Process and Outcome

Changing patterns of resource allocation in a London teaching district

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Summary and conclusions

The health plans of the Tower Hamlets district management team were studied to determine what effects the report of the Resource Allocation Working Party and the White Paper "Priorities in the Health and Social Services" have had on resource allocation in a teaching district. The study showed that at present acute services are allocated a greater proportion of the district budget than occurs nationally, while geriatrics, mental health, and community services receive proportionately less. In the next three years spending on acute services is expected to decrease, while spending on geriatric facilities and community services will increase. Nevertheless, cuts in acute services will take place mainly through a reduction in the number of beds serving a community function, concentrating all acute services in the teaching hospital.

Services to the district might be better maintained by creating a community hospital to meet the needs of patients who would otherwise need to be accommodated in acute beds with unnecessarily expensive support services.

Introduction

The report of the Resource Allocation Working Party (RAWP)[1] was seen by many doctors as an attack on the teaching hospitals, particularly those in the Thames regions.[2] When the priorities document *The Way Forward*[3] was published further fears were expressed about the effects that a reduction in expenditure on acute care would have on these "centres of excellence."[4] To assess the effects of the resource allocation and priorities documents on resource allocation I studied the consequences for one teaching district in the North-east Thames Region.

My analysis shows that the proportion of the District budget which will be allocated to the local teaching hospital will increase as a result of implementing district plans. The funds which are to be used both for this purpose and for increased spending on geriatric and community health services are to be freed by closing hospital beds which currently serve a predominantly community function.

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The region and its resources

North-east Thames Region covers a population of roughly 3·8m people in north-east London and Essex. Of the six areas in the region, two contain teaching hospitals—Camden and Islington Area and City and East London Area. The population of City and East London Area is estimated at around 590 000.[5] Within that area, Tower Hamlets District, with a population of 150 000, and City and Hackney District, with a population of 210 000, both contain teaching hospitals, while Newham District (population 230 000) is a non-teaching district.

North-east Thames Region is, according to the RAWP report, the most overprovided region in England, and might consequently be greatly affected by resource reallocation. Within the region, moreover, it is the declared intention to divert resources towards non-teaching areas, which in the past have been relatively underprovided.[6] The regional health authority has stated, however, that it is for individual areas to decide how to allocate their resources, both between districts and between services.[6]

As yet, no substantial resource reallocation has taken place, either at regional or subregional level. The allocation to the region in 1978-9 is to be increased by only 0·27% over the previous year's allocation (allowing for inflation), compared with an average increase of 1·4% for all regions.[7] The share of the region's budget allocated to City and East London Area (Teaching) for 1978-9 represents a proportional reduction of only 0·1% over the last two years.[8] Tower Hamlets District has also suffered no appreciable reduction in the proportion of its allocation; in 1978-9 it will receive 36·6% of the area budget compared with 36·8% in 1976-7.[8] Thus, while district plans have been formulated to allow for possible resource reallocation in the future, no substantial reduction in budgets has yet occurred.

Tower Hamlets District

By most criteria the population of this district is one of the most deprived in the country. For example, the number of children in care, of homeless families, and of households with more than one person per room are all over twice the GLC average.[9] The proportion of people in social classes IV and V is 42·3% compared with a GLC average of 24%,[9] and the district contains over 1000 vagrants. In 1976 the infant mortality rate in the district was 13% higher than the national average, while the crude death rate was as much as 23% above the national norm.[9]

In June 1976 there were 1025 staffed acute beds and 183 regional specialty beds in the district. These figures correspond to 6·8 acute beds per 1000 population, which is over twice the mean national figure of 2·67 acute beds per 1000 population.[10] Roughly 900 of the acute beds and all of the regional specialty beds are in three of the hospitals in the district—the London Hospital (Whitechapel) (with a total of 717 beds); the London Hospital (Mile End) (378 beds); and Bethnal Green Hospital (227 beds).[9] The district is poorly provided for in primary and community care, however, having just over half the number of health visitors and district nurses recommended by the DHSS and one-third of the number of chiropodists.[9] There is only one health centre in the district. Thirty-three percent of the district's general practitioners are single-handed[11] compared with a national average of 19·4%.[5]

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TABLE I—*Percentage allocation of health resources by services: Tower Hamlets District and national figures*

Sector	District allocation 1976–7	Estimated national allocation 1975–6[1 5]
Acute services (hospital inpatient and outpatient)	73·8	55·5
Obstetrics	6·7	5·5
Geriatrics	5·5	8·2
Mental health	5·7	17·5
Community services (including home nursing, health visiting, and chiropody)	4·6	9·1
Administration	3·7	4·2

Note—Ambulance services are funded at regional level, so their cost is not included in district allocation. National allocation for ambulance services has also been excluded.

Table I shows the proportions of the district budget allocated to different services in 1976-7[12–14]*; the estimated national allocation in 1975-6 is shown for comparison.[15] Whereas the acute services in the district are allocated a substantially greater proportion of the budget than occurs nationally, community services receive roughly one-half of the national figure. Since there is no long-stay mental hospital in the district, a very small proportion of the budget is spent on mental health. One of the reasons for the disproportionate expenditure on acute services in the district is that over half the people using these services are resident outside the district, while other services are used mainly by people living in the district.[9]

Plans for the district

Several attempts have been made in the district plans to redistribute district funds between the services.

ACUTE BEDS

To comply with national bed norms, the regional health authority recommended a reduction in the number of acute beds from 1025 to roughly 350.[10] The area health authority and district management team have pointed out, however, that over 50% of acute admissions in the district are of patients who live outside the district.[9] Because of these specialist referrals, as well as the degree of social deprivation in the district the target figure for acute beds was subsequently revised to 665,[9] a reduction of 35% in the current number. The district management team has also suggested that since several of the acute services provide for a population that is much wider than the district, these should be upgraded to regional specialties and funded separately by the region.[9]

The district proposal for reducing the number of acute beds is to close down the London Jewish Hospital (70 beds) and to remove acute beds from Mildmay Mission Hospital (56 beds) while requesting additional area funds to convert this hospital for use as a health centre or community hospital.[9] It is proposed to convert Bethnal Green Hospital into a geriatric hospital, bringing back into the district the patients currently resident in St Matthew's Hospital in City and Hackney District.[9] It is hoped to construct a purpose-built geriatric unit at the London Hospital (Mile End), although such a project has not yet been approved by the regional health authority.[10] The *Regional Strategic Plan* states that despite the emphasis placed by the priorities document[15] on the importance of housing acute geriatric units in general hospitals, other factors may cause delays in implementing such schemes.[10] The London Hospital (Whitechapel), where most of the medical student teaching currently takes place, is to have no geriatric beds.

There has been much opposition from local general practitioners, unions, and the community to the proposed change of use of Bethnal Green Hospital. An alternative strategy has been proposed,[16] whereby the hospital would serve the role of a community hospital by keeping non-geriatric beds and dividing the geriatric care between that hospital, the London Hospital (Whitechapel), and the London Hospital (Mile End). The area health authority[5] and the district management team[9] contend, however, that acute beds require full support services, and that it would be impossible to provide these on three sites.[17]

*To identify the proportion of resources allocated to different sectors of health care in the district an estimate must be made of the relative costs of different types of hospital patient care. A regression analysis of inpatient costs was recently carried out in 402 Thames-region non-teaching hospitals,[1 2] from which a formula was derived capable of accounting for 95% of the total variation in these costs. This formula has been applied to hospital costs in Tower Hamlets District, making the assumption that *relative* costs between different specialties are similar in teaching and non-teaching hospitals.

REGIONAL SPECIALTIES

The regional specialty beds in neurology, cardiology, nephrology, and radiotherapy are sited at two separate hospitals within City and East London Area, and the regional health authority recommended that for economic reasons only one unit of each specialty should be retained within the area.[5] Consultation within the area "revealed unequivocal opposition to the proposal," and the area health authority has decided that the economies are too small to justify disrupting established centres of repute.[5] At present regional specialties consume an estimated 20·4% of the total district health budget.[12–14]

COMMUNITY SERVICES AND PRIMARY CARE

It is widely recognised that the level of primary care and community service in the district is poor, and the region has stated that funds are to be allocated to improve these.[18] Between 1974-5 and 1976-7 the proportion of the district budget allocated to these services increased from 4·46% to only 4·58%.[13 19] The area health authority has requested districts to achieve a target of 2% growth in community health staff yearly,[20] but this target is to be surpassed in Tower Hamlets. Tower Hamlets District Management Team has proposed funding an extra 14 health visitors (there are 27 at present) and 12 district nurses (35 at present) over the next three years,[9] which will improve the numbers to about 80% of DHSS norms. The present number of chiropodists (six) will be doubled by 1981, but the district management team calculates that at least 16 are necessary to meet current demands.[9] Two health centres are being funded as a capital scheme by the region during the next three years; three others are being provided from a docklands development grant.

Effects of the proposals

The effects of the planned bed closures and of the other proposals will be to save, at current prices, £1·339m, or 4·8% of the district's recurrent budget over the next three years.[9] The district management team allows £621 000 of this for an expected reduction in the district allocation as a result of resource reallocation; this leaves an annual revenue saving of £718 000 by 1981.[9] Nevertheless, it is estimated that phase 1 of the new clinical block that is being constructed at the London Hospital (Whitechapel) will cost £500 000 a year in running expenses,[9] accounting for over two-thirds of the available revenue savings. If the proposals are implemented, the proportional allocation of the district budget in 1980-1 will be as shown in table II.[9 13 21] The effect of reducing the number of acute beds by 35% is to reduce the overall *sum* spent on acute services by 13·1%. However the London Hospital (Whitechapel) will be allocated 58·7% of the district budget in 1981, compared with 55·2% in 1976,[9 13 21] while spending on community services in 1981 will still be less than two-thirds of the projected national figure. Most of the expected savings will result from the reduction in manpower needs consequent on the reduction in bed numbers. By 1981 the district expects to employ 22 fewer doctors (a reduction of 6%), 125 fewer nurses (a reduction of 5%), and 162 fewer domestic and ancillary staff (a reduction of 11%).[9]

TABLE II—*Estimated percentage allocation of health resources by services: Tower Hamlets District and national fiugres*

Sector	District allocation 1980–1	Change in district allocation from 1976–7	Projected national allocation 1979–80[1 5]
Acute services (hospital inpatient and outpatient)	67·7	−6·1	55·0
Obstetrics	6·8	+0·1	4·9
Geriatrics	8·5	+3·0	8·9
Mental health	6·4	+0·7	17·5
Community services (including home nursing, health visiting and chiropody)	6·2	+1·6	9·8
Administration	4·4	+0·7	3·8

Ambulance services—See note to table I.

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In summary, the budgeting proposals for the next three years in the Tower Hamlets District allow for a reduction in district revenue of 2·2% consequent on reallocation. Furthermore, the proportion of the budget to be spent on acute services will be cut by 6·1% to allow for more spending on geriatric and community health services. Nevertheless, the proposed allocation to the district's teaching hospitals will increase by over £500 000, representing almost 60% of the district's budget by 1981. While no explicit anticipation of this changing pattern of distribution appeared in the report of the Resource Allocation Working Party, the *Regional Strategic Plan*[10] stated that, "The strength of the University hospitals should remain substantially undisturbed whilst allowing significant resource movements to take place from the associated institutions within the Districts (T)." This seems to be precisely what is happening in Tower Hamlets.

Discussion

One important point that the area health authority and the district management team do not seem to have taken fully into account is that acute beds may serve both a medical and a social function. Many patients are admitted to hospital predominantly for supportive care because their home circumstances are unsuitable—for example, patients living alone or in a hostel who have had a mild stroke or have leg ulcers or heart failure. Admitting these patients to acute beds that are provided with extensive support services and large numbers of medical staff increases the cost of patient care. Moreover, health workers in acute hospitals often claim that the functions of these institutions do not include social care—the term "blocked beds" is often applied to beds occupied by social admissions. Sometimes patients who are admitted with an acute medical problem or for surgery must remain in a hospital bed because home circumstances prevent the patient from being discharged.

In many areas attempts are being made to cope with these problems through establishing community hospitals[22 23] to provide nursing care and supervision rather than acute medical intervention. About one-third of all admissions to acute hospital beds might be suitable for care in a community hospital.[22] The evidence suggests that Bethnal Green Hospital has largely been serving the function of a "community hospital." Patients aged over 75, for example, constitute 2% of all medical and surgical admissions to the London Hospital (Whitechapel) and 7·5% of all those to Bethnal Green Hospital.[24] The average length of stay in all acute *medical* beds (excluding geriatrics and regional specialty beds) is 13·7 days at the London Hospital (Whitechapel) and 25·1 days at Bethnal Green Hospital.[14] In 1976-7 he daily cost per inpatient at Bethnal Green Hospital was 63·9% of the cost per inpatient at the London Hospital (Whitechapel). Even allowing for the different case-mix at the two hospitals,[12] the inpatient costs at Bethnal Green Hospital are still less than 80% of those at the London Hospital (Whitechapel). Pathology and *x*-ray costs per patient at Bethnal Green Hospital are less than half the corresponding costs at the London Hospital (Whitechapel) and pharmacy services less than 60%.[13] Figures for London Jewish Hospital and Mildmay Mission Hospital are similar to those for Bethnal Green Hospital, again suggesting that the acute beds in those hospitals serve more of a community hospital function than those at the London Hospital (Whitechapel).

The community function of acute hospital beds must be seriously considered if the effects of resource allocation in Tower Hamlets are to be correctly understood. If the number of acute beds in the district is to be cut by 35%, this will require either that the length of patients' stay be reduced or that fewer patients be admitted. The district management team believes that "concentrating facilities on a smaller number of well-equipped centres"[9 17] will increase patient throughput, but the availability of back-up services will be unlikely to shorten the hospital stay of the social admissions who were previously in Bethnal Green Hospital. There is, morever, no evidence to show that it is the availability of these facilities that determines the duration of stay of even a purely medical admission; indeed, a more rational consideration of the ideal duration of hospital stay for myocardial infarction or hernia repair, for example, may permit greater improvements in patient throughput.[15 25]

One of the objectives of improving the community services is to allow patients to be treated at home when they would otherwise require hospital admission. It is difficult, however, to see how improvements in these statutory services would obviate the need for many of the social admissions, especially of vagrants or of elderly people living alone. Moreover, transferring the responsibility for such patients on to the community entails costs that are not taken into account in regional health authority or district management team calculations. It is often necessary, for example, for a female relative to leave paid employment to care for the person at home. An increase in local authority services such as meals-on-wheels and home helps will also be needed, but no extra allocation of funds has been envisaged.

Given that the need for social admissions in Tower Hamlets is unlikely to decrease greatly, concentrating acute beds on two sites will inevitably mean that a greater proportion of admissions to the London Hospital (Whitechapel) and the London Hospital (Mile End) will be for social reasons. It is to be hoped that a greater awareness of the social function of many acute beds will follow from this. Nevertheless, the emphasis of the district management team on concentrating facilities in well-equipped centres, and current attitudes of the staff of large hospitals to social admissions offer little basis for such optimism. It would therefore seem to be both more cost effective and more advantageous to patients to recognise that using high-technology hospitals for social admissions is inappropriate and to study the feasibility of developing community hospitals in inner-city areas. Clearly the maintenance of acute beds in a community hospital could be done only by reducing the bed numbers in, and thus the allocation to, the teaching hospital, but in this way it might be possible to provide better services for the people of the district at a lower cost.

Several other teaching districts in the Thames Regions are facing the same problems as Tower Hamlets District. Many of the small hospitals in these districts have been closed or are under threat of closure, which suggests that other districts may also be reducing expenditure on acute services by reducing the number of beds that are used predominantly for social admissions. Thus, while the objectives of the priorities document are admirable, the indications are that the reallocation of resources, both by region and by service, may have little effect on the funding of teaching hospitals, but may drastically affect services for the very people it was designed to help.

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Letter from . . . Chicago

Errors of taxidermists

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Faced with an ungrateful electorate of whom only 44% still approved of how he was handling his job, President Carter last spring returned to the campaign trail to attack two of the oldest, though not *the* oldest, of professions. The lawyers were first to incur his wrath for being greedy and selfish, concerned with only their interests, working only for the rich, and helping "big shot crooks" to escape the law, while letting the poor and powerless languish without hope in America's overcrowded prisons. Then came the doctors' turn, and the President conceded that as individuals they cared about their patients; "but when you let doctors organise into the American Medical Association," continued Mr Carter, "their interest is to protect the interest not of the patients but of the doctors. And they've been the major obstacle to the progress in our country to having a better health care system in years gone by."

As might be expected, both the lawyers' and doctors' organisations protested against the attack. The AMA called the President's speech a disservice to the profession and outlined a long list of accomplishments in promoting "the science and art of medicine and the betterment of public health," while also charging that efforts to limit health costs were being hampered by the Federal bureaucracy. Others thought the remarks were unprovoked and inappropriate, reflecting good politics but deplorable logic. The press agreed that lawyers and doctors had many faults, but was inclined to view the attack as delivered in the "familiar sour strain of populism, denouncing the powerful and the worldly." The *Washington Post* thought that to "*let* organise" had unwholesome connotations. The *Chicago Tribune* pointed out that even peanut farmers had organised to protect their interests, and that perhaps one could not blame the doctors for taking the money pushed at them by Federal government and the liberal democrats. One newspaper proposed a massive export programme of lawyers, judges, bailiffs, and deans of law schools—perhaps to Saudi Arabia, in lieu of warplanes or in exchange for more oil, to help reform their penal system, and at the same time ease our own unemployment. Another writer predicted imminent attacks on ice-cream vendors, boy scouts, Franciscan monks, ballet-dancers, and American Indians. There was concern also about the nudists' organising into colonies rather than sunbathing in solitude in their backyards; and about the venal taxidermists who have long victimised the public by despoiling American wild life, ripping off the customers, and padding their bills as much as stuffing the American animals we love.

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But, whatever one may think of the errors of taxidermists, there was much agreement in our all too powerful press that Mr Carter had surrounded himself with such friends and advisers that he hardly needed enemies. His latest disappointment, following closely on his trouble with bankers, beer drinkers, and roving ambassadors, was the case of Dr Peter Bourne, the British-born psychiatrist, described only too recently as the man who had the President's ear on health matters so much so that the two were in fact "thinking alike."

Dr Bourne, special assistant to the President on health issues, had long kept alive Mr Carter's promise of a universal national health service with uniform standards and payments, incentives for reforms, reorganisation and productivity, built-in cost and quality controls, advance setting of fees, representation of consumers, concern for the individual rather than for his wealth, and all the other "goodies" perenially promised by pious prophets and professional health-care reformers. But reform has been slow in coming, and in July the House Commerce Committee so badly chewed up the President's hospital cost containment scheme that the left-over bones were hardly worth picking up. The administration protested against this extreme case of "lobbyitis"; computed that the rejection of its pet programme would cost America $56 billion; and subsequently announced that national health insurance would be introduced by stages, painlessly, non-coercively, inexpensively, with no Federal spending until 1983 at the earliest, and with implementation geared to a five- to ten-year phase-in. Senator Edward Kennedy denounced the plan as "too little and too late," but many economists sighed with relief.

Indeed, if one is to believe Mr Peter Drucker,[1] the concept of a national health service would by now have been all but forgotten were it not for Senator Kennedy's understandable desire to achieve a limited degree of immortality by attaching his name to a major health bill. Most Americans, however, do not perceive the problems of health care as assuming the proportions of a crisis. True, they might complain about the high cost of medical care, just as they complain about the high cost of dying, buying peanuts, obtaining justice, or having their beloved animals groomed, treated, stuffed, or embalmed. But, with an increasing number of people being covered by some

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