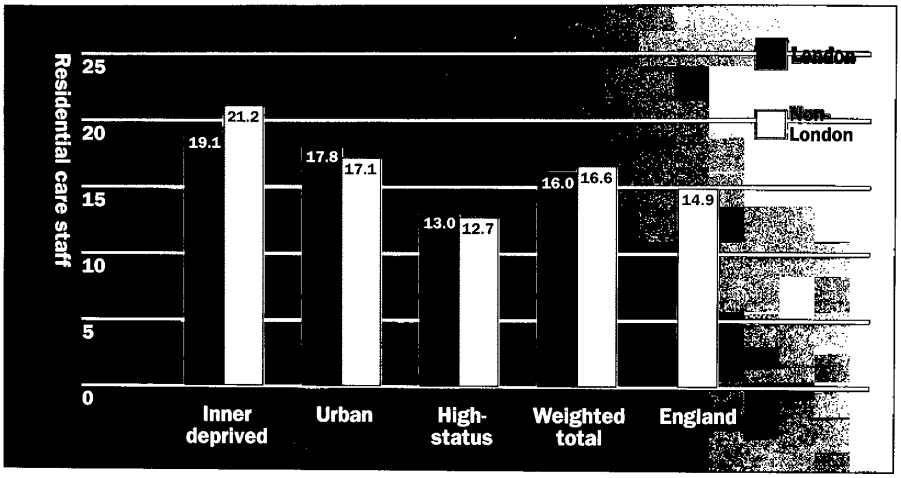


Figure 4.3

SSD expenditure on residential care per place available in LA residential homes, 1989–90

Figure 4.4

Number of WTE staff of residential care establishments for adults per 10,000 resident population, 1989–90



compared to £9,260 and £9,930 respectively (Laing and Buisson, 1990). Although there is no simple comparison between the costs of public and private provision presented here because of the shared/single room distinction, local authority provision in inner London is almost as expensive as a single private room. Also, the differential between costs in London and England is of a similar level in both the private and public sectors.

To summarise, London spends more on residential accommodation than is the case elsewhere in the country at a greater cost, both per capita client group resident population, and per available place. Local authority residential care is as expensive as that provided privately.

Some of the difference in costs between London and elsewhere is due to higher costs per unit of input. The most substantial of these is the cost of staff. The financial comparison is made worse by the fact that London also employs more residential staff per capita resident population.

Figure 4.4 shows that inner deprived London employs 28 per cent more WTE staff in residential care establishments for elderly people, per capita population, than the England average. However, it is worth noting that there is little difference between staff levels in London and those in comparable areas elsewhere in the country: in fact, non-London inner deprived areas employ over 10 per cent more residential staff per head of population than their London equivalents. There remains the familiar gradient from inner deprived to high-status areas.

Although higher staffing levels offer a partial explanation of excess costs in London, there is also an element of extra cost per unit of staff used. In terms of the availability of residential places, the capital is a more expensive locus of care, this being particularly true of inner deprived London.

Non-residential services

The last ten years have witnessed a considerable growth in the provision of non-residential services. These include home helps, day

care, the provision of meals and other services including personal aids to daily living, adaptions to property, and SSD contributions to sheltered housing. In this section three categories of non-residential services for elderly people are examined. These are:

- home help services;
- meals-on-wheels; and,
- day care centres.

After residential care, the home help service is the next biggest expenditure item in local authority services for elderly people, claiming approximately 30 per cent of overall expenditure in London. The number of home help hours received by all client groups is usually related to the resident population aged 75 and over, as users of the service are predominantly in this age group. Figure 4.5 shows gross current expenditure on home helps for all client groups, per capita resident population aged 75 and over.

Inner deprived London spends over twice the national average, £347 compared to £160; the overall London figure is 38 per cent above the England average. Even when London is compared with similar areas, the overall figure is still 26 per cent higher. Table 4.4 examines in detail how the level of provision in London varies across the status groups.

The second column of Table 4.4 reveals that some 52 per cent more hours per resident aged 75+ are provided in inner deprived London than is the case nationally. However, relatively less is provided in urban and high-status areas, with the result that London as a whole is just 3 per cent above the national average. Comparing like with like, London overall delivers the same level of care, in quantitative terms, as similar areas elsewhere. The issues of differences in the type and quality of care provided and of the relative dependency of the client population, though clearly important, are not ones which can be addressed from the data available.

The average cost per received home help hour is considerably

Figure 4.5

Gross current expenditure on home helps for all client groups per capita resident population aged 75+, 1989–90

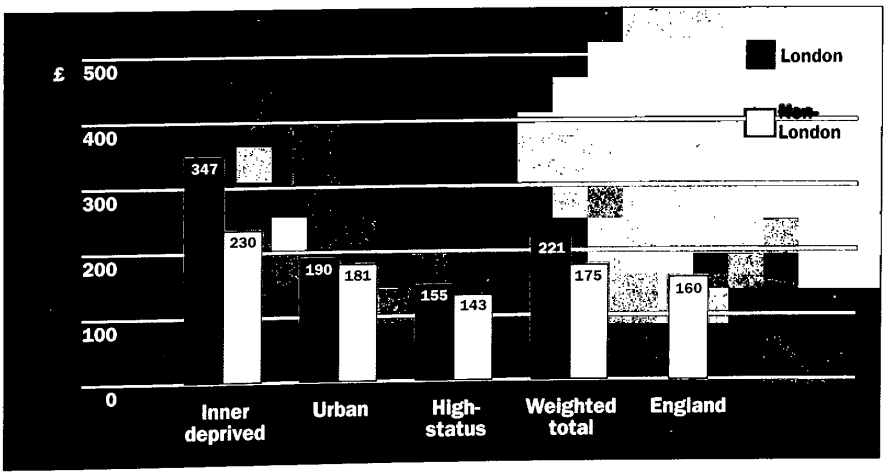


Table 4.4

A profile of home help services, 1989–90

Type of area	Average cost per received home help hour	Annual home help hours received per capita aged 75+	Number of WTE home helps per 1,000 population aged 75+	Daily number of delivered home help hours per home help
	£			
LONDON				
Inner deprived	7.9	44	30.6	3.9
Urban	8.5	22	21.9	2.8
High-status	6.5	24	15.1	4.4
Weighted total	7.2	30	21.7	3.8
NON-LONDON				
Inner deprived	5.9	39	24.1	4.4
Urban	4.9	37	22.3	4.5
High-status	6.2	23	15.2	4.1
Weighted total	5.8	30	19.7	4.2
ENGLAND	5.6	29	18.0	4.4

more in London than elsewhere – some 41 per cent more in inner deprived London compared to the national average, and 36 per cent more than that in comparable areas elsewhere in the country. This is explained to some extent by the relatively greater input costs which prevail in London, and also, as the last column of Table 4.4 shows, a lower rate of delivery of home help hours per home help. The inner deprived London figure is over 11 per cent less than both the national average and comparable areas elsewhere.

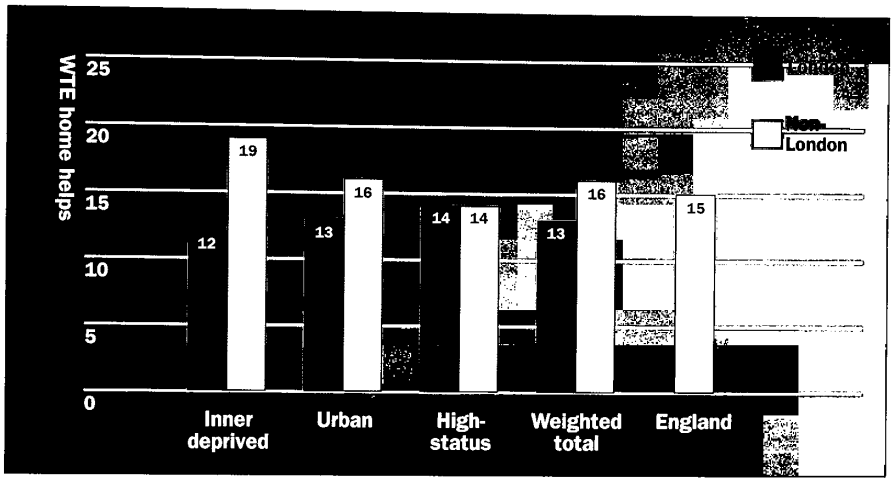
Relating the number of home helps to the resident population aged 75 and over, inner deprived London employs 70 per cent more than the national average and 27 per cent more than non-London inner deprived areas. Interestingly, although London as a whole employs some 20 per cent more home helps than the national average, the annual rate of delivery achieved per resident is approximately the same. This is due to the lower average rate of delivery of hours per home help.

We can look in a little more detail at the type of care provided, in terms of administration and staff seniority, factors which may reflect a smaller average scale of provision. Box 2.2 showed that there is a greater expenditure on administrative staff in London. Figure 4.6, which reveals the number of home helps per home help organiser or assistant home help organiser, shows that there are relatively more senior staff in London than elsewhere, particularly in inner deprived London.

In London as a whole there are 13 per cent less home helps to each

Figure 4.6

Number of WTE home helps per home help organiser and assistant home help organiser, 1989–90



senior staff member employed than is the case nationally, and in inner deprived London the figure rises to 20 per cent. The situation is even more marked when London is compared with similar areas. Non-London inner deprived areas have nearly 60 per cent more home helps for each senior staff member than is the case in inner deprived london; the non-London comparator groups overall come out at just above the national average.

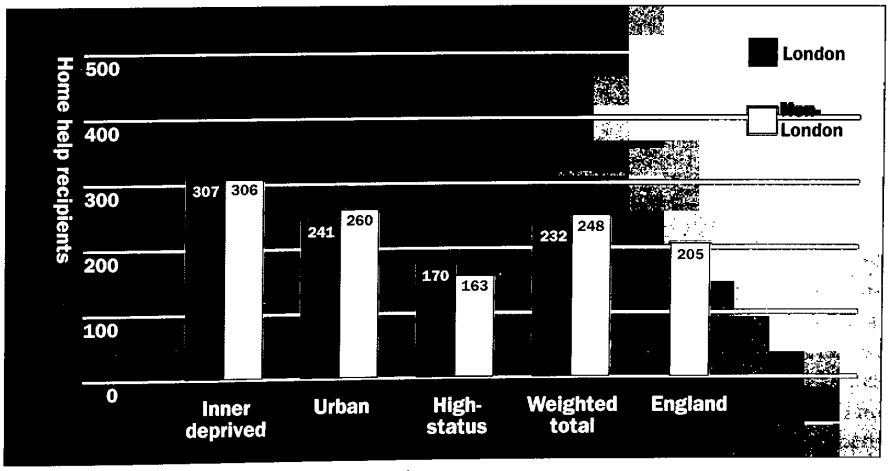
One clear implication of these higher seniority ratios is that the average cost of staff in London will tend to be higher because of grade differences, hence contributing to greater costs in London. The more expensive provision of home help services in London, therefore, is due both to differences in the cost of inputs, which reflect a different grade mix as well, and also a lower level of delivery per home help employed.

It is possible to examine briefly the extent of coverage of the population by home help services: it may be that services in London reach a wider range of people than is the case nationally.

Figure 4.7 shows the number of people in receipt of home help services per 1,000 population over the age of 75. It is immediately

Figure 4.7

Number of people in receipt of home help in all client groups per 1,000 population aged 75+, 1989–90



apparent that home help services in London reach a greater number of people than is the case nationally. This is particularly true of inner deprived London where there are 50 per cent more people in receipt of home help than in England as a whole. However, comparing like with like, some six per cent less of the potential client population in London receive home help than is the case in comparable areas in the rest of England.

Comparing these figures with those in Table 4.4 where it was shown that inner deprived London actually delivers some 13 per cent more hours than comparable non-London areas, it appears that areas in inner deprived London supply somewhat more help to approximately the same proportion of potential clients as occurs in similar areas outside of London.

There are two other major areas of SSD expenditure on elderly services: these are expenditure on meals – both meals-on-wheels and lunch clubs – and expenditure on day care centres. In Tables 4.5 and 4.6 a familiar pattern is revealed with London expenditure levels per capita resident population substantially higher than both national and comparator group levels. Inner deprived London spends nearly five times as much on meals, per resident population over the age of 65, than the national average, and approaching four times that in comparable areas outside of London.

Expenditure on day centres for elderly people in inner deprived London is nearly two and a half times the national average and twice that in non-London inner deprived areas. While there is a clear

Table 4.5

A profile of SSD meals services, 1989–90

Type of area	Gross current spend on meals per capita population aged 65+ £	Number of meals served per capita population aged 65+	Cost per meal served by SSD £
LONDON			
Inner deprived	44.6	15.6	3.0
Urban	20.2	11.8	1.9
High-status	16.6	8.0	2.1
Weighted total	25.9	11.3	2.5
NON-LONDON			
Inner deprived	12.4	8.2	1.8
Urban	7.6	6.1	1.3
High-status	8.0	6.4	1.3
Weighted total	9.4	7.0	1.5
ENGLAND	9.2	6.2	1.6

Table 4.6

A profile of day care services, 1989–90

Type of area	Gross current spend on day centres per capita population aged 65+ £	Number of LA day care places per 1,000 population aged 65+	Weekly gross spend on day care per place provided £	Number of WTE day care staff per 10,000 population
LONDON				
Inner deprived	29.5	12.7	50.4	5.9
Urban	24.6	4.7	187.4	3.8
High-status	19.1	8.1	42.0	4.3
Weighted total	23.2	9.3	49.8	4.9
NON-LONDON				
Inner deprived	13.4	5.4	48.7	6.0
Urban	12.1	6.2	38.0	4.5
High-status	11.0	3.2	66.7	3.4
Weighted total	12.0	4.4	58.2	4.6
ENGLAND	12.0	6.0	40.9	4.1

gradient from higher spend in inner deprived areas to a lower spend in high-status, in the case of both day centre and meals expenditure, all non-London comparator groups are close to the national average, and less than half that in London.

In terms of outputs, London provides substantially more of both services. For example, a quarter of all meals served in England are in London. Over 80 per cent more meals were served than the national average and 61 per cent more than in non-London comparator groups. On the same basis, there are 50 per cent more day care places in London, per capita resident population over the age of 65, than there are nationally and over twice as many as there are in comparable non-London areas.

It is possible to compare the relative costs of providing these two types of service. Interestingly, as Table 4.6 shows, the cost of a day care place in inner deprived London is only slightly higher than that in non-London inner deprived areas, although it is still some 23 per cent higher than the national average. On the other hand, costs in high-status London areas are substantially less than those in equivalent non-London areas – nearly 40 per cent less – and are approximately equal to the national figure. Overall, although London day care places cost some 22 per cent more than the national average, they are still 14 per cent less expensive than those in equivalent non-London areas. The situation in urban London is somewhat distorted by the fact that there

are very few places available, and those that are show an abnormally high average cost.

Day care centres in inner deprived London employ a comparable number of staff to other inner deprived areas of the country, and nearly 44 per cent more than the national average. London as a whole is some 20 per cent higher than the national figure, although it has similar staffing levels to those in comparable parts of the country. These figures would suggest a particularly effective provision of day care services in London in terms of the ratio of places provided to number of staff.

Turning to the provision of meals, these are considerably more expensive in London. Table 4.5 shows that the average cost per meal in inner deprived London is some 88 per cent higher than the national average and 67 per cent higher than that in equivalent non-London areas. The cost of a meal in London as a whole is over 50 per cent greater than that nationally and two-thirds as much again as that in comparable areas in the rest of the country.

Considerably more is spent in London on both services. In the case of day care services this is due to greater provision at a slightly higher unit cost than the national average; for meals, on the other hand, inner deprived London spends nearly five times as much, receiving two and half times the level of provision at approaching twice the unit cost. To summarise, this section has shown that, whereas there are relatively more non-residential services available in London, the cost of provision of such services is generally higher.

Conclusion

The provision in the capital of social services is marked by two distinctive features. First, there is a very different pattern of private as opposed to public provision of residential care for elderly people. Second, there is considerably more reliance on non-residential forms of care.

The level of local authority expenditure on social services for elderly people per capita population aged over 75 is considerably higher in London than elsewhere. Inner deprived London authorities spend over 50 per cent more than comparable areas and over twice the national average. London overall spends 50 per cent more than the England average. This chapter has focused on services for elderly people, but these expenditure differentials are common to most areas covered by social services.

London also employs more staff per capita resident population both than comparable areas of the country and England as a whole. Inner deprived London has staffing levels 80 per cent higher than the England figure but just 20 per cent greater than non-London inner deprived areas. Clearly the expenditure differential is greater than the difference in staff levels: the average cost of staff is higher, reflecting to some extent the different cost of inputs in London, but also the different staff-mix. For example, there are two and a half times as many administrative and ancillary staff per capita in inner deprived London as in England. Moreover, there are twice as many senior management

Box 4.3

NURSING CARE PROVISION

The main arguments of this chapter concentrate on the provision of residential care. Here some analysis of nursing care is provided, based on a report by Laing and Buisson (1990), *Care of Elderly People: market survey 1990–91*. However, this only allows a comparison of the situation in London as a whole, with that in England, in 1990.

England had 105,539 independent nursing places, but only 5,515 of these were located in London. In other words there were approaching three times as many places per head of population in England as there were in London; to bring London up to national levels requires an increase of nearly 10,000 places.

Although NHS long-stay care hospital beds act as a compensating factor, overall London was still 75 per cent down on the England average. The average cost of private nursing care in London was some 37 per cent higher than the England average – £360 per week for a private room and £334 for shared accomodation compared to the England average of £263 and £243 respectively. Annually this amounts to nearly £19,000 per private room in London compared to under £14,000 in England as a whole.

Comparing this with data on cost per patient day, in the elderly services specialty, it was found that the cost per day in London hospitals overall was 36 per cent higher than the England average, practically the same differential as applied in private nursing homes; in inner deprived London, however, it was nearly 58 per cent more. Translating these to annual charges the London figure of over £16,000 compares to a national average of just over £12,000; the inner deprived London figure was almost £19,000.

So nursing care provided by long-stay hospitals is not an expensive option for London relative to the cost of private nursing homes – a place in a private nursing home costs almost 20 per cent more; however it is questionable whether it is the appropriate form of care. It is interesting that nationally the differential between the cost of private care and NHS long-stay hospitals is also approximately 20 per cent, raising the question in a somewhat different way of why there remains such a relative shortage of private places in London.

It has already been shown that 44 per cent of care provided in the independent sector is funded publicly. An additional complexity arises because a substantial part of the budget for care in the community, both residential and nursing home care, comes from the social security budget in the form of income support. It has been estimated that between 60 and 70 per cent of residents of residential care and nursing homes are in receipt of income support (Hansard, 1992). This amounted to £1.9 billion in 1991–92, and a recent government estimate put it at £2.4 billion for 1992–93, of which £1.1 billion was spent on residential care and £1.3 billion on nursing homes.

This will be transferred to local authorities over the three years from April 1993, initially most of it as a ring-fenced element of the social services budget. There remains considerable disagreement over the formulae which are used to distribute these resources. The Association of Metropolitan Authorities (AMA) argues both that the overall level of transfer is too little and that its distribution is unfairly weighted towards areas where existing levels of private provision are already high (AMA, 1992b). The latter point militates severely against the London authorities.

and advisory staff. The evidence, on the basis of various output measures, suggests less return for staff employed.

The cost of care in London is considerably higher. At the same time there is a shortfall in the provision of residential places for elderly people when compared with other parts of the country, which is due primarily to a lack of private provision in the capital. It has been suggested that this is due to lower profit margins in London, but there is no firm evidence to support this. Box 4.2 showed that there are significant flows of elderly Londoners to better provided areas of the country. Thus, although residential services for elderly people in London appear less adequate, a proportion of the capital's elderly go elsewhere when they need continuing care.

The shortage of residential care places is accentuated by a lack of private nursing care in London, which is discussed in Box 4.3. The lack of places in both residential and nursing homes will put more pressure on the use of hospital beds, both in the acute sector and in designated beds for elderly people and those with mental health problems. This is an issue to which we return in Chapter 6.

There are more non-residential services in London, particularly the inner deprived areas. It would be over-simplistic to characterise this balance of care in London merely as an expensive form of provision, particularly at a time when less residentially-based forms of care are an important government policy objective. Nevertheless, the lack of residential and nursing accommodation must influence the development of non-residential services in London. There is an urgent need for further detailed analysis of the cost and substitutability of different forms of care for the elderly.

CHAPTER 5

Some neglected issues

This chapter examines two very different aspects of the provision of primary health care in London: community nursing and pharmaceutical services. The higher level of expenditure per capita in London on community nursing contrasts with the provision of drugs under FHS, where the capital for once spends less than England as a whole. The latter has perhaps been neglected on the grounds that a lower level of expenditure is not seen as a problem, the former primarily because the available data makes national comparisons difficult.

As Chapter 2 revealed, CHS expenditure is spread over a number of disparate services. The next section considers the provision in London for the two largest elements, district nursing services and health visiting which together account for over 67 per cent of expenditure on the community nursing service. This represents 37 per cent of the total CHS budget. Although London is shown to spend more per capita relative to the national picture, the result is a considerably lower level of service provision. This suggests the need for a closer examination of the reasons behind these differences, so as to establish how effectively London uses its financial resources in these areas.

The final section examines the provision of pharmaceuticals. In Chapter 2 it was shown that PS expenditure per capita in London was considerably less than is the case nationally. Since pharmaceuticals account for over half of all FHS expenditure, this constitutes a significant differential in resources. The overall cost of drugs has been a consistent government concern. Recent figures reveal that the drugs bill has more than doubled in real terms between 1980 and 1990 (Parliamentary Office of Science and Technology, 1993). A number of central initiatives have attempted to limit this growth, including the introduction of the limited list in 1980, PACT data in 1988 and indicative prescribing amounts (IPAs) in 1990.

Pharmaceutical expenditure is increasingly subject to financial scrutiny which in turn requires a better understanding of the determinants of GP prescribing behaviour. The factors which seem most clearly to underlie national variation in prescribing behaviour are unable to account for the lower level of prescribing in London. It is important, however, that the basis of any mechanism for tightening the control of pharmaceutical budgets is grounded in an equitable distribution of resources between London and elsewhere. The reasons behind current lower levels of prescribing in London relative to the rest of the country must therefore be understood.

Community nursing services

District nurses and health visitors play an important role in the provision of primary care, often working closely with family doctors, in primary health care teams, and the social services departments of local authorities. Examining the nature of provision of each in turn reveals a considerably lower level of services provided at a higher average cost.

District nursing services

Figure 5.1 indicates expenditure on district nursing services per capita resident population. In contrast to the 30 per cent difference observed in Chapter 2 between overall CHS expenditure in London and England, the capital spends just 11 per cent more on district nursing services than its non-London comparators, and 14 per cent more than the national average. This pattern is reflected across the status groups.

This is not a particularly high differential in view of the higher cost of provision which is generally acknowledged to exist in London. However, we shall see that the actual level of provision in the capital is less than that available elsewhere in England.

Table 5.1, presents a more detailed profile of district nursing provision in London. Taking face-to-face contacts as a measure of service provision, column 2 shows that contacts per capita in London are eight per cent less than that nationally and 16 per cent less than comparable areas in the rest of the country. Both contacts and staff numbers are measured against the resident population aged 75 and over, since this is the principal client group of the district nursing service. In fact, the resulting pattern is not dissimilar if the figures are related just to the total resident population.

Inner deprived London displays an even greater discrepancy in service provision with some 26 per cent less contacts per head of population than in comparable areas elsewhere.

Differences in the level of service provision can result from two sources: the number of district nurses employed or the average number

Figure 5.1

Total CHS expenditure on district nursing services per capita resident population, 1990–91

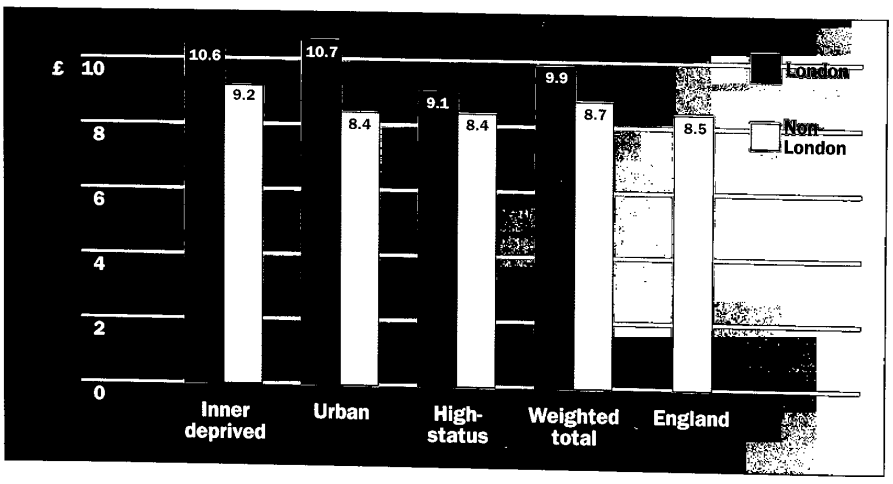


Table 5.1

A profile of district nursing services, 1990–91

Type of area	Cost per contact £	Contacts per resident aged 75+	DNs per 1,000 residents aged 75+	Daily contact rate per DN
LONDON				
Inner deprived	16.3	10.2	5.4	5.2
Urban	13.0	11.1	5.8	5.2
High-status	12.6	9.6	4.3	6.1
Weighted total	14.1	10.0	4.9	5.6
NON-LONDON				
Inner deprived	10.2	13.7	5.6	6.7
Urban	9.7	12.8	5.1	6.9
High-status	11.8	10.3	4.6	6.1
Weighted total	10.9	11.9	5.0	6.5
ENGLAND	10.9	10.9	4.7	6.4

of contacts by each nurse. Column 3 of Table 5.1 shows that there are roughly the same number of district nurses employed per capita population in London as there are in comparable areas – nearly 5 per 1,000 residents.

However, as column 4 reveals, the daily contact rate per district nurse in London is lower than both the national average and that of comparable areas. Nurses in inner deprived London achieve a contact rate some 19 per cent less than the national average and 22 per cent less than comparable areas such as Birmingham and Manchester. The shortfall in the number of contacts per resident in London compared to England as a whole, is therefore primarily due to a lower than average contact rate per district nurse.

Although more money is spent in London on district nursing services, the result is a lower level of provision for the residents of the capital. This is reflected in the average cost per contact, calculated as the ratio between expenditure and the total number of face-to-face contacts. On this basis, London – and inner deprived London in particular – is expensive, especially when compared with similar areas elsewhere in the country. Column 1 of Table 5.1 shows that the average cost of a contact in inner deprived London, at over £16, is nearly 50 per cent greater than the national figure of £11, and 60 per cent greater than the £10 prevailing in other inner deprived areas of the country. A district nurse contact in London as a whole costs nearly 30 per cent more than both the national average and that of comparable districts elsewhere.

Differences in average cost per district nurse contact can arise

from three sources: staff costs, non-staff costs and differences in the contact rate itself. Staff costs are generally greater in London than elsewhere and so the average cost per unit of staff will be more. However, district nurse expenditure is not all staff-related, and a second factor may be costs relating to the actual provision of service. For example, travelling time and expenses may exhibit a significant differential in London or there may be differences in the administrative element of costs in London. Unfortunately, the impact of these factors cannot be disentangled with the data to hand.

However, relating total expenditure to the number of district nurses, the average expenditure per district nurse in London is seen to be just 10 per cent more than the England figure. This seems low in the context of higher input costs in London; a possible explanation is a different staff-mix in the capital. There are a wide range of staff included under the definition of district nurses including, among others, bank and agency staff and enrolled nurses with district nurse training.

The final factor is a significantly lower contact rate. This may arise simply because it is more difficult to achieve contacts. Also, more time may be spent by district nurses on administrative duties dealing with the many additional agencies existing across the whole of London. It is also possible that there is a more expensive mix of contacts in London. A simple quantitative measure of service such as the number of contacts can conceal differences both in case-mix and in the nature and quality of service provided.

Nevertheless, to summarise, London provides less district nursing services than elsewhere in the country, and at a higher than average cost. Using average contact rate per district nurse as a simple measure of the efficiency of provision suggests there is room for improvement in London, although this result should be treated with a fair degree of caution for the reasons outlined above.

Health visitor services

A similar pattern emerges when health visiting services in London are considered. More is spent in London on less provision. Figure 5.2 indicates that expenditure on health visiting services per capita resident population is higher in the capital. London spends 13 per cent more than equivalent non-London districts, and 20 per cent more than the national average: inner deprived London districts spend 47 per cent more than the national average.

A detailed examination of service provision is provided in Table 5.2. The exposition is similar to that which was used for district nursing services, but in this case measures are presented in terms of total resident population.

Taking the number of contacts received per capita resident population as a measure of service provision, levels in London are less than elsewhere. For inner deprived London districts, there are 19 per cent less contacts than in equivalent non-London districts. London overall has some 9 per cent less contacts than the national average and 12 per cent less than that in comparable districts elsewhere in the country.

Figure 5.2

Total CHS expenditure on health visiting services per capita resident population, 1990–91

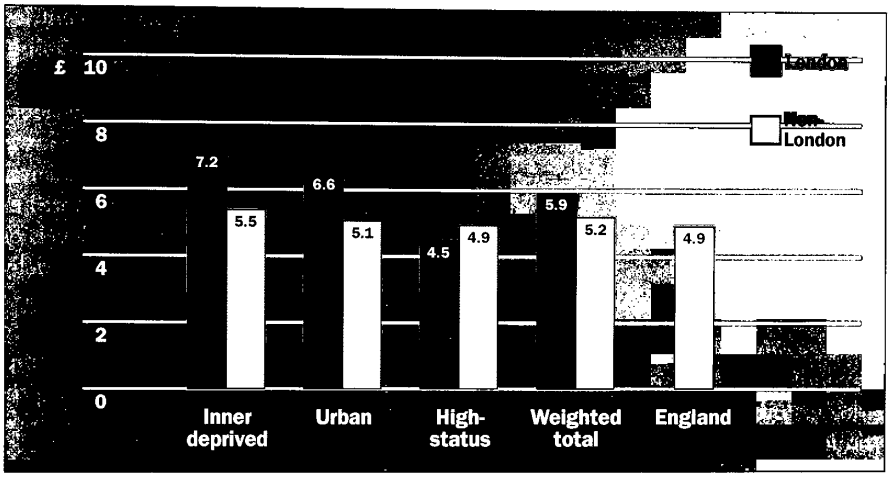


Table 5.2

A profile of health visiting services, 1990–91

Type of area	Cost per contact £	Contacts per 1,000 residents	HVs per 100,000 residents	Daily contact rate per HV
LONDON				
Inner deprived	25.4	289	25.8	3.1
Urban	16.6	398	25.5	4.3
High-status	15.1	297	18.8	4.4
Weighted total	19.1	309	22.5	3.8
NON-LONDON				
Inner deprived	16.3	357	23.8	4.1
Urban	15.0	336	23.5	3.9
High-status	13.8	355	21.0	4.6
Weighted total	14.9	353	22.5	4.3
ENGLAND	14.5	339	22.1	4.2

These differences may result from less health visitors being employed or lower average contact rates for individual health visitors. Table 5.2 shows that there are approximately the same number of health visitors employed per capita population in London as there is both nationally and in similar areas of the country – over 22 per 100,000 residents.

However, no simple, homogeneous picture of London emerges. While both urban and inner deprived London districts employ more health vistors than their equivalent groups elsewhere, and also than the national average, high-status London districts employ less. On the other hand, the high-status and urban London average contact rates per health visitor are slightly higher than the national average, but the inner

deprived London contact rate is over 26 per cent less. The overall London contact rate is nearly 10 per cent less than both comparable areas elsewhere and the national average.

As in the case of district nurses, the lower number of contacts per resident population appears to be attributable to a lower daily contact rate per health visitor rather than less staff. This is certainly true in the case of inner deprived London where there are more health visitors per capita than the national average. These lower levels of provision are reflected in a higher than average cost per contact delivered. London is an expensive provider of services.

The cost of a health visitor contact in London overall exceeds the national average by some 32 per cent and that of comparable districts elsewhere by over 28 per cent. Care in inner deprived London is particularly expensive at over £25 per contact; this is over 75 per cent higher than the national average of £15, and 56 per cent higher than other inner deprived areas at £16.

Of course, the crude contact figure may mask differences in case-mix or quality of service. For example, in London there may be more 'special index families', defined as those with more complex needs and problems. It has been suggested that it is more difficult to provide services in London because the higher degree of non-coterminosity between health authorities and local authorities in London results in health visitors having to liaise with several social services departments. National data sets do not allow such detailed comparisons, but these issues may warrant some closer examination at the local level.

Summary

The cost of community nursing provision in London is considerably higher than comparable areas elsewhere in the country. In the case of both district nurses and health visitors this would appear to be due to a lower contact rate per staff member employed.

Whatever the reason for this, the overall impact on services to Londoners is revealed in contacts per resident shown in column 2 of Tables 5.1 and 5.2. London as a whole receives eight per cent less district nurse contacts than the national average and 16 per cent less than comparable areas of the country. For health visitors the figures are nine and twelve per cent respectively. Comparing inner deprived London districts with similar non-London districts, health visitor contacts are 19 per cent less and district nurse contacts 26 per cent less.

The need for community services in London has not been shown to be less than elsewhere and yet the level of provision is indeed less. This is a particularly striking result when comparing the inner city areas of London with areas in the rest of England with similar levels of deprivation. This lower level of provision will tend to put pressure on other health services in the capital as residents have more difficulty in obtaining appropriate forms of care in the community. This is an issue to which the final chapter returns.

Pharmaceutical services

Chapter 2 showed that the most significant factor underlying the difference between FHS expenditure in London and elsewhere was the low level of expenditure on Pharmaceutical Services (PS). A reduction in national expenditure per capita to the London level would reduce overall PS expenditure by more than £200 million.

PS expenditure can be sub-divided into two categories: remuneration to community pharmacists for the services they provide, and reimbursement for the cost of the drugs they dispense. In 1990–91 the latter component accounted for nearly 80 per cent of total PS expenditure. This section looks at the relative level of reimbursement – essentially the cost of prescribed pharmaceuticals that are dispensed – which principally underlies the differential in PS expenditure. Some discussion of remuneration levels and the distribution of community pharmacies is provided in Box 5.1.

The total cost of prescribed pharmaceuticals is a function both of the price and the quantity of the drugs which are prescribed. This can be represented by the simple formula:

$$P_E = P_C \times P_N$$

where P_E is the total expenditure on drugs, P_C the average cost of each item, and P_N the total number of items prescribed. In the next section the average cost and quantity of prescriptions is examined comparatively, to establish the nature of the overall differential in expenditure which has been observed. In essence, we show that it is a lower prescription rate in London which underlies the disparity.

Box 5.1

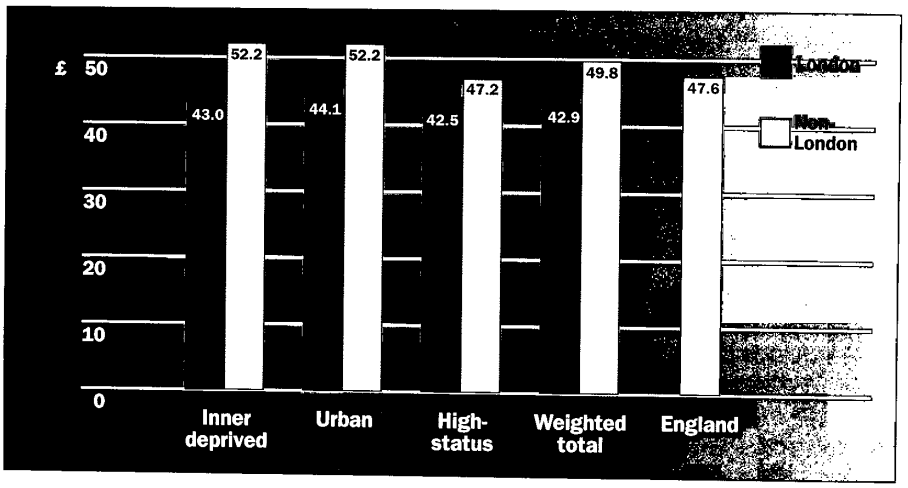
DISTRIBUTION AND REMUNERATION OF PHARMACISTS

Relative to its resident population, London is extremely well provided with community pharmacies in comparison with the rest of the country. The National Audit Office (1992) showed that, while there are about 20 pharmacies per 100,000 resident population in England as a whole, all but four of the London FHSA areas have a figure in excess of 26 per 100,000. In fact, of the fourteen FHSA areas in England with the greatest relative number of pharmacies, no fewer than twelve are in London. More generally, perhaps as might be expected, urban areas tend to have a greater concentration of community pharmacies per resident population than rural ones.

However, when the level of remuneration to pharmacies is considered a rather different picture emerges. Although it is impossible to provide an exact breakdown of the remuneration figures, the London value is around £9 per capita resident population, compared to a national figure of about £11. This is largely because remuneration is tied to prescription level bands; all but 3 per cent of NHS payments are for the core dispensing services of the community pharmacies. Since, as the text demonstrates, the prescription rate in London is especially low, the low level of remuneration is to be expected. This rather begs the question of why there are therefore so many pharmacies in the capital. It may relate to pharmacies' non-NHS retail business. For our purposes, however, it is sufficient to note that London does not suffer from a shortage of pharmaceutical suppliers.

Figure 5.3

Net ingredient cost per capita resident population, 1990–91



The cost of prescribed pharmaceuticals

The most common measure of the overall drug bill is known as the net ingredient cost (NIC). Figure 5.3 shows the NIC per capita resident population of the drugs prescribed by GPs in each status area.

It is perhaps not surprising, in view of the figures for overall PS expenditure presented in Chapter 2, that for each London status area NIC per capita resident population is less than both the comparator figure and the national average. Overall, the cost of drugs in London per capita is 10 per cent less than the national value and 14 per cent less than that of the comparator group.

This pattern must be a function of differentials either in the

Table 5.3

Quantity and cost of prescriptions, 1990–91

Type of area	Prescriptions per capita resident population	NIC per prescription
		£
LONDON		
Inner deprived	7.3	5.9
Urban	7.3	6.0
High-status	6.9	6.1
Weighted total	7.1	6.0
NON-LONDON		
Inner deprived	9.8	5.3
Urban	9.1	5.7
High-status	7.7	6.2
Weighted total	8.7	5.8
ENGLAND	8.0	5.9

Box 5.2

DISPENSED OR PRESCRIBED?

Routine data concerning the number of items paid for under PS is available on the basis of drugs dispensed by community pharmacies in FHSA areas (Department of Health, 1992b), or those prescribed by GPs within the FHSA area and subsequently dispensed by pharmacies (Prescription Pricing Authority, 1992). Neither can be tied exclusively to the FHSA resident population. In the former case, pharmacies may dispense to people who received prescriptions elsewhere; this would seem especially likely in London with its large commuter population. In the latter case, GPs often have patients who live outside the FHSA's geographical area.

Despite these potential sources of difference, the two figures are highly correlated. Nationally, the correlation coefficient between dispensed and prescribed drugs in 1990–91 was 0.95. In London about a million more prescriptions were dispensed than prescribed. However, this apparent "commuter effect" represents only 2 per cent of all drugs dispensed in London.

From the point of view of the distribution of health care resources, the important measure is dispensed drugs, since, nominally at least, the FHSA reimbursement responsibility is channelled through this route. However, in order to understand the nature of the differential in the prescription rate, the more appropriate measure is prescribed drugs, since this more closely represents local patterns of pharmaceutical consumption. For this reason, data on prescribed rather than dispensed drugs are used throughout this section. The strength of the association between the two measures is such, however, that the choice of measure is not crucial, since they are very accurate proxies for one another.

For the reason outlined above, the level of prescribed pharmaceuticals cannot be tied to the level of consumption by a particular FHSA resident population. However, patient flows across FHSA boundaries are insufficient to distort the general picture painted by the prescription data, particularly at the aggregate level with which we are principally concerned.

quantity of drugs dispensed or in their average cost. Table 5.3 examines this by displaying data on prescriptions per capita resident population and NIC per prescription respectively.

Broadly speaking, the table shows that average cost per prescription is fairly similar at an aggregate level. Although there is some variation across the status categories, London as a whole differs from the comparator areas by 3 per cent, and from the national value by just 2 per cent. Clearly, it is the number of prescriptions per resident population – 18 per cent less in London overall than in the comparator areas – which principally underlies the differential in costs.

It is not possible to provide time-series data corresponding to the information in Table 5.3. However, such data is available on the basis of drugs dispensed rather than those prescribed within the relevant areas. The methodological issues underlying this distinction are discussed in Box 5.2. In essence, it can be shown that the level of both prescribed and dispensed drugs in a given area are adequate proxies for the consumption of drugs prescribed to the resident population of that area.

Consideration of time-series data on the average cost of dispensed prescriptions indicates that there has been some fluctuation from year to year. In 1990–91 average costs in London exceeded the comparator areas by about 2 per cent; in the previous year the difference was 6 per cent. The more important point, however, is that the prescription rate in London has been consistently lower than elsewhere for at least the last four years, rising from 7 per cent less than the national figure in

1987–88 to 11 per cent less in 1990–91. A higher average cost per prescription in previous years partially masked the impact of the low prescription rate on the overall differences in NIC per resident population.

When the English FHSAs are ranked in order of their prescription rates from highest to lowest, only one, City and East London, falls in the top half of the range, and more than half of them are in the lowest quartile. There is a statistically significant difference between the London and non-London authorities (Mann-Whitney test, $P < 0.01$). As Box 5.2 shows, the fundamental point at issue is the relatively low consumption of drugs by London's residents. In the next section we examine the factors underlying these levels of consumption.

What determines the prescription rate?

In examining differences in the prescription rate it is worth distinguishing between possible supply- and demand-side factors. As Figure 5.4 illustrates, demand-side factors such as the age and sex structure of the population may be implicated or, alternatively, supply-side factors such as GP prescribing behaviour may be more significant. A supply/demand approach provides the basis for a useful analytical model since the policy implications of the disparity in the prescription rate will differ according to which type of factors are most significantly involved. We therefore turn to an examination of the factors identified in the figure.

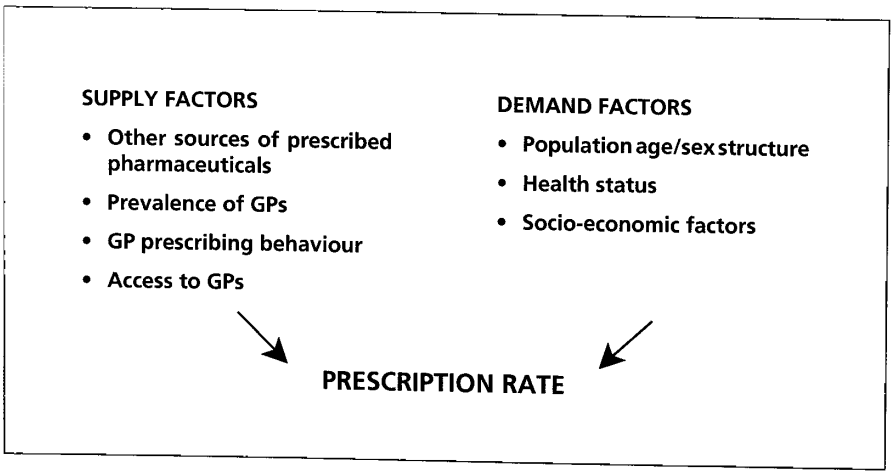
Supply-side factors

Perhaps the most obvious supply-side factor is the possibility that patients in London have access to alternative sources of pharmaceuticals. In Chapter 3 evidence was presented which suggests that in London greater use is made of hospital facilities as sites of primary care. This is particularly true of hospital A&E departments, and perhaps also of out-patient departments. Hospital prescribing may therefore act as a substitute for the provision of drugs under PS.

Analysis of the 1990–91 hospital pharmaceutical expenditure

Figure 5.4

Supply and demand factors



figures reveals that in London as a whole expenditure per capita resident population, at £13, exceeds the national value by 43 per cent, and the comparator areas by 3 per cent. This largely reflects the situation in the inner deprived areas, both in London and elsewhere, where acute hospital services are particularly concentrated.

Compared to the national figure at least, this appears to indicate that hospital prescribing in London may indeed compensate to some extent for low GP prescribing. However, the data are potentially misleading. Hospital drug expenditure is considerably lower than the cost of drugs under FHS; some £90 million compared to £290 million in London in 1990–91. It is true that an addition of the two figures gives an overall drugs bill per resident population for inner deprived London in excess of the national value. However, although there is some evidence to suggest that London's hospital services are used as primary care facilities by local residents, there is no reason to suppose that hospital prescribing is in the main directed at the same patient group.

For example, information provided by regional health authorities suggests that only about 10 per cent of hospital drug expenditure is devoted to out-patients. Acute in-patient care tends to dominate hospital drug bills. Thus, the overall amount of hospital drug expenditure devoted to primary care episodes of the sort covered under the PS budget is rather small.

Moreover, a significant proportion of hospital drug expenditure is incurred for patients who reside outside London: in 1989–90 approximately 11 per cent of all acute episodes in London hospitals were non-London residents (Boyle and Smaje, 1992c). Taking a figure – somewhat arbitrarily, perhaps – of 10 per cent of hospital drug spend as primary care related, and adding this to the PS figure gives an aggregate 'primary care' drug spend. This amounts to £45 per capita for inner deprived London – less than both the comparator group, at £53, and the national figure, at £47. In reality, 10 per cent is probably an over-estimate. Although there may be some compensatory effect it would therefore appear that the differential cannot be explained simply in terms of extra hospital prescribing in London.

Other potentially important supply-side factors are the prevalence of GPs, their prescribing behaviour and the ease of access to their services. Chapter 3 showed that there were slightly more GPs per capita population in London than elsewhere. In an analysis of national variation in GP prescribing based on 1987 data, Forster and Frost (1991) found that the number of GPs relative to resident population was positively related to rates of prescription.

Another analysis, using 1987–88 data on the number of GPs per capita registered population, reported broadly similar results (Baker and Klein, 1991). However, as Chapter 3 showed, the number of GPs per capita resident population in London is very close to the national figure. It therefore seems unlikely that the prevalence of GPs alone can account for the differential in London's prescription rate.

Perhaps the most important supply-side factors are access to GP services and the nature of GP prescribing itself. Unfortunately, neither is easy to quantify. However, in Chapter 3 evidence was presented

which suggests that the profile of GPs and their services in London is considerably different from that elsewhere in the country. This may result in systematic differences in prescription rates through a number of possible mechanisms. However, such reasoning will remain speculative until detailed comparative research is undertaken to examine geographical variation in patterns of GP prescribing.

Demand-side factors

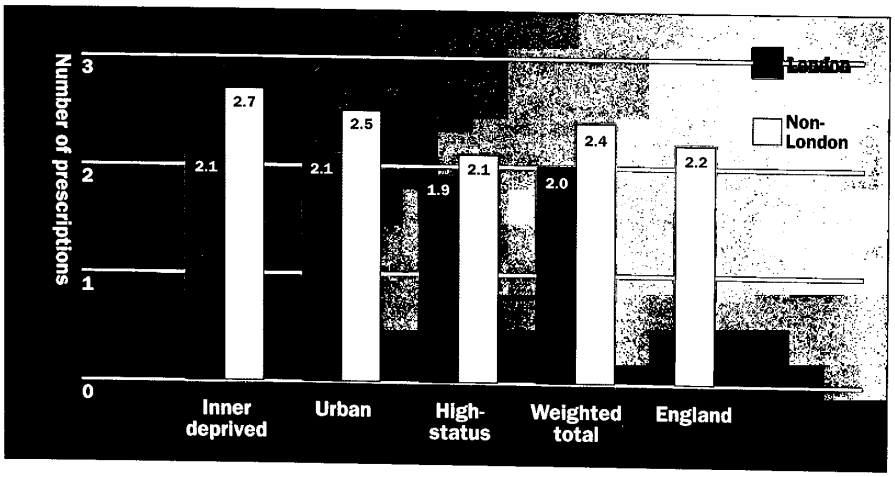
The starting point for any demand-side analysis is to determine the extent to which the demographic structure of the resident population affects the level of prescribing. Forster and Frost (1991) found that 51 per cent of national variation in prescribing rates could be accounted for by demographic structure. Age in particular affects the level of prescribing, with elderly people consuming a disproportionate quantity of drugs. This has been recognised in the allocation formula for practice level indicative prescribing amounts, which weights elderly people by a factor of three (Department of Health, 1990). More sophisticated age/sex weightings have recently been produced by the Prescribing Research Unit at Leeds University (Harris, 1992). Figure 5.5 displays the number of prescriptions per capita resident population using the Leeds weightings.

Despite the age weighting, the relative number of prescriptions in London is still 17 per cent less than the weighted total of the comparator areas and 9 per cent less than the national average. Even controlling for London's demographic structure, then, the greater part of the observed disparity remains. At an aggregate London-wide level the evidence therefore suggests that other factors underlie the disparity in the prescription rate.

One such possible factor on the demand-side is the health status of the resident population; it may be expected that less healthy people need more prescriptions. Analyses by Forster and Frost (1991) and Baker and Klein (1991) used standardized mortality ratios (SMRs) as proxies for health status, and showed there to be a positive correlation between prescription rate and SMR nationally. However, both analy-

Figure 5.5

Prescriptions per age/sex weighted resident population, 1990–91



ses assumed that health status has a constant effect on prescription rates across age-groups. A fuller analysis is required before conclusions about the effect of health status on the prescription rate can be drawn. The SMR for London as a whole is lower than that for both the comparator groups and the national average (Benzeval *et al* 1992). However, the estimated effect of SMR on prescription rate is very small. It is therefore unlikely that better health status in London, as measured by SMRs, can explain fully the difference in prescription rates.

Finally, there may be demand-side effects on prescription rate arising from socio-economic factors which are independent of health status. Thus, for example, factors such as the class or ethnic composition of the population, or the level of employment, may affect the attitudes of both patients and practitioners towards pharmaceuticals. Again, the impact of this is extremely difficult to quantify. However, both Forster and Frost (1991), and Baker and Klein (1991) found there to be no relation between the prescribing rate and the Jarman score, which is a composite index of such socio-economic and demographic measures.

Summary

The prescription rate in London is substantially less than in England as a whole. Conclusions about the reasons behind this, however, can only be tentative. It has been shown in this chapter that the factors which most clearly underlie national variation in the prescription rate are insufficient on their own to explain the low rate in London. Particularly significant factors may well be those that are least quantifiable, such as GP prescribing behaviour and patients' access to GMS.

Whatever the reason, it is clear that there is less per capita expenditure on pharmaceuticals in London than elsewhere because Londoners receive fewer prescriptions. It is not possible in this analysis to address the clinical efficacy of this situation. However, it would be unwise to conclude that the lower prescription rate in London merely reflects lower levels of need.

CHAPTER 6

Conclusion

Previous chapters have revealed a distinctive pattern of primary health care in London when compared to the rest of England. Here, by bringing together information on the resource use by each element of primary health care services, the overall picture in London is related to that in the rest of the country. The main factors distinguishing primary care in the capital from elsewhere are discussed.

The next section examines the use of resources by primary health care services in London. This is followed by a discussion of the overall level of provision, and some of the problems faced in providing primary care in the capital are then considered. The final section looks at some policy options for primary health care in London, with particular reference to the Tomlinson Report and the Secretary of State's response, *Making London Better.*

Although this paper has shown that London spends considerably more on primary health care than is the case elsewhere in the country, the evidence suggests that there is not a commensurately higher level of provision. But such evaluations are complicated by the diverse nature of the agencies responsible for services. This is as true of the rest of England as it is of London. There are, however, a number of additional factors affecting the provision of services in London.

For example, the higher cost of inputs in London generally would cause the unit cost of provision of any service to be greater. In addition, the agencies responsible for the provision of services in London are typically smaller than elsewhere leading to a more complex administrative structure. Finally, historically there has been an emphasis in London on the provision of acute hospital services, but this has been at the expense of corresponding developments in primary health care services leading to an imbalance between the two sectors.

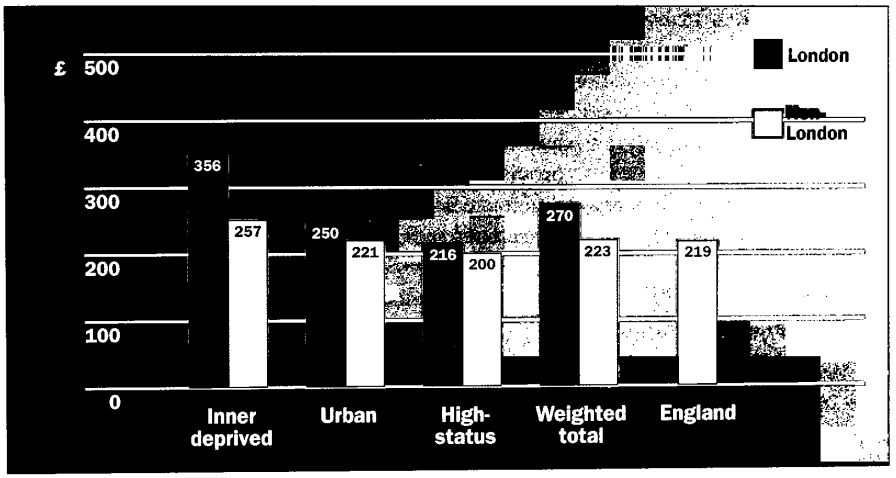
The use of resources in London

In Figure 6.1 total expenditure on primary care per capita resident population is set within the usual comparative framework. This is calculated as the total expenditure on FHS, CHS and that part of SSD expenditure which we have identified as health-related. The responsibilty for each of these services rests with different agencies, but, in the sense that the client population and needs which they address are similar, it is useful to consider the totality of resource use.

Each London status area spends more than both the national average and comparable areas elsewhere in England. In fact, London as a whole, at £270 per capita, spends almost 25 per cent more on

Figure 6.1

Total expenditure on primary health care services per capita resident population, 1990–91

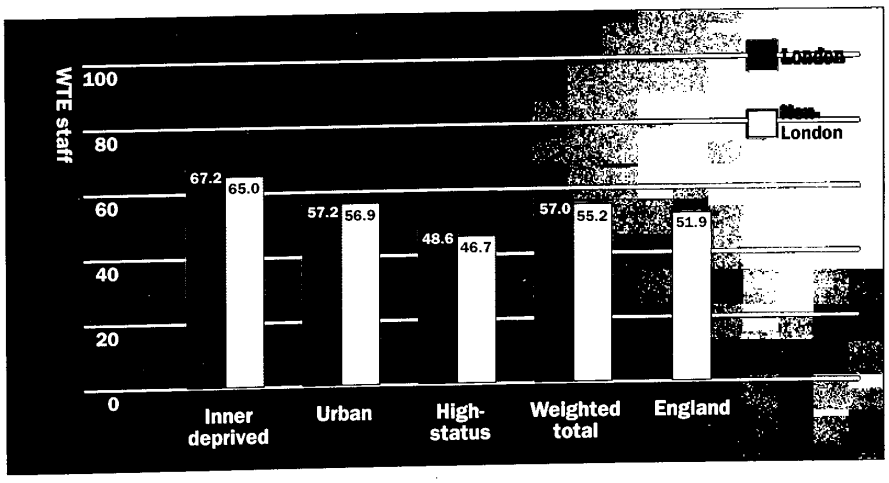


primary care than both the national average and that in comparable areas. Inner deprived London, at £356, exhibits an even more marked difference, nearly 65 per cent greater than the national average. These differences are due to the considerably higher spend on social services and, to a lesser extent, CHS in London. Chapter 2 showed that expenditure on FHS in London is roughly equivalent to that nationally, since the relatively higher spend on GMS is counterbalanced by a lower level of expenditure on pharmaceutical services.

Figure 6.2 shows the quantity of human resources made available to primary care. The differential between London and elsewhere is nowhere near as marked as in the case of financial resources. London overall employs just ten per cent more staff per head of population than the national average and three per cent more than comparable areas elsewhere in the country. The difference between inner deprived London and non-London areas is equally small, both employing approximately 30 per cent more staff per capita than the national average. The fact that the proportion of extra staff employed in London is not commensurate with the extra expenditure there reflects a greater

Figure 6.2

Total WTE staff employed in primary care activity per 10,000 resident population, 1990–91



average cost of employing staff in London, and a higher level of associated non-staff costs.

Differences in staff levels occur throughout each of the services considered, although the magnitude of the difference varies. There are just two per cent more staff employed in London, under GMS provision, per capita resident population, than nationally; for CHS the difference is four per cent, and for social services, nearly 15 per cent. Once again social services account for a substantial amount of the extra use of resources in London, though Figure 6.2 refers only to staff employed by local authorities. It was shown in Chapter 4 that nationally there are six times as many private residential places per capita as there are in inner depived London. The staff of these private residential homes are not included in the above figures.

The overall level of provision in London

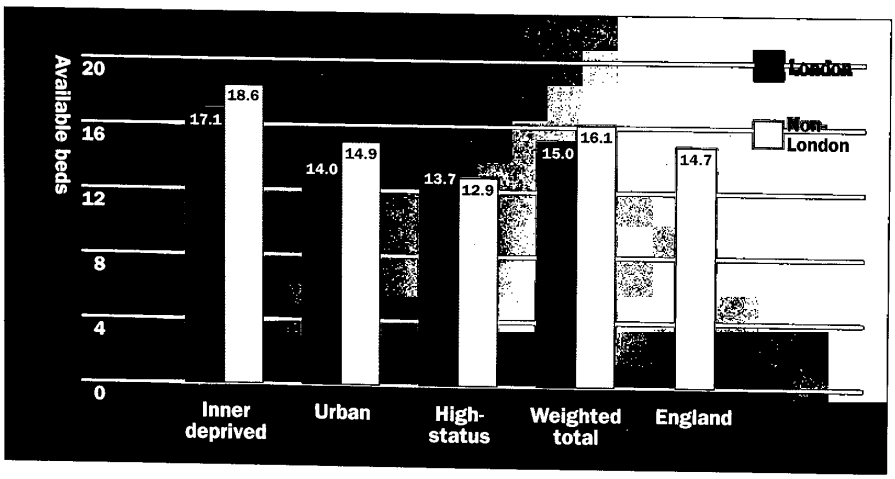
This paper has shown that the level of service provision in London is not commensurate with the quantity of financial resources which are spent there. Indeed, frequently the evidence would suggest a lower level of provision in London than is the case nationally.

For example, Chapter 3 suggests that GMS are less developed than elsewhere in England. This is almost as true of the high status suburbs as inner city deprived areas. Also, the average level of pharmaceutical provision was shown, in Chapter 5, to be some 11 per cent less in London than is the case nationally. We have not produced evidence on the appropriateness, or otherwise, of prescribing levels in London. These may in fact represent best practice. However, it remains the case that the rest of the country receives a larger relative proportion of the national pharmaceutical budget than London.

Although there is above average expenditure on community health services in London, Chapter 5 indicates that there is not a higher level of provision. In fact, simple measures such as district nurse or health vistor contacts per capita resident population suggest precisely the opposite is the case.

Figure 6.3

Available NHS beds for elderly services per 1,000 resident population aged 75+, 1989–90



A large proportion of primary care services is directed at the elderly population. It is possible, therefore, that shortfalls in provision from FHS and CHS may be compensated by social services. Certainly expenditure per capita on social services in London is substantially higher – over twice the national average in the case of inner deprived London.

However, a combination of lower levels of private residential and nursing provision for the elderly, higher average costs of social services in London, and a relative lack of acute hospital beds for elderly people has produced a situation where the level of residential provision is still notably less than that available elsewhere in the country. Jarman (1993) has recently shown that there are just four per cent more beds per resident population in London than England, if beds for acute and elderly services are combined.

Figure 6.3 shows the situation, in 1989–90, when beds for elderly services alone are related to the resident population over the age of 75. Although in London overall there were two per cent more beds than the England average, the position was worse than that in comparable areas. In inner deprived London, for example, there were eight per cent less beds for elderly people than were available in inner deprived areas elsewhere in the country. The overall lack of residential provision is unlikely to be compensated by a higher provision of non-residential services in London, which is also provided at a considerably higher cost than elsewhere.

Problems for primary care provision in London

This paper has highlighted some of the factors behind the underdeveloped nature of primary health care services in the capital. This section focuses on three factors: excess costs in the capital, greater administrative complexity, and the different balance between primary and hospital-based services.

London is generally regarded as a high-cost environment, and so the cost of providing any service will be higher. This is certainly the case with respect to acute hospital care (Boyle and Smaje, 1992a). Provision in both the CHS and social services sectors exhibits higher unit costs than might be explained by a simple mark-up for the London cost factor. On the other hand, the cost of GMS provision per capita resident population is similar in London to that nationally. However, the breakdown of payments to GPs in London is weighted more towards automatic payments for list size and deprivation than payments for provision of services or achieving targets. Equalisation of costs per resident may in this case reflect less actual provision of services.

It has been suggested that the sheer size of London acts as a disadvantage in securing adequate service provision. Certainly this is one tangible difference between London and other major cities in England. Also, London is divided between a number of small and diverse administrative areas. This operates at two levels. First, there is a multiplicity of agencies dealing with the care of Londoners. Second, the administrative costs are spread over a smaller population base. This

second factor is certainly true of social services, where administrative costs in inner deprived London are nearly three times the national average per head of population. Whereas Birmingham and Manchester have one social services agency dealing with their populations of approximately one million and half a million respectively, in London there are 33 local authorities, each with their own administrative structure.

A lack of integration of service provision, both between providers of primary care as well as between the primary care sector and the hospital sector, particularly acute services, may also be a factor contributing to the inappropriate use of health services in London. The result may be the blocking of hospital beds by patients, often elderly, who cannot be safely discharged. For example, the Chief Executive of one London teaching hospital has reported that some ten per cent of its medical beds, over a period of several months, were occupied by patients who could be discharged, if appropriate follow-up care in the community were available (Goodwin, 1993). However, it is impossible to quantify the extent to which this remains more of a problem for London than elsewhere in England.

Historically there has been a concentration of acute hospital services in London, often of a highly specialised nature. London overall spends some 26 per cent more per head of resident population on acute care than the national average, and over twice as much is spent in inner deprived districts of the capital (Boyle and Smaje, 1992a). However, much of this is spent on the provision of specialist services to non-Londoners, sometimes, it is claimed, at the expense of basic hospital services for local residents. Although there may be five specialist teaching hospitals within a one-mile radius of an inner-London surgery, it can still be difficult to find space for a routine emergency admission.

Overall expenditure figures clearly show the different balance between primary and hospital-based care in London compared to England. In England, in 1990–91, £255 per capita resident population was spent on hospital services compared to £220 on primary care: in

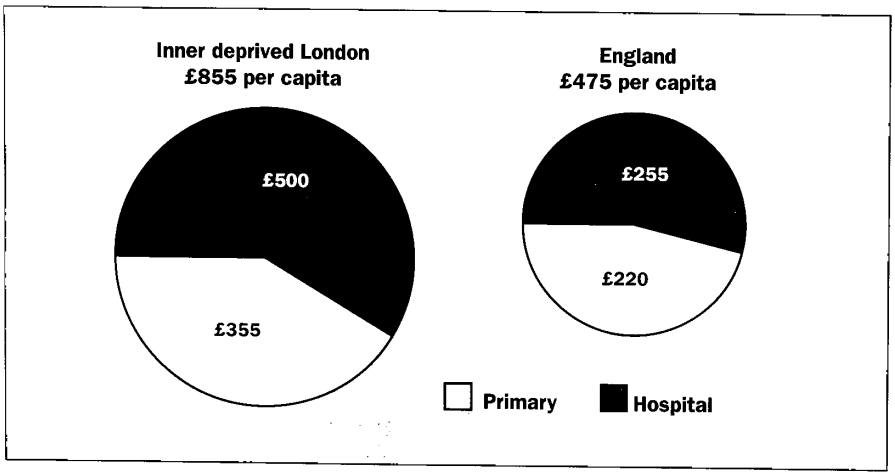


Figure 6.4

The balance between expenditure on primary and hospital services, 1990–91

inner deprived London the figures are approximately £500 compared to £355. In the inner city areas of the capital 40 per cent more is spent on hospital care than on primary, whereas nationally the difference is only 16 per cent. The Tomlinson Report has alluded to the considerable potential for substitution between secondary and primary care in London. This will necessitate a shift in expenditure between acute hospital care and the primary and community sector, and clearly there is substantial scope for this to happen.

The future for London

Both the Tomlinson Report and *Making London Better* have claimed that higher costs and an historic emphasis on the development of hospital services have hindered the effective provision of primary care in London.

The Secretary of State, acting upon Tomlinson's recommendation that parts of London be designated as 'primary care development zones', has established the London Initiative Zone (LIZ). Within this area, it is intended that primary health services in London will be strengthened by developing more accessible services at a local level, provided through GPs, nurses and other professionals working in the community.

LIZ is intended to be a focus for the development of new ideas in primary health care in London, some of which are extensions of what is already happening elsewhere. While many of the issues highlighted in the previous chapters of this report have been raised, it remains to be seen how successfully they are addressed.

One issue still unresolved is the means by which effective pan-London coordination of health services can be secured in the longer term. Linked to this is the coordination of budget allocations, both within London, and across all health care services. The Tomlinson Report recommended the development of a uniform approach to the calculation of capitation formulae for the distribution of financial resources in London, at a district level. This will be of particular importance as the Department of Health constructs new national formulae using the 1991 Census. The blurring of the interface between primary and secondary care makes of equal import the need for a joint approach to the allocation of financial resources across all health services.

In Chapter 2 it was shown that nearly 50 per cent of GP premises in London fail to meet minimum standards. To address this issue, *Making London Better* announced a programme of investment in GP surgeries and primary health care centres. However, some commentators have expressed concern that the additional £170 million available for capital projects over the next six years will prove inadequate.

We have also seen that the 1990 GP contract has not been as effective in London as elsewhere in generating an increase in the range and quality of services offered. While some of this may be addressed by improvements in premises, the Government also proposes to intro-

duce flexibility into some aspects of the GP contract within the area of LIZ so that, for example, different pay-scales might be introduced, or experienced GPs may be brought into the capital on short-term contracts.

Primary Health Care Teams, incorporating GPs, practice nurses, district nurses and health visitors, have been slow to develop in London. *Making London Better* has therefore proposed a programme of investment in training and establishing teams of doctors, nurses and other professionals to provide services in the community. This will include the development of more training practices – including nurse training practices – in London, a feature which was shown in Chapter 3 to be relatively sparse in the capital.

The Government has recognised the need for effective integration of health and social services at the local level, in order particularly to meet the problems posed by the long-term care needs of elderly people. Expanding the role of the community nurse service is just one part of this. Chapter 3 indicated that London has considerably higher use of A&E services relative to the rest of the country, often as a surrogate for primary care. It will be necessary to ensure a consistent 24-hour GP service, with extensions to out-of-hours nursing and support services. At the same time, primary care professionals could be introduced into hospital A&E services, an approach successfully piloted at King's College Hospital (Dale, 1992), so as to ensure that patients get the service appropriate to their needs.

In Chapter 4, we saw that the provision of social care for elderly people implied particular problems for London since there is a relative shortage both of independent nursing and residential provision and also NHS beds for the elderly. The result has often been inappropriate use of acute hospital beds by elderly patients. While this problem of elderly bed blocking was recognised by Tomlinson, the response of *Making London Better* is muted.

The implementation of the community care element of the NHS and Community Care Act in April 1993, with its transfer of resources and responsibilty to social services may be particularly problematic in London. It will be difficult to comply with the requirement that 75 per cent of funds transferred from the DSS budget to social services – money previously applied to income support for elderly people living in residential and nursing homes – should be spent on independent provision, when there is a shortage of such provision in London.

Making London Better has recognised the need to encourage local health and social services authorities to work together to ensure coherent service provision, for example with a coordinated home help/health care assistant service, and with high-intensity home support services based on hospital-at-home schemes. Such schemes reflect a general trend towards more home-based, long-term care for elderly people. However, no clear guide is offered to the means by which an integrated service can be achieved.

We have shown that in many respects London has already moved more towards non-residential provision than other parts of England. It is difficult to assess the extent to which this is policy-led rather than a

reflection of the lack of residential provision in London. However, initially London's social services face the more fundamental problem of ensuring that adequate residential and nursing care for elderly people can be purchased within the expanded budgets which they now control.

It remains to be seen what the response of the providers of primary health care in London will be to the challenges posed by the Tomlinson Report and *Making London Better*. A fully integrated system of local health and social care for Londoners requires more than just a shift of funds from the acute to the primary and community sector. There must be a radical, coordinated programme of change in London.

Appendix
Health Authority Classifications

Table A1.1
FHSAs in the London Initiative Zone

Brent (excluding Harrow)
Ealing, Hammersmith & Hounslow
Kensington, Chelsea & Westminster

Barking (excluding Havering)
Camden & Islington
City & East London
Eastern Enfield and Edmonton area of Haringey
Waltham Forest (excluding Redbridge)

Greenwich (excluding Bexley but including Thamesmead)
Lambeth, Southwark & Lewisham

Wandsworth (excluding Sutton & Merton)
Croydon (North only).

Table A1.2
DHAs by status group

Inner deprived (London)	**Inner deprived (non-London)**
Riverside	Central Birmingham
Parkside	East Birmingham
Hampstead	West Birmingham
Bloomsbury	Wolverhampton
Islington	Liverpool
City and Hackney	North Manchester
Newham	Central Manchester
Tower Hamlets	
Haringey	
West Lambeth	
Camberwell	
Lewisham and North Southwark	
Wandsworth	
Urban (London)	**Urban (non-London)**
Hounslow and Spelthorne	North West Durham
Ealing	Gateshead
Waltham Forest	Newcastle
Greenwich	North Tyneside
	South Tyneside
	Sunderland
	Hull
	Bradford
	Calderdale
	Huddersfield
	Dewsbury
	Leeds Western
	Leeds Eastern
	Leicestershire
	Sheffield
	South Bedfordshire
	Portsmouth and
	South East Hampshire
	Salford
High-status (London)	**High-status (non-London)**
Barnet	North Hertfordshire
Harrow	East Hertfordshire
Hillingdon	North West Hertfordshire
Barking, Havering and	South West Hertfordshire
Brentwood	West Essex
Enfield	Southend
Redbridge	Dartford and Gravesham
Bexley	North West Surrey
Bromley	South West Surrey
Croydon	Mid Surrey
Kingston and Esher	East Surrey
Richmond, Twickenham and	East Berkshire
Roehampton	Wycombe
Merton and Sutton	

	Southampton and South West
	Hampshire
	Milton Keynes
	Bristol and Weston
	Plymouth
	South Birmingham
	Coventry
	Sandwell
	Halton
	St Helens and Knowsley
	Preston
	Blackburn, Hyndburn and Ribble
	Valley
	Burnley, Pendle and Rossendale
	Bolton
	South Manchester
	Oldham
	Rochdale
	Frenchay
	Southmead
	Rugby
	South Warwickshire
	North Birmingham
	Solihull
	Macclesfield
	Southport and Formby
	Stockport
	Trafford

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