Risking their jobs by criticising standards of care: Helen Zeitlin and Graham Pink

(1980) Mr Callanan satisfied the tribunal that he was "dismissed" unfairly for whistleblowing but it had no power to give him his job back. Dr Zeitlin acknowledged the difficulty of returning to work after her success. Employers are never happy to welcome back employees who have embarrassed them.

American experience

Although whistle blowing is more formalised and studied in the United States the experience of whistle blowers seems to be much the same. They are often regarded as spoil sports not only by the employer but by their peers. An American study in 1987 reported that whistle blowers became the victims: most in the private sector and half in the public sector lost their jobs as a result.[3]

In the United States whistle blowing is considered a vital part of the regulatory process. Whistle blowers are seen as the guardians of the health and safety of the public, particularly since they will always be in the best position to determine when that health and safety is put in danger. State and federal legislation exists to protect whistle blowers—for example, the Whistle Blowers Protection Act 1989.

British legal position

In Britain the courts consider the position of the whistle blower in relation to the disclosure of information when employers seek injunctions. In several leading cases Lord Denning stated that injunctions were not issued to stop employees disclosing publicly any misconduct on the part of employers such as crimes, frauds, and misdeeds and any activities that are "dangerous to members of the public."

The British courts do not, however, have sufficient power to protect the whistle blower against victimisation, dismissal, and subsequent blacklisting. Indeed, courts are impotent if an employer refuses to re-employ or reinstate vindicated employees. The law will receive another airing next year when the courts will consider the case of the nurse Graham Pink, who made disclosures in the *Guardian* about conditions at Stepping Hill Hospital.

There is an urgent need to recognise that whistle blowers serve a vital purpose in ensuring the disclosure of information in the public interest. Those who want to stop whistle blowing have a vested interest in ensuring that misdeeds do not come to the public's attention. Employers can do much to ensure that employees have a proper procedure to whistle blow on matters concerning them within the organisation. Ultimately, though, the whistle blower who discloses information publicly must have the realistic protection of the law to ensure that he or she does not become the victim after acting in the best interests of society.

At present a combination of restrictive government guidelines and inadequate legal protection conspire either to silence any employee from revealing matters of public concern or to leave the employer free to punish them.

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London after Tomlinson

Public health in inner London

Bobbie Jacobson

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

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One of Sir Bernard Tomlinson's aims in his inquiry into London's health services was to advise the secretary of state for health on the future balance of primary and secondary health care "taking account of the health needs of Londoners."[1] Sir Bernard, however, also made it clear that "we have not seen it as part of our remit to carry out a comprehensive needs assessment for the whole of London," but concluded that the extremes of health need found in London were "unparalleled in the rest of England." Dr Jacobson highlights some of the major determinants of health inequality in inner London and assesses the extent to which the proposed solutions are likely to meet these needs.

Inequalities in health in London

How should the health of Londoners be compared with those elsewhere? The division of routine health data into the four Thames regions and their districts conceals rather than reveals health problems that might be London-wide or common to the inner city. In its report *The Health Status of Londoners*, the King's Fund has attempted to address this problem by comparing indices of mortality and morbidity between comparable areas in London and outside.[2] Using a modified version of the Craig classification of socioeconomic clusters, the fund concluded that indices of economic and social deprivation were important determinants of patterns of mortality and morbidity both inside and outside London.

The King's Fund developed a material deprivation score of 0-5 based on indices of housing tenure and quality, employment status, and educational attainment. It analysed this in relation to a composite health index of physical and psychosocial health and fitness drawn from the health and lifestyle survey.[3] There was a strong and statistically significant relationship between the material deprivation score and the overall health index (table I). These findings support earlier

evidence from the survey of Londoners' living standards,[4] and national studies such as *The Health Divide*[5] and *The Nation's Health*,[6] which concluded that reducing levels of material deprivation, such as income inequalities, homelessness, poor housing, and unemployment, would have a major, positive impact on health.

Within London, however, the contrasts between extremes of affluence and poverty which have a bearing on health are best illustrated by comparing inner and outer London along the lines suggested in the Tomlinson report. Table II, which shows selected data from the 1991 census, indicates that unemployment, poor quality overcrowded housing, and lack of access to a car are still concentrated in the inner city.

Comparative mortality data in London are more difficult to interpret and show complex differences between inner and outer London. Taking coronary heart disease mortality in the under 65s—one of the key targets in *The Health of the Nation*[7]—Table III shows that while the highest age standardised death rates for coronary heart disease are in Tower Hamlets and Newham, there is a widely overlapping distribution between inner and outer London. The reasons for this—including the effect of inaccurate denominators—need further exploration.

Health of London's invisible populations

Inner London family health services authority (FHSA) areas, as indicated in the Tomlinson report, have the highest estimated population turnover in the country. Such mobile communities are doubly disadvantaged. Firstly, their mobility makes access and continuity of care difficult. Secondly, inaccurate records of their addresses on FHSA registers deny many people the opportunity to take up preventive services such as immunisation and screening for cervical and breast cancer. The consequent inflation of FHSA registers is a major contributing factor to the low uptake rates observed for such programmes in inner London.[8]

Estimates of the size of the homeless problem depend on the definitions used which range from the statutory "priority homeless," whom local authorities must house, to the so called "non-priority" homeless, for whom no routine data exist. Between 1979 and 1991 the number of people of officially recorded homeless in England has doubled—a quarter of whom (39 600) are from Greater London.[9] A recent study estimated that the total number of homeless people including those living in hostels and on the streets in London in 1991 was 60 000.[10] Use of hospital services by such populations was two to three times higher than that by resident populations. Up to 9% of unplanned admissions in one study were accounted for by those in temporary bed and breakfast accommodation.[11] A unique study of the health status of people who were temporarily homeless in hotels in the London boroughs of the North West Thames region showed that while rates of acute and longstanding limiting illness in the homeless population were similar to those in the resident population, levels of mental ill health were twice as high among the homeless.[12]

Home Office statistics show that the number of refugees or "asylum seekers" permitted to enter Britain has risen dramatically from 5000 in 1988 to nearly 50 000 in 1991. Routine data on where refugees settle is not available, but inner London, with its well established black and ethnic communities has traditionally been home to many. A recent unpublished study based on interviews, estimates of membership of local refugee community support groups, and other local information in Hackney suggested that there were about 24 000 refugees living in the borough—more than 10% of the total local population. Turkish and Kurdish groups (12 500), Eritreans (3500), and Somalis (3000) formed the three largest groups. There is a dearth of research on the health needs of such groups, although qualitative research in the Hackney study identified health and social needs of Third World magnitude with needs for housing, family planning, abortion, and maternity services ranking highly. Difficulty in registering with a general practitioner and the need for advocacy services were also highlighted.

TABLE I—*Material deprivation and the overall health index*

Overall health index	% With material deprivation score: 0	1	2	3+	No of subjects
Good	29·2	25·1	20·2	16·7	1432
Fair	57·8	55·8	54·6	52·4	3404
Poor	13·0	19·1	25·2	30·9	1314
No of subjects	1495	1946	1574	1135	6150

TABLE II—*Selected census indicators in London (1991)*

	Inner London (%)	Outer London (%)	Greater London (%)
Unemployed	15·5	10·3	12·3
Households: lacking or sharing bath and lavatory	3·5	2·3	2·7
No central heating	20·9	17·4	18·8
Households: no car	53·9	32·0	40·7
Households: two cars	10·1	23·5	18·2
Owner occupier	38·6	69·4	57·2
Rented private	27·6	14·1	19·5
Rented (local authority)	33·8	16·5	23·3
Over 1·0 persons to a room	5·6	3·2	4·1

TABLE III—*Age standardised mortality rates for coronary heart disease (0-65 years)* *

Outer London district health authorities		Inner London district health authorities	
Bromley	41	Hampstead	43
Richmond, Twickenham, and Roehampton	42	Riverside	49
Kingston and Esher	44	Haringey	57
Merton and Sutton	46	Parkside	57
Barnet	48	West Lambeth	57
Bexley	48	City and Hackney	58
Harrow	49	Wandsworth	61
Croydon	50	Lewisham and north Southwark	64
Enfield	51	Bloomsbury and Islington	66
Hillingdon	53	Newham	74
Redbridge	54	Tower Hamlets	81
Barking, Havering, and Brentwood	55		
Ealing	59		
Greenwich	59		
Waltham Forest	60		

* Rates are quoted per 10 000 resident population and are rounded up to the nearest whole number.

Health of ethnic minorities in London

While ethnic minority communities are overrepresented in London's homeless populations, there are many well established, stable ethnic minority communities in London—each with distinctive health needs. Most, but not all, are concentrated in the inner city. Analysis of the first ever question asked on ethnic origin in the 1991 census in Table IV shows that over a quarter of the resident population of inner London were of black and ethnic minority origin compared with just over 20% for Greater London. These estimates require further analysis as it is known that there has been undercompletion of census forms owing to widespread fear among ethnic and other communities—especially refugees—that completion may have led to deportation or prosecution for non-payment of the community charge. In inner city areas such as Hackney the most recent electoral register had fallen by 30 000—which adds weight to this idea.

A paucity of information on the health status and health needs of black and ethnic minorities prevents a proper analysis of the contribution of ethnic status to health in general and to health in London in particular.

ULRIKE PREUSS

With more health education these children might not develop the unhealthy behaviours of their elders

Most studies have not been able to disentangle the effects of socioeconomic disadvantage from specific ethnic effects—with the exception of a few genetic diseases such as sickle cell disease and thalassaemias. The Immigrant Mortality Study[13] and a more recent study[14] have highlighted the high mortality from coronary heart disease among Asians and lower levels among those born in the Caribbean. Mortality from hypertensive disease and stroke was also shown to be much higher among those born in the Caribbean or Africa. These findings—together with the young age distribution of such populations—exert relatively well concealed effects on the standardised mortality rates in parts of inner London. A study of ethnic differences in the proportional mortality ratios for diabetes and cardiovascular diseases (City and Hackney) among the 35 to 64 year olds showed that the high standardised mortality rate in this age group for diabetes and stroke is largely explained by high levels of mortality for these diseases in Asians and Caribbeans respectively.[15]

Communicable diseases in London

While non-communicable diseases are the major cause of preventable mortality and ill health in London as elsewhere, inner London displays a unique pattern of communicable diseases that presents a major public health challenge. The spread of HIV infection and AIDS is a major cause for concern in London. The most recent quarterly report from the Communicable Disease Surveillance Centre shows that two thirds of all AIDS cases and 63% of those testing HIV positive in Britain are reported from the four Thames regions. Although this does not reflect the size of the resident HIV problem, London's health services clearly have a major part to play in the prevention and treatment of HIV related disease.

A study comparing the standardised mortality rate for a selection of "avoidable" causes of mortality which the health service could help avert showed high levels of mortality from tuberculosis in inner London.[16] The low levels of neonatal BCG uptake in some parts of inner London should be reviewed, and the investigation and treatment of refugees arriving in London require more commitment.

Although immunisation uptake rates for the preventable childhood infections have increased substantially throughout the country, a recent analysis by the Communicable Disease Surveillance Centre showed that the four Thames regions had the lowest vaccine uptake rates in the country for measles, mumps, and rubella and pertussis. Yet at the same time notification rates for mumps were lower than anywhere else for three of the four Thames regions.[17] This paradox is almost certainly due to undernotification of these diseases by general practitioners. It is not possible to disaggregate the effects of inner and outer London because notifications from general practitioners across London are so poor that the Communicable Disease Surveillance Centre does not disaggregate these data. Because communicable disease outbreaks often cut across district and local boundaries, it is important for the purposes of both surveillance and outbreak control that a London-wide perspective is adopted.

The future health of London's children

Little information is accessible about the health of London's children. Probably the most wide ranging health and lifestyle study of 9 to 15 year olds was commissioned by the Health Education Authority and conducted by MORI.[18] The findings are based on a self completed survey of a nationally representative sample of primary, middle, and secondary schools in England at the end of 1989 (table V).

The table shows that while regular cigarette smoking and alcohol drinking are as common in inner London as elsewhere, inner London schoolchildren are more likely to have been offered class A drugs (heroin, "acid," ecstasy, cocaine, and "crack")—especially ecstasy and "acid." Drug experimentation levels were higher among inner London's schoolchildren for class B drugs (cannabis, amphetamines, tranquillisers)—with most of the difference attributable to higher levels of cannabis use. This study has been replicated in Hackney[19] and the findings reinforce the need to focus more effective preventive efforts by education and health services on drug, alcohol, and cigarette use and to provide more accessible information and services to

TABLE IV—*Ethnic origin of Londoners*

Ethnic group	Inner London (%)	Outer London (%)	Greater London (%)
White	74·4	83·1	79·8
Black	13·5	4·7	8·0
Black—Caribbean	7·1	2·7	4·4
Black—African	4·4	1·3	2·4
Black—Other	2·0	0·7	1·2
(South) Asian	8·8	9·9	9·5
Indian	3·0	6·5	5·2
Pakistani	1·2	1·4	1·3
Bangladeshi	2·8	0·4	1·3
Other Asian	1·8	1·6	1·7
Chinese	1·1	0·7	0·8
Other	2·3	1·5	1·8

TABLE V—*Prevalence of selected health behaviour in 9 to 15 year old London schoolchildren*

Behaviour	Inner London (%)	Outer London (%)	All regions (England) (%)
Ever smoked	34	33	21
Ever tried alcohol	54	58	63
Regular drinker	11	9	12
Exposure to class A drugs	12	7	7
Exposure to class B drugs	16	8	7
Experimentation with class A drugs	2	2	2
Experimentation with class B drugs	12	6	4

young people on sexually transmitted diseases and family planning.

Implications of the Tomlinson report for the health of inner London

The central and laudable tenet of the Tomlinson report is to strengthen primary health care in inner London by diverting resources from the hospital sector. The extent to which such a strategy—even if achieved—can have a major impact on the health of inner London without equally radical change in other sectors is questionable.

While the Tomlinson report deliberately concentrated on health services alone, it is clear from the evidence of health needs in inner London that the greatest potential for health gain lies outside the control of the health service and in the realms of central and local government policy on housing and employment. Nevertheless, the health sector clearly has a contribution to make to the health of Londoners, and there is evidence that primary health care in particular can make a cost effective contribution to achieving the targets in *The Health of the Nation*[6,20] and that primary and community health services, together with local authority services, provide the backbone of community care.

The Tomlinson recommendation to ensure that there is a pan-London mechanism for finding an equitable formula for subregional weighted capitation is welcome and should aim to eliminate the inequities created by the current system where the four Thames regions now speak in quadruplicate. Two issues need addressing urgently to ensure that the people of inner London get their fair share of health resources. The first is the need for a method to estimate the size of the invisible, transient populations, and the second is the way in which capitation funding is weighted for levels of deprivation and ethnic origin. Weighting by all cause under 75 standardised mortality rate alone is inadequate and has been shown to underestimate the burden of ill health in primarily young inner city populations.[15] Ethnic origin as well as levels of deprivation need to be considered; extra resources need to be spent on services to make them more accessible to people whose first language is not English. The extra costs of such services for two inner city health authorities, Haringey and City and Hackney were estimated at nearly £10m in 1991.

The Tomlinson report and its precursor, the King's Fund report *London's Health Care in 2010*,[21] claim that closures and rationalisation in the hospital sector will release sufficient resources for developing primary care. This, together with unspecified transitional moneys and a ludicrously small injection of capital to develop premises is expected to achieve these aims. The assumption that hospitals serving deprived populations can increase efficiency to the level of the top quartile of health providers is not realisable. Deprived communities are likely to continue to have above average admission rates and longer lengths of stay—much of which may not be remediable in the short term even in a strengthened primary care setting. The disappointing, or perhaps politically driven, reliance in the Tomlinson report on achieving savings from the acute sector to finance primary care is reminiscent of the kind of thinking which characterised community care policy for the mentally ill.

The report outlines potentially imaginative ways in which primary care and its practitioners can become more responsive to the needs of local communities. These together with initial thoughts on the creation of "primary care development zones" are welcome. But the sketchiness of the criteria and mechanisms by which such laudable goals are to be achieved is disappointing compared with the detail devoted to securing closures in the hospital sector. It is astonishing that the report completely glosses over the public health function in London—especially as it has a central role in defining public health needs. Indeed, the proposals for mergers of clusters of inner London authorities may put public health at risk by distancing public health physicians from their communities, general practitioners, and local authorities, who are essential to their work. The proposed London wide implementation group is welcome, but how will its ideas be translated into practice and will its solutions be political or public health driven?

Finally, if the proposed closure of the teaching hospitals occurs without adequate funding to provide the desired developments in primary care and to ensure that the remaining hospitals are able to provide high quality medical care the people of inner London will be right to claim that the Tomlinson report will simply be a further exercise in cutting health services to Londoners.

Criteria to assess Tomlinson recommendations

The recommendations in the Tomlinson report can be assessed against four criteria which are likely to have an effect on health:

- The extent to which proposals for district health authority resource allocation take account of inequalities in health in London
- The extent to which resources to develop primary care are guaranteed
- The mechanisms proposed for making primary care more responsive and accountable to distinctive local population health needs
- The measures recommended to ensure that the people of inner London have adequate access to appropriate high quality secondary care.

I am grateful to Professor R Balarajan for providing *The Health of the Nation* data.

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