MANAGING LONDON'S HEALTH SERVICES

A preliminary analysis

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for the King's Fund Commission
on the Future of Acute Services in London

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Contents

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The authors have attempted to take on board the views of managers who have the responsibility for managing health care across the whole of the Thames regions. With such a diverse range of viewpoints it will never be possible to achieve complete unanimity. We have attempted to arrive at what we hope is a broad consensus of opinion that has allowed us to develop a preliminary set of solutions for London's health care. The responsibility for achieving that objective is ours alone.

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January 1992

EXECUTIVE SUMMARY

Introduction

Health services in London are in a critical situation. Although this study is principally concerned with acute and secondary care, the interdependence of all sectors must be acknowledged, including local authority and social services. There is a need to recognise that to overcome problems will take considerable political and managerial skill as well as a determination to overcome entrenched beliefs and structures.

There is no single answer to London's problems. Progress will emerge from the development of a strategy based on a combination of solutions. Any strategy must fulfil four basic criteria to achieve appropriate levels of care within budgetary limitations while acknowledging the significance of London as a specialist centre. These are:

- a strategy must be based on the needs of the population;
- the changing requirements of medical education must be addressed;
- a balance must be found between the provision of local, district, regional and national health needs;
- there must be a clear decision-taking mechanism for the whole of London.

A strategy based on the needs of patients

The primary objective of the NHS is to meet identified health needs. In order to achieve this the focus of provision should be centred on patients and populations and not on the needs of powerful political, professional and organisational lobby groups.

Decisions about planning and provision must be taken closer to the population to be served. Local needs should be given priority in planning local services.

There should be a shift of emphasis towards providing care in the primary and community sectors at the expense of the large acute teaching hospitals. Health care planning should reflect this changing emphasis.

If assessed needs are to be met, the nature, depth and complexity of deprivation in London has to be acknowledged and addressed within current patterns of funding.

Changing requirements of medical education

The pattern of patient care in London has been strongly influenced by the requirements of medical education. However, education must, in future, be shaped by current clinical practice and service needs. It can no longer be allowed to dictate the pattern of provision.

Declining bed numbers, lengths of stay and more primary- and community-centred treatment have all posed a challenge to the traditional teaching methods in medical education. There is an increasing acknowledgement of this by the medical schools and some attempts to alter the curriculum accordingly. These changes are to be encouraged.

Medical schools could be amalgamated into the main college campuses in London. They would not be attached to any particular teaching hospitals.

The balance between local, district, regional and national services

London has developed into a specialist centre at district, regional and national levels. It has been suggested that the provision of these (usually high technology, high cost, low volume) services has been to the detriment of more basic services for the local population.

Large teaching hospitals obstruct change to the pattern of provision. They can also threaten the concept of equitable access as patients outside the "home" district of the major specialist centre may only have limited access to services.

A clear decision-making mechanism for London

London's problems are compounded by, if not partially due to, the complex organisational structures for planning and delivering health and social care. A clear definition of strategy, goals and managerial structure is required. This has to begin with the Department of Health (DoH) via the NHS Management Executive (NHSME) and progress through regions to local level. This does not suggest top-down "management by edict" but a clear statement of policy, strategy and objectives along with clear lines of accountability and areas of responsibility.

What is required is a management structure that is responsive to input from the bottom up and is politically sensitive but not politically impressionable.

The means of clarifying boundaries and roles is open to debate. The two most common solutions are the "starfish" (which is currently in use) in which the four Thames regions have inner London, outer London and shire districts and the "doughnut" which would create one inner London region with the boundary drawn anywhere from the old Inner London Education Authority (ILEA) area to the area described by the M25 motorway.

The majority view from managers supported the option of two regions, a North Thames region and a South Thames region.

The effects of the health reforms

One of the most important effects of the reforms will be the alterations to well-established patient flows from outer London and the shires to inner London precipitated by health authorities now having to make explicit the cost of patient care and to provide local care for their own populations.

As patients are diverted away from inner London, providers in those districts will have to charge more for basic care as well as for specialist services for the local population. This will inevitably lead to greater and more explicit rationalising of care.

Inequity of access, as well as the problems of cost may be further increased as GP fundholders gain momentum. There is evidence that through the contract process GP fundholders have been able to negotiate preferential treatment for their patients.

The market in health care cannot be allowed to operate unchecked. Were it to do so there would be no sense of overall strategy and leadership in London's health services. It would severely undermine access to health care for the local population as hospitals in central London battled to stay in operation and there would be little incentive to provide alternative types of care.

There is clearly a need for a controlled market of some kind. Where this control lies is still to be resolved. Political sensitivity would dictate some involvement by the DoH and the NHSME.

There are three possible types of market. They are: the manipulated market which is controlled largely by the Government; the planned market in which the key players would be the DoH and the regions; the managed market in which it is the purchasers and providers who combine to achieve explicit outcomes.

Towards a blueprint for London

It is clear that a solution to the inherent and potential problems has to be found quickly by the creation of a radical and determined strategy. This strategy should include innovations which cross existing organisational boundaries.

London's reputation as a major teaching, research and clinical centre is suffering both from the degradation of the physical environment of the hospitals and because of financial pressures.

It is not sufficient to focus on structures and organisation. A fundamental review of London's health care needs is paramount. Strategic decisions have to made as to what services are going to be provided and to whom. This would involve political will and commitment to ensure an overall policy and strategic plan for London is implemented.

Any funding formula must take into account the complexity and depth of deprivation in the capital.

The important special interest groups such as the medical education lobby must also have their legitimate concerns addressed.

Abbreviations

AIP	approval in principle
CHC	community health council
DoH	Department of Health
DGH	district general hospital
DHA	district health authority
ECR	extra-contractual referral
FHSA	family health service authority
ILEA	Inner London Education Authority
LHPC	London Health Planning Consortium
NHSME	National Health Service Management Executive
RHA	regional health authority
RAWP	Resource Allocation Working Party
SIFTR	service increment for teaching and research
SHA	special health authority

INTRODUCTION

It is intended that this working paper should contribute to the King's Fund London Acute Services Initiative by introducing a discussion about some of the organisational options that might be considered if the widely held aspirations for change are to be achieved.

The work is based partly on an analysis of some of the literature on London's health care system. It is, however, largely founded on a series of interviews with managers who are grappling with the problems of running London's health care. It is also based on a workshop held at the King's Fund Centre on 30 May 1991 which offered many interesting insights into the organisation of health services in the Thames regions.

It is not intended that the scope of this study extend beyond a preliminary analysis. No attempt, for instance, has been made at detailed modelling and nor is there the very full discussion about the future role of regions, district health authorities, FHSAs and other elements in the NHS which would be necessary to provide a proper organisational blueprint.

It is intended that this working paper should indicate some of the current thinking among health service managers about the future direction of the organisation of London's health care. It is an attempt to identify some of the essential components upon which a further analysis might be built.

Before any effective structure can be put into place it is necessary to be clear about the expectations of the health services and their delivery. From the discussions and interviews carried out by the authors, the criteria discussed in the following chapters emerged as the major requirements for any organisation and structure of health services in London and the Thames regions. It is on the basis of these criteria that a tentative blueprint has been constructed.

CHAPTER 1

A strategy based on the needs of the population

Patient choice and patient needs

The fundamental criterion for any health service is to serve the needs of patients. This sentiment is expressed by politicians of all persuasions in addition to everyone involved in service delivery. The most notable restatement of this theme was by Margaret Thatcher in her introduction to *Working For Patients* who said, "All the proposals in the White Paper put the needs of the patients first" and "the patients' needs will always be paramount" (CM 555, 1989).

This assumed primacy of patient care is threatened by other interests and powerful lobby groups as they pursue their own agendas. These are longstanding tensions. In the 1920s the King's Fund refused to allow its grants to hospitals to be used for medical education, only for direct patient care (Rivett, 1986). In the 1966 reorganisation the then government reiterated the importance of patient care when it stated that teaching hospitals should also perform the role of district general hospitals (DGHs) and that, " the students be taught where the patients required treatment not vice versa"(Rivett, 1986).

Present government policy is about increasing patient choice and basing services on assessed needs. The particular make-up of London's health care system makes these policies more difficult to deliver. Patients' needs and wants are particularly frustrated by the rigid pattern of acute provision which is geared towards satisfying the demands of medical education and supraregional specialties.

Examples of this bias include plans from North West Thames Regional Health Authority which claimed not to be able to measure patients' needs for acute beds but that it was able to measure and quantify the needs of undergraduates in medical education and further claims by the community health councils (CHCs) in London that,

> *In order to meet what it views as teaching needs, the medical establishment wants "interesting cases" and "good educational material". But from their point of view, most of our health needs are neither sufficiently interesting nor sufficiently educational.*
>
> Community Health Councils in London, 1980

Much attention is currently focused on the idea of a "seamless service" The number of different agencies, possibly with conflicting aims, with which an individual client or patient may have contact, is cause for concern. In London this is compounded by the lack of geographical coterminosity between the various agencies and the consequent plethora of inter-agency boundaries.

The provision and planning of health services

There is the issue of the locus for the health service. It is generally accepted policy that more services should be provided in a community setting. London is disadvantaged by having both established acute care facilities and relatively poor primary care services (London Health Planning Consortium, 1980); Greater London Association of Community Health Councils, August 1990).

There are conflicting views on the use of acute services to make up for shortfalls in primary and community care. One argument was that acute care is a legitimate use of available services until the primary and community services are brought up to par. Others argued that this parity would never be achieved until the acute sector was cut back. The London Health Planning Consortium (LHPC) (1980) seemed to back a Thames regional plan to cut acute services *in order* to force an increase in primary services. The former has certainly happened but the evidence as to the latter is not apparent.

Service provision should be planned around the projected needs of the population. Regional health strategies are directed at this objective. This brings into question the location of some of the regional specialist services currently centred in London. For example, if the population is in decline and getting older, is it appropriate to continue to cluster specialist services for women and children and infertility services in the centre of London or should they be moved outwards?

The debate could be taken further and assess the health services people want. A survey along the lines of that carried out in Oregon may well indicate that people want easy access to simple services in preference to funding high technology and expensive services that will be utilised by relatively few patients (Dixon and Welch, 1991).

Bed numbers and their utilisation

There has been an assumed historical and persistent overprovision of acute hospital beds. It is also assumed that there are too many hospitals and the distribution is biased towards the centre of the capital. Up to the inception of the Resource Allocation Working Party (RAWP) London was also perceived to have a disproportionately large share of revenue for its population (RAWP, 1976). Since the RAWP formula came into use, the differences in expenditure between regions have decreased dramatically but the four Thames regions remain above their target allocations. For example, North West Thames in 1977 was 13 per cent above target and by 1988 had reduced this to 4.5 per cent. However, there are still marked variations of revenue allocation between health districts.

Some of the assumptions behind these assertions have been strongly challenged. It is widely held that inner London might not have a simple excess of acute inpatient hospital beds (London Advisory Group, 1981; Greater London Association of Community Health Councils, January 1991). It is claimed that much of the inpatient provision does not benefit Londoners but instead is used by patients,

from the shires and beyond the Thames regions, requiring particular forms of highly specialised treatment.

Because of the oversupply of acute beds in London there is much debate about reducing the level of acute provision. A more detailed analysis of bed utilisation indicates the position is more complex than statistics about bed numbers would suggest.

The designation of beds as "acute" often requires clarification. Acute beds are not always occupied by acute cases. According to the London Advisory Group (1981) there were 13 per cent fewer geriatric beds available in London compared with the rest of the country (Department of Health, 1990). This shortfall is thought to be at least partially redressed by using acute beds leading to what is known as "bed-blocking" (Murphy, 1990). It is also widely assumed that there are increased admissions due to sub-optimal primary and community care facilities such as residential care, nursing home and Part III accommodation. The number of acute beds available for acute cases (that is those cases in which hospital admission is a clinical imperative) is, therefore, significantly reduced.

The effect of primary and community services on levels of acute provision

In addition, the inadequacy of community and primary care provision has meant that a high proportion of inner London acute hospital beds are being used for sub-acute and chronic conditions. These include long-term geriatric care which in one district accounted for 15 per cent of all acute beds, (Murphy, 1990). That same survey found that of the 100 beds at Guy's that were allocated for psychiatric patients, one-third were occupied by people whose major problem was homelessness. The impact of other aspects of deprivation such as overcrowding, the percentage of single people and transience are less easy to quantify but they undoubtedly affect admission rates and increase the average length of stay. These factors force hospitals to provide accommodation for needs that are essentially social rather than clinical.

It is generally accepted that primary and community care services are underdeveloped in London (Greater London Association of Community Health Councils, 1990). The LHPC in 1981 suggested that,

> *There has been a continuing reduction in the number of acute hospital beds and many accident and emergency departments in the inner city have closed in recent years ... At the same time, the effects of the recession are leading to contraction of the social services financed by local authorities which support the sick and frail and other deprived groups at home. Thus two buttresses which traditionally have supported the primary health care services seem likely to give way together.*

Although the fears of the Consortium have not fully materialised in that services have not given way, the situation has not improved and little has been done to implement the recommendations of that report such as "the four Thames regions jointly set up and finance a team of

co-ordinators for inner London".

The extent to which accident and emergency and social services support primary care in London is highlighted by the information in the Jarman Report of 1981. Compared with the rest of England and Wales, London, especially inner London, had higher rates of hospital admission, considerably higher rates of accident and emergency attendance and significantly less contact with GPs. Given that the number of GPs per 100,000 is higher in London that for the rest of the country this implies problems with access to primary care services (Community Health Councils in London, 1980; Government Statistical Service, 1990).

Accident and emergency departments are often used inappropriately in that the patients could be treated elsewhere. However, if those patients cannot find a general practitioner who will take them on their list or who is open at the necessary times, then is it an inappropriate use of accident and emergency? The number of single-handed GP practices in the four Thames regions is 15 per cent compared with an average of 11 per cent in England (Government Statistical Service, 1990). In Ealing, for example, 47 per cent of GPs were single-handed practices (*NHSME News,* 1991c).

The predicament of primary care in London is a perfect example of a problem for which the solution has been understood for many years but which has not been tackled by appropriate action. In 1979 the Royal Commission on the National Health Service stated,

> *Improving the quality of care in inner city areas is the most urgent problem which NHS services in the community must tackle. Many of the difficulties are severe. Additional financial resources are needed and, in the case of London in particular, this will involve hard choices. We recommend that they are provided. Many London health authorities' expenditure is being squeezed as a result of the application of the RAWP formula. The London RHAs must make additional provision in distributing funds for primary care services to inner city AHAs to ensure that the improvement to services which we recommend is not impeded by lack of finance.*
>
> (CMND 7615, 1979)

Strategy

Government policy places great emphasis on defining patients' needs. It follows, therefore, that services are only effective if those needs are identified and being met. Whatever indices are used to measure deprivation, such as Jarman, Department of Environment Index of Deprivation, Townsend or UPA8, London always comes out "top" of the table. Reports such as those of the RAWP and the "Black Report" have all added weight to the fact that London is characterised by pockets of deprivation, extreme wealth, ethnic minorities as well as the problems of homelessness, a transient population, high ages of elderly, single parent families (RAWP, 1976). These demographic characteristics imply that planning takes place on the basis of small localities. Some health authorities have made good progress in this area but social

services and FHSAs have often developed this concept further. One obvious conclusion is to question the wisdom of these distinct statutory agencies triplicating this activity. For example, needs assessments and epidemiological surveys are likely to be carried out by local authorities, FHSAs and DHAs.

If information is gathered at a local level it may be that for the first time it will be possible to assess the effects of deprivation on the population. Jarman (1981) and others have proposed several indices of deprivation which are only partially recognised under RAWP and weighted capitation (DHSS, 1988).

If deprivation is not being adequately recognised this implies that there is an inbuilt underfunding factor and that services are failing to take sufficient account of these needs. It is unlikely that the types of service that respond to the demands of multiple deprivation match the current pattern of provision. For example, areas of multiple deprivation have needs that go beyond the provision of facilities for elective surgery. There is a need to go out and educate the public about their health and take services out to them. This implies complex and sophisticated primary care services. These services are largely absent in London and are unlikely to attract the level of funding required for them to function effectively.

If the response to the specific needs of London is to be successful then it will require a great deal of innovation in terms of both organisation and methods of care. It will require a fundamental shift of emphasis away from the preservation of large, historically prestigious hospitals designed to treat those with complex acute illnesses towards more community-based services that emphasise health education and prevention. The major problem for health service planners and managers is that such moves are politically fraught.

In order to satisfy the criteria of meeting local needs changes might have to be made to the way care is funded. Notwithstanding the difficulty of costing deprivation, a targeted source of funding could be developed either within existing funding formulae or in some protected form (King's Fund, 1987). This funding, however, would achieve very little unless it was linked to specific kinds of service response for deprivation.

CHAPTER 2

The changing requirements of medical education

Dwindling acute provision has had a significant impact on the organisation of medical education in London. There have been mergers of medical schools, the increased use of peripheral hospitals such as the relationship between Guy's medical school and Lewisham and students have been encouraged to widen their clinical experience through placements in primary and community care settings (Joint Planning Committee Working Party on Academic Strategy for Medicine, 1989).

The principal issues

These developments will not overcome the disparity between the number of beds needed for teaching and those needed for service provision. The LHPC (1980) commented, "the problem in London is, in essence, that the level of clinical facilities needed to support the medical schools concentrated in the centre can no longer be justified on service grounds". The other issue about centering services in inner London for teaching purposes is the assumption that it is acceptable for patients to have to travel often long distances while medical students cannot seemingly travel to see patients.

This apparent dearth of "clinical material" opens up a debate about the real needs of medical education as opposed to what could be described as assumed needs. Many of these assumed needs rest on the traditional belief that medical education must be hospital based rather than located, for instance, on a university campus. In addition, current educational practices take little account of the technological innovations such as computer modelling and skills laboratories both of which are already used in the training of Project 2000 nurses.

A further element is that a disproportionate amount of the country's medical education takes place in London although the total in south-east England is roughly in line with the rest of the country. It is widely perceived that the concentration of this activity within an area of dwindling population distorts the provision of service to the population of the four Thames regions. This also creates a difficult environment in which to carry out undergraduate medical education.

Several reports have attempted to explain why teaching hospitals cost more and lengths of stay are longer but once obvious teaching costs are removed, there does not seem to be a plausible explanation for the rest (DHSS, 1988; Akehurst, Hutton and Dixon, 1991). It is true that the lengths of stay have been reduced but then there is an issue of case mix. There is an assumption that the teaching hospitals attract and

indeed encourage the more complex and complicated conditions which mean patients require more expensive care and longer inpatient treatment. The availability of acute beds makes it easier for local and health authorities to exploit these factors in order to avoid committing resources to the primary sector and by implication cutting resources to prestigious teaching hospitals (Office of Health Economics, 1987).

This use of acute facilities has been fortuitous for the medical schools in that it has ensured, until now, sufficient clinical material for students. As the acute sector contracts, even if the primary sector is not expanding, there will be an increasing lack of patients available for traditional teaching purposes.

There is some evidence that there is a change of emphasis within medical education towards primary care but it is still very much centred on hospitals. There has been some work done in America assessing the impact of the educational setting on the career choices of doctors (Parkhouse, 1991). This work suggests that medical students, educated in high technology hospitals with easy access to research facilities opt to continue their medical careers in this setting rather than take up primary medicine. While there are obvious differences in the way education is structured in the UK there are parallels in the attitude towards general practice. The requirement to take postgraduate training to become a GP is relatively new. Despite considerable progress, a career in general practice is sometimes perceived as having a lower status than that of a hospital consultant, especially in surgery.

While these changes are to be welcomed and encouraged, other medical schools may be forced to adopt new approaches as hospitals become unable to support a training function as they cannot attract or are unwilling to provide services for a wide enough range of patients who would be the students' clinical material. Some of this shortfall may be overcome by grouping hospitals but even this may not be enough to offset the changes in provision in inner London wrought by the current reforms. Some hospitals may become even more specialised as they are too expensive to compete for district general hospital (DGH) type work while others may drop certain specialties as they are no longer viable in a market setting.

There are already quite marked differences in the number of medical students allocated to specialities in different schools for example the size of the student groups seconded to general medical firms ranged between four and five (at UCH) to 10 (at St Thomas') but in gynaecology groups were as large as 15 (Guy's). The time spent in various specialties is also variable. For example, the paediatric rotation can last from six weeks (The Royal Free) to 10 weeks (St George's) (London Health Planning Consortium, 1980).

At present, medical education is inextricably tied to the provision of acute facilities in London. The perceived overprovision of inpatient beds is complicated by the particular interests of teaching hospitals. It is clear that within the medical education establishment there is an acknowledgement that new models of education need to be developed (Joint Planning Committee Working Party on an Academic Strategy for Medicine, 1989).

Possible solutions

One solution that has been mooted is based on an attempt to clarify and separate the sometimes conflicting needs of medical education and the provision of services. This has been studied before, most notably in 1980 by Lord Flowers (University of London, February 1980). It was suggested on several occasions that medical schools should be attached to universities rather than hospitals. A given university would take over responsibility for the clinical teaching at several hospitals. For instance Imperial College might be responsible for St Mary's, Charing Cross and Westminster; University College for UCH, The Royal Free and so on.

This would benefit medical students in that they would have access to a much larger clinical population, being treated in a variety of clinical settings other than acute hospitals, as well as easy access to the academic and research facilities offered by a university. There may also be other advantages to this scenario if inner London's acute facilities are to be rationalised in that it would break the problem into manageable proportions.

Changing the funding of medical education is a major national issue but it is likely that any changes would be made with a view to solving the difficulties in London. The options for funding include subsidising the cost of patients treated in teaching facilities. At the moment the service increment for teaching and research (SIFTR) formula is said to be inadequate in total and also not always distributed equitably.

Another option would be to fund the medical schools (or the university) from the Department of Education so that they could buy clinical teaching facilities wherever they chose (Greater London Association of Community Health Councils, 1990). The schools would be funded on the basis of the number of students that they were teaching. In the parlance of the health White Paper reforms, the money would follow the students and the students would follow the patients.

Any changes to medical education, especially those expedited by changes to the pattern of acute service provision will, inevitably, have political ramifications if only because of the prestigious reputations enjoyed by the major London teaching hospitals. This makes the need for a clear, consistent and comprehensive strategy from the DoH through to individual units even more critical.

Postgraduate medical education

Changes in undergraduate medical education need to be planned in conjunction with postgraduate education. Apart from general practitioner training, the foci for most postgraduate training is the major teaching hospitals and more importantly the special health authorities (SHAs) whose patients are referred from other hospitals and specialist units.

The SHAs have even more of an emphasis on teaching and research than do the "ordinary" teaching hospitals and, therefore, have

less emphasis on providing services for the local population even though they are all based in London.

If undergraduate training was more generic there might well be an increased need for postgraduate courses. It could also mean that postgraduate training would become both more diffuse and more specialised. It would become more diffuse in that more doctors would have access to it and, therefore, the hierarchical structure of the profession might become diluted. It would become more specialised in that, much like postgraduate nursing programmes, courses could be structured to teach specific skills that are highly relevant to everyday patient care.

One benefit for London in particular would be to ease the pressure on the teaching hospitals to find enough clinical material for their undergraduates as they would not be cramming such a large syllabus into such a relatively short period of time. Postgraduate teaching could take place in a variety of hospitals rather than concentrating expertise and facilities on to a few sites. Students would be exposed to a wider range of patients and would increasingly treat them in environments other than large sophisticated hospitals. Patients would benefit by not being exposed to large numbers of medical students and would potentially have a better chance of being treated in a hospital closer to their home.

CHAPTER 3

The balance between local, district, regional and national services

There is an argument that Londoners benefit from having national centres of excellence in the capital. There is an alternative argument that suggests these services displace provision for the local population.

In terms of accessibility and cost, it is unclear whether national needs are best served by concentrating regional and supraregional specialist services in London. South East Thames regional health authority, for example, has moved some of its specialist services out of London without any apparent negative impact on care but with a reduction in costs. Many other national and regional specialties could be relocated out of London. For example, as central nervous system malformations are more common in the North of England it would seem justifiable to base research work in Manchester or Liverpool rather than in London (OPCS, 1988). Clinical services attached to this research would be more accessible and possibly less expensive.

Given proper planning and funding, the presence of national and regional specialties should not have to conflict with local provision.

Acute service provision for inner London, as manifest by bed numbers, is not completely related to the resident population. The hospitals provide accident and emergency services not only for residents but also for commuters and tourists. If it is assumed that the 1975 figure of 10 per cent of all accident and emergency attenders require admission this could arguably add up to 10 per cent to the number of acute beds needed to service the population who *utilise* the hospitals (London Coordinating Committee, 1975).

There is little reason to believe that admissions through the accident and emergency department have fallen. For example, 85 per cent of admissions to Ealing Hospital (currently applying for trust status) are through accident and emergency, leaving little, if any, scope for planned admissions and elective surgery (London Health Emergency, 1991). Other inner London hospitals claim their admissions via accident and emergency are up 50 per cent and that waiting lists are lengthening (*Independent,* 8 November 1990). These levels of emergency service severely limit the ability to plan elective services and they will add to the financial problems of these hospitals as emergency admissions are paid for as extra contractual referrals.

London hospitals are not conventional district general hospitals in that they do not have discrete catchment areas and in some cases provide acute services on a national as well as regional basis. Market forces in the new environment may affect the balance between availability of beds for patients outside London and the Thames to the

detriment of local residents. Those coming from outside the region may get preference because their health authorities may be willing to pay a higher cost for fewer patients. The local health districts on the other hand will curtail their use of expensive services as they will have more patients requiring the services of acute hospitals in London.

The highest patient flows are still from the shires to outer London and from outer London to inner London (Akehurst, Hutton and Dixon, 1991). Any changes to bed numbers in inner London will have a knock-on effect on both outer London and the shires (Association of London Authorities, 1988). How equitable will be the effects of these changes throughout regions remains to be seen. However, simply looking at bed numbers across the region will not improve the situation either as the provision of other secondary services as well as primary and community care is variable across regions and these play a role in the utilisation of acute services. Such a pan regional approach also ignores the social variables which affect the ability of many patients to travel in order to receive care.

The distribution and pattern of acute services is further complicated by two conflicting trends in the general development of acute care. There has been an increasing development to increase the size of acute facilities in order to achieve economies of scale of capital investment. In addition, clinicians providing specialist services argue that the best results come from a concentration of their skills and facilities. This is countered by a possibly even longer-term trend which is the development of "lap top" medical technology which implies, for at least some specialties, a decentralisation of acute services and the development of home care (Banta, 1990). There is a danger that the continued development of large-scale acute facilities could well result in them being finished in time for them to qualify for obsolescence.

The SHAs highlight the problems of location, role and size of highly specialised service provision. A circular from the NHSME suggests that the SHAs should serve the needs of the local population but if they do they will have to be competitive with other providers and funding from the centre will only be given to tertiary work (NHSME, 1990). In the case of SHAs the providers rather than the purchasers will lead the service.

If there is a need to reallocate and relocate supraspecialist services (and within London regional specialist services) the problem arises as to who would be able to enforce such changes. It would be unlikely that a London based authority or the SHAs themselves would be able to balance local and national needs.

Although it is hazardous to predict the future pattern of acute service provision, some broad trends are becoming apparent in the light of the health reforms. Hospitals are likely to continue to reduce the number of acute beds. If general practitioners take up the opportunity to perform more minor surgery and purpose-built day case units become attractive investments for providers, then the volume of acute work carried out in what are now conventional hospitals will decrease.

This implies that there at least three possible scenarios for the various specialist services within the NHS. Firstly, they could be

concentrated in single speciality providers serving a supraregional population and, as potential monopoly providers, may not be under the same pressures to offer competitively priced services. This would entail a rationalisation of specialist services between London teaching hospitals. A second option could be that regional specialist services are spread out among several smaller providers to the extent that they lose their innovative capacity and the cutting edge that comes with extensive highly specialised experience. As provider units are forced to assess what services are viable there will be a period of reassessment about the nature and scope of specialist services. This could spill over into advances in medical technology so that new equipment and procedures will be more stringently assessed, not just in terms of benefits to patient care but also whether they fit the service profile of the provider unit. Purchasers too will influence the introduction and development of technological and procedural innovation in that they may refuse to purchase certain procedures on the basis that they are still experimental or that they are not cost effective (Moore, 1991b).

The debate about rationing is likely to become more explicit. For instance, some purchasers may refuse to pay for intensive care of patients over 70 years of age or for peripheral vascular surgery on patients who are recalcitrant heavy smokers.

A third option for specialist units and indeed for more general acute work is that it will be taken up by the private sector. If specialist services are forced out of the NHS the private sector, especially in London, would be well placed to take up some of the slack. There is already evidence of the private sector getting involved in such work. For instance, BUPA has set up a lithotripter in St Thomas' on the basis that 25 per cent of the patients treated will be private.

The future organisation of London's health care is as much about process as it is about structure. How organisations function is as important as the location of their physical boundaries. The speed at which these effects take place will principally be determined by the extent to which the market is allowed to operate.

CHAPTER 4

A clear decision-making mechanism for the whole of London

From central government through to regional and district management level there has been little evidence of a consistent style and strategy in the approach to health service provision (King's Fund, 1987; Press Release, 9 January 1987). Policy has alternated between centralised control, based on economies of scale and tight accountability, to an approach that encouraged devolution of authority and accountability along with increased responsiveness to local needs (DHSS, 1983; CM 555, 1989).

The complexities of health care provision in London make the harmonisation of style and strategy throughout the health service organisation an essential requirement if agreed objectives are to be achieved. The first step towards achieving a cohesive approach is to clarify the process of decision making from the centre to local level. This criterion does not prejudge any particular type of structure but rather that future structures should be able to deliver a particular process.

It is evident both from the interviews carried out and by the consensus of opinion at the workshop that the present arrangement of London's health care, divided between four regions, with many decisions being referred to civil servants in the Department of Health (DoH), is not thought by managers to achieve that objective.

Equally important is that decisions which emerge have tended to come either from the DoH or through special committees. Strategic planning decisions cannot be taken by one region in isolation from its neighbours (London Health Planning Consortium, 1981; London Advisory Group, 1981). Given that both district and regional health authorities are publicly accountable bodies whose decision-making process should be accessible to the public, it is important that this process is visible.

The relationship between the DoH and local health authorities was cited as being at the heart of many of the perceived organisational issues concerning the provision of health care in London. There is a wider debate about the role of the DoH in relation to the NHS in general which is beyond the scope of this document. There are, however, a number of factors which are peculiar to London.

The complexity of inner London boundaries, combined with the general proximity and volume of provision in inner and outer London, creates a myriad of decisions that need to be taken beyond regional level. There are regional boundary changes which would help to bring London under tighter overall managerial control. Most of these options are well known, for instance the creation of one inner London

regional health authority. This could be the size of the former Inner London Education Authority, the former Greater London Council or even an area described by the M25 motorway surrounding the capital. The "doughnut" option as it is described, would leave the outer London health districts to form regional boundaries in permutations that would leave them without the usual pattern of regional acute facilities.

The prime argument in favour of a central region is that there would be one publicly accountable health authority that would have a pan London perspective. This is countered by notions about the political acceptability of a powerful central London region. In addition the socio-geographical make-up of London is about interdependence between the centre and the hinterland. The transport links and huge volume of commuter traffic inextricably link central London to the shires.

In the course of several interviews and at the workshop much more support was given to a solution which created two regions north and south of the Thames. There was particular support for any option that removed the boundary between North West and North East Thames. There was far less concern about the regional boundaries south of the Thames.

The boundaries between the north and south Thames regions approximate the line of the river Thames. There is relatively little activity across the river. For example, only 9 per cent of patients from the inner London areas of North West Thames cross into either South West or South East Thames for treatment in local acute specialties (Akehurst, Hutton and Dixon, 1991). Between the two regions south of the Thames there is no substantial cross-boundary movement. From South West Thames to South East Thames for instance, the largest flow is 15.5 per cent for local acute specialist services (Akehurst, Hutton and Dixon, 1991).

The greatest cross-boundary flow between regions is between North East and North West Thames. For example over 32 per cent of general medical patients from the shires of North West Thames are treated in North East Thames (Akehurst, Hutton and Dixon, 1991).

Despite a seeming majority view by managers in favour of a two region structure, there was a minority in favour of the "doughnut" option. Although in basic organisational terms there might be more complexity by having one region spanning the Thames, there would be other gains because one region would afford a greater opportunity to achieve the strategic harmony referred to earlier.

The presence of four regions was often cited as one of the stumbling blocks to the production of a consistent and comprehensive strategy. Before any serious debate can take place over the options for regional structures, including current plans to reduce the number of regions nationally, the role of the region itself has to be clarified. Prior to the health reforms, the regions had a clear line management relationship with districts. Their function was to monitor, control and finance health care provision. In the new climate that role has changed as has their function. Regions no longer have clear line management

roles with providers and although finance is still allocated from the centre on a regional basis, the regions have a reduced role in controlling expenditure within districts.

This does not suggest that there is no longer a role for regions. Clearly there has to be a linkage between district health authorities (DHAs), FHSAs and the DoH. There are three main functions that have been identified for regions.

- They will continue to have a direct managerial relationship with DHAs as purchasers and with FHSAs.
- They also have a role to play in monitoring the providers (i.e. in the formation of trusts). By doing this, the regions can ensure that the concept of core service provision as mentioned in *Working For Patients* is not lost. They can monitor more effectively than individual purchasers the overall provision of care for their population and are powerful enough to create change where necessary.
- Thirdly, regions could provide the main focus for education and training for the health professions. Regional training directorates would have the ability to ensure that adequate teaching facilities were available on a regional basis, which would mean that more specialised treatment facilities were also available in each region. The impact on London could be enormous as it would break the stranglehold the capital currently has on the teaching provision at both undergraduate and postgraduate levels. Regions that serve London, however many there are, would also be free to concentrate on the provision of health care for their region only.

Regional boundaries could also interfere with the natural merging or combining of health districts. There was also some uncertainty about the optimal size of future purchasing health districts. There was a concern that the natural progression to combine in order to achieve economies of scale might reach a point where it was at the expense of the very detailed localised planning necessary to satisfy the needs of patients.

These concerns could be ameliorated although not entirely satisfied by creating an overall strategic cohesiveness and planning framework. There are at least two approaches to this. The first set of options concerns the debate about whether or not to set up an *ad hoc* or temporary arrangement to accomplish a specific number of objectives within a limited time span. In practice these objectives might imply the closure, rationalisation or relocation of two to three inner London teaching hospitals in order to achieve the reduction in what is assumed to be an overprovision of acute hospital services.

A "task force" solution implies that "the London problem" is partly a temporary situation that will be solved once a limited set of objectives have been achieved.

The alternative view is that many of the factors which make London's health care a special case are unlikely to have vanished before the end of the century and will persist for the foreseeable future.

The task of co-ordinating the Thames regions within the DoH

has, since 1976, rested with the Regional Liaison Division. Under the latest guidelines published by the NHSME this role will essentially be carried out by the Performance Review Directorate (NHSME, 1991a). It is noteworthy that one of the two performance managers will cover only the Thames regions while the other will cover the remaining 10 English regions that have a combined population of over three times the size.

The role of the Performance Directorate appears to be wider than that of its predecessors: "it will have a managerial/leadership role, rather than a secretariat/co-ordinating function". More specifically, the role of the Thames performance manager is to "have responsibility for making sure a coherent strategy for health services in the capital is developed and implemented". This responsibility includes the SHAs. This structure is due to be in place by 1992 when the NHSME moves to Leeds.

This involvement is complicated by the conflicting goals held by the NHSME and the DoH in which it is placed. While no part of the NHS can expect to be immune from the demands of politics, it is clear that the closer to the centre decisions are being made the more likely it is that political considerations will have more impact on that process of decision making.

On the assumption that managerial decisions are being made in the best interests of patient care, the inevitable addition of political considerations can only be detrimental. This is particularly so when decisions are challenged by the clinical groups. The potential of powerful clinical lobbies to make their case heard may interfere with what should be clear managerial decisions.

Nevertheless, it is clear that the centre sees itself as having the major role in tackling the perceived problems of London. What is also evident from the views gathered by the authors is that the complexity of managing London's health care through four separate regions (if this configuration is to persist) demands a consistent and institutional mechanism to bridge the limits of regional authority.

A further characteristic of the centre is that it is responsible for both SHAs and trusts. In the context of London it is frequently referred to a the "fifth region". Clearly the increasingly direct involvement of the DoH through the NHSME at both strategic and operational level will have considerable effect.

The performance management structure set up within the NHSME would theoretically be capable of producing the necessary managerial dynamic to achieve the desired objectives. There remains a lingering doubt that very sensitive decisions would remain immune to political considerations. In fact the reverse argument was presented, namely that ministers would be able to allow more radical action to be taken if decisions were made outside their department, precisely because they would be better able to distance themselves from them.

The appointment of a team to advise the Secretary of State under the chairmanship of Sir Bernard Tomlinson is welcome in that it should shed some light on the overall situation. The context in which that team issues its advice should be treated with care.

Another centralist option would be for some kind of formal consortium to be set up between existing regions to determine a pan London perspective. This option would appear to be little more than theoretical under the present arrangements. It would by necessity function on the basis of consensus, bargaining and lobbying and would appear to attract all the managerial problems that are generally associated with this form of confederalism.

Each Thames regional health authority has now set up a "London" team at a senior level. This allows the DoH to co-ordinate London's problems through the regional health authorities (RHAs). There is an inherent logic in this plan. The Department has the advantage of being able to produce final decisions at a level that individual regions would never be able to do. In particular, decisions over planning matters such as approvals in principle (AIPs) would be more readily taken. Given the understandable parochialism of regions, a departmental perspective would have the advantage of being able to take in London as a whole at an earlier stage of strategic planning.

There are cogent arguments in favour of the opposite view. As a matter of principle as much decision making should be made at the lowest possible level, although it must be recognised that this level may not be as low as is desirable due to the enormity and complexity of the NHS as an organisation. There is a danger that local needs will be subordinated in favour of centralist social engineering. Also, just as the DoH is able to gain access to major decisions because of its organisational proximity to political power, that very proximity could interfere with the managerial priorities.

It was consistently pointed out that there is a vast amount of informal discussion between the DoH and the four regional health authorities at both managerial and chairman level. There is also much linkage through the regional hierarchies. It would, therefore, be inaccurate to say that there does not already exist a great deal of sharing of problems, views and perhaps even a broad consensus over strategy. There is, however, a vast difference between this kind of informal collaboration and a definitive decision-making process which straddles all the Thames regions.

There is a tension between the creation of a structure which would be capable of having authority to take decisions across regional boundaries but which at the same time would be perceived as offering a clear, explicit and open decision-making process.

Because the NHSME is organisationally couched within the Department of Health, political considerations will tend to congregate around sensitive decisions. From our material it is clear that even where this is not the case it might well be perceived as such and thus decisions will face a loss of credibility. It must be concluded that as much decision taking as possible should be made within the health authority structure even if change is required to facilitate that objective. It was suggested that although it would in principle be organisationally acceptable for the NHSME to maintain such a high profile, it should only do so on the understanding that it had to deliver strategic decision making which was crisp, clear and visibly accountable.

CHAPTER 5

The effects of the health reforms

The major obvious impact that the health reforms will have on health services in the Thames regions will be to accelerate the shift in demand away from inner London to outer London and shire districts. This could be construed as the effect of market forces but might be more helpfully understood as simply outer London and shire health districts attempting to provide local services for their local populations.

It is clear from recent work that the likely readjustment of demand and, therefore, ultimately supply is not a simple shift from inner to outer London (Akehurst, Hutton and Dixon, 1991). Indeed, there is considerable potential movement both between the Thames and neighbouring regions and also between the outer districts. In a report commissioned by the Inner London Health Authorities, the Health Economics Consortium stated,

> *after April 1991 a different set of incentives will govern the behaviour of District Health Authorities responsible for purchasing services for their resident population – the cost of services will be an explicit consideration, and co-ordination of service provision through the planning process will be less important.*
>
> (Akehurst, Hutton and Dixon, 1991)

Another factor is the effect of GP fundholders on the pattern of purchasing. Evidence is starting to emerge which shows that this demand will become quite unpredictable as GPs simply shop around for the best deals. At the moment this evidence is largely anecdotal and reported on an individual case basis in the popular press and other journals, but as the number of fundholders increases the effects are likely to become more apparent and quantifiable.

This might encourage local providers to move into some form of linkage with local GP practices, giving them incentives (which could only be provided locally) in return for their business. This would emulate the preferred provider model of the US health care system. Under this system, individual patients, through their GP are free to seek treatment wherever they want but will only be fully reimbursed for the cost if they choose to utilise a service that is a "preferred provider". Where there are geographical gaps in acute facilities, it is possible that private providers would enter the market and develop relatively small scale acute facilities to compete for the same business.

The link between GPs and private sector providers should not be ignored or underestimated. Many GPs have been involved with private sector providers for many years through private health care insurance

schemes. The ability to purchase health care for their NHS patients would simply be an extension of an existing activity and not a new development.

The other major development is for purchasers to merge or form consortia. There has already been rapid progress in this area such as the South East London Commissioning Agency. This would allow purchasing districts to have more flexibility and power. It could make purchasing less localised and it is unclear what the optimum size for purchasers would be.

The impact of the "market" will be the key factor that could bring about change and it would appear it might be used to achieve what a "task force" approach might fail to do.

In the workshop there was a school of thought that argued that "the market should be allowed to decide" the future pattern of acute hospital provision in inner London. There are three reasons why this is not viable.

Firstly, there is not as yet a fully operational market in health care. In theory, the method of funding (weighted capitation) allows the outer London and shire districts to purchase their health care wherever they wish. If the market were allowed to operate, it would have a devastating and immediate effect on acute hospital resources in inner London. This would be in addition to the already severe difficulties in which they find themselves.

The first year of the post-reform NHS (1991–92) operates on the basis of "steady state" which means that health authorities have to follow existing patterns of referrals. It is clear, however, that even from 1992–93 onwards when "steady state" is lifted, a weighted capitation system will not be fully operational. Some views indicated that weighted capitation would not be properly realised until as late as 1997 but most estimates were slightly less pessimistic. The NHSME (1991b) still aims to have weighted capitation implemented at regional level by 1993–94 (EL(91)103).

Although there is no way of knowing when the full force of the market is going to be unleashed on inner London, it is clear that decisions over the pattern of future provision are going to be made by other means.

The market is not considered the appropriate method to rationalise health care provision. There was a predominant view among managers that if the market were allowed to "decide" then the process of transition would be traumatic and possibly chaotic and the consequences would not produce the best pattern of provision.

It is clear, for instance, that acute hospitals operate in terms of specialities and functions. Although the whole is bigger than the sum of the parts the specialities would, for market purposes, operate in their own right. All hospitals would vary in their market performance in each specialty. It is unlikely that any one hospital would fail completely early on, but rather there would be a gradual contraction of functions. It is almost certain that every major inner London acute hospital would face accelerated attrition but in a way that was not always easy to predict.

Hospitals would face the added complications of a chaotic

relationship with their support services. At what point would a hospital cease to have adequate back-up for an accident and emergency service? What would be the effect on medical teaching? What would happen to services that were backing up or complementing provision in the community? Block contracts and other specific actions by the local purchaser to rescue the situation, if thought desirable, would probably be unsuccessful as the hospital would remain too reliant on external sources of work.

The third reason why the market should not be allowed to proceed untrammelled is that it would provide random planning solutions. For instance, a particular provider might for a couple of crucial years be led by an extremely successful entrepreneurial management team who would ensure its survival over its competitors. There is no guarantee that this provider would have been offering better quality health care over its competitor and would in the long run be preferable over its competitors in offering the best acute facilities.

What is more likely to happen is that a modified version of the market will be used to achieve predetermined objectives. In a sense market pressures have been operating for some years. The demand for inner London acute facilities has been reduced as the population has declined and services in outer London have grown. It could be said the post reform market merely makes this process more explicit.

There are three ways in which the market might be allowed to work more explicitly to achieve change. These are: the *manipulated* market; the *planned* market and the *managed* market. They are not mutually exclusive options but rather separate pressures which might well operate at the same time.

The market could be manipulated to achieve desired ends. It is clear that this form of action could only be orchestrated by the government or an agent such as the NHSME acting on its behalf. In essence decisions based a variety of criteria, including political expediency, would be made as to which hospitals should close and what the desired pattern of provision should be.

There is no explicit organisational model which would operate on this basis but there was a substantial body of opinion that this is how matters would probably be dealt with. The role of medical education and its powerful lobby in determining the distribution of acute facilities is well documented. The perfectly reasonable demands of this lobby are viewed as the major stumbling block in resolving the issue of rationalising London's acute facilities on the basis of the best service for all the patients in the Thames regions. The market would be manipulated so as to create a process whereby a desired objective would be achieved without an explicit decision being taken.

Another proposed model could be a planned market. Here the key players would be the regions and the DoH acting in concert to plan the pattern of acute provision. This would be based on a prediction of market forces tempered by the traditional values of public sector planning.

A third model is the managed market. This entails groups of purchasers and providers within the market combining to achieve

explicit outcomes. One version of this would entail a group of purchasers forming a type of confederation in order to co-ordinate the demand for health care. The most notable example is the Inner London Health Authority Chairmen's Group. This group has lobbied for greater central co-ordination for some years and has at various times been seen in opposition to the traditional regional structure (King's Fund, 1987). Other examples range from the formal setting up of a south-east London consortium, to the informal co-operation taking place throughout the Thames districts (Moore, 1991a).

A powerful coalition of purchasers could obviously have a profound effect on the pattern of provision especially through its own directly managed units. Its influence will, however, always remain limited. There are too many other factors beyond the control of purchasers (both organisational and geographical) for them to carry out the task of completing a rationalisation process.

A potentially more effective coalition would be between providers. There is as yet little evidence of this development except in the most informal sense. Progress has been impeded by the current differences between types of providers together with only limited separation between purchasers and providers. There is certainly the prospect of co-operation over competition but again the management structure would constrain their authority.

There is, therefore, no one market pressure but rather a number of factors which will seek to influence the market. The three identified above are likely to offer only part of the picture.

Within the market itself, the patterns themselves have still to be established. Apart from the one major trend of provision moving towards the source of weighted capitation, the other trends cannot yet be identified. The potential effect of GP fundholders is not evident apart from the high degree of influence they will have because they are able to use their resources more freely than health districts. Similarly the pattern of acute provision is equally difficult to predict because the number of large facilities in the planning phase means that the future pattern will not just be a simple matter of rationalising the current level of provision.

CHAPTER 6

Towards a blueprint for London

Although the enormity of the task of devising a workable strategy for the Thames regions should not be underestimated, it is an achievable goal. The seemingly intractable problem is solved by creating a process that will deliver that strategy.

The current situation is a legacy of the failure to create that process. The excess of acute hospital beds in inner London and the overconcentration of teaching facilities is a symptom rather than the problem. It is possible that the creation of some kind of task force mechanism is necessary in order to reach very quick short-term or temporary solutions although the arguments against this are perhaps more persuasive. What is clear is that the task force solution, even if proved necessary, would be insufficient. It would, at best, buy time.

Time itself is not an ally in solving the problem. There are issues that should have been tackled at least a decade ago (and indeed were attempted). In terms of geography and type of provision, the advent of the market will accelerate the decline of the inner London acute hospitals without allowing appropriate alternative provision to be built up. It is also clear that the "London problem" is not a simple matter of closing two or three much loved teaching hospitals. It is equally important to build up patterns of care which serve the clearly established needs of the local populations.

The exact nature of those populations needs to be identified. Although the needs of the population of inner London are both pressing and urgent, these should not be pursued at the expense of the resident populations of outer London and the shires. The strongest views expressed by managers in the course of the study were from those based in the latter areas who felt their patients had for too long received too little local provision at the expense of patients in central London. In addition, population needs cannot be restricted to residents. Much health care in London is demanded by commuters, who spend the majority of their waking hours in the capital, as well as by large numbers of tourists.

One cannot reach firm conclusions about the preferred structure for London's health care without a much more detailed analysis that includes a precise definition of the roles of the component parts, particularly at district and regional level. However, any plan for London's health services has to address five basic criteria:

- The established needs of all patients within the Thames regions are paramount.
- London's position as the premier provider of pan regional and

national specialist services has to be balanced against the more basic requirements of the local population. This means that the district health authorities in the shires and outer London have to be explicit about their plans.

- Medical education must change and develop to meet the new challenges of health care post White paper reforms, however this must not compromise the quality of that education.
- There must be clear lines of accountability, responsibility and communication.
- The fundamental changes set in train by the NHS reforms require proactive and effective management.

Options for achieving these criteria have been discussed in preceding chapters. In summary they include the following.

- The transfer of medical education to the universities. This could perhaps include one central body that co-ordinated the placement of students utilising all the health services available irrespective of district or regional boundaries.
- The boundaries between the various health and social service agencies are in need of urgent consideration as their complexity acts as a barrier to effective service delivery and management but especially to the implementation of one of the key components of the White Papers, namely the concept of a seamless service.
- London's population scores highly on all of the deprivation indices in current usage and that in itself is an argument for increased funding to the capital.

However, this argument could be taken further by suggesting that London is a "special case". It is not simply a problem of deprivation but rather that the deprivation is complex in scope and degree and is responsive to factors outside the provision of health services. The complexity and intensity of the health and social problems in London are sufficient to warrant special consideration. These problems are compounded by the unique patterns of acute service delivery and organisation in London.

In suggesting a possible model of health care for London, we are not proposing that radical structural and organisational change is needed throughout the country. The model is meant to address the very specific needs of London while taking into account the need to preserve pan regional and national services. It is possible that some of the tension between the provision of local, regional and national services will decrease under this model as hospitals in London rationalise their service provision and become clear about the types of service they can provide and at what costs. The hospitals will no longer have to try and balance the provision of local services with the desire to compete for prestige as specialist institutions in a number of areas.

Once a decision has been taken that change is needed in the organisation of care in London it is important that it is properly

implemented. This implies a long-term strategy, even if its implementation is staged, rather than a series of short-term measures which are more open to equally short-term political considerations and which may in fact impede the more long-term goals.

During the course of interviews with managers and at the workshop it became clear that the preferred structure for health care in London was one based on two regions – a North Thames and a South Thames Regional Health Authority. Below this would be conglomerations of purchasing or commissioning bodies and the providers. There was a minority view which favoured one pan London authority.

The purchasing authorities would be responsible for purchasing health and social care for their designated populations. This would remove one and possibly two sets of organisational boundaries, that is, between local authorities and district health authorities and FHSAs. It would also remove the increasingly artificial boundaries that exist between providers of services, that is, what is health care and what is social care and where should primary care begin and secondary care end? Providers would be forced to be more specific about the services they offered and would have to operate in a way that was not contradictory to other providers in the locality.

A reorganisation of services in London would provide an opportunity to establish pilot sites to assess the most appropriate way of setting up these combined authorities.

An amalgamation of purchasers implied in this model would mean the removal of several tiers of management and bureaucracy. It would also clarify the lines of managerial accountability and responsibility. The removal of two regions would streamline the management of London's health and social care services possibly to the point where the role of the centre is limited to that of monitoring the way the market is operating and the dissemination of national strategic initiatives. The special relationship between the trusts as providers and the DoH would have to be clarified in respect of directly managed units.

The issue of the market and the process by which it might become modified was by far the major immediate matter for debate. Although the various combinations of formal and informal alliances would be able to steer the process, they would reach organisational limits to their authority. Given the undesirability of placing the major strategic role in the civil service (albeit in the guise of the NHSME), the only option which might offer a long-term solution is for the regional tier (with appropriate authority) to take on the complete role of regulator.

In summary, there is not one solution but rather a series of solutions which, if implemented within the framework of a long-term strategy, would provide the health and social care required by the population of London while taking into account the legitimate claims of several special interest groups. The most difficult task is to establish a proper organisational dynamic which will realise the widely shared aspirations referred to in the Introduction.

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The King's Fund Commission on the Future of London's Acute Health Services' terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.

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