Health care in London

Other cities also overbedded

EDITOR,—Brian Jarman takes issue with the recommendations of the Tomlinson report and the government's response, which have suggested the closure of several hospitals in London, by arguing that the data on provision and use of beds in all specialties by London residents do not amount to a case for reducing the total stock of hospital beds in London at a rate faster than elsewhere.[1] He shows that the admission rate for acute plus geriatric services for 1990-1 (table I) was only 2% higher in London than in England as a whole. He also shows that the admission rate for the inner deprived parts of London in the same year was about 9% below that for comparable areas outside London, such as central Liverpool and Manchester. On the basis of this evidence he argues that hospital use does not indicate a need to reduce the total acute and geriatric bed capacity in London, judging by national norms of use.

Though there are several general difficulties in using data on use to approximate to the relative need for health care resources, including beds, of different areas, there is a specific difficulty with the comparison that Jarman makes between inner London and similar parts of other cities in England. In table I he shows that the rate of admission to hospital in London in what he calls the inner deprived area was 146·7 consultant episodes per 1000 residents and in similar inner deprived areas outside London it was 161·6 consultant episodes per 1000 residents. The problem with this analysis is that the inner deprived areas outside London with which he is comparing inner London are subject to the same sorts of alleged overprovision of beds as inner London itself. In fact, there is evidence that several inner city areas outside London have a higher relative level of provision compared with the peripheral areas of their particular regions than does central London in relation to outer London and the remainder of the south east of England. Thus it may not be surprising that the inner area of London has a lower rate of admission to hospital than inner areas of other cities.

As Jarman himself seems to recognise in the concluding section of his paper, the key issues for policy and analysis are to establish an appropriate fair share of resources for the purchasers of the London area, taking into account the likelihood that the costs of health care provision will be higher in the capital, and to ensure that an appropriate range of services is available to satisfy the needs of these purchasers. This is better than comparing use of beds between parts of London and other areas of England when it is known that the same problems of historical inequity of resources are present in these comparison regions.

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1 Jarman B. Is London overbedded? *BMJ* 1993;306:979-82. (10 April.)

BMA slow to condemn Tomlinson

EDITOR,—The Tomlinson report's recommendations regarding bed closures in London and the government's response are based on two fundamental unproved principles: firstly, that London is overbedded and, secondly, that improving much of the underresourced primary care in the inner city will result in reduced referral rates to the secondary sector. The first principle has been seriously challenged by Brian Jarman's evaluated conclusion that London is not overbedded, with, consequently, no case for a reduction in the total bed capacity in the capital.[1] The second principle has never been evaluated, and there is indeed a view that improving primary care results in an increase in the demand for secondary care.

The profession—including those inner city general practitioners who will supposedly benefit from the proposed investment into primary care—has been united in its opposition to the proposed bed closures.[2,3] In contrast, the BMA's passive response has been lamentable, as Robin Russell Jones and colleagues point out.[4] A reply to their letter by the BMA's secretary further reinforces the view that our representatives are capable of little more than lip service.[4] Equally disappointing has been the *BMJ*'s coverage of the Tomlinson proposals, with abstract articles written by authors colluding with, and even supporting, the proposed bed closures.

Many of us are despondent at the BMA's apparent inability and unwillingness to challenge effectively successive health secretaries, who are using the NHS as an experimental ground for implementing radical changes without adequate evaluation. The closure of 2500 of London's beds is clearly not objective, with irrevocable and grave consequences for London's doctors and patients alike.

Given that the government has yet to announce its final decision regarding hospital and bed closures, the BMA still has an opportunity to redeem itself in the eyes of its disillusioned members. Instead of focusing on how best to manage possible redundancies among consultants[5] it should be fighting for a moratorium on any bed closures until investment in primary care has been achieved. This should be followed by piloted evaluation of the effect of improved primary care on the secondary sector, and only if this results in a reduction in demand for secondary care should hospital or bed closures be considered. The BMA should take a stand and recommend that all current negotiations on the development of primary care should be stopped until the above criteria are guaranteed.

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2 General Medical Services Committee. *Response to the Tomlinson report*. London: GMSC, 1992.
3 Royal College of General Practitioners. *Response to the Tomlinson report into London's health service, medical education and research*. London: RCGP, 1993.
4 Russell Jones R, Cramer P, Hedge U, Owen R, Thompson J, Patel PR, *et al.* Tomlinson and the BMA. *BMJ* 1993;306:1000-1. (10 April.)
5 Lauermann E. London after Tomlinson: managing change—the human aspect of the NHS. *BMJ* 1993;306:130-2. (9 January.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

Inadequate provision for long term care

EDITOR,—Brian Jarman in his analysis of the provision of acute beds in London suggested that the capital was underprovided with residential home places.[1] Data collected for Kensington, Chelsea, and Westminster Commissioning Agency supports this hypothesis. A recent census in the agency enumerated 792 residential home places for elderly people (17 places per 1000 people aged ≥65), a level of provision considerably below the 20·5 places per 1000 quoted by Jarman for inner London and 316 nationally. Even if all forms of long stay care provided in Kensington, Chelsea, and Westminster are included the number of places (1111, 24·5 per 1000 aged ≥65) is still well below national norms of provision. The pressure placed upon acute services by this shortfall of provision for long stay care has been demonstrated by the enumeration of acute beds in local hospitals that are being used inappropriately.[2] The use of acute beds as a substitute for long term care is an inefficient use of resources and is unsatisfactory for the patients concerned. Although the provision of long stay care has been neglected and often derided, it is an essential element of the spectrum of care facilities required by older people.

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1 Jarman B. Is London overbedded? *BMJ* 1993;306:979-82. (10 April.)
2 Victor CR, Hudson M, Fulop N, Nazareth B. The inappropriate use of acute hospital beds in an inner London DHA. *Health Trends* (in press.)

London low on residential and nursing homes

EDITOR,—Brian Jarman has helped to shed light on comparative hospital bed provision in London,[1] but has omitted mention of nursing home beds. The relation between the supply of residential and nursing homes places and hospital bed use is crucial to the bed and resources debate in London.

When compared with shire counties, London is relatively poorly provided with residential homes. Private provision is low and local authority provision and expenditure is comparatively high in inner London (table I).

Nursing homes are registered by health authorities and information collected on K036 returns. The two North Thames regions are ranked lowest in the country, with nine and 10 beds per 1000 resident population aged over 75 years (table II). Both South Thames regions include districts on the south coast that have relatively high provision. For example, Worthing district has 1463 nursing home beds, which is nearly 50% more than inner London as a whole.

Within the Thames region inner London health districts as a group have the lowest nursing home bed supply, averaging six beds compared with outer London's 13 beds per 1000 population aged over 75 years. Some inner London districts such as Tower Hamlets have no registered private