How Do Community Hospitals Make Economic Sense?

A. J. M. Cavenagh

The long-awaited official publication *Community Hospitals: Their Role and Development in the National Health Service*¹ sets out in 10 pages the present Departmental policy in general terms, and represents a major, if barely acknowledged, review of the 1962 Hospital Plan. I suspect that there are at least six economic advantages of shifting emphasis to community hospitals rather than providing district general hospitals that have contributed to this volte-face.

Firstly, the expense of building. A new bed in a district general hospital costs about £16,000 at 1973 prices, whereas that in the community hospital costs between £5,000 and £10,000, depending on the ancillary services and facilities. So if the community hospital bed can provide an equivalent service to the patient it will probably be about half as expensive. Secondly, the running costs, which are variously estimated as one-half to two-thirds that of a bed in a district general hospital. There are more savings on the third factor, the cost of medical staffing. Resident medical staff should not be necessary for community hospitals; continuous on-call cover being provided by the general practitioners using the hospital. With the increased trend to group practice and duty rotas this is likely to be cheaper than providing the equivalent service in a district general hospital. Fourthly, travelling costs will be cheaper, an important factor over the next two decades. It has been shown that the total cost to the community is reduced when hospital facilities, including consultant clinics, can be provided locally in community hospitals.

Of more ultimate value are the final two factors—the saving in skill and time which follows the provision of local hospital facilities. Most younger general practitioners are willing and able to help in hospital staffing generally, but can do so only if a hospital is situated within a few miles. Building more community hospitals will enable their skill to be tapped. The same argument applies to nursing, technical, and domestic staff. Each community can make a major contribution to the staff required on a part-time basis. As soon as the hospital moves to a distance, as in the 1962 District General Hospital plan, this pool of local talent is lost. The wards closed for lack of staff in many district general hospitals are a melancholy witness to this fact.

Personal Experience

If the economic facts speak for themselves debate will centre on the correct scope and furnishing of the community hospital and the Department's document suggests that this should be decided by consultation at area and district level. My own experience is of a 40-bedded community hospital containing an x-ray and casualty department, an operating theatre, and an obstetric department. Consultants in all major specialties visit at least monthly and the policy followed is with their express co-operation and encouragement.

This hospital deals with 70% of total inpatients in its area, the remaining 30% requiring the facilities of the district general hospital or base hospitals. Numerically more important is the casualty service provided, where 98% of casualties are dealt with locally and only 2% need referral. Compared with D.H.S.S. estimates the rate of referral for consultant opinion is roughly halved. Extrapolation of these figures on a national scale makes the Departmental estimate of a quarter of future bed requirements in community hospitals appear unduly conservative.

If an x-ray department is not included in the community hospital as of right then its value to the community served declines sharply. X-ray examinations exceed admissions by four to one; five casualties attend to every patient admitted, and many of these require x-ray examinations. About 200 barium examinations are performed annually by the visiting consultant and over 100 intravenous pyelograms. On the emotive subjects of surgery and obstetrics the arguments in favour of concentrating facilities and skill in special departments must be recognized. At the same time it is right to examine the quantity and type of work in these departments being performed by junior staff. No one would suggest that the surgical, obstetric, or, above all, anaesthetic services provided in community hospitals should be more ambitious than those which junior staff would normally supply in the district general hospital. Nevertheless, if this work can be performed

as safely, less expensively, and at greater convenience to the patient in a smaller unit nearer home then the reasons for planning otherwise must be compelling indeed. In general, the busier the community hospital is, the more efficient it is likely to be clinically, and the more economic to its community. Limitation of its functions in an arbitrary manner should be subjected to critical analysis in every case.

Last and perhaps most important of all is the community hospital's role in teaching—which is an entirely free byproduct and represents the cheapest possible postgraduate education. By providing a regular meeting ground for consultants and general practitioners to discuss current clinical problems and exchange views and queries, the community hospital bridges the abyss which opened in 1948 and has yet not been closed. No amount of formal—and expensive—postgraduate courses can achieve this essential element of discussion which only regular encounters provide. It is this that gives the North American general practitioner an edge on his counterpart in Britain. If we fail to improve our educational facilities by cutting costs all round and plumping for more and better community hospitals it will be a strange and tragic mistake.

¹ Department of Health and Social Security, *Community Hospitals: Their Role and Development in the National Health Service*. London, H.M.S.O., 1974.

Brecon, Wales

A. J. M. CAVENAGH, B.M., D.OBST.R.C.O.G., General Practitioner

Would Nurses Take Clinical Responsibility if Given It?

Jacqueline Flindall

Whether nurses should take clinical responsibility has been argued in both professions over the last ten years. Nevertheless, during this time nurses have been increasingly involved in making clinical diagnosis and are making clinical decisions without official acknowledgement. A general practitioner might argue that in the domiciliary services the patient is his responsibility yet, if primary visiting is extended though responsibility is not ostensibly delegated, one could argue that the nurse nevertheless becomes the responsible person for a period: in effect the patient is transferred from the doctor to the nurse who may have to take upon herself the initial responsibility for certain decisions—for example, is the advice of a doctor needed immediately or at all? (this implies an element of diagnosis). What immediate treatment or action is required? (a matter of life or death—or simply advice on basic care or simple medicines, or both).

The present primary visiting schemes contain careful guidelines which try to eliminate the nurse from taking responsibility, but this is unrealistic. Is this elimination of the nurse from taking responsibility necessary or desirable, or does it arise because some doctors are afraid of a poorer quality of care—or must the cause in part be sought in professional jealousy? A further question must, however, be faced concerning the confidence of the nursing profession itself to undertake and accept the implications involved in taking this clinical responsibility.

What does Clinical Responsibility mean in Practice?

In several general practices the role of the nurse has been to "save the doctor's time." This may be interpreted as a direct and possibly incorrect assessment of the relative values of the doctor and the nurse in the medical care team. In what some may consider to be more enlightened circumstances the nurse has become a colleague in the primary care team, where all are said to work in the same field, having equal but different roles. The question of saving time is secondary to the quality of patient care; this must include the most economical and effective use of resources, particularly trained personnel. From experiments well described by Weston Smith and Mottram,¹ nurses have proved willing and able to take clinical responsibility—yet even where this occurs it is not openly acknowledged but hidden under the "doctor's responsibility."