Primary health care in London—changes since the Acheson report

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Abstract

***Objective*—To examine changes in primary care in London in the 11 years since the Acheson report on primary health care in inner London.**

***Design*—Analysis of key data from the family health services authority performance indicators and from the Department of Health; study of trends since the time of the Acheson report; examination of the provision of primary care in 1990-1 and its relation to health and social factors.**

***Setting*—Comparisons between the family health services authorities of inner London, outer London, and England as a whole, with a special study of Birmingham, Liverpool, and Manchester.**

***Subjects*—The family health services authorities of England.**

***Results*—There has been an improvement in the provision of primary care in inner London as judged by the criteria of the Acheson report, but these improvements have occurred only as part of an overall improvement in the provision of primary care in the country as a whole. None of the recommendations of the Acheson report specifically oriented to London have been implemented. There are some worrying trends in inner London, such as the increasing proportion of practices with more than 2500 patients. The problems faced by practitioners in inner London resemble those in other large inner city areas, but the primary care provision to deal with them is relatively poor.**

Acheson report recommendations now implemented

- A retirement age for general practitioners (recommendation 1)
- A registration fee for new patients (recommendation 7)
- Extending the lower limit for payment of full basic practice allowance (recommendation 9)
- Higher payments in defined underprivileged areas (recommendation 10)
- Minimum standards for reimbursement of rent and rates of main surgery premises (recommendation 13)
- Modifications of the arrangements for the use of deputising services (recommendations 42 and 43)
- Alternative arrangements where there are particular difficulties—for example, for homeless people (recommendations 51 and 52)
- Community medicine specialist to coordinate district health authority services for children (recommendation 79)
- Development of confidential computerised child health records (recommendation 81)
- Regular screening of people aged over 75 (recommendation 87, limited to elderly people living alone)
- Establishment of a unit of management for community services (recommendation 89)
- Establishment of district primary health care planning teams (recommendation 91)
- Computerisation of family practitioner committee registration functions (recommendation 92)
- Academic departments of general practice accepting some responsibility for fostering primary care in the district they serve (recommendation 103)
- General practitioners in the locality of medical schools being given the opportunity to take part in undergraduate teaching (recommendation 104)
- Allocation of funds for the development of departments of general practice (recommendation 105)

Introduction

The Acheson report on primary health care in inner London, published in 1981, drew attention to the high levels of social and health problems that primary care workers in inner London have to deal with and the generally inferior structure and availability of primary care services.[1] Attention was drawn to the high proportion of single handed and elderly general practitioners, the lack of primary care teams working from health centres, and the lack of good practice premises.

The report made 115 recommendations. Of the 31 most important recommendations, 26 have already been implemented. Overall, about a third of the recommendations have to some extent been acted on, either shortly after the report was published or when family practitioner committees (subsequently called family health services authorities) became independent in 1985, or as part of the 1990 general practitioner contract[2] or the NHS review.[3] The more important recommendations that have been implemented are listed in the box.

The report served to emphasise the deficiencies that had already been noted in the provision of primary care in inner London.[4] When family practitioner committees became independent health authorities in their own right with stronger management functions in 1985, this provided them with definite objectives towards which they could work. The Acheson report emphasised low cost, feasible solutions. Now, with the Tomlinson inquiry covering primary and secondary care in London, is therefore a good moment to reflect on what has happened since the Acheson report.

Method

Our study had two aims: to assess the trends since the Acheson report and to analyse the current situation in inner and outer London (defined as the four inner and 12 outer family health services authorities respectively; see table I) and to compare these with both England as a whole and with the authorities at the centre of three other large conurbations—Birmingham, Liverpool, and Manchester.

For the first part of the study data were collected from the authorities' performance indicators and the Department of Health for the key areas of general practice provision in inner and outer London and England annually from 1984-5 to 1990-1. Similar data

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TABLE I—*Key general practitioner variables for family health services authorities in London and England, 1977-8 to 1990-1*

Year	No of general practitioners	% of aged ≥65	% of single handed	% with lists >2500
		*Inner London**		
1977-8	1 131	17·2	38·5	33·2
1984-5	1 122	13·9	28·2	19·6
1985-6	1 134	12·8	25·6	18·4
1986-7	1 142	12·7	26·2	21·4
1987-8	1 145	11·9	24·4	20·6
1988-9	1 159	9·8	24·8	20·6
1989-90	1 182	8·9	24·3	18·5
1990-1	1 173	8·8	22·2	18·9
		Outer London†		
1977-8	2 392	11·7	26·9	35·6
1984-5	2 571	9·6	21·7	22·7
1985-6	2 583	9·5	22·0	23·9
1986-7	2 611	9·3	21·2	22·3
1987-8	2 635	8·1	20·6	21·6
1988-9	2 684	7·6	19·6	20·3
1989-90	2 700	6·9	19·8	19·0
1990-1	2 660	5·9	19·8	19·0
		England		
1977-8	20 796	6·0	16·3	40·3
1984-5	23 640	5·0	12·4	18·6
1985-6	24 035	4·8	12·1	16·5
1986-7	24 460	4·5	12·0	14·3
1987-8	24 922	4·0	11·5	12·6
1988-9	25 322	3·6	11·5	11·5
1989-90	25 608	3·1	11·4	10·0
1990-1	25 622	2·7	11·6	9·8

Sources: FHSA Performance Indicators, Department of Health, RCGP Occasional Paper 16.
*Inner London=the four inner family health services authorities: Camden and Islington; Kensington, Chelsea and Westminster; Lambeth, Southwark, and Lewisham; City and East London (Tower Hamlets, Hackney and Newham).
†Outer London=the remaining 12 family health services authorities in greater London: Barking and Havering; Barnet; Brent and Harrow; Bromley; Croydon; Ealing, Hammersmith, and Hounslow; Enfield and Haringey; Greenwich and Bexley; Hillingdon; Kingston and Richmond; Merton, Sutton, and Wandsworth; Redbridge and Waltham Forest.

for 1977-8 were obtained from the Royal College of General Practitioners' occasional paper 16.[4]

For the second part of the study the 1990-1 family health services authority performance indicators and data from the Office of Population Censuses and Surveys were used to compare key health and social factors and the provision of primary care for inner and outer London and England and for the three other large inner cities, Birmingham, Liverpool, and Manchester.

The standardised mortality ratio (England=100) to age 65 was chosen as the health indicator (following the custom of the family health services authority performance indicators) since standardised mortality ratios for the full age range include the deaths of elderly people who die in residential and nursing homes. Because there are fewer such institutions than average in London, standardised mortality ratios for the full age range will be underestimates, the deaths in institutions being attributed to the area in which the institution is situated after the elderly person has given the institution as their address or has been resident for six months.[5]

Results

TRENDS

Table I and figures 1-3 indicate the variation from 1977-8 to 1990-1 of a number of key indicators of general practice provision in inner London, outer London, and England. There has clearly been overall improvement in most of these indicators in inner and outer London and in England. The proportion of general practitioners aged 65 or more has been reduced (helped by the introduction of a compulsory retirement age of 70 in 1990). In inner London and outer London, however, the reduction in the proportion general practitioners aged 65 or more (by 49%) has been less than in England as a whole (55%), and the proportion of general practitioners aged 65 or more is now more than three times that for England as a whole (table I and fig 1, top). There are still about twice as many single handed general practitioners in inner London as in England (table I and fig 1, middle).

The trend of the proportion of general practitioners with list sizes of more than 2500 patients is particularly disturbing, the reduction in inner London (43%) and outer London (47%) being considerably less than for England as a whole (76%). In 1977-8, in inner and outer London, there were lower proportions than in England of particularly large practices (33·2% and 35·6% compared with 40·3%). However, in 1990-1 these proportions were considerably higher in inner and outer London than in England as a whole (18·9% and 19·0% compared with 9·8%). The trend in inner London shows a small increase in the proportion of large practices, in contrast with a decreasing proportion in England as a whole (table I and fig 1, bottom). Although inner London list sizes are more "inflated" than those in other inner city areas (the populations registered with general practitioners exceed the census populations by higher proportions in inner London), it is the trend in inner London which is worrying.

In 1990-1 the number of general practitioners aged 65 or more in London (inner and outer London) was equivalent to 60% of the total in the whole of the rest of England, and the number with lists of more than 2500 was equivalent to 40% of the total for the rest of England.

OVERALL SITUATION FOR PRIMARY CARE IN 1990-1

Table II summarises the values of some key variables that indicate the levels of health, social conditions, and primary care provision in inner London as compared with the whole of England in 1990-1. In inner London,

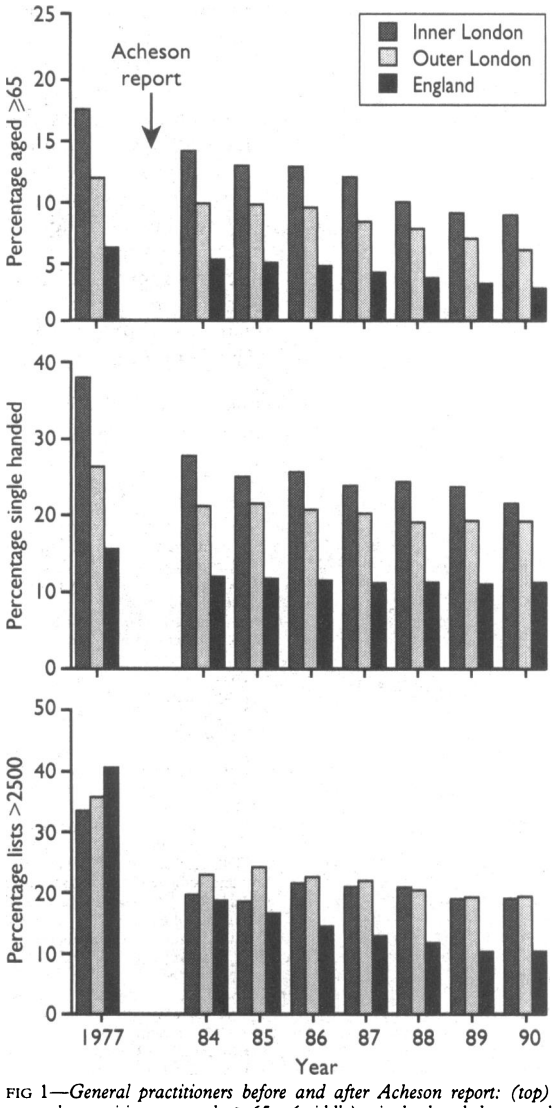

FIG 1—*General practitioners before and after Acheson report: (top) general practitioners aged ≥65; (middle) single handed general practitioners; (bottom) general practitioners with lists ≥2500 patients*

as compared with England as a whole, the indicators show poorer levels of health (standardised mortality ratios to age 65) and worse social conditions (overcrowding of households, etc). In addition, in London general practitioner services are less well adapted to deal with these primary care problems.

In inner London general practitioners are more likely to be elderly or single handed and have a higher proportion of large lists; work from premises that are below minimum standards; remove patients from their lists; and receive formal allocations of patients who are unable to find a general practitioner. They are less likely to have practice nurses and to reach the higher targets for childhood immunisations, preschool booster immunisations, or cervical cytology.

Positive changes are less easy to quantify, but they should be noted. In some inner city areas there has been an increase in the number of innovative practices with younger partners investing in premises, taking part in vocational training schemes, and employing practice nurses.[6] Young doctors may have served as trainees in the area and then been recruited as partners with a longer term commitment. Recently such practices have shown further innovation in health promotion and in employing additional staff such as counsellors.

COMPARISON OF LONDON WITH OTHER INNER CITIES

Table II compares the key variables between inner and outer London and the family health services authorities of three other inner city areas—Birmingham, Liverpool, and Manchester. Figure 2 compares the average values for Birmingham, Liverpool, and Manchester with inner London, outer London, and England. Broadly speaking, the problems faced by general practitioners in inner London resemble those in other inner cities (fig 2, top left). However, key characteristics related to general practice (percentages of elderly or single handed general practitioners and those with large lists) indicate a more poorly developed service in inner London. This is shown in figure 2, top right: the other inner cities resemble England or outer London more than inner London. Similar observations are true for the characteristics of the primary care team (percentages with practice nurses and below minimum standards for reimbursement of rent and rates; fig 2, bottom left). In terms of outcome indicators (percentages of general practitioners reaching targets) the other inner city areas resemble inner London, rather than outer London or England, in having particularly low values (fig 2, bottom right), although in each instance the figures for inner London are poorer.

Examination of all of the 1990-1 performance indicators for all of the family health services authorities in England shows that the other inner city authorities that most resemble inner London and the four large inner city areas chosen are Bolton, Bradford, Calderdale, Coventry, Kirklees, Leeds, Newcastle upon Tyne, Oldham, Rochdale, Salford, Sandwell, Sefton, South Tyneside, St Helens and Knowsley, Sunderland, Tameside, Walsall, Wigan, and Wolverhampton.

Discussion

There has been a considerable improvement in primary care in inner London since the Acheson report, and many of its most important recommendations have been implemented. There are, for instance, fewer single handed practices, fewer elderly general practitioners (and a retirement age of 70 for principals), payments for working in defined underprivileged areas, and support for departments of general practice. These changes reflect national trends for improvement in general practice as a whole rather than specific improvements in London. The problems faced in inner London are similar to those in other inner cities outside London, but inner London general practice continues to be less well adapted to deal with the problems than the other inner cities studied.

One trend of note is the increase in the proportion of large practices (over 2500 patients) in inner London. This trend may indicate an attempt on the part of some general practitioners to increase their incomes in an area that is more expensive to live and work in than the rest of England.

The Acheson report made recommendations concerning the coordination of community health and family doctor services; little progress has been made in this area and a new agenda is opening up for management of the wider primary care budget.[37] Family doctors will be able in principle to play a greater part in

TABLE II—*Values of key variables for family health services authorities, 1990-1*

	England (n=90)	Outer London (n=12)	Inner London (n=4)	Other large city family health services authorities		
				Birmingham	Liverpool	Manchester
Standardised mortality ratio under age 65, 1986-90	100	93	125	114	137	138
Underprivileged area (UPA) score 1981 (average values)	0	−4	42	26	26	38
% Of registered population attracting deprivation payments	11	10	56	26	20	31
% Of overcrowding, 1981	7	9	15	14	12	13
% Of one parent families, 1981	2	2	4	3	3	3
% Of population from New Commonwealth and Pakistan, 1981	5	13	19	15	2	8
% Of general practitioners:						
Aged ⩾65	3	6	9	4	7	2
Single handed	12	20	22	20	16	16
With lists >2500 patients	10	19	19	8	15	7
% Of practices:						
Achieving high target preschool booster	62	38	15	52	24	6
Achieving high target childhood immunisation	69	48	20	58	33	19
Achieving high target cervical cytology	65	29	7	40	18	10
On minor surgery list	67	40	16	55	41	53
With consent to use deputising services	38	65	22	86	77	84
Without practice nurse	15	26	33	39	22	22
With premises below minimum standards	7	9	46	0	12	Not available
Patients removed at doctor's request/10 000 registered population	19	26	41	69	32	18
Formal allocations/10 000 registered population	13	5	29	1	3	2
Night fees (high rate) (£000s/10 000 registered population)	8	4	3	7	6	11
Total expenditure on general medical services (£000s/GP)	58	58	62	63	57	57
List inflation (%)	6	16	28	9	9	8
FHSA administration cost (£000s/10 000 census population)	22	32	45	18	25	25
FHSA staff cost (£000s/10 000 census population)	14	21	26	13	14	17
Registration transactions:						
In and out of FHSA (as % of registered population)	12	15	21	10	13	10
Excluding block transfers	27	28	39	30	35	28
Dispensing doctors (as % of all GPs)	14	0	0	0	0	0

Sources: FHSA performance indicators, 1990-1; Department of Health; OPCS 1981 census (1991 data not yet available).

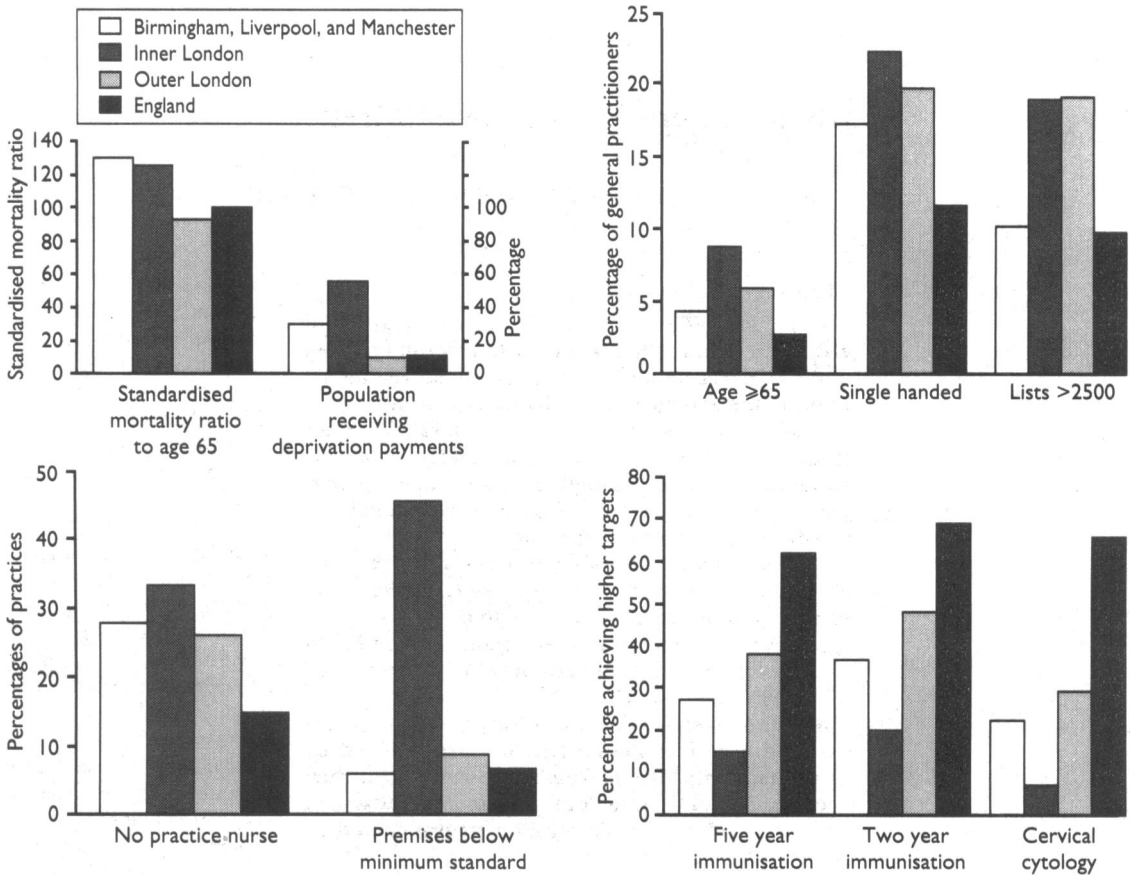

FIG 2—*(Top left) population characteristics; (top right) general practitioner variables; (bottom left) primary health care characteristics; (bottom right) achievement of targets*

purchasing secondary care. They will also be under pressure as providers to contribute to local targets for health promotion.

It is clear that general practitioners and other primary care workers in inner London still have to contend with more adverse medical and social conditions than are general nationally and are working in conditions that are generally worse than average. General practitioners' incomes from target and other payments (such as maternity services) are below average, and none of them receives the considerable additional payments that are available for dispensing doctors. The difficulty in reaching targets is related to patient characteristics and attitudes as well as to practice performance. For instance, the variation among the family health services authorities of England of the percentage of general practitioners reaching the higher cervical cytology target is significantly related (in a regression analysis using the family health services authority performance indicators and a range of social variables) to the percentages of people in ethnic groups and of people changing house within one year. This is to be expected since women in some ethnic groups have reservations about cervical cytology testing, especially by male doctors. In areas of high mobility it is more difficult for general practitioners to keep good records, especially if the cervical cytology tests are performed by a variety of agencies other than general practitioners. Deprivation payments do not, on average, sufficiently compensate for the reductions in income from other services for general practitioners working in expensive inner city areas.

The King's Fund Commission on the Future of London's Acute Health Services has recently said that "health care in London must become primary health care led" and has recommended the transfer of resources for London's health care from acute hospital services to primary care to finance the construction of several large health centres.[8,9] The results of our study are in general agreement with the King's Fund's analysis of the problems of primary care in London, particularly the poor standards of inner London general practitioners' premises compared with those in outer London and England and even in other comparable inner city areas.

The data presented in this paper can only be as accurate as the original source material and in some instances (such as the standards of premises) there could be inconsistencies in the definitions used by different family health services authorities. The overall picture, however, is clear: a considerable investment is still needed in primary health care in inner London to bring the services up to the standards of the rest of the country and to enable practitioners to deal with the problems that are faced in London.

The pressing need is for an active investment process in primary care in our inner cities. An extension of deprivation payments, linked to improvements in service provision—for instance, additional ancillary staff to help achieve targets—would help to overcome the obvious problems still faced particularly by inner London general practitioners. The pace of change may well be faster in the 1990s than in the 1980s, and precise, effective action is therefore increasingly necessary.

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