Other cities, same problems

Robert Maxwell

This is the ninth article in our series looking at the issues highlighted by the Tomlinson report into London's health care and medical research and education

London's health care problems, particularly underfunding, are mirrored in other major cities in the United Kingdom and abroad. None has found the perfect solution, but the debates on the Tomlinson report provide an opportunity to review how to manage the three major areas of service provision, medical education, and research in London. Mr Robert Maxwell suggests that some aspects of the successful ambulatory care initiative in New York could be adapted by the capital's primary care providers while the secondary services might learn from the rationalisation of specialist services in Paris.

Whatever people's views are about specific recommendations in the Tomlinson report, there is no doubt that London inherits great medical resources and intractable problems in health care provision and in health. Something has to be done about the imbalances in the city's health services in order to provide better value for Londoners as quickly as possible and to lay the foundations for future development. Medical care will continue to develop at a dazzling rate and London has the chance to be in the forefront of international medicine once again. But this will happen only if it gets its act together in the three areas of service provision, education, and research.

The problems are formidable and they interlock in ways that make them more difficult to tackle. So it is reassuring to recognise that London is not alone. Parallels can readily be found in other large cities of the United Kingdom, such as Belfast, Birmingham, Glasgow, Liverpool, Manchester, and Newcastle upon Tyne. London's problems are certainly similar in kind, even if they have an added dimension simply because London is the country's capital. On the other hand, London inherits relatively more resources—human and material—with which to tackle them, and it also has the dubious advantage of commanding the attention that goes with being the seat of national government.

Even more compelling are some of the overseas parallels, such as Boston, Chicago, New York, Paris, and Sydney. What these cities shared was fast growth and great prosperity in the second half of the nineteenth century, leading to extremes of poverty and wealth and the establishment of a large number of hospitals, either as a result of private philanthropy or of government intervention. All these cities have continued as centres of wealth, but they also show varying signs of relative decline in terms of economic activity and of population movements.

London's main health problems (box) apply equally to New York and Paris. Their populations are broadly

Population comparisons: London, New York, and Paris

	London	New York	Paris
Population	6.8m	7.1m	6.1m
Over 65	15%*	13%*	13%*
Foreign born	NA	24%	15%
Non-white	20%	NA	NA
Births to adolescent women	6%	11%	2%
Infant mortality	8.7	13.6	7.8
Neonatal mortality	4.7	8.8	4.0

* = Approximate percentages.
NA = not available.

London's health care problems

- Exceptional poverty and deprivation alongside affluence. Among the poorest and most deprived groups are the homeless, refugees, people without jobs, and elderly people living in social isolation. In most of these groups the black and ethnic minorities are disproportionately represented
- A shortage of affordable housing of reasonable quality
- Large numbers of commuters (on weekdays) and of tourists (seasonally)
- Relatively weak primary and community based health and social care, and a deficiency of nursing homes and residential care for the elderly
- Heavy reliance on hospital accident and emergency departments and on short stay hospitals to make good deficiencies in primary and community based health and social care
- Strong trends towards specialisation within hospital medical and surgical departments, leading towards excellent treatment for some conditions and a relative neglect of others. To some degree the bias is systematically away from uninteresting conditions requiring care rather than cure, towards ones that are treatable or are interesting in research terms
- Fragmentation of specialist units, with heavy duplication of specialist services among hospitals, variable standards, and some service and research activities that fall below threshold levels for likely high performance
- Inadequate funding to maintain, let alone to develop, the existing range of public hospital services.

comparable (table). New York has substantially worse infant and neonatal mortality than London or Paris and some signs of worse problems of social deprivation. On these indicators London falls between the other two cities. All three cities are multicultural and multiethnic, though this is hard to capture in the statistics and the mix varies from city to city.

New York's voluntary hospitals can match patients to funding

Like London, New York has inherited a large number of hospitals, including some of the country's most prestigious medical centres and medical schools. Competition among them has been intense in the past decade as a result of the switch to reimbursement based on diagnostic related groups rather than historic costs, a difficult regulatory environment aimed at reducing short stay hospital capacity and at cost containment, and a much tougher climate for research funding. More than 10% of the city's hospital beds closed in the 1980s, including more than 20% of the beds in the municipal hospitals.

Despite the squeeze on hospital budgets, health professionals visiting from the United Kingdom are likely to be struck more strongly in the leading New York voluntary hospitals by the relatively lavish level at which they are equipped than by their shortage of money, perhaps because they can shape the patient population that they actually serve to match the funding available. This impression of relative pros-

The King's Fund, London W2 4HT
Robert Maxwell, secretary and chief executive

BMJ 1993;306:199-201

perity would be even more the case in physicians' private offices, but these are unevenly distributed and are largely absent from the poorest parts of the city. Much as we may complain about standards of some general practice in London—and rightly so—there is at least some system to seek to achieve geographic coverage by primary care doctors. This is not the case in the United States.

To a British observer the most scandalous feature of health care in America is the position of the poor and near poor. On the whole the poorest citizens are covered by Medicaid; the group just above them, numbering some 35 million Americans, are not covered by Medicaid but have no effective alternative in terms of private health insurance. In New York, as in other cities such as Boston, Chicago, and Los Angeles, the poor have historically relied on the public hospitals, largely financed and administered by city or county government, for their health care. There has been, and continues to be, a sharp contrast between the municipal and voluntary hospitals in terms of the populations that they serve and how these clients are paid for. While the medical care, in a technical sense, is generally excellent in the municipal hospitals, all of which are affiliated to major teaching centres to try to ensure high standards, these institutions are like the NHS only more so. Budgets are tight and subject to sudden change, and inessentials, such as maintenance, are cut to the bone. If people think that any London accident and emergency department is stressed let them try Bellevue in New York.

In 1970 New York City handed over the management of its clinics and hospitals (accounting for about 20% of all general care discharges at that time) to a new Health and Hospitals Corporation, with the purpose of freeing the management of the system from city bureaucracy, and enhancing its ability to raise revenue from Medicaid, Medicare, and private health insurance.¹ The corporation has had a chequered history since then. Its difficulties have partly stemmed from cuts in Medicaid, but also from political interference. The aspiration to distance the management of a massive public service of this kind from politics has simply proved unrealistic. Too many jobs are at stake, and the safety net service that the municipal hospitals provide, without financial triage to determine whether the patient can pay, is too important for politicians to stay out of the kitchen. Managers of the system have had a continuing battle for the funding and managerial autonomy required to run it, and the corporation's survival has at times been in serious doubt.

New York has even worse problems of social deprivation than London and medical facilities are unevenly distributed within the city

Success of ambulatory initiative

Nevertheless, there have been successes, particularly in the 1980s with a major initiative to enhance the quality and effectiveness of the ambulatory—that is, non-inpatient—care provided by the municipal hospitals and clinics. The municipal system has always been even more important proportionally in outpatient, emergency, and primary care services than it is in terms of inpatient activity. Remember that, in the poorest neighbourhoods of New York, private medical practice barely functions, so there is virtually no first contact care unless the public system provides it. With only about 20% of the city's beds, the Health and Hospitals Corporation in the early 1980s provided over half of all organised outpatient visits and 40% of all emergency care in the city. The goals of its ambulatory care initiative were to improve access—for example, by maximising the hours when clinics were open and linking them closely to back up services in the hospitals, increasing the comprehensiveness of care on offer, improving continuity (by linking regular attenders to an identified primary care team), and making the management of the clinics more autonomous and more accountable. A recently published account of this initiative suggests, using quite tough performance measures, a considerable measure of success for this initiative, which surely ought to have lessons for the NHS in London after Tomlinson.¹

More long stay beds in Paris

Like London and New York, Paris inherits a heavy concentration of hospitals, hospital beds, and hospital staff. It also has more than its share of France's doctors, whether hospital based or office based. In terms of bed numbers it has substantially more relative to population than either London or New York, but like them has been closing short stay beds steadily since the mid-1970s. In part, this has been balanced by increases in long stay beds of which—unlike London—Paris has a large and growing number.

The core of Paris's hospital system is the Assistance Publique, with 26 short stay hospitals containing some 20 000 beds, more than 20 other facilities (medium and long stay), and a home care programme. It has 43% of the city's short stay beds; the other 57% being in private hospitals, two thirds of which are run for profit and one third not. The Assistance Publique originates from the middle ages and was, until around 1960, essentially an organisation to provide health and social care of all kinds for the poor of Paris—including, for example, provision for abandoned children and material assistance to those in need. What has happened since 1960 has turned this ancient social welfare institution into the country's leading tertiary hospital referral, teaching, and medical research system. Because public investment in major new equipment has been concentrated in France in the public hospitals, and because specialists in these hospitals are full time, it is the public hospitals that provide the setting for major medical care in France.

The largest of them are also the country's teaching hospitals, affiliated to the faculties of medicine in the universities. Thus in Paris all medical education and virtually all clinical research conducted by the Faculty of Medicine of the University of Paris take place in the Assistance Publique hospitals. In no sense are these hospitals now seen as second rate. While they still have a special mission to serve the poor, they are the preferred setting for major medical care for the whole population.

High technology in the public hospitals

This transformation would not have been possible

without the framework established by the government to concentrate high technology medicine and medical education in the public hospitals. Equally, however, it has been driven from within the organisation by reducing beds, shutting old hospitals, or transforming them into nursing homes, and concentrating high technology investment in a small number of centres, well equipped and well staffed. Ten years ago Assistance Publique established a technology assessment process for the whole system, which assesses the cost effectiveness of new innovations before they are introduced and helps to rationalise their introduction within the system.

While the history of Assistance Publique in the past 25 years is a most impressive one, with positive lessons for London about rationalisation of specialist services, it has its dangers as well as its successes. Overcentralisation is a continuing threat in any large public system of this kind. Moreover the story is basically one of the dynamics of medical specialisation—London's story of hidden (and not so hidden) subspecialties is even more apparent in Paris. Assistance Publique's responsibility

as the community hospital system for the poor of Paris is constantly in danger of being overwhelmed by its newer role as the country's leading provider of tertiary referral services. Like so much else about Paris and New York, that sounds only too familiar in London.

No perfect model has been found

Overall what stands out from intercity comparisons such as these is that firstly, London's difficulties are echoed elsewhere, which is comforting since it is generally easier to put up with a problem if you know that others share it. Secondly, no city yet has a perfect model to copy. Thirdly, there are examples of real progress being made—for example, the ambulatory care initiative by the Health and Hospitals Corporation in New York, and the national development of specialist services in the Assistance Publique system in Paris.

1 Rodwin VG, Brecher C, Jolly D, Baxter RJ, eds. *Public hospital systems in New York and Paris*. New York: New York University Press, 1992.

OBITUARY

A L Crockford

A L CROCKFORD

CBE, MC, TD, DSO, MB, BCHIR

Allen Crockford had three careers: in the army, in general practice, and as the secretary of St Thomas's Hospital Medical School. He joined the Gloucesters in 1915 and on the eve of the battle of the Somme won the MC for conspicuous gallantry. Having joined the Territorial Army in 1928, inevitably he served in the second world war. Again his gallantry and leadership made their mark: he was awarded the DSO and the OBE and left the army with the rank of brigadier.

Crock's appointment as secretary of St Thomas's Hospital Medical School came at a challenging time, for the war had caused extensive damage to the hospital and much of the medical school was dispersed throughout Surrey. His immediate task was to supervise the repair of the school and to draw together the student community at a time when it included former captains and colonels as well as 18 year olds. Crock was in his element, using qualities of leadership and enthusiasm. He took a full part in student selection, always searching for wide interests. One aspiring author asked at his interview if he could be a part time student as he wished to continue writing. "My dear chap," Crock replied, "I thought all our students were part time." The student was admitted and subsequently achieved literary distinction.

Crock's main aim was to care for the student body. He encouraged all extramural activities and, for his part, kept youthful and active and particularly enjoyed his boat on the Medway, on which he entertained many students and staff. He was the perfect example of a man manager, galvanising the school with his energy, enthusiasm, and humour. He visited every department regularly and knew every person there, from painters to professors. His laugh and his clipboard were his hallmarks.

He is survived by Doris, whom he married in 1924, and two daughters. His son, David, a plastic surgeon, died of cancer at a young age.—BRIAN CREAMER

Allen Leppard Crockford, doctor and administrator, the medical secretary of St Thomas's Hospital Medical School 1946-64, died 27 September. Born 11 September 1897; educated Gresham's School and King's College, Cambridge, and St Thomas's Hospital (MRCS, LRCP 1922; MB, BChir 1923). Served with British expeditionary force 1915-9 (awarded MC 1916). General

practitioner in Axminster 1924-39. Served in Royal Army Medical Corps 1939-45, mainly in north Africa and Italy (awarded DSO 1943, OBE 1945). Honorary surgeon to the King 1952 and the Queen 1952-7. Appointed CBE 1955.

A memorial service for Dr Crockford will be held in the chapel of St Thomas's Hospital on Wednesday 7 April at 3 pm.

E P HALL DRAKE

FRCS

Edward Percival Hall Drake's dynamic approach to problems ensured the early establishment of a well organised surgical department in Lancaster, where formerly the surgical services had been provided by general practitioner surgeons on a part time basis. He preferred the direct approach rather than what is euphemistically called political manoeuvring, and the department achieved high standards of surgical care during his tenure and subsequently. Hall exhibited exceptional manual dexterity as an operator, and his diagnostic skills were highly regarded. These clinical skills he passed to his trainees, in whom he took a great interest.

Hall's main other interests were gardening, philately, and golf. A private man, he enjoyed family life with his two sons and four grandchildren. He is survived by his wife, Nancy.—A KILPATRICK

Edward Percival Hall Drake, a consultant surgeon to Lancaster district hospitals 1950-75, died 4 September. Born South Shields, 30 April 1910; educated Leys School, Cambridge, and Jesus College, Cambridge, and St Bartholomew's Hospital (MB 1937, BChir 1935). Served in Royal Army Medical Corps 1939-45 in Burma and Germany, becoming lieutenant colonel. Senior registrar, Sheffield Royal Infirmary.

C P T ALEXANDER

FRCP

A general physician with a special interest in gastroenterology, Conel Alexander was a good clinician and a conscientious teacher. His gastroenterological skills and enthusiasm caused him to initiate the first endoscopic service in Leicester in the mid-1960s, although he had great difficulty persuading the management to buy the first endoscope. He served on many district

Obituaries must be submitted exclusively to the BMJ; they should be under 250 words; and submitted within three months of the person's death. We welcome self written obituaries and good quality, recent photographs, and, as a medical journal, we encourage authors to include the cause of death.