Healthcare for London: a framework for action

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The provision of health services in London has been of concern for many years and has resulted in a number of enquiries and reports. Between 1992 and 1998, for example, there were three major reports by: Bernard Tomlinson, a pathologist and chairman of a regional board in north east England (1992);[1] the King's Fund (1997);[2] and Leslie Turnberg, professor of medicine and former President of the Royal College of Physicians (1998).[3]

All three commented on inadequacies of some services, resulting in inequalities of health in London and proposed a variety of measures to rectify the identified failings. In addition, in 1981, Donald Acheson (Chief Medical Officer 1983–91) chaired a committee which analysed some of the deficiencies in general practice in the capital and put forward recommendations for improvement.[4]

This fascination with London's health services did not end in 1998 as the report from Lord Darzi, honorary surgeon and parliamentary under secretary of state, and his colleagues has proved.[5] This most recent report briefly acknowledges the previous enquiries, but the majority is concerned with proposed changes needed to meet future challenges. Many of the recommendations are similar to those made over the past 26 years but, unfortunately, there is no attempt to analyse the possible reasons for failure to implement some of the previous proposals. This is a very great pity, as the report may thus result in a similar fate. The five principles underlying the Darzi Report are to focus on individual needs and choices, localise where possible, integrate care, focus on prevention rather than cure, and to concentrate on health inequalities.

These are all welcome. But it is when details are examined that problems appear and the unimplemented lessons from previous reports become all the more glaring.

The Darzi Report was prepared largely by clinicians, medical and non-medical, some health service managers, and a great deal of input from management consultants (McKinsey). Although the views of the 'public' are said to have been sought in a number of meetings and surveys, no lay person or patient was a member of any group. Unfortunately there also appears to be a deficit in input from academic researchers who have worked in the field. There is no evidence of any mental health clinician being involved, with input stemming from the chief executives of mental health trusts. The emphasis of the report is on changes in primary and community care. In view of the importance of mental health as a cause of consultation in primary care this omission is unfortunate.

Deficiencies in general practitioner (GP) services in some parts of London have been noted on many occasions in the past. The suggested solution is to create polyclinics on a few sites in each primary care trust, but there is little detail about what this implies. If the aim is to improve the physical facilities for GPs in London and improve patient access it would be welcomed. Land and buildings, however, are scarce in the capital and it is feared that existing practices or institutions will be converted as locations for the new polyclinics.

The report emphasises the likely improvement in coordination of primary and secondary care services, if primary and secondary care practitioners work from the same premises. But many examples already exist of close coordination between GPs and consultants. These are not discussed and it is difficult to see how polyclinics could replace existing good arrangements.

The polyclinic has been tried in other places, most notably Berlin and Cuba. Little notice, however, seems to have been taken of the experience of the patients and practitioners of these institutions in very different health systems. Personal experience in Berlin, over many years, has shown that neither patients nor practitioners necessarily welcome the clinics. There are even more profound difficulties in concentrating GP services in a few centralised sites in the capital. Access to general practice is crucial, particularly for the old, the young and the deprived. Centralising these services in a few locations will not improve access but may cause harm since they will be further from where people live and transport arrangements are crucial.

One of the purported advantages of a polyclinic is easier access to specialist advice and investigation but it is often forgotten how few consultations in general practice lead to referral for specialist opinion, investigation or care. In a study in Lambeth, for example, it was found that of about 4,400 patients on the list only about 3,400 (77%) consulted, on average six times during the year.[6,7] Of the consultations, only 11% were referred to outpatients on 529 occasions and 58 patients were admitted as emergencies to hospital on 62 occasions (an admission rate of 1.4%).

There was a marked age gradient in the use of general practice and only about 25% of consultations could be classified as 'new patient-initiated consultations'. Of the cause for consultations, the second most common were mental health problems. Many other more recent studies have had similar findings.

The Darzi Report's primary aim emphasises the importance of 'prevention being better than cure'. Unfortunately, the main recommendations of the report's subcommittee, the Staying Healthy Working Group, have been neglected in the final conclusions of the main document.

In the report's focus on acute clinical care, both immediate and long-term physical illness, many recommendations are welcome. It is realistic in defining the various gradations of hospitals, for example local hospital, elective centre, major acute hospital and specialist centre. Great care will be needed, however, in the decisions regarding precise location and designation of institutions, a major stumbling block in previous reports.

The emphasis on polyclinics as the major location for GPs and primary care neglects the fact that by increasing the distance from a patient's home, demand on ambulance services will also increase since it is the old, the poor, children and the deprived who will have difficulties in getting to a clinic. Increasing the size of clinics and reducing their number will have major implications on the amount of land needed since more will require car park facilities as well as transport links.

The importance of access to healthcare for influencing inequalities has been copiously reviewed.[8] It is sad that although the Darzi Report is supposed to emphasise the problems of inequalities in health, so little space is devoted to effective measures which could reduce the inequalities. The report envisages that these inequalities will be remedied by a change in the provision of health services and yet the Staying Healthy Working Group demonstrates the relatively small part that clinical services play in influencing levels of health. Perhaps it is not surprising that one of this working group's recommendations of reducing expenditure on acute care is ignored. It is, however, particularly surprising that a major report concerned with improvements of health, neglects the input that can be provided by public health practitioners. The importance of environmental, social and occupational factors on health inequalities and how these problems can be tackled and coordinated with clinical care is omitted. It is unfortunate that the working party did not contain active public health researchers who would have identified a variety of measures which should be introduced to reduce inequalities and improve health.[9,10]

The reliance on management consultants, rather than experienced academic health service researchers, for models showing how demand and utilisation in London would increase and how the measures suggested might help is unfortunate. For example, the authors do not appear to recognise the difference between individuals seeking care and events treated. Work in Oxford and Scotland, using methods of record linkage, have shown how important distinguishing between individuals and events is in forecasting methods of treatment, planning and designing of services. Patients with tuberculosis, for example, consult on many occasions, while individuals with acute respiratory illnesses only consult once or twice. A further difficulty with the models is that they are all based on opinion rather than on experiments or direct observations. No attempt seems to have been made to assess the validity of the opinions used in the models. It is not possible to disentangle who provided the various estimations that were used for modelling patient flows or forecast possible changes. For example, community care data was only available for two primary care trusts, and this varied fourfold. The higher figure was used in the model and no justification for this is given.

The fallacies in the forecasting of future disease incidence also demonstrate the lack of expert knowledge. No notice seems to have been taken of changes in smoking habits or levels of pollution for chronic obstructive pulmonary disease and coronary heart disease. Smoking, ethnicity and obesity are also omitted in the hypertension models.

Let us, however, not be too pessimistic. Changes in the organisation and provision of healthcare in London are necessary if health is to be improved and inequalities reduced. The suggestions of a federated model for the provision of GP services and improvements put forward by the Royal College of General Practice are far more realistic and should be implemented rather than the simplistic foreign concept of polyclinics.[11] The authors of the Darzi Report have recommended a solution which neglects many of the characteristics of good general practice and the relatively rare need for secondary care referral. The polyclinic concept with its ready availability of technological equipment and specialist expertise can (and does) encourage its unnecessary utilisation and is thus bound to lead to an increase in healthcare expenditure and further medicalisation. The neglect of preventive strategies is also counterproductive. But perhaps the greatest omission is the lack of emphasis on the need for training of healthcare professionals to meet the demands of changes in disease prevalence, an ageing population and newer methods of treatment. All this implies that if healthcare in London is to improve, meet the demands of the 21st century and reduce health inequalities, closer cooperation between the health and social care services is needed. This also appears to have been omitted.

References

1 Tomlinson Report. *Report of the inquiry into London's health service, medical education and research*. London: HMSO, 1992.
2 King's Fund. *Transforming health in London*. London: King's Fund, 1997.
3 Turnberg Report. *Health services in London: a strategic review*. London: Department of Health, 1998.
4 London Health Planning Consortium. *Primary healthcare in inner London: a report of a study group*. London: London Health Planning Consortium, 1981.
5 Healthcare for London. *A framework for action*. London: Department of Health, 2007.
6 Morrell DC. Expressions of morbidity in general practice. *BMJ* 1971;2: 454–8.
7 Morrell DC, Gage HG, Robinson NA. Referral to hospital by general practitioners *J R Coll Gen Pract* 1971;21:77–85.
8 Gulliford M, Morgan M (eds). *Access to health care*. London: Routledge, 2003.

9 Killoran A, Swann C, Kelly M P (eds). *Public health evidence. Tackling health inequality*. Oxford: Oxford University Press, 2006.
10 Griffiths S, Hunter D (eds). *Perspectives in public health*. Oxford: Radcliffe Publishing, 1999.
11 Lakhani M, Baker M, Fields S. *The future direction of general practice*. London: Royal College of General Practitioners, 2007.

A reponse from Ruth Carnall, Chief Executive, NHS London is included in the correspondence section on page 227