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When a man is tired of London he is tired of life

Johnson's dictum that when a man is tired of London he is tired of life is not one that would be embraced by health service planners. The concentration of resources in the capital has always been a problem for a national health service with the basic principle of equity. Most attempts to dilute the concentration encounter the opposition of the London teaching districts and their medical schools. Well tuned antennae combined with a proximity to Fleet Street and the government ensure both public debate and political manoeuvring at an early stage of any proposals. The response is the same whether it is external or internal change that is proposed.

The only comfort for planners is that their problems are not new. Geoffrey Rivett's fascinating book on the London hospital system shows that for the past 200 years various bodies have struggled to reconcile hospitals, beds, doctors, students, and patients in the metropolis with varying degrees of success.[1] Yet another document on London's health services might thus expect to be greeted with a yawn and quickly dismissed as more special pleading, but this has not been the case with the King's Fund report on planned health services for inner London.[2] Rather its publication caused anxiety if not anger in the Department of Health (the briefing note for ministers was almost as long as the report itself) and the headquarters of the four Thames regional health authorities, as well as receiving widespread and sympathetic coverage in the public and medical press. What was different?

Firstly, its source. The King's Fund is eminently respectable and, more important, independent. Also, the report was commissioned by the chairmen of the 12 inner London districts, which ruffled feathers and caused political and managerial anxiety. These districts are not meant to work together—they are in four different regions; coordination is the job of the regional health authorities. Nor are they meant to take the lead in strategic planning—that again is the role of their regions.

Secondly, both the aim and the format of the report were low key. Its deceptively simple brief was to collate the likely effect on inner London of the changes proposed in the Thames regions' strategic plans for 1983-4 to 1993-4 and to describe what changes had taken place in the first two years of the planning cycle. The report was to be a descriptive analysis rather than a critique. This approach certainly helped the districts to work together, achieve consensus rapidly (by health service terms), and see the exercise through to publication.

Thirdly, the chairmen went out of their way to emphasise that this was not special pleading. In their foreword they pointed out that they supported the principle of equity underlying the approach of the Resource Allocation Working Party, although they did not go so far as to support the method. Their aim was merely to describe what was going on in their "patch" and to point out that this had national implications.

Lastly, and most importantly, there were the findings of the report. The key finding was the remarkable fact that it was not possible to say what inner London health services would look like in 1994. It suggested that this was partly because of the different methods used by the regions in their strategic planning and partly because their horizons were constrained by their boundaries: each looked outward from the point of its respective wedge. This led to the title of the report, *Back to Back Planning*, and to a heated denial by the regions, who pointed out in an immediate press release that the difference in methods was unimportant and that considerable effort went into coordinating activities.

The report then went on apparently to contradict itself by producing a succession of findings. The meat, however, is concentrated on one figure (figure 8, page 13), which shows that regional plans require a reduction of £109m in spending in inner London and that the money is to be found by reducing the number of local acute beds by 1487 (15·7% of the total). In the first two years of the planning period, however, 1100 local acute beds (74% of the planned 10 year reduction) had been closed, yielding £30·9m—34·5% of the required reduction.

What does this mean? Was the bed capacity surplus to requirements, allowing a pace of life in the capital's hospitals that would appear leisurely to a provincial patient or consultant? Are inner London health authorities and their managers incompetent? Have they gone for the (relatively) easy option of bed and hospital closures and either not achieved the necessary savings or used them in lieu of the other (efficiency) savings that other districts are achieving? Are the savings going into hidden developments within the same local acute services? The report tried to anticipate these questions, showing that, according to the Department of

Health and Social Security performance indicators, both activity and cost, when adjusted for case mix, are near the expected level; they compare favourably with other districts, particularly provincial teaching districts. Indeed, the Thames regions top the league table in "cost improvement" programmes.

Many other questions are raised by the report—not least the lack of information on priority services. But so what? Raising questions and the subsequent debate are part of health service planning. Should what might appear to be a parochial issue not be settled by the 12 districts and their regions unruffling their feathers and sitting down quietly to review their strategies and adjust them as necessary? The special funds made available to reduce the pressures inflicted by the Resource Allocation Working Party will lubricate the process and also reduce the pressures on ministers in what for them is an important year.

The problem should not be settled in this way, primarily because the issues raised in the report are not peculiar to the inner London districts: they just happen to have raised them. Patients are not behaving as planned: the Thames regions have relied on a 15% reduction in hospital admissions in inner London but so far there has been a 2·5% increase. The flow from outside London appears to be increasing, not decreasing. Bed reductions do not reduce activity—not if the number of consultants is not also reduced, and there are no realistic plans to do so. If, as is the case, the easy and most cost effective reductions have taken place by closing entire hospitals, what further reductions will have to take place to find the remaining 60% of the £109m?

This is the nub of the issue and the not so hidden agenda behind the report. Can the Thames regions develop priority services, cope with demographic change, fund new developments in health care, and still run a viable acute service? Perhaps they cannot. Perhaps no part of the country can, and the concept that Britain can run a health service with a lower number of acute beds per head of population, with less of our gross national product going on health than most other countries, is akin to that adopted by Canute's courtiers. Waiting to see whether the tide will engulf us is not advisable. The DHSS and the regions must therefore tackle the issues raised in the report and in addition they must be seen to be tackling them. They should recognise that such debate will and should take place in public and welcome reports like this one.

They could in addition be looking across the Atlantic. If further savings can be achieved without compromising patient care then they will probably come from clinical work. In most hospitals the non-clinical budgets are virtually squeezed dry. The American hospital system has rapidly had to learn how to control and rationalise clinical activity because of the system of a fixed cost for each case. Some of that knowledge might be transferable to this country. We must also have some way of monitoring what is happening in the acute sector. The various agencies who pay the bills in American hospitals have advanced external audit systems that masquerade under the friendly title of peer review organisations. They look at both the process and the outcome of clinical activity. Perhaps what we need is a health advisory service for the acute hospital sector.

And, lastly, where we began—London. It should not distort the national picture but neither should its present and potential contribution to teaching and treatment be underused or run down piecemeal. Why not call its bluff? The only reason for other people from outside London to receive their care in London is that it is either cheaper than elsewhere because of its historic volume or better because of its special skills. An inner London health authority funded to provide local services and relying on an internal NHS market to attract the rest of its money might tackle the issues raised in *Back to Back Planning* rather faster than conventional planning systems.

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1 Rivett G. *The development of the London hospital system 1823-1982*. London: King's Fund, 1986.
2 King Edward's Hospital Fund for London. *Planned health services for inner London. Back to back planning*. London: King's Fund, 1987.

Why the excess mortality from psychiatric illness?

The association between psychiatric illness and premature mortality has long been known but surprisingly little studied. Esquirol had noted high mortality between 1784 and 1794 at Bicêtre,[1] and Farr, in making the first psychiatric study in 1841, considered that the risk of death was increased six to seven times for lunatics in British asylums.[2] The major causes of death in earlier accounts of hospitals were gastrointestinal infections such as cholera, which killed 226 out of 601 residents in the West Yorkshire Lunatic Asylum in the autumn of 1849,[3] and respiratory diseases, especially tuberculosis, because of poor hygiene and overcrowding in large institutions in the United States,[4] Norway,[5] and Britain.[6] Savino and Brody pointed out that the mortality in institutions was closely linked to the average length of stay and that this reflected the optimism of that period about recovery from mental illness[7]; mortality rates, in part, thus comment on the nature of psychiatric care.

Mortality is still greater for psychiatric patients than expected, although less excessive since the introduction of modern treatments and shorter durations of inpatient care.[8] This increase occurs from suicide, accidental death, and natural causes among those previously psychiatrically ill and for all major psychiatric diagnostic groupings—organic states, schizophrenia, affective disorders, and neuroses and related conditions.[9] It occurs in both sexes, in many different countries and ethnic groups, and is independent of type of treatment (Corten P, Ribourdouille M, unpublished observations)[10]; this increased death rate is of real importance for public health.

The association between psychiatric illness and suicide is obvious and well known.[10,11] A depressive illness or another psychiatric disorder could be diagnosed retrospectively in most cases of completed suicide[12]; psychiatric morbidity was high among those for whom a coroners' open verdict was returned[13]; and psychiatric illnesses are the most common predisposing causes for suicide.[14] Similarly psychiatric illness is associated with accidental death.[15-17] Those with psychiatric illnesses are more likely to be the victims of violence and are more likely to put themselves at risk; and alcohol and drug abuse is associated with other mental disorders and with risk of accidental death.[18,19]