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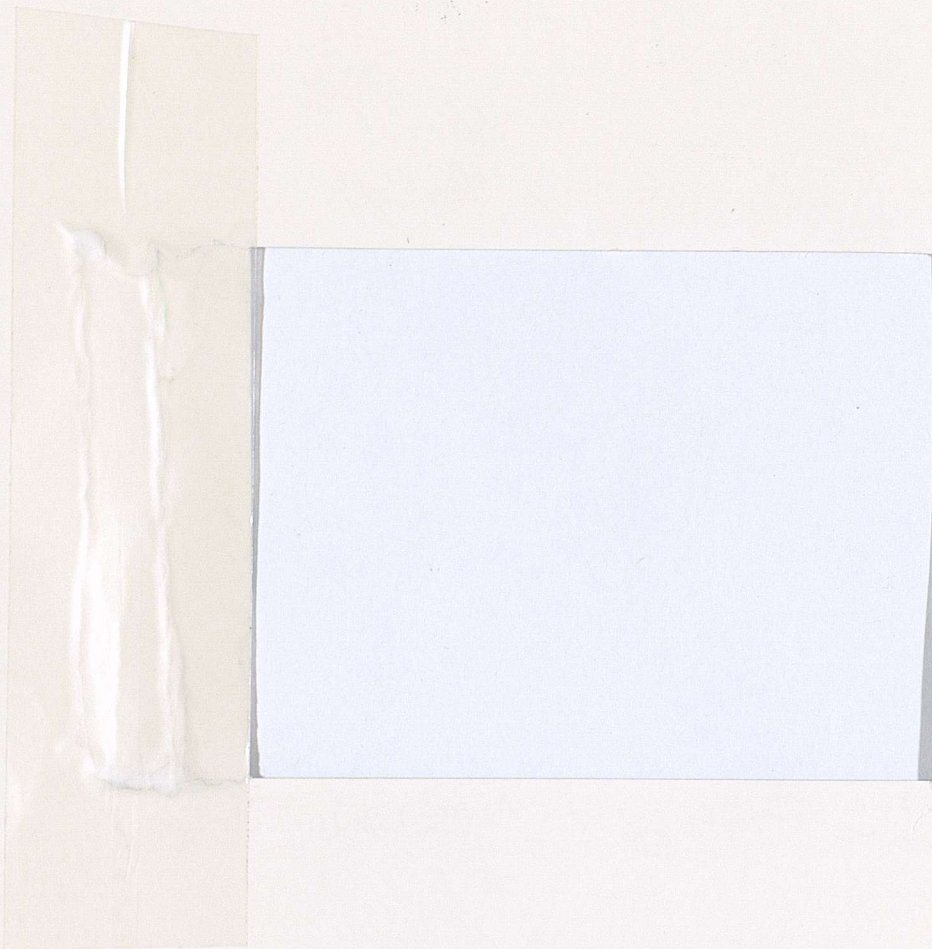


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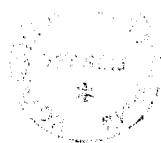
**The future of small hospitals
in Britain**

by

**Professor Joan Higgins
Professor of Health Policy**



The future of small hospitals in Britain



Joan Higgins

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This paper is based on research carried out for the King's Fund and Milbank Fund entitled Hospitals and Health Services into the Next Century. The project on small hospitals was one of nine projects undertaken in the UK and USA in 1991/2, designed to explore the policy issues facing health services in the next 10 - 20 years.

I am very grateful to the Funds for supporting this research.

Joan Higgins

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1. Introduction

The proper role of small hospitals in the overall pattern of health care in Britain has been a subject of controversy since the first 'cottage hospital' was opened in 1859. They began as an alternative to family and home care and to care in the large, urban general hospitals. For many observers the small hospital has played a key role at an intermediate level of health care, relieving pressure on acute hospital and long-stay beds and providing informal and appropriate care close to the patient's own home. Most small hospitals began as an extension into in-patient treatment from primary care rather than as local outposts of larger hospitals. They have occupied an anomalous position in the financial and administrative structure of the NHS, funded through the Hospital and Community Health Services budget but frequently controlled by General Practitioners.

Since the creation of the National Health Service small hospitals have been vulnerable to closure. Surveys of hospital care before World War II revealed poor standards of care and unmanaged services. The eradication of the unco-ordinated patchwork of hospital services and its replacement with large modern hospitals was one of five key arguments advanced by Aneurin Bevan in favour of creating a National Health Service.

"Although I am not a devotee of bigness for bigness' sake", he maintained, "I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one" (Bevan,1946).

The question for the next decades is whether those are really the choices and really the questions - efficient acute in-patient treatment in a large hospital or inefficient but humane care in a small one.

The future of small hospitals, and policies for them, has been a matter of debate, decade by decade, since 1948. After the NHS came into being their role was in doubt, as plans for large District General Hospitals (DGH) found favour. The Hospital Plan for England and Wales, published in 1962 (Ministry of Health,1962), recommended the centralization of hospital services and the closure of many small hospitals. However, the concept of the

cottage hospital was revived again in 1969 when the Oxford Region led a national movement to develop the idea of modern community hospitals, and by 1975 the Department of Health and Social Security had become warmly supportive of these developments, in Health Circular HSC(IS)75: Community hospitals: their role and development in the NHS (DHSS, 1975). The 1980s saw what had now become a familiar pattern of purpose building of small hospitals counterbalanced by bitterly fought closures. This ebb and flow of enthusiasm for small hospitals in Britain is unlikely to change in the short term - if at all. It hinges upon the diversity of such institutions, the inability to generalise about the worth or otherwise of their contribution, the lack of information about small hospital activity and outcome and the lack of clarity about their role in the wider scheme of things. It is unlikely that the King's Fund/Milbank Review will produce a definitive answer but what it will do is to locate the small hospital within a wider perspective and evaluate its role within new patterns of care, in relation to the health and social needs of the 21st century.

Any discussion of hospitals and health services in the next century should start, of course, with the requirements they will be expected to meet and not with the services themselves. However, providing the right patterns of care for the future involves a transitional process in getting from here to there. Britain, at present, has more than 1,000 units/hospitals with 50 or fewer beds and their current contribution and future potential in meeting changing needs are of some significance. The report below examines four key issues: the policy context and the social context of small hospital care; small hospitals on the continuum of primary and secondary care; policy problems in small hospitals and future scenarios. It begins with a description of the methods used in carrying out this review.

2. Aims and methods

The aims of the present study fall under six broad headings:

- (1) An historical review of small hospitals (50 beds or fewer) in Britain
- (2) A description of the present size and type of small hospitals today
- (3) A review of Regional and District Health Authority and Regional Health Board policies for small hospitals
- (4) An analysis of the policy issues surrounding small hospitals
- (5) A survey of 'expert opinion' on the future of small hospitals
- (6) A discussion of policy options and future scenarios

Various sources of information were used to explore these issues and the following sections provide a brief commentary on the data available and its limitations.

2.1 Historical review

Much of this review has drawn upon secondary sources and bibliographical research. The medical and social policy literature provided most of the information on small hospitals in the last century and a half. The main limitations of this literature are that it relates almost exclusively to 'cottage' or community hospitals and that it is written by partisan supporters of the community hospital movement. Nevertheless it has proved useful source material.

2.2 Small hospitals in Britain today

The data on small hospitals in Britain today is drawn from three sources: Scottish Health

Service Costs, published by the Scottish Health Service Common Services Agency; Hospital Bed Use Statistics, published by the Welsh Office and KHO3 Returns, published by the Department of Health (England) and the Hospital and Health Services Yearbook.

Although every effort has been made to establish the accuracy of this information it does not present an entirely reliable picture of small hospitals in Britain today. The hospitals concerned are often isolated, heterogeneous and still - to a degree - a law unto themselves. Within a year there can also be closures, partial openings, change of use and a number of other factors which make perfectly accurate data difficult to obtain. The codings which have been used for some of the English hospitals (indicating their specialty mix) are also idiosyncratic and may not represent their activities accurately. The Association of GP and Community Hospitals has reasonably good data on the hospitals in England and Wales which it represents but this gives only a partial view of small hospitals in general and, therefore, has not been used. Similarly, the two main studies of the work of general practitioner hospitals in England, Wales and Scotland (Cavenagh, 1978; Grant, 1984) are useful sources but are now somewhat dated and do not present a full picture.

The categorisation of local hospitals according to bed numbers also has its limitations. Many of the more innovative hospitals in recent years rely more heavily upon day care and day hospital treatment than on in-patient care. A simple description of hospitals and bed numbers, then, conceals the enormous diversity of actual provision and performance.

The task of describing small hospitals in simple terms, according to a classification of their beds, is also complicated by aspects of their style and philosophy. As Rosemary Rue commented in the early thinking about Community Hospitals in Oxfordshire:

" If the general practitioner and his team are to care for the patients themselves, they will think of the case not as 'surgical' or 'geriatric' but as an individual requiring a particular level of medical and nursing care. This patient-oriented and more flexible approach renders allocation of beds to 'specialties' unrealistic in the GP-managed community hospital" (Rue,1974,p.4).

Thus, some beds which would otherwise be entered in the statistical returns as 'medical', 'surgical' or 'geriatric' beds may, for reasons of value and belief be described as 'GP beds'. An examination of the Scottish data reveals a quite separate problem. Because Health Boards in Scotland also have some discretion over the ways in which they complete statistical returns, the outcome may reflect particular local difficulties rather than an objective statement of fact. Grampian Health Board, for example, in their report on General Practitioner and Community Hospitals in 1989, noted that the designation of beds as "GP acute" had been financially disadvantageous and they had decided to reclassify them as "long stay" for statistical purposes, even though their usage remained unchanged (Grampian Health Board (1989), General Practitioner/Community Hospitals Working Party Report, pp2-3).

It is very difficult, then, from the data which currently exist to form a clear picture of small hospitals and their functions.

2.3 Policies for small hospitals

The third aim of the study was to examine Regional, District and Health Board policies for small hospitals, today and in the last decade. All Regional Health Authorities in England, all Health Boards in Scotland and all District Health Authorities in Wales were asked for policy documents and other relevant literature relating to their strategies for small, GP and community hospitals. Many of them responded generously with long detailed letters accompanying their policy documents. Responses were received from 12 Regional Health Authorities, 5 Welsh Health Authorities and 10 Scottish Health Boards. Two Health Boards in Northern Ireland also wrote to us, as did the Department of Health in Northern Ireland and the Department of Health in Guernsey.

2.4 Cross national survey of expert opinion

One of the aims of the King's Fund/Milbank Memorial Fund review has been to draw together comparative, cross national data to illuminate trends, issues and policies in different

countries. The award of a grant to Professor Tom Ricketts, University of North Carolina, to study rural hospitals in the USA created an excellent opportunity to explore cross national variations and similarities in policies for small, often isolated, hospitals. A number of discussions, including a meeting at the Annual Conference of the National Rural Health Association in Washington DC in May 1992, enabled the development of some joint thinking. As a result, parts of a questionnaire designed to elicit 'expert opinion' on rural hospitals in the USA were adapted to suit the British context. A questionnaire seeking views on the role, contribution and future of small hospitals was distributed to a random, 1 in 4, sample (n.98) of locality managers obtained from the mailing list of the Association of GP and Community Hospitals. The response rate was low at only 45.9%. A further 64 copies were distributed to the District General Managers/Chief Executives in whose Districts these hospitals were located. Again the response rate was low, at 54.6%. Section 6 summarises the results. Although the opinions collected in this way may not be representative (the AGPCH mailing list only covers GP and Community hospitals in England and Wales and not all small hospitals, for example), they do reflect some of the priorities, concerns and preferences of key groups of purchasers and providers in the British health service.

Finally, a number of interviews were conducted with key policy makers and analysts who have influenced the growth and development of small hospitals in Britain in recent years.

3. A history of small hospitals in Britain

This brief review examines, chronologically, key stages in the growth of small hospital care in British health services and illustrates the ebb and flow of opinion in their favour and against them.

3.1 The cottage hospitals

The history of hospital care in Britain is essentially a history of small hospitals. From the middle of the nineteenth century many such hospitals were built (or adapted from existing dwellings) and they served populations in both the new cities and remote rural areas. Most of these hospitals became known as 'cottage hospitals' and were often accommodated in settings which were built to resemble country cottages, or which had actually been domestic housing. As Edward Waring, one of the early enthusiasts for these hospitals put it, in 1867:

"The cottage element should never be lost sight of. The building should in all cases be a cottage - or a model cottage if circumstances permit - with all the advantages of efficient drainage, good ventilation, and a cheerful exterior, but still essentially a cottage in character and pretension" (quoted in Emrys-Roberts, 1991,p.59)

Although the literature contains no clear definition of the term, the cottage hospitals were mostly around 6-8 beds, staffed by one nurse and available to all local general practitioners. It was prestigious for them to have access to hospital beds, and general practices with this facility were noticeably more popular (and costly) than those without (McConaghey,1967,p.138). Doctors who had been trained in hospital medicine appreciated the opportunity to practise their skills in their own communities and to reassert their standing vis-a-vis the hospital doctor (Abel-Smith, 1964, p.103). Doctors received no fees for the in-patient care they provided but the new hospitals were a source of status and professional satisfaction. Patients, on the other hand, were required to pay for their treatment, partly as a way of raising revenue and also as a means of deterring "trivial and improper cases" (Annual report of Mildenhall Cottage Hospital,1869, quoted in McConaghey,1967,p.133).

The larger urban hospitals at that time - particularly the workhouse hospitals, which provided most of the in-patient care for the poor - had a bad image and often low standards of care. Patients who could afford to be treated at home generally took this option. The charging of fees in the new cottage hospitals, then, was meant to signify a certain status for the patients they admitted. It was aimed at preserving their dignity and avoiding the stigma of pauperism (RCGP, 1983, p.1).

The first cottage hospital was opened in Cranleigh, Surrey in 1859 and by 1896 a further three hundred similar hospitals had been established (McConaghey, op cit, p.132). Several of these early hospitals had developed from the dispensary system which had been set up to supply low cost medicines and advice to the poor. Over the years the dispensaries opened a number of beds, and cottage hospitals grew from them (McConaghey, op cit, pp129-30). In the early twentieth century many small hospitals were built as war memorials to the dead of the Great War and the cottage hospital movement was further extended (McConaghey, op cit, p.137). All these hospitals were as diverse as the communities they served. On the whole, they provided acute medical and nursing care, and some surgery, for patients who could not be cared for satisfactorily at home, as well as emergency treatment after accidents.

The alleged benefits of the cottage hospital were almost precisely those which are cited today in defence of small, community hospitals. They were convenient, accessible and informal. As the first annual report of the Mildenhall Cottage Hospital put it in 1869:

"Cottage hospitals occupy different ground to the large county establishments, in the simplicity of the domestic arrangements, the comfort of being within easy reach and therefore inexpensive reach of relatives and friends, the quiet of a private room and the homely feeling which prevails throughout, combined with a certain amount of liberty" (quoted in McConaghey, op cit, p.133).

It was argued that the quality of care and outcomes were just as good as those in the larger hospitals (McConaghey, op cit, p.137) and indeed there was some contemporary evidence to suggest that mortality after surgery actually declined with the size of the hospital (Starr, 1982, p.151). Some of the benefits of cottage hospital care were not susceptible to

quantification, however, but they sound a familiar note. As Brian Abel-Smith explains:

"Far away from the towns where the 'old orders' controlled hospital beds, the rural patient was able to enjoy a continuous relationship with one doctor and had the 'privilege' of being able to pay something, however small, according to his means, for the treatment he receives" (Abel-Smith, op cit,p.103)

From the beginning, local communities developed strong attachments to their hospital, especially where they had been built with local donations, subscriptions and legacies. Many were financed entirely, or in part, from the gifts of local business people and philanthropists and from the donations of working men. However, it was not just the well to do who financed new development. Areas like South Wales, for example, relied heavily on the contributions of local miners in setting up their first hospitals. Fund-raising events and concerts enhanced the profile of cottage hospitals in the surrounding community, and the local population - quite as much as the local GPs - felt that the hospital belonged to them.

Support for hospital, rather than home, care may, however, have had more pragmatic roots. It is likely that the popularity of cottage hospitals was due not just to their size and intimacy but also to a growing demand for an alternative to care by friends and relatives in the inconvenience of a domestic setting. Surgery on the kitchen table seemed increasingly inappropriate. Not only were cottage hospitals preferable to the large and remote (both geographically and emotionally) general hospitals but changes in industrial and family life led to demands for alternative care. Paul Starr, in his history of American health care, has described what he calls the "segregation of disorder" in a newly industrialising society:

"changes in work and family structure probably created a growing disposition in favour of extra-familial care ... The segregation of sickness and insanity, childbirth and death was part of a rationalization of every-day life - the exclusion from daily experiences of disturbances and strains that made difficult participation in the routine of industrial society. The segregation of disorder also reflected the growing tendency to exclude pain from public view" (Starr,1982,p.75).

It is likely that the cottage hospital movement in Britain was inspired by similar imperatives: the clinical, social and economic inappropriateness of care at home, the need to differentiate between family health care and professional health care and the desire to provide the last of these not at home but near home.

3.2 The pre-War situation

The number of small hospitals grew, unchecked, until the outbreak of World War II. As Brian Abel-Smith remarked "Britain became littered with small hospitals" (Abel-Smith, op cit,p.406). Local Authorities had built relatively large institutions for the care of the mentally ill and handicapped, but of the 700 or so voluntary hospitals more than 500 had fewer than 100 beds and 250 of these were small cottage hospitals with no more than 30 beds. Although most of the small voluntary hospitals were in rural Wales and the provinces, London and the South East had a significant number and, of these, 44% had fewer than 50 beds (Titmuss, 1950, p.67). The pressure to rationalise the hospital service in the 1930s grew from the preparations for war, but also from a strengthening belief in centralised planning and a concern about prevailing standards in many existing facilities. Although the cottage hospital movement had been launched in the expectation that smaller hospitals could provide better standards of care it was not universally agreed, in the late 1930s, that this target had been met. Indeed, Abel-Smith singles out the small hospitals as being particularly poor:

"It was in these small hospitals that some of the really bad medical care was provided. There were general practitioners who were prepared to attempt surgery which was beyond their competence and to attempt it in conditions which denied them the services of skilled and experienced nursing staff or a proper range of equipment. Some of them were 'entirely self-taught'" (Abel-Smith, op cit,p.406).

Despite widespread dissatisfaction with hospital services generally when the NHS came into existence in 1948, there was little pressure to close hospitals - largely through lack of alternative provision. The financial pressures on the new Service in the 1950s meant that capital expenditure focused on patching up rather than on new build and it was not until the 1960s that coherent plans were drawn up for the replacement of inadequate buildings by

purpose-built District General Hospitals. Many small hospitals survived unscathed but with a reputation for poor standards of care and out of date facilities. In many areas they have been unable to shake off this pre-war image, despite innovation, diversification and modernisation. They were burdened too with an anomalous administrative position.

The National Health Service, in 1948, was organised as a tri-partite structure: community health and welfare services became the responsibility of Local Authorities; a separate hospital service was established and a series of Executive Councils was created to manage family doctors, dentists, chemists and opticians. All small hospitals fell under the wing of the new Hospital Management Committees and this made sense where admissions were controlled by consultants. However, most were -in effect - managed by general practitioners and they straddled uncomfortably the secondary/primary care administrative divide. The infrastructure belonged to the hospital service and accountability was through that line, but the medical staff belonged to the Executive Councils and devised their own rules and procedures. As the Royal College of General Practitioners comments "They were isolated from each other and usually a law unto themselves" (RCGP, op cit, p.1).

3.3 Policies in the 1960s

The relatively benign period of small hospital development after the War came to a sharp halt with the publication of A Hospital Plan for England and Wales in 1962. This was unequivocal in its plans for small hospitals:

"a large number of the existing small hospitals will cease to be needed. This is implicit in the new pattern and indeed is part and parcel of the improvement of the service for hospital patients" (Department of Health, 1962, p.7)

Twenty five years after the pre-war hospital surveys revealed poor conditions in these hospitals the Department of Health at last seemed prepared to take action to close them. Some small hospitals were to be retained for maternity and geriatric care. They would also remain open in areas which were remote, inaccessible or isolated or which had seasonal



influxes of visitors. By and large, however, the 600-800 bed District General Hospital was to be the main provider of hospital in-patient services. According to the Plan it offered "the most practicable method of placing the full range of hospital facilities at the disposal of patients and this consideration far outweighs the disadvantage of longer travel for some patients and their visitors" (Department of Health, op cit, p.6).

Fortunately for the vulnerable hospitals earmarked for closure, the focus of energy for the rest of the decade was upon opening up bigger hospitals rather than on closing down smaller ones. Many of them escaped closure by default. Finally, it was in the late 1960s that the beginnings of order were brought into the scattered provision of small hospital care and a revival in fortunes was on the horizon. 1969 was a turning point in two ways. First, it marked the inauguration of the Association of General Practitioner Hospitals (now the Association of GP and Community Hospitals). The Association was set up to provide support for small hospitals in England and Wales threatened with closure, to maintain and improve standards of care, to collect information on the work of GP Hospitals and to further their interests. Second, the Oxford Regional Hospital Board took a positive decision to establish small community hospitals and a number of experimental units, which led the way nationally, were established. The "conceptual breakthrough" in thinking about small hospitals, according to Dr Rosemary Rue - one of the pioneers of the Oxford policy - was that they were seen as "an extension of primary care rather than, as previously suggested, a peripheralisation of secondary services" (Rue, 1974,p.5).

3.4 The new revival

The trend in favour of community hospitals was confirmed by the incoming Secretary of State for Health, Sir Keith Joseph, in 1971 when he declared that

"I am a healthy sceptic of over-centralisation and there will be local hospitals. The Government sees the need for what we are now calling community hospitals - for patients who need hospital care but do not need all the expensive facilities of a district general hospital. In these hospitals they can be looked after nearer their homes and

friends, benefiting from the goodwill and service, whether voluntary or paid, that can be focused on a small hospital serving its local community" (quoted in Watkin, op cit, p.67)

The Minister of Health from 1974-7, David Owen, was also committed to local provision, though many GPs and managers of small hospitals were angered by a DHSS circular, on community hospitals, in 1974 (DHSS,1974) which recommended that they should have between 50 and 150 beds and that other small hospitals should be closed to make way for a modern network of community hospitals. In a foreword to the circular, the Secretary of State for Social Services and the Secretary of State for Wales emphasised the need to secure public commitment to this policy:

"Local understanding of the role of the community hospital and the limits of the service it provides is essential to success. Local residents should also be told why it is intended to choose one local hospital rather than another for conversion to this new use and why those not chosen will need to be closed when the services they used to provide are replaced by equivalent or improved services" (op cit).

By the end of the decade, however, the issue of hospital size was being squeezed from both ends - while smaller hospitals were under pressure to grow, the plans for large DGHs were being scaled down. As Rudolf Klein put it, the DHSS paper on the future of hospitals, in 1980, "officially buried" the concept of the "giant District General Hospital ... It was a decision", he went on, "which at one and the same time reflected the new philosophy of 'small is beautiful', rationalised the cuts in the capital investment programme and satisfied local political demands for accessible community hospitals" (Klein,1989,p.136).

Through the 1980s and early 1990s national and local policies for small hospitals have ranged along a continuum from positive commitment, through benign neglect, to actual neglect and sometimes closure. Successive waves of major reorganisation and administrative change marginalised the policy question of what -if anything - to do with small hospitals. The abolition of Area Health Authorities in 1982, the introduction of General Management in 1984/5, the NHS Review in 1988/9 and publication of the 1990 NHS and Community Care

Act all commanded more attention and energy than the seemingly minor issue of the small hospital. The position of such hospitals, however, illustrates, in microcosm, one of the fundamental dilemmas of the National Health Service - whether to centralise and standardise services, with strong accountability upwards, or whether to decentralise, diversify and strengthen accountability downwards. Although there has been a commitment to decentralisation, with greater and lesser degrees of enthusiasm, since the 1970s the reality has, generally speaking, been different - with strong central direction and control. There is no clear national policy stance on small hospitals, at present, and the plans and intentions of other agencies are summarised in the sections below. The story of the community hospital (where the medical practitioners are GPs) is only one aspect of small hospital care. There are also many units with fewer than 50 beds, both in the NHS and the private sector, where admissions are controlled by hospital consultants and treatment is provided by consultants, GPs or both. The next section provides factual information on the numbers and variety of small hospitals and summarises what is known about such hospitals in Britain today.

4. Small hospitals in Britain today

As Section 2.2 indicated, the information on small hospitals in Britain is less than perfect. Some of it is incomplete and there are no data sources which allow simple comparisons between England, Scotland and Wales. Several useful publications, such as Helen Tucker's survey of Community Hospitals in England (Tucker, 1987) and the Welsh Medical Committee's review of Community Hospitals in Wales (Welsh Medical Committee, 1989), refer only to certain types of small hospital (normally those under the control of a General Practitioner) and do not present a full picture of the range of activity and facilities. A further problem with the data is that the different countries use different ways of classifying the type of hospital so that it is not possible to compare like with like. The information below is for the most recent available year, from the most reliable sources, which have been cross checked with other sources. It gives the most complete picture yet of the numbers and types of small hospital in Britain. Nevertheless it is lacking in important respects.

The definition of a small hospital, for these purposes, is that it should have 50 beds or fewer. The English definition of a hospital (according to KH03 returns) includes a large number of hostels for people with a mental handicap/learning difficulty or a mental illness. The KH03 returns also fail to distinguish between hospitals with GP beds, those with consultant beds and those with a combination of the two. The gross figures for England do not, therefore, readily compare with those for Scotland and Wales.

4.1 Small NHS hospitals in England 1989/90

Small hospitals (total no.)	1061
Type/specialty	
Mental handicap	459
Geriatric medicine	123
Mental illness	113
General practice (other than Maternity)	98
General practice	49
Others (including Maternity; Obstetrics and Gynaecology; Child and Adolescent Psychiatry; Forensic Psychiatry; Neurology; Rheumatology; Oral Surgery; Radiotherapy)	219
Average occupancy	Not available

Source: KH03 Returns, 1989/90, Department of Health

Ninety eight of these hospitals have operating theatres. 186 have an Accident and Emergency department, the majority of which are staffed by nurses, but with no medical staff on site.

4.2 Small NHS hospitals in Scotland 1990/91

Small hospitals (total no.)	107
Type/specialty	
GP Hospitals (some long-stay geriatric beds)	30
Long-stay geriatric	20
Specialist Hospitals	22
GP Cottage Hospitals (Maternity, no surgery) 11 (Maternity and surgery) 6 (No maternity, some surgery) 2	19
Mental deficiency	9
GP Maternity units	7
Average occupancy	75.8%

Source: Scottish Health Service Costs (year end March 1991), Common Services Agency, Scottish Health Service

As Welsh Social Trends indicates, hospitals in Wales are, on average, smaller than those in England. In 1988 Welsh non-psychiatric hospitals accounted for 11% of all beds compared with only 6% in England. There are similar figures for psychiatric hospitals (Government Statistical Service, 1991, p.39).

4.3 Small NHS hospitals in Wales 1989/90

Small hospitals (total no.)	76
Type/specialty	
Mixed (GP Maternity; General medical; General surgical; Trauma; GP; 'other')	22
Geriatric	18
GP 'other'	16
Old age psychiatry/ mental illness	15
Mental handicap	5
Average occupancy	75.8%

Source: Hospital bed use statistics 1989/90, Welsh Office

Although this review is concerned with National Health Service hospitals it is worth noting that, in 1992, there were also 219 private, acute hospitals in the United Kingdom. They are rather different in case mix, location and management style from the typical NHS small hospital but their presence cannot be ignored. In the future health care marketplace they will compete with NHS hospitals, particularly for 'cold' surgery, and are one part of the diversifying mix of health care resources in Britain. The experience of the private sector may also herald trends in the NHS. Until the late 1970s small private hospitals were

essentially non-competitive. One provider (Nuffield Hospitals) was dominant and one purchaser (the insurance company, BUPA) controlled a major share of the market. 57.5% of hospitals were owned by charities. However, the increasing competitiveness of the market has led to an increase in hospital size, the growing dominance of for-profit providers (now owning 62% of all hospitals), the development of niche markets (screening, sports medicine, psychiatry, cold surgery) and a shift towards short stay acute care.

The average size of private hospitals in Britain is 50 beds (an increase from 44 in 1979) and almost half are located in the four Thames Regions, although there has been significant growth in the private sector outside London since 1979. 201 of the hospitals are in England, 9 in Scotland, 6 in Wales and 3 in Northern Ireland (Independent Healthcare Association, 1992).

The rather pessimistic assumptions about the decline of small hospitals, which are common in the literature, are not borne out by the data - at least in England. In 1989/90 there were 18.6% fewer hospitals in England than there had been in 1979. In contrast the number of hospitals with 50 or fewer beds had declined by only 13.1% over the same period. A similar picture emerges if bed numbers are compared. In 1989/90 the number of available beds in all hospitals had declined by 23.6% over the decade but had gone down by a slightly smaller proportion, 23.2%, in small hospitals with 50 beds or fewer. Any decline in small hospitals, then, is mirroring that in the hospital sector as a whole but with a rather smaller impact (Department of Health, 1991,p.76).

5. A review of policies for small hospitals in Britain

As Section 2.3 indicated, all English Regional Health Authorities, all Scottish Health Boards and all Welsh District Health Authorities were asked about their policies for small hospitals in the last decade and in the future. Replies were received from 12 (out of 14) English Regional Health Authorities, 5 (out of 9) Welsh District Health Authorities and 10 (out of 15) Scottish Health Boards.

This Section begins by describing Health Authority policies and responses in England, Scotland and Wales and goes on to discuss the common themes which emerge.

5.1 Policies for small hospitals in England

Twelve Regional Health Authorities in England responded to the enquiry about strategic policies for small GP and Community Hospitals. Of these, six had no policies for such hospitals and no policy documents. However, this did not necessarily reflect a lack of interest in the role and potential of small hospitals. Three of the six Regions were reviewing or about to review their strategies for these hospitals, having not done so in the previous decade, and several of them spoke positively about the part played by these hospitals. One Regional officer said that "they perform useful roles in a variety of ways, for a variety of client groups" and another said he was "convinced that this type of facility is going to become a much more common feature of the local health service".

A number of these RHAs without strategic policies did support the development of local initiatives and had recently commissioned new Community Hospitals. However, in rethinking the Regional role after the passage of the 1990 NHS and Community Care Act, they had deliberately stood back from a strongly interventionist strategy. As one of them commented:

"In light of the NHS reforms, which place the focus on the district as purchaser of health care for its resident population, I would not envisage the RHA having a

proactive role in guiding developments of this nature. I would see this being very much a local matter based on the particular characteristics and local service needs of each District".

Of the remaining six RHAs which did have a strategic vision for small hospitals, four (Trent, West Midlands, South East Thames, South West) had positive and clearly articulated policies, which are described below. One other (Wessex) had no overarching strategy for small hospitals, though a number of general principles are evident in Annual Reports over the last decade.

In Wessex it was expected that 80% of medical and surgical acute beds would be provided in DGHs in the Districts and the remaining 20% in Community Hospitals. The main role of the Community Hospital was the provision of a range of services for elderly people, including acute care, long-stay care, continuing care, rehabilitation and respite care. The intention has been to locate just 30% of geriatric beds in DGHs and to place the remainder in Community Hospitals, with the ultimate goal of returning as many patients as possible to independent living in their own homes. In addition, it was expected that all day places for people with a physical handicap would be provided in Community Hospitals and that primary health care services would be strengthened by, inter alia, the development of Community Hospitals (Regional Plans, 1977-90). The rationale for supporting this strategy derived from the spread and location of the population:

"A large proportion of the population is rural or semi-rural, so that centralisation of hospital services will therefore be impossible in many parts of the region. For this reason the maintenance of many cottage hospitals and their eventual development into Community Hospitals is a key objective"(Planning in Wessex: progress report and summary of long-term planning proposals, 1977, Appendix B).

Trent Regional Health Authority has also set its policies for Community Hospitals within an overall strategy for rural health care. In a report entitled Grasping the Nettle (no date) it emphasises the need to provide a comprehensive network of primary and secondary services for all residents, in ways which

"take account of the needs of people living in rural communities and, in particular, those who experience problems of mobility and travel" (p.7)

The definition of 'rurality' relates to the accessibility of DGH out-patient provision. All patients who take more than half a day for a return journey to the DGH would be considered rural for these purposes. Within this group are patients who are not just "house bound" but "village bound". Grasping the Nettle maintains that the health needs of people in rural areas may be qualitatively different from those in towns and urban areas, demanding different responses from health services. In particular, it suggests, there are needs which result from "remoteness and isolation" which demand "exceptional flexibility on the part of care staff and agencies" and "push the constraints of professional and interagency demarcation to their limits" (p.20).

While many Health Authorities in recent years have increasingly cast off the responsibility for patient transport, Trent sees transport as an essential service in ensuring access to health care, particularly in rural areas. It maintains that DHAs should sustain the accessibility of services "either through transport which they themselves fund or provide directly, or through negotiations with other providers of general and specialist transport" (p.15)

The Trent document takes the view that it would be inappropriate to be prescriptive about the services provided in Community Hospitals and argues that the range of services must be determined by "what can reasonably be provided in a clinically safe and cost effective way" (p.51). Particular mention is made, however, of the problems of including minor casualty units and maternity units in small hospitals. On the latter, it was noted that, while many mothers wish to be delivered in a small local unit, the predominant clinical view was that consultant maternity units or GP units in DGHs were safer alternatives. As far as minor casualty units were concerned, the report notes the reservations of medical staff about the location of such units in local hospitals but concluded:

"We were, however, made very aware in the isolated areas we visited, that a facility many miles away did not meet the needs of the population however good it was" (p.50).

The Trent model envisages three essential types of community hospital, each with a different range of services. The first is the "Basic Community Hospital" which would include consultant-run out-patient clinics, GP beds and respite care, day hospitals, part-time minor casualty and a limited range of support services. The second would be a "Community Plus Hospital" which, in addition to the above services, would include consultant medical beds, elective minor surgery and anaesthesia, rehabilitation beds for elderly people, beds and day care for elderly mentally ill people, full time occupational therapy and a 24 hour minor casualty service. The third model is the "Enhanced Community Plus Hospital" which would add in maternity services, a wider range of surgery, speech therapy and a greater range of diagnostic facilities as well as more day hospital care and health promotion (pp44-46).

The West Midlands RHA had also given some attention to the use of small hospitals and, in 1984, published a document entitled Community Hospital Planning. It identified factors which contribute to the success of Community Hospitals and set out planning guidelines for such hospitals, together with the main requirements of an operational policy. The document noted that there had been a traditional reluctance to invest in small hospitals because of "ignorance of their role" and "a half-expressed fear that the standards of care in them might not be adequate" (p.7). It argued that few research studies had compared clinical outcomes in DGHs and small hospitals, but those which had been undertaken suggested that key elements in providing high quality care in small hospitals centred upon appropriate patient selection and admission. Other factors which contributed to the success of small hospitals included the commitment and proximity of GPs. At least 30% of local GPs must be supportive of the hospital, and their surgeries or health centres should be located close to the hospital. The report quoted a number of research studies which suggested that anywhere between 4 - 57% of patients currently seen in DGHs would be suitable for assessment, treatment or follow-up at Community Hospitals and concluded that:

"there are strong arguments in favour of building more peripheral community hospitals as viable alternatives to providing hospital care (however unspecialised) at district general hospitals" (p.7).

Like Wessex RHA, West Midlands saw a particular role for small hospitals in the provision

of services for elderly people, close to their own homes. However, the report noted that "there is a very real danger that community hospitals may degenerate into single specialty repositories for the very old" and it was at pains to argue that this should not be allowed to happen (p.9).

The West Midlands report saw Community Hospitals as one way of breaking down the "artificial divide" between primary and secondary care and between GPs and hospital doctors (p.10). It drew on Cavenagh's work on GP access to hospital beds in the USA (Cavenagh, 1970) to substantiate the view that the extension of "hospital privileges" to GPs in Britain would reduce the "comparative clinical isolation" in which they normally work (Cavenagh, 1970, p.10).

Overall, the report was very supportive of the further development of Community hospitals on the grounds that they extended the primary care role of the GP and provided a cost effective service.

The South Western Region has been similarly enthusiastic about the role of small hospitals. The RHA's strategic policy, as set out in the report Community Hospitals in the South West (1989), states that Community Hospitals "have been and will continue to be an essential component of health care delivery in the South West" (p.A1). The report sets out the general principles for Community Hospital care, the range of in-patient and other clinical services which might reasonably be provided in such hospitals and the organisational and management issues involved. It includes a statement about the monitoring and audit of Community Hospitals in the South West, together with proposals for a pilot project on accreditation (which was subsequently undertaken). It does not provide a blueprint for Community Hospital provision and maintains that "the services provided by Community Hospitals will not only vary between districts but between hospitals in the same district" (p.A1).

The other region to have developed coherent policies for small hospitals is South East Thames. In the last three years the Region has issued two relevant consultation documents, Community Hospitals (1989) and Shaping the future: a review of acute services (1991). The first of these suggested that community hospitals are "a potentially valuable part of a

district's pattern of provision" and offered guidance on the type of services which were "likely to be safe, cost-effective and valued by the community" (no page number). However, in contrast to Regions such as Trent where the belief in community hospitals seems to be deeply embedded in Regional policy, the South East Thames documents highlight the vulnerability of small, isolated hospitals to closure and suggest that "the onus ... is on the community hospital to demonstrate cost-effectiveness" (1989,p.1). The 1989 report questions the wisdom of permitting surgery in "peripheral units" because of low throughput of patients and the absence of resident medical staff and adequate blood supplies (1989,p.5). It concludes that "the ultimate aim is likely to be phasing surgery out of community hospitals" (1989,p.11). Nevertheless, the report is supportive of community hospitals if they are used "efficiently and appropriately" (1989,p.13). It argues that they are a valuable resource, prized by local communities and that there are "many exciting possibilities which make the community hospital uniquely responsive to local and individual needs" (1989,p.13).

On the whole, the community hospital policy in South East Thames is not a response to problems of rural isolation. Of the 15 hospitals in the Region, all were within 16 miles of their nearest DGH and within 32 minutes travelling time (by car). At one end of the scale was a community hospital which was only 1 mile (and 2 minutes) away from the DGH and another (in Central London) which was 1.5 miles (and 3 minutes) away. Part of the South East Thames thinking has been that small hospitals which are located close to DGHs can take immediate post-operative patients for recovery and rehabilitation. Regional intentions, as set out in the second document Shaping the future, envisage a range of four types of acute provision: the Acute General Hospital; Elective Resource Centres (dedicated to planned elective work); Local Hospitals (of around 50 beds) and Polyclinics. Services in Local Hospitals would be determined by local need, not Regional edict, and the only constraints on them would be that they did not offer acute emergency care, highly specialised care, planned surgery (other than that which a GP would undertake in his/her own surgery) or complex investigations (1991,p.4).

While willing to enhance the role of Local Hospitals South East Thames has apparently set its face against the notion of 'substitution'. It has argued that, although wishing to develop primary care and to deliver services as close as possible to the patient's home, shifting the

majority of acute care out of DGHs is "not realistic as a stand alone option" (1991,p.35). As far as the boundaries between primary and secondary care are concerned, it has argued that

"while the potential for better integration is high, the potential for direct transfer of a substantial volume of work is low and uncertain" (1991,p.18).

5.2 Policies for small hospitals in Scotland

The development of health policies in Scotland in recent years has taken place within the context of the recommendations of the SHARPEN Report (Scottish Health Authorities Review of Priorities for the Eighties and Nineties, Scottish Home and Health Department, 1988). The Report argues that services for elderly people, especially those suffering from dementia, in both hospitals and the community, should have the highest priority. The historic contribution of small hospitals as key providers of care for these groups at a local level, has therefore received some prominence.

However, four out of the 10 Scottish Health Boards who replied to our enquiry had no policies for small hospitals. In 3 cases this was because the Board did not have, or had closed, its GP and Community Hospitals. The fourth had no written strategy for its Community Hospitals but was currently redeveloping two of them, stating that "it is our current thinking that such hospitals have a significant role to play in the future provision of services to the Board's area" (personal communication).

A consultative document issued in April 1992 by Highland Health Board, The role of hospital services in rural areas, clearly highlighted the central problem inherent in delivering health care to dispersed rural populations. In essence, this was the need to balance "professional viability" against the desire to provide "outreach services" and equity of access to health care. The document recommended that:

"the objective of the Board's policy for rural hospitals should be to ensure that local diagnosis, assessment, treatment, rehabilitation, respite and on-going care are provided whenever possible, unless this is not professionally viable" (p.2).

In order to be "professionally viable" a service needed to have sufficient throughput of patients, and an appropriate range of patients, to maintain the skills of clinical staff. Professional viability was threatened in situations where single handed staff were constantly on call and where services were disrupted by the absence of staff from small departments. Tayside Health Board, in its local health strategy document, Improving Health and Health Care in Tayside (1991), agrees that the main challenge lies in maintaining

"a balance between local accessibility of acute services and the advantages (both financial and in using staff resources effectively) of concentrating services on a limited number of sites" (p.30).

Despite the commitment to an outreach policy, Highland Health Board also noted that the provision of services to local areas by centrally based staff could mean that the considerable time which staff spent travelling reduced face to face contact with patients (p.2). In situations where major surgery was required it was argued that, in the interests of safety, patients should travel to specialist facilities, where such surgical intervention was an infrequent or a "once in a lifetime experience" (p.3). It was argued that the higher quality and safety of centralised specialist services should outweigh the relative inconvenience.

The document concludes that "the advantages of admission to central hospitals for much acute care are incontrovertible" (p.8). However, local hospitals have an important role to play in many other areas, especially in non-acute or long-stay care. In this type of work, the responsibilities of the health service, social work agencies and the private and voluntary sectors are blurred and it is suggested that an appropriate solution may often be joint provision of care on a single site (p.4).

A similar solution to the provision of services at the boundaries of health and social care had also been devised by Borders Health Board. In Hawick, for example, the Board was running

a 29 bed "cottage hospital" on the same site as two day hospitals for elderly patients, adjoining which was a 37 place nursing home run by a not-for-profit agency. As the Chief Planning and Contracts Manager put it:

"All these facilities are, literally, within a few hundred yards of one another and de facto constitute a community hospital on a slightly dispersed basis" (personal communication).

In the Borders Region the development of joint policies for community care between health and social services agencies was well advanced and the community hospital was to play an important role alongside domiciliary and non-residential care in local communities. The overall objective of the Board's strategic policy was to "localise as much service provision as possible ... in order to make maximum use of capacity and skills available, minimise the social costs to Borders' residents of seeking health care and, particularly, satisfy the health care needs of the increasingly elderly population" (Borders Health Board Local Health Strategy, 1991, p.SP1).

Lothian Health Board's redevelopment proposals for Leith Hospital also illustrate the ways in which health authorities are using community hospitals to meet a range of health and social needs, particularly of elderly people. The original Leith Hospital, which was built in 1851, was closed in 1987 because it could no longer provide adequate health services. However, joint planning with social services, voluntary agencies and housing associations has resulted in a proposal for new facilities in the existing hospital buildings which would meet the housing, health and social needs of local elderly people and others unable to live independently. These would include in-patient beds (including 6 for AIDS patients and 6 respite care beds), a day centre and a continuing care scheme as well as "mainstream housing" (Inhouse Architects, 1989, pp1-4). One aim of the developments, especially the proposals for mainstream housing, was to "deinstitutionalise the site" (p.11), as it evolved into a more broadly based facility.

It is clear, from this example, that the contemporary community hospital can take many forms and provide a range of services not normally associated with "health" care.

However, the increasing emphasis nationally upon the need to develop primary and community care and the growing recognition that services to maintain health go beyond what is provided by the NHS, underline the significance of the innovative role which may be played in the future by community hospitals of this type.

The draft strategy for primary care and community health services in Ayrshire and Arran bears interesting similarities to that in South East Thames. It envisages the development of community based long stay facilities which are "domestic in nature and as close to local communities as possible" together with "polyclinics" in smaller population centres which would accommodate primary health care teams, out patient clinics and day care facilities as well as dentistry, child health, pharmacy and paramedical services (Proposed local health strategy for Ayrshire and Arran, 1992-2001, Ayrshire and Arran Health Board 1992, p.24). Like Borders and Lothian, the Ayrshire and Arran Health Board sees an inevitably "grey area" between health and social services in which it is "neither possible nor desirable to try to separate precisely each party's responsibilities" (op cit,p.59). Community hospitals sit reasonably comfortably in this middle ground providing a range of services.

Grampian Health Board, which has the highest rate of provision of General Practitioner and Community Hospital beds of any Scottish mainland Health Board, has reached the "overwhelming conclusion" that such hospitals are "a valuable resource providing a range of services which are responsive to local needs" (personal communication). Furthermore, the Board has demonstrated that the service can be provided economically and at lower costs than those prevailing in general acute hospitals for both in patient treatment and out patient and A and E attendances (General Practitioner/Community Hospitals Working Party Report, Grampian Health Board, 1989, Appendix 8). In an informative report, published in 1989, the Board showed that, in 1988, community hospitals in the area were used predominantly by the 75-94 year old age group (around 60% of all in patients) but that 70% were discharged within 2 weeks, and another 20% within 4 weeks, 70% of them to their own homes. Over 70% of patients were admitted as emergencies and another 15% were transferred from other hospitals. Typically they had been admitted as the result of an accident, or suffering from diseases of the circulatory or respiratory systems. The future of community hospitals in Grampian is secure in the medium term and the Board's purchasing

intentions for 1992-2002 confirm a wish to see them survive and develop.

5.3 Policies for small hospitals in Wales

Of the five Welsh Health Authorities who responded, four had very clear and positive strategies for small hospitals. The fifth Authority, though supportive of community hospitals in the past, now felt that it was inappropriate to develop District strategies for their use. This Authority maintained that the introduction of the Health Service 'reforms' and the purchaser/provider split meant that the District, as a purchaser, should now seek to shape community hospital provision through the contract process and not through other measures. "We do not see that it is proper for us to be telling providers where and how such services should be provided, although of course we continue to be interested in issues of accessibility and equity of provision" (personal communication).

Two of the Welsh Health Authorities (Powys and South Glamorgan) described three specific functions for local or community hospitals. These were that they should provide in-patient care

- where it could not reasonably be provided in a patient's own home
- where highly specialised care or special investigations were not required
- where patients would derive benefit from being closer to home and to their friends and families

All the Authorities described the benefits of small hospitals as a focus for a range of health interventions (both primary and secondary care) in the localities and one (Gwynedd) described its small hospitals as "health care resource centres". These hospitals, it was argued, not only reduced pressure on expensive, acute beds and made more efficient use of buildings and land but served as a focus for the community, enhanced team work and improved communication and morale.

The response from Powys illustrated the difficulties of providing good quality health care for scattered populations, and the importance of a flexible and locally appropriate approach. Powys has one quarter of the surface area of Wales (2000 square miles), the lowest density of population (n.179,000), no natural concentration of population, no District General Hospital and - because of this and the development of community hospital care -three times the number of beds per head of population of any other Welsh Health Authority. The "Powys Philosophy", since the 1970s, has been to strengthen its network of community hospitals and in 1986 it opened the first purpose built community hospital in Wales. The overall aim has been to "allow the patient to remain at home with adequate support, to admit only when that becomes unsatisfactory, and then to provide hospital care as near to home as possible" (The Powys Philosophy, undated).

Other Authorities had plans for developing or rationalising small hospital provision, including the absorption of their functions into larger units as well as new build. The intention in South Glamorgan, for example, was (between 1992-9) to build four new purpose built "neighbourhood hospitals", each of 85 beds (to include GP Medical beds, long stay beds for elderly mentally ill people and geriatric long stay beds), with out-patient facilities and treatment for minor injuries. There was broad agreement, amongst the Welsh Health Authorities, on the range of services which it was appropriate for small hospitals to offer though only one insisted that "it is no longer considered safe to undertake surgery in hospitals where resident medical staff and other supporting services are unavailable" (West Glamorgan Strategic Plan 1984-1993, p.170)

5.4 Policy themes around Britain

It is clear, from this review of policies for small hospitals in Britain, that certain common themes emerge. However, the degree of emphasis placed upon them and the responses to them do vary from area to area. Three issues, in particular, are evident.

First, the provision of small hospitals (particularly GP and Community Hospitals) is a response to the problem of delivering health care in rural areas. This issue was highlighted

most commonly in Regional and District policies in England and Wales, but is obviously of concern in Scotland where the population is dispersed across remote rural areas.

The second, and related, issue is the tension between centralisation and decentralisation in the provision of health care. Although those Health Authorities reported here with positive policies for small hospitals have developed a decentralised style, there are others which maintain that the only safe way to provide high quality services, especially acute care, is in large DGHs or Regional Units with experienced staff and a high throughput of patients. The commitment to decentralisation demonstrated here reflects a belief in local, patient-oriented services as a good thing in themselves, as well as a pragmatic response to providing services in isolated areas.

The third theme is one of bridge building and collaboration between different sectors of the health and social care system. In England and Wales small hospitals were seen as strategically important in strengthening the links between primary and secondary care and between hospital doctors and general practitioners. At best, they relieved DGHs of work which could be carried out more appropriately at a local level and they could take patients post-operatively for rehabilitation and convalescence, freeing up space in DGH acute wards. In Scotland, in contrast, the emphasis was upon developing relationships between primary care, social services and housing agencies. Small hospitals were at the hub of local services which were responding, in the broadest terms, to the health and social care needs of local communities. It was the community element of small hospital care which had taken on a new prominence, rather than the hospital element. New styles of collaboration were evolving in highly localised ways in different parts of England, Scotland and Wales and, in many areas, the small hospital played a central role.

6. A survey of 'expert opinion'

One of the other grant holders on this King's Fund/Milbank project, Professor Thomas Ricketts of the University of North Carolina, undertook a survey of 'expert opinion' in the USA to establish the views of key individuals working in or with small, rural hospitals in the USA. Parts of the questionnaire used in the North Carolina survey were included in a questionnaire to a comparable group of 'experts' in England and Wales (Appendix 1). The object was to gather some comparative, cross-national data on the optimum size, workload and case mix in small hospitals, likely patterns of purchasing and provision of small hospital care, factors influencing the future of such care and the role of small hospitals in local communities.

Questionnaires were distributed to a 1 in 4 sample of Locality Managers running small hospitals in England and Wales (n.98). The sampling frame was the list of community hospitals held by the Association of GP and Community Hospitals. A further 64 questionnaires were distributed to the District General Managers/Chief Executives of the Districts in which the hospitals were located. The overall response rate, at 49%, was low. 45.9% of Locality Managers responded, compared with 54.6% of the District General Managers. Firm conclusions cannot, therefore, be drawn from these findings but they do give some indication of the issues which concern the purchasers and providers of small hospital care now and in the future.

Many of the questions in this survey were taken direct from the North Carolina questionnaire so that comparisons could be made as closely as possible with the American responses. However, this led a number of respondents in the present study to complain that they were not appropriate in a British context and reflected an "American bias". It is clear that there were some problems in interpretation but, on balance, the responses were appropriate and meaningful.

6.1 The first question asked what would be the minimum number of beds for a viable, in-patient, acute hospital. A number of respondents queried the definition of an "acute

hospital" in this context. 59% put the minimum figure at between 10 and 30 beds, with the majority nominating 20 or 30 beds as the appropriate number. 17.5% of the respondents said that a much larger number of beds was necessary, one DGM suggesting 400 beds and another 700 beds.

6.2 Question two asked what were the essential services that should be maintained in a small hospital. 95% of respondents mentioned physiotherapy, 94% outpatient services, 79% respite care and 78% diagnostic X-ray. 63% mentioned outpatient surgery, 58% primary health care nursing and 53% an accident and emergency department. Not surprisingly, no-one expected to find an ITU in a small hospital and only one saw CT scanning as an essential service. Ultrasound facilities were mentioned by 31% of respondents. Relatively few felt that a pharmacy or pathology services were essential requirements and a small minority mentioned in-patient care for AIDS patients. Other facilities mentioned included day hospital care, rehabilitation and GP beds.

6.3 The third question, which was open ended, asked what were the greatest barriers or problems facing small hospitals today. Many respondents described the 'cultural' problems facing these hospitals, including misunderstandings of their role and potential contribution, the low status attached to them and their staff and a lack of imagination about their use. GP/Consultant relationships were sometimes cited as being problematic and one DGM expressed the feelings of several others when he talked about "the dead hand of consultants in big hospitals protecting their interests". The pressure exerted by medical staff to centralise facilities and their unwillingness to visit peripheral units were also mentioned. Several respondents spoke about the need to clarify the aims of small hospitals and one said the problem lay in "establishing a role which is compatible with public expectations".

A number of respondents talked about the financial problems facing small hospitals, including the capital costs of maintaining buildings and the inability to enjoy economies of scale in some areas. Historic under-funding was also blamed. The costs of technology and the non-availability of technology were problematic and many staff feared competition from DGHs and newly established Trusts. A major problem was the recruitment of adequately qualified and experienced staff, including appropriate medical cover and many of the locality managers

described the problems of maintaining professional standards and up-dating professional skills in isolated, often rural, hospitals.

6.4 The fourth question asked what the barriers or problems were likely to be in the year 2000. Again this was open ended. On balance, respondents were essentially pessimistic about the medium term future. Several of them felt that the question was academic because there would not be many small hospitals in existence unless their value was appreciated soon. Many respondents said the problems would be the same but worse, especially in relation to funding and staffing issues. There would be additional pressures arising from litigation and defensive medicine and from the growth in the number of over 85 year old people. Some respondents saw the development of GP fund holding and the Trust movement as disadvantageous to small hospitals, which they felt might be squeezed out of the marketplace by bigger and more aggressive competitors. Others, however, did see some potential for new developments arising from fund holding and felt that GPs might be increasingly inclined to purchase services from small hospitals where these were cost effective and were what patients were demanding. A minority of respondents saw fewer problems in the year 2000 than at present and were optimistic about the push towards the decentralisation of services and disinvestment in secondary care. Some of them talked about the increasing mobility of technology and the strength of patient preferences for local services. They expected that the growing emphasis upon community care would enhance the role of small hospitals. Two or three respondents claimed that they were completely unable to predict what was likely to happen in the year 2000. The pace of change in the National Health Service had been so rapid that further developments might intervene to change the context of small hospital care in ways which could not be anticipated.

6.5 In question five respondents were asked whether they thought that the successful small hospital of the future would be a diversified independent hospital with a wide range of services on site, a member of a group of small hospitals with common management or part of a health care system centred in larger hospitals. The possibilities were not mutually exclusive and, in some cases, respondents circled more than one answer. There was no consensus on this question with all three possibilities achieving very similar levels of support. 20 of those who responded opted for the first answer, 20 for the second and 21 for the third.

However, there were interesting differences between the two groups of respondents. 40% of District General Managers who responded felt that small hospitals were likely to be part of a health care system centred in larger hospitals, compared with only 19% of the Locality Managers, whereas 37% of the Locality Managers felt that small hospitals would be diversified, independent units with a range of services on site compared with only 12% of DGMs. Locality managers were also more likely to see small hospitals as members of a group of similar institutions under common management. It was clear from the response to this question that - as a number of critics had commented in their responses to an earlier question - many DGMs saw small hospitals essentially as peripheral units to DGHs rather than as independent units located within primary care. In contrast, the locality managers responsible for the hospitals saw them as capable of achieving a degree of autonomy beyond the traditional secondary care sector. Several respondents suggested a fourth option which was that these hospitals would be part of an integrated health care system centred upon primary and community care with, in some cases, increasingly specialist functions.

6.6 The sixth question was designed to identify the attractions to doctors of working in small hospitals. Doctors themselves were not asked in this survey and the replies reflect the perceptions of managers. There was strong agreement that doctors felt that small hospitals were a place to provide continuity of care for their patients and to maintain clinical skills. Other factors were much less significant although there was some agreement that they afforded access to more complex diagnostic tests than were normally available. Not surprisingly there was little support for the idea that doctors worked in small hospitals in order to earn additional income; the bed fund payment through which most of them were reimbursed is extremely small and cannot be said to constitute a strong financial inducement. The feature which managers felt was of least importance to doctors when they worked in small hospitals was the opportunity for "colleagueship", though whether doctors themselves would agree is a matter for speculation.

6.7 In question seven, respondents were asked what local communities should expect from small hospitals. Again the options were not mutually exclusive and some respondents circled more than one answer. 50% of all the responses suggested that local communities should expect to get "quality care with some limitations on available technology", 29% said that

they should expect "short term care or a different level of care with appropriate referral to a large in-patient facility" and 23% mentioned the importance of "a more personal environment with reasonable quality". There was no support for the notion that they should expect to be offered high technology care equivalent to a general hospital. Some respondents added comments suggesting that care should not simply be of a "reasonable" quality but it should be of high quality. They argued that people had a right to expect local, accessible and "personal" services.

6.8 Question eight asked purchasers (ie the DGMs/Chief Executives) what they expected to buy from small hospitals in the next 5-10 years and providers (ie Locality Managers) what they expected to provide. The question was open ended and, as a consequence, some responses were difficult to group together or analyse. The results should only be taken as a very general indication of purchaser and provider intentions but some clear patterns do emerge. Purchasers expect to buy in-patient acute care provided largely by General Practitioners, some minor surgery (including day surgery), out-patient services and diagnostic services, together with physiotherapy, occupational therapy and speech therapy. Several purchasers mentioned convalescent care, rehabilitation and respite care as well as terminal care. A number of other specialties or services, such as maternity care and minor casualty, were mentioned by small numbers of purchasers. The intentions of providers were broadly similar to those of purchasers, as one would expect, but here there was more emphasis on diagnostic investigations, maternity care, day case surgery and casualty services. The role of therapists, chiropodists and dieticians also figures more prominently. The differences between the two groups are not great but they suggest that providers might wish to offer a slightly wider range of services and slightly different services from those which purchasers want to buy.

6.9 The aim of question nine was to establish the respondents' views on who was most likely to determine the future of small hospitals. 33% expected General Practitioners to be the key actors in influencing change in these hospitals while 26% expected it to be the District Health Authority and 19% a Trust Board. Very few expected Regional Health Authorities or the Department of Health to exert much influence. Only 16% thought that the local community would play a key role. Again there were interesting differences between

the two groups of respondents. A clear majority of DGMs, as might be expected, saw the District Health Authority as having the greatest influence while the Locality Managers were equally clear that it would be General Practitioners. None of the DGMs saw a role for the Regional Health Authority in the process and only one expected the Department of Health to be involved. Locality Managers were more likely than the DGMs to anticipate an intervention by a Trust Board or the local community.

6.10 In two final questions respondents were asked to say whether the importance of the small hospital to the local community extended beyond the provision of health care and were invited to add any further comments on the future of small hospitals. Only one respondent (a District General Manager) felt that small hospitals did not have a wider role in their communities. He said that "by definition, the purpose of a small hospital was the provision of health care" and its significance did not go beyond that. In contrast, all other respondents who answered these questions - particularly District General Managers - felt strongly that these hospitals fulfilled important social roles. Six themes came up consistently: community pride; health promotion; economic functions; staffing; intersectoral relationships and carers.

Several respondents wished to emphasise that small hospitals were a central focus of community life and that any plans to close them posed serious threats to the stability of that community. One DGM argued, for example, that:

"Communities can be as protective about their hospital as they are about their church or public houses. They are usually built by public subscription which instills a strong sense of ownership. The closure of a community hospital is often one major step toward the closure of that community as a whole".

A similar point was made by another DGM:

"The presence of a small hospital is seen as an integral part of the whole community - there is local ownership and pride which, if lost, completely depresses local self-image"

Small hospitals were said to have a symbolic purpose and function which was not easy to describe but which was meaningful and recognisable to local communities and to everyone associated with the hospital. A DGM said that they were "a symbol of a caring community" while another described them as "a symbol of 'good' and 'unity'". Many of the hospitals had a very positive and caring atmosphere, evident even to the casual observer.

A number of respondents talked about the importance of allowing and encouraging fund raising and voluntary giving - not simply for the income raised but because people enjoyed the process and wanted to contribute. One DGM said:

"The community hospital is the object of intense local pride, interest and concern. It provides a focus for health promotion and improvement issues. It provides an outlet for charitable giving and local fund raising. It is seen as an essential element of a civilised and caring town".

Certainly the impact of local fund raising is striking, although its extent has not been quantified. The popular image of charitable giving may conjure up a prosperous League of Friends donating a television but it is clear that community involvement in financing local hospitals goes well beyond that, in both well heeled retirement areas and relatively poor rural villages. Many major capital building schemes and improvement programmes have been financed by local efforts and it is not unusual to see whole wings of small hospitals built from public subscriptions. Most small hospitals do not even have to ask for local support, indeed they may be faced with the opposite problem of donations and gifts (such as medical equipment) which cannot be used through lack of staff or revenue. At a time when the population of Britain is being encouraged to take an interest in health and health care, through the Patient's Charter, the Health of the Nation, locality planning and other initiatives, communities with small hospitals offer good lessons in how to involve people in meaningful ways and how to mobilise local communities. A sense of ownership is clearly

crucial.

A number of respondents highlighted the health promotion function of local hospitals. In an interesting observation, one DGM said that they were "A 'way in' for health promotion as well as a 'way out' of large DGHs" and another added that they provided "education in life enhancing strategies". They were seen as a good base from which to engage in health promoting activities of the conventional type, led by health professionals, but they were also regarded as having a wider role which would encourage a healthier outlook, in the very broadest of senses.

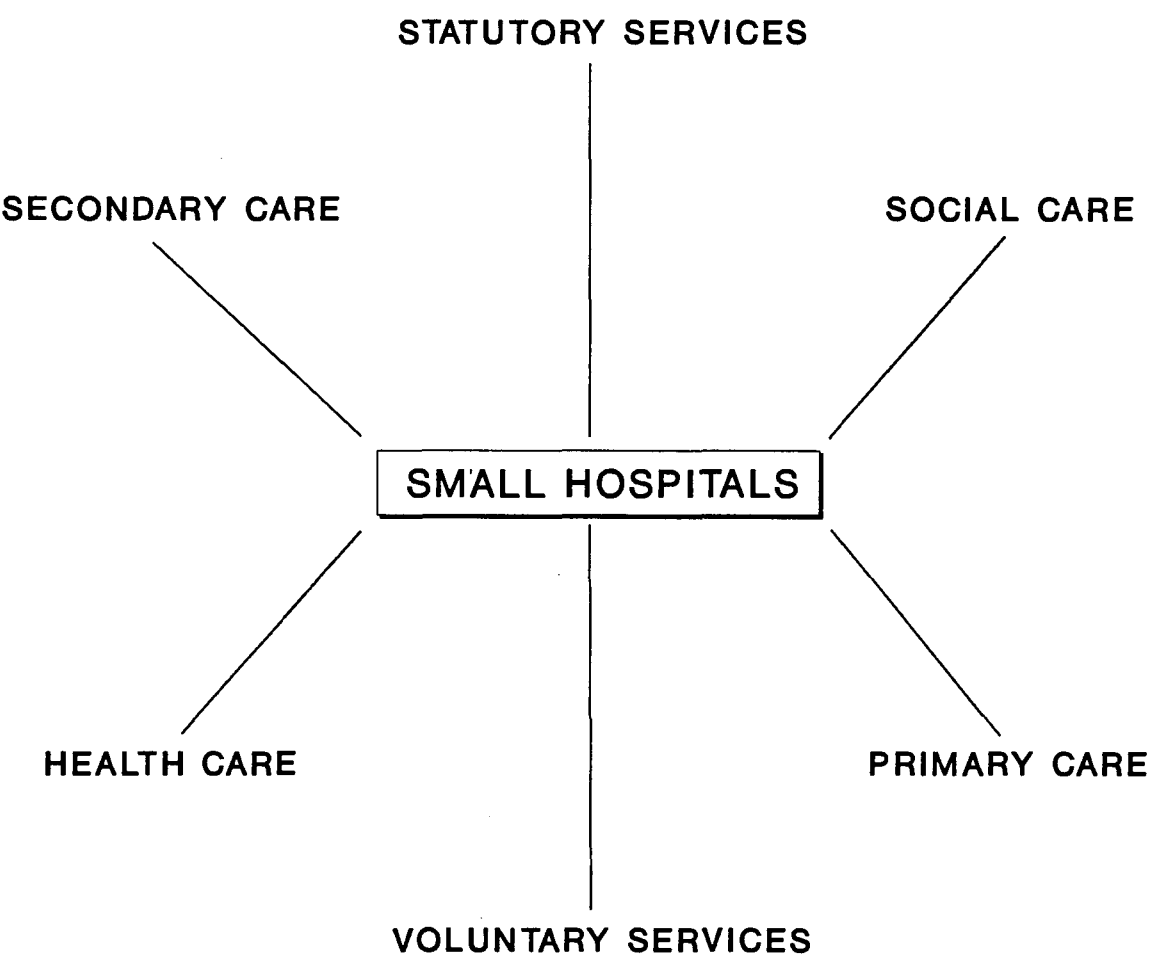
There were several comments about the positive economic functions played by small hospitals. Not only did they have a multiplier effect on the local economy but they provided work in areas which were often isolated and which had few alternative sources of employment available. One locality manager said that they provided job opportunities for trained nurses who couldn't (or wouldn't) travel further afield to work, retaining valuable skills within the NHS. A DGM said that:

"To some extent the local hospital attracts a better calibre of staff to the community and provides a much needed injection into the local rural community"

Several other respondents highlighted the important function of these hospitals in the local economy.

A further theme which emerged from the responses was the current role of small hospitals at the crossroads of different intersectoral links and the potential for a growing contribution in this respect. There were three points at which small hospitals made key contributions: in the relationship between statutory and voluntary organisations, in the overlap between health and social care and at the interface between primary and secondary health care.

Small Hospitals at the Crossroads of Care



One DGM commented that the small hospital was "the focal point for shared provision of health and social care" and several others added that the strengthened role of General Practitioners would enhance their function in primary care, especially as a centre for user and community involvement. It was expected, as one put it, that they would continue to "blur the distinction" between secondary and primary care. Small hospitals were also acting as community centres, drawing in voluntary organisations and engaging in joint planning for patient discharge and care. It could almost be said that the concept of "care management" or "case management" which is now so prominent in Social Services thinking was invented in small hospitals. The scale of care and the geography of care in small hospitals has, in many areas, meant good liaison and close collaboration in the assessment and treatment of individual patients for some years.

The final and related point which was made by some respondents, on the current activities of small hospitals, was about the role they played in supporting carers and other family members. In many respects they took a holistic approach to care and the fact that the circumstances of patients and their carers were often well known to hospital staff meant that appropriate and timely help was often given. Small hospitals are important providers of respite care and terminal care and, as one DGM put it, they were often the only local facility reflecting the community's " 'ownership' of terminal care and issues of death, dying and bereavement".

In looking at the future of small hospitals many respondents focused on the same three points. First, they said that the recent changes in the NHS looked generally positive for small hospitals. One said that the advent of NHS Trusts could mean that "with active and imaginative management" small hospitals could grow and develop and "lose the 'elderly care' hospital label that some held". There was a new opportunity (or indeed a requirement), through business planning and other mechanisms, to define the distinctive contribution of small hospitals and market their services. Virtually all the respondents agreed that the GP would play a crucial part in the future of these hospitals and that all staff might need to adopt a more flexible attitude to professional boundaries. The need for protocols and audit were highlighted as being important elements in maintaining standards of care.

Second, the DGMs and Locality Managers anticipated that small hospitals would take on new functions which, again, would blur the edges of traditional divisions between health and social care and primary and secondary care. Respondents frequently saw the small hospital of the future as a community resource centre rather than a hospital in the conventional sense. One said that they should "be regarded as health care resource centres for defined local populations" and that they must be "part of a totally integrated approach to health care", while another argued that they should be "a focus for events within the community whether health related or not". Some favoured campus style developments with a range of services, including Part III accommodation and ordinary housing, on the hospital site.

The third theme was that small hospitals would provide a highly valued patient-oriented alternative to care in large, remote hospitals and the kind of local services which would be increasingly demanded by users empowered by the Patient's Charter and other measures. One DGM described the small hospital of the future as "a resource effective, people centred alternative to inappropriate admissions to high tech secondary care hospitals" while another concluded

"I think they are a vital counterbalance to the large impersonal high tech hospitals".

The phrase "small is beautiful" figured frequently in responses to this question and many respondents, locality managers and DGMs alike, spoke with real conviction about the need to nurture small hospitals, agreeing wholeheartedly with the DGM who described them as "an underutilised resource with tremendous potential". The last word goes to a District General Manager who captured vividly what many of his colleagues had also said:

"I feel passionately that the future of small hospitals must be protected, not at all costs but by highlighting the strengths and opportunities which they present. There is a need to change the view of professions whereby the doctors 'dabble' in small hospitals, nurses are seen as second class professionals and the buildings (mainly unsuitable Victorian) are seen as dumping grounds. The total economic package of retaining and expanding the range of services in modern small units providing a (limited) range of services has not, as yet, been undertaken and is urgently required".

It cannot be said, because of the limitations of the survey, that the views set out above are necessarily representative and, indeed, it is likely that it was the enthusiasts who returned completed questionnaires. Nevertheless, these comments do reveal the depth of feeling (and even passion, as some of them put it) in favour of small hospitals in at least part of the influential and informed community of health service managers.

7. Small hospitals, small issue?

In looking at future patterns of health care provision in Britain a number of policy issues suggest themselves. Within most of the scenarios for the future the questions of what to provide at the local level (whether that locality is urban or rural) and how to provide it are central. In many respects the small hospital is a symbol of the problem - and possibly of the solution. It raises questions about equity, access, diversity, fragmentation, decentralisation, subsidiarity, cost-efficiency and effectiveness, quality, professional standards, locality, consumerism and appropriateness of care.

It can probably be assumed that the period from 1948-91 in British health policy was, in the larger scheme of things, an uncharacteristic blip. Over the longer term - from the middle of the 19th century to the end of the 20th century - it is likely that the period of the National Health Service (from 1948 until the introduction of the 'internal market') will be seen as out of step with both national and international developments in public policy. The British NHS, with its emphasis on a centralised, planned, national service (with finance and provision almost exclusively in the public sector), was a unique response to the problems of post-War health care and the model was never replicated in Europe or North America, despite its clear achievements in some areas (eg cost control and value for money). For clues about the future of health care in Britain, therefore, it may be useful to look not at the current NHS but at pre-NHS services, post-1991 services and patterns of health care in other countries.

In very general terms, the health care systems of other eras and other countries have been characterised by fragmentation, diversity and decentralisation. Despite the commitment to an egalitarian ethos and equity of provision, the National Health Service too has failed to eradicate striking regional differences in service provision and outcome, and the chances of achieving equity in the next decades appear to be more and not less remote. The thrust of GP fund-holding and the NHS Trust movement seem likely to lead towards local responses to local problems. If current national and Regional policies prevail, these developments will take place within an infrastructure of national rules and guidelines, but the overall effect may look more like 1939 than 1949. Whatever the details of health care organisation in the next

decades in Britain, it seems likely that the broad trend will be in the direction of more localised forms of care and a diversity of solutions to health care needs. The experience of small hospitals highlights both the strengths and weaknesses of such an approach and should be examined for what it tells us in itself, but also for what it tells us about likely futures.

8. Policy issues raised by small hospitals

This discussion about small hospitals raises a number of broader issues for policy, which are discussed below.

8.1 A centralised or decentralised service?

The tenor of the debate in health policy in Britain and other advanced countries over the last decade suggests that the health service of the immediate future will become increasingly decentralised, certainly in its provision and probably in its planning. Although the last decade has seen more centralisation of directives and standards in terms of what is to be done, there has been some decentralisation of how things should be done and more scope for local discretion. This trend seems likely to persist. A number of factors - the development of more mobile technologies, the increasing specialisation of acute hospitals, patient expectations and the development of imaginative non-residential forms of care - all suggest a shift away from the concentration of services in large District General Hospitals. Over the last hundred years, small hospitals in Britain have demonstrated what can be achieved by decentralising services but they have also illustrated the difficulties and tensions in pursuing this approach.

Small hospitals and local services are almost universally popular in the communities they serve, but clinical opinion is firmly divided about benefits (or otherwise) to patients. One set of views maintains that small hospitals are unsafe because of overambition on the part of medical staff, inadequate staffing levels (particularly the absence of resident medical cover), insufficiently large throughput to maintain clinical skills and poor facilities and equipment. The opposing view insists that, with careful patient selection, high standards of care can be and are provided. In many cases the balance lies between providing local care which is of an acceptable (but possibly not high standard) because of the social and economic benefits to patients, and providing top quality care in a less accessible and less patient friendly environment. Any decision around the issue of decentralisation may involve these questions, but patients' views about the elements in health care which they value should also be

considered. Given an informed choice of the alternatives, patients may well opt for local, personal services in preference to clinical excellence. It is not self evident, however, that these are necessarily alternatives and the next section reports on what is known about clinical outcomes and patient satisfaction in small hospitals in Britain.

The argument about small hospitals, within the context of the centralisation/decentralisation debate, has also been about the substitutability of services in different settings. One very interesting perspective on this point was offered by Meyrick Emrys-Roberts, a GP and ardent advocate of small hospitals, in a letter to the Times in 1962, criticising the Government's Hospital Plan:

"the ideological centralization proposed in the Hospital Plan is about as realistic as would be a plan to scrap all the ships in the fleet except the aircraft-carriers, and about as moral as would be a plan to close all parish churches on the grounds that the work done in them could be more efficiently organised in the cathedrals" (Emrys-Roberts, 1992, p.194).

Centralisation, then, may be appropriate if all services currently offered in small hospitals can - in all respects - be delivered as efficiently in large, more remote units. There is reason to doubt that this would be so and to question the degree of substitutability which exists.

Advocates of small hospitals and local services invoke the principle of subsidiarity in defending localism. Their perspective would be that all services should be provided locally and at the primary care level unless it can be shown that some degree of centralisation would be beneficial to patients.

8.2 Clinical outcomes and patient satisfaction in small hospitals

Although the importance of collecting data on clinical outcomes for patients in small and large hospitals was recognised more than 30 years ago, the evidence today remains weak and unreliable. In her evidence to the House of Commons Health Committee early in 1992, for

example, the then Minister of Health, Virginia Bottomley, agreed that in obstetric care - despite years of controversy about the best place to give birth -there was still very little hard evidence about alternative locations.

"She acknowledged, without reservation, that there was no reliable statistical evidence which established the superior safety of birth in consultant obstetric units as against home births and those in GP units, stating that 'there is no overwhelming ... unequivocal evidence, about the relative merits of different settings (for delivery) and some of the evidence is conflicting' " (House of Commons Health Committee, 1992, para 29).

Despite this lack of evidence, however, British health policy has been pushed firmly in the direction of centralised facilities and in-patient DGH care, particularly in obstetrics. As the Report suggests, this policy is more a reflection of the dominant medical model of care and of medical politics and professional pressures than of a dispassionate assessment of the evidence for or against care and treatment in small hospitals. It endorses the conclusions of the National Perinatal Epidemiology Unit at Oxford which maintained that

"There is no evidence to support the claim that the safest policy is for all women to give birth in hospital, or the policy of closing small obstetric units on the grounds of safety" (House of Commons Health Committee, op cit, para 26).

Such policies, the Committee concluded, go "against the grain of many women's wishes" (Ibid, para 32) and are based on "unproven assertions" (Ibid, para 33).

As Bennet commented in 1974, there have been very few randomised control trials or random allocation studies comparing the clinical effectiveness of treatment in different settings (Bennett, 1974). When Oxford Regional Hospital Board decided to invest in community hospitals in the early 1970s it was recognised that the experiment should be evaluated, and considerable effort was invested in careful evaluation of the initiative. Although some critics have said that this was "an experiment with enthusiasts and therefore not a fair test" (McFarlane et al, 1980,p.11) it was a thoroughgoing attempt to collect sound

evidence. Nevertheless, sixteen years later - in 1990 - the Royal College of General Practitioners in its report, Community hospitals: preparing for the future, could still argue that:

"At present there are scanty data on the type of cases admitted, the standard of care offered, or the outcome of care in Community Hospitals" (1990,p.4).

One of the difficulties of carrying out comparative studies of in-patient treatment in small hospitals and other settings is that factors such as patient selection have a significant impact on the outcome. Liddell, Grant and Rawles, for example, undertook a study of 451 patients with myocardial infarctions in Scotland. 62% of them were admitted to a Community Hospital, 28% to a District General Hospital and 11% were kept at home. The mortality rates of patients admitted to Community Hospitals and DGHs were 25% and 23% respectively, compared with 21% and 24% in previous studies. However, the patients chosen for treatment in the different settings varied considerably in terms of age, morbidity, home circumstances and other factors. As the authors concluded:

"It has been shown that the selection of patients by age, history of heart failure and coexisting illness largely explains the variations in mortality rates for patients with myocardial infarction treated in different types of hospital and ward" (1990,p.321)

It has proved difficult to produce genuinely comparable data on outcomes for patients in different settings, including small hospitals, because of the problems of controlling for inputs and patient selection. On the other hand, single case studies suggest that standards of care are generally acceptable. A study of coronary care in Brecon War Memorial hospital, for example, concluded that mortality rates and resuscitation rates compared favourably with coronary care units and medical wards in DGHs (Davies,1982,p.1470). Similarly, a study of casualty and surgical services in five GP hospitals in Perthshire between 1954-84 concludes that standards of care are good and post-operative complications negligible and that there is no scientific evidence to suggest that the operations or anaesthetic procedures are unsafe (Blair et al, 1986). In 1990 the Royal College of General Practitioners agreed that elective surgery, which is performed in almost half the community hospitals in the UK, is

carried out competently:

"It is known that the standard of surgery is high, with few complications, shorter than average waiting lists, and convenience for patients. The esteem of the hospital is enhanced locally by this provision. There is no evidence that centralization of surgical services in large hospitals improves quality of patient care or reduces expenditure" (Royal College of General Practitioners, 1990, p.4).

Despite these persuasive studies, however, it cannot yet be said that the quality of care and clinical outcomes in small hospitals in Britain have been objectively assessed. Criticisms of clinical standards are largely anecdotal. Health professionals with doubts about the performance of small hospitals have not rushed to collect data to substantiate their claims or to publish their findings. In contrast, small hospital enthusiasts have been assiduous in their attempts to counteract the criticisms, and the studies which have been made of clinical outcomes originate with this group. On the basis of the evidence produced to date there are no real reasons to doubt that clinical outcomes in small hospitals can be as good as those in larger units if patient selection is carefully monitored and patient throughput is maintained at a reasonable level. However, this conclusion is drawn on the basis of inadequate data and without the contrary view having been tested fully.

Although the information on clinical outcomes in hospitals of different size and type is very limited, there have been some studies of patient satisfaction which confirm many of the positive views about the quality of care in small hospitals. Ann Cartwright's study, Human relations and hospital care, for example, showed that patients in small hospitals had higher levels of satisfaction with their care generally than those in larger units. A higher proportion knew and remembered the name of their doctor and anaesthetist and they were more satisfied with their medical treatment and with levels of communication with the medical and nursing staff. Other studies showed that hospital food and staff morale were better in small hospitals (Cartwright, 1964, pp174-6). Our own studies of private patients (Higgins and Wiles, forthcoming) also show that small hospitals -in this case small, private hospitals - have positive benefits for patients, in terms of better communication and a more egalitarian relationship with their doctors, as well as better information about their treatment and

prognosis. The one point on which Cartwright challenges the accepted wisdom, however, is in relation to continuity of care and care by one's own GP. Her findings suggest that patients do not feel strongly about this issue one way or another. Of the group who received in-patient care from their GP she writes:

"There was no indication that these patients were more or less satisfied with their treatment than other patients, nor that they differed from others in the extent to which they were satisfied with the information they had received ... The numbers are, of course, small but there is no evidence that, as is sometimes suggested, this form of medical care is especially appreciated by the patients concerned" (Ibid,p.120).

This conclusion is at odds with most of the thinking about GP care and contrasts with some research carried out in Wales. A study of 488 patients undergoing surgery in Brecon War Memorial Hospital showed high levels of satisfaction (Johnson, 1984,pp1293-5). Of those who responded, 95% rated their nursing care as excellent and 96% said the same of their medical care. They found the hospital friendly and informal, with a happy atmosphere, and appreciated being cared for by their own GP. They liked knowing the doctors, nurses and other patients and the experience of being treated as "a person not a case". Shorter travelling times and waiting lists and choice of operation dates were also mentioned as advantages. However, 80% of the patients who responded had never had surgery elsewhere and could not compare their experience in the small hospital with that in other hospitals. Furthermore, a high proportion were also drawn from an area in which their current and future care would be provided by the same doctors and nurses. Half the population served by the hospital live within a mile of it and the rest are from an area of 300 square miles (Davies,1982,p.1469). This may have inhibited their willingness to express negative views. The literature on patient satisfaction warns against the problems of 'false positives' and notes, in particular, that where patients are likely to return to the same practitioner (because of a chronic condition) or to the same facility (through lack of choice) there is a strong likelihood that patients will feel constrained to appear positive and grateful. As Porter and Macintyre observed, in a study of women's responses to antenatal care, patients tend to assume that the care they are receiving has been well planned and is probably the best available. They prefer their present arrangements to possible options and feel that 'what is, must be best' (Porter

and Macintyre, 1984, p.1198).

Similarly, it is very common to find in studies of in-patient care, (as the Brecon research confirmed), that there are high levels of patient satisfaction with hospital staff, whatever the size of hospital. However, a useful study of maternity services in Bath Health District distinguished between patients' experiences in "neighbourhood" hospitals and DGHs. Women's satisfaction with their care during labour and delivery was generally good, although only 66% of women delivering in a DGH described the birth as "a really good experience" compared with 78% in the neighbourhood hospitals. During the post-natal period there was a clear distinction between the two groups, with a much higher proportion of women commenting favourably upon the food, the amount of rest and sleep, the lack of boredom and the personal attention in the neighbourhood hospitals than in the DGHs (Taylor, 1986, pp 158-9). The size and scale of the hospitals was clearly a factor in determining levels of patient satisfaction. As the author commented:

"While large-scale environments were often perceived as clinical and impersonal, and could make mothers feel 'one of thousands', small-scale environments were seen as being homely and friendly and as diminishing the social distance between staff and patients" (Ibid, p.160).

Neighbourhood hospitals were also favoured because of the continuity of care they afforded. Mothers complained that, in consultant clinics, they never saw the same doctor twice whereas the GP in the neighbourhood hospital knew them and their families and treated them "as a person" (Ibid, p.160). Having access to a local service was important at all stages of ante and post-natal care, and the proximity of friends and family was particularly welcomed by working class mothers. There is some evidence from other studies that a 'high technology' labour (which would be more common in large maternity units and DGHs) is more likely to result in postnatal depression and that isolation and the absence of family support lead to negative experiences in the postnatal period (Miles, 1991; Oakley, 1981).

The House of Commons Health Committee visited the small hospitals in Bath Health District as part of its review of maternity services. It concurred with the view that services in these hospitals were "highly valued by the women who had chosen them" and that the environment, accessibility and professional support available was impressive (House of Commons, op cit, para 85). It concluded, however, that a home birth or birth in a small hospital were options which have "substantially been withdrawn from the majority of women in this country" (Ibid, para 86).

8.3 The cost-effectiveness of decentralised care

Part of the rationale for centralising health care in larger and larger units has been to achieve economies of scale - through the concentration of staff, capital, technology and other resources -and to achieve high standards of care through the concentration of professional skills and expertise. Any move to decentralise services, whether to small hospitals or to other local facilities, calls into question these original assumptions about the savings achieved by centralisation.

Again there is very little good data on the cost-effectiveness of small hospitals and on the comparative costs of small and large hospitals and domiciliary care. Very crude measures, such as cost per inpatient day, have been used to draw comparisons but these describe only one element in a very complex equation. Studies by Sichel and Hall (1982) and others do suggest that, on this basis, small hospitals represent good value for money. However, such measures do not take account of possible differences in types of patient, morbidity and services available. GP hospitals also offer good value for money because of the anomalous way in which medical staff are reimbursed. GPs working in small hospitals are typically paid from the so-called Bed Fund (though they can be paid as clinical assistants). Because, in 1990, the Bed Fund rate stood at 68 pence per day per in-patient the costs of medical staffing in small hospitals are artificially low (Royal College of General Practitioners, 1990, p.10).

Rickard's analysis of the costs of small hospitals in 1970 suggested that assumptions about economies of scale in larger units may not necessarily be borne out, especially in relation to capital costs. His results suggest that, purely on cost grounds, the optimum size for a small hospital would be 35 beds, with anything smaller being less cost effective and anything bigger showing relatively few variations in costs with size (Rickard, 1976). Similarly, the House of Commons Health Committee challenged the view that centralisation necessarily resulted in economies of scale. It doubted whether the use of GP maternity units and hospitals was "necessarily more expensive than wholesale centralisation" (House of Commons, 1992, para 312).

One charge against small hospitals is that they are a luxury which the NHS cannot afford because they encourage hospitalisation in circumstances which cannot be justified and that they increase the overall usage of in-patient facilities rather than relieving DGHs and other hospitals. Sichel and Hall (1982) assemble evidence to counter this argument and maintain that general practitioner beds are not being "frittered away" on patients who do not require admission. Similarly, Baker et al in a careful assessment of this issue in Oxfordshire conclude that community hospitals have been used as a substitute for DGH in-patient treatment instead of an add-on luxury. Although they point out that, in populations with access to community hospital beds, utilisation rates overall are slightly higher the figures are not large enough to suggest gross overuse. Indeed the evidence suggests that community hospitals are being used efficiently and appropriately to reduce demands upon more expensive DGH facilities (Baker et al, 1986).

As many writers have noted, any calculations about the cost-effectiveness of small hospitals should also take account of the value of voluntary giving and the social costs and benefits to patients as well as the more conventional and more easily measurable capital and revenue costs (Royal College of General Practitioners, 1990). Davies was critical that these factors were not sufficiently recognised:

"assessments of costs by professional health planners take account only of outgoings from the public purse and not those from individual pockets" (Davies, 1982,p.1470)

The same point was made by the House of Commons Health Committee:

"No effort is made in such calculations to include the costs to mothers and their families in time, fares and petrol of centralisation. No value is given to the very real benefit of families being able to be together at this crucial period" (House of Commons, 1992, para 312).

Leagues of Friends, volunteers and members of local communities have all made very substantial contributions to the provision of small hospital care over many years. Helen Tucker's study shows that 95% of all community hospitals have a League of Friends. In addition, 50% had a generous level of endowment funds and 84% reported a "generally good response to fund-raising ventures". This was particularly marked in the smaller hospitals. 49% had a high level of volunteer involvement and many enjoyed visits from local schools (Tucker, 1987, p.51). A great many of the original cottage hospitals were built out of voluntary contributions and donations and these remain an important income (though it is difficult to measure its size) to small hospitals. This money has been used not just for domestic luxuries but for major capital building and maintenance projects around the country.

The social and economic costs to patients of not providing local services is very high. Admission to a remote hospital for in-patient care can lead to isolation, a loss of social ties with family and friends and greater difficulty in coping with eventual rehabilitation. The financial costs of out-patient appointments, child care and visiting may also be considerable for rural populations and for the oldest, poorest and sickest whose need for health care is invariably higher than that of other groups of the population. The study by Haynes and Bentham of rural accessibility in Norfolk illustrates these costs in detail (Haynes and Bentham, 1979).

8.4 Hospitals and communities

It is clear that small hospitals are more to local communities than simply a place to receive health care. Any threat to close such hospitals provokes almost universal outcry and bitter

opposition. This intense support often prompts cynicism upon the part of health planners who attribute it to a deep conservatism, to territorialism and to a wish to preserve privileged access to local facilities. On the face of it, this seems a gross oversimplification and a misunderstanding of the social meaning of health services and hospital care. A better appreciation of these subtleties could lead to more appropriate forms of care and greater sensitivity to patients' needs.

The desire to preserve and extend small hospital services appears to reflect a number of concerns: a sense of history, safety/security, reducing isolation, continuity of family care, financial investment, a feeling of 'ownership' and community solidarity. It is often the case, in both urban and rural communities, that the local hospital is the oldest building and public facility. It was frequently bought by public subscription, even in very poor areas where incomes were low, at a time when only the poorest and the very rich had access to hospital care. As Christine Hoy said, in her history of Leith Hospital (which she described as "a beacon in our town"):

"It is an old and integral part of a community which has already lost many important landmarks in recent years. The voluntary spirit of earlier years demanded local participation and loyalty, and there is no doubt much of this spirit survives" (quoted in Inhouse Architects, 1989, no page number).

Even if the hospital was fortunate enough to acquire land and property from wealthy patrons it was often the poorer members of the community who provided the revenue, either through subscriptions, fees, donations, legacies or any number of fund raising activities. Communities today feel attached to their hospital because this tradition has often continued and the financial investment made by individuals and families makes them feel that they, and not the health authority, own the hospital -at least in part. Certainly the voluntary donations have been substantial in many areas and have paid for major building or rebuilding schemes. Quite apart from this monetary link with local hospitals there is a much more subtle sense of 'ownership', with many staff, patients and local people talking frequently of their hospital.

Local hospitals often have very personal significance for the families living around them: babies were born there and parents died there. In rural areas where the population has been relatively immobile, this sense of continuity in family care is very important.

Attachment to community hospitals is also about security and safety and, as one general manager put it, about the 'mythology of the bed'. In other words, the existence of a hospital provides reassurance that if anything 'goes wrong' there are skilled staff on hand who can provide treatment and - if necessary - a bed. The association of hospital treatment with being in bed or having emergency care is strong, but may be ill-founded. Many small hospitals do not have a 24-hour casualty service and are unable to treat anything other than minor injuries. Few have any resident medical staff and rely upon transferring patients elsewhere when the emergency is serious. Nevertheless, the existence of a hospital produces real feelings of security. Gillian Wilce, in her book about Lambeth Community Care Centre (a 20-bed inner city community hospital) quoted patients who thought of it predominantly as "a safe place to be sent to" which gave them "a sense of safety" (Wilce, 1989, p. 10). The Centre was located not, as in the case of many community hospitals, in a remote rural area but in a London borough with high levels of deprivation and poor facilities. Despite the proximity of large internationally renowned hospitals, local residents and local professionals experienced a sense of isolation which was no less profound than that of their counterparts in rural villages. As one GP put it:

"Rehousing schemes have often destroyed close neighbourhoods and weakened community initiative. Younger people with get up and go have done just that. Neighbours may be strangers and visitors are by definition up to no good. High rise schemes ... have left the elderly isolated in the upper floors while the ground is the territory of the car and the street criminal" (Ibid, pp42-3).

The problems were just as great, although different, for the health professionals within the area. Many felt alone and insecure, remote from their professional peer group. As one of them commented:

"many of the GPs are working in isolation, not knowing who their nearest neighbour is" (Ibid, p.43).

The Centre, therefore, provided security and stimulation for doctors and patients alike and an opportunity for social and professional interaction that was otherwise lacking. "It might be argued", one GP added, "that if the Community Care Centre did not exist, life would inevitably go on for all our patients, but in the final analysis I must say with all the sincerity at my command that I have no doubt whatsoever that the quality of life for very many of my patients has been greatly improved at the time when it was most needed" (Ibid,p.13).

The House of Commons Health Committee report on maternity services illustrated the particular benefits for pregnant women and new mothers of local hospital care and other facilities. Quoting evidence from the Maternity Alliance it concurred that

"there should be clear recognition of the social importance of the community setting for antenatal care which will sow the seeds of the postnatal support which is vital to the mother and baby. Antenatal care should be regarded as one phase within a continuous web of care which is provided, as far as possible, by the same small group of professionals and within the woman's own community" (House of Commons, 1992, para 42).

It went on to say that:

"Whenever one of these units has come under threat, the often almost universal opposition of local communities has frequently been overridden on arguments of safety or cost, although we have not been offered evidence establishing the validity of such justifications" (Ibid, para 83).

On the contrary, there is other evidence (though much of it is anecdotal) to suggest that post-operative and post-natal care and rehabilitation are achieved more rapidly and more satisfactorily within the more familiar surroundings of a local hospital, surrounded by friends and family. The long term benefits in terms of, for example, reduced readmission rates have not been measured but may be considerable.

Although NHS hospital doctors have a record of opposition to community hospitals,

especially for obstetric care, surgery and accidents and emergencies, they too appear to recognise the social value which may be attached to them by local people. In a survey by Bath Directorate of Public Health in 1991, for example, only 38% of Consultants regarded community hospital in-patient services as having a high clinical value but 76% said that they had a high social value. When asked about out-patient services these figures went up to 79% and 82% respectively. Overall, 63% said that the District Health Authority should continue to support community hospitals (Bath District Health Authority, 1991a, pp 6-10). Consultant geriatricians and surgeons, in particular, recognised the social value of community hospitals. A survey of the general public of Bath Health District, undertaken at the same time, showed that 82% wished to see community hospitals kept open, even if this meant a reduced service at the District General Hospital. Not surprisingly, the greatest support for community hospitals came from people living outside the city (Bath District Health Authority, 1991b, pp 9-10).

The social benefits to communities of small hospitals are incalculable. Because we cannot measure them, however, we should not simply ignore them. The beneficial influence of a local facility may have a multiplier effect which produces long term gains in terms of the health and wellbeing of many individuals and families. That is certainly the perception of those groups affected by small hospital development and closure but considerably more work needs to be done to explore these sentiments fully.

8.5 Risk and gain

Part of the medical opposition to the use of small hospitals, particularly for surgery and obstetrics, centres upon the question of the risk to patients and the quality of care they receive. Part of the popular support for such hospitals reflects a view that the benefits of a local facility may well outweigh the risks (insofar as they exist).

Medical and popular opinion may diverge on the question of risk because the general public are poorly informed, but it is also possible that the patient's criteria in assessing risk and the values which s/he attaches to those criteria may be different from those of the doctor. The

vast majority of health interventions do not involve life or death decisions and the grey area of subjectivity and judgement around all other decisions allows plenty of scope for differences of opinion and value. As Jean Robinson of AIMS said, in evidence to the House of Commons Health Committee:

"Women's criteria for risk and what is risk and morbidity are not the same as the criteria which obstetricians are using" (House of Commons, 1992, para 82).

This did not mean that women were "deliberately flouting evidence of risk" (Ibid, para 82) but that their perceptions of risk were not shared by professionals. As the Committee concluded:

"The purported risk of birth in a peripheral maternity unit is not proven. Nor has any sensible attempt that we are aware of been made to assess the different risks associated with DGH maternity units in terms of morbidity and a reduction in maternal satisfaction, let alone mortality" (Ibid, para 311).

As the Committee concluded:

"we do not close rural roads because the accident statistics for them are worse than motorways, and there are many other areas of public policy in which risk must be balanced against gain" (Ibid, para 311).

Although local communities may have very poor information about the consequences of opting for treatment in small hospitals rather than a DGH, it does appear that some at least - insofar as they are able - calculate that the benefits of proximity, informality and so on outweigh the possibility that the standard of clinical care may be higher elsewhere.

8.6 Staffing issues in small hospitals

It is clear that the two essential requirements in small hospitals are that they should have the active support of general practitioners and that all staff, but particularly nursing staff, should have a flexible approach to their work.

Although some small hospitals arrange in-patient and out-patient consultant sessions, the vast bulk of work is undertaken by local GPs. On average, each community hospital in England has 15 GPs with admitting rights (Tucker, 1987, p.45) and national figures show that 15% of GPs in the UK as a whole have access to small community hospitals (Royal College of General Practitioners, 1990, p.2). Not all General Practitioners, however, are eager to work in their local hospital and it is estimated that around 50% of GPs in the area need to be involved for the hospital to be viable. Where GPs are reluctant to do hospital work a lack of confidence, fear of litigation and inadequacy of remuneration are cited as reasons. The House of Commons Health Committee commented on the ways in which the persistent concerns expressed by hospital consultants about home births and deliveries in small hospitals had led to anxiety on the part of health professionals in primary care. It had resulted in a "deskilling" of GPs and midwives and a loss of confidence in their own abilities (House of Commons, 1992, para 312). Several witnesses to the Committee said that medical training now focuses so strongly upon the management of abnormal births and the risks involved that they are increasingly reluctant to provide obstetric care. Junior hospital doctors were trained on "a diet of abnormality and fear, sufficient to discourage them for life" (Ibid, para 77). The increasing concern about litigation, especially in obstetrics, had also made some GPs reluctant to work in small hospitals.

Kernick and Davies, reviewing a number of studies of GPs' attitudes to working in community hospitals, showed that around half of all GPs eligible to do so decided against it. Typically they described themselves as being 'too busy', 'too out of touch' or just not interested in hospital work. There was a strong correlation between age and attitudes to small hospitals, with no doctors under the age of 40 being unwilling to work in them if the payment was adequate (Kernick and Davies, 1977, pp 1238-9). A study by Haynes and Bentham in King's Lynn showed - in that area at least - a higher level of interest in working

in community hospitals than this earlier study suggested. In King's Lynn 47% of GPs said they were definitely interested in working in a community hospital and a further 40% said they might be. Factors such as age, the possession of a higher qualification and the type of practice in which the GP worked did not appear to influence their decision, though the distance of the community hospital from their home was important to them as was the possible inconvenience of being on call for a minor accident service (Haynes and Bentham, 1979, pp 65-8).

One of the arguments which has been voiced against GP managed small hospitals is that GPs may have a tendency to 'hang on' to patients when they should actually be referred elsewhere. It is also suggested that they may attempt more sophisticated treatment than they are able to manage and that they are over ambitious. Indeed Bevan's early fears about small hospitals centred upon what he described as the "vaulting ambition" of GPs. These comments are largely anecdotal and there is no hard evidence to suggest that these practices are prevalent in small hospitals in Britain.

It is often argued that flexibility is an essential ingredient in making small hospitals successful. It was an expectation at Lambeth Community Care Centre, for example, that a ringing phone would be picked up by whoever was passing. This was not without its problems. As Gillian Wilce put it

"Answering that ringing phone is taking the little risk each time that you'll have to shoulder the responsibility for something rather than waiting for someone else to deal with it" (Wilce, 1989,p.55)

Where there are no resident medical staff it is particularly important that nurses are able to take on a range of roles, and most of the literature on small hospitals suggest that they are accomplished in doing so.

As the Royal College of General Practitioners has observed

"Since there are no resident doctors in community hospitals, nurses must make the initial management decision on a wide variety of medical problems and often take considerable responsibility in the telephone management of others" (Royal College of General Practitioners, 1990, p.4).

One critical comment was made by Liddell et al in their study of the management of myocardial infarction in Scotland, but this was atypical. They complained that clinical outcomes would have been more favourable if nurses had been prepared to undertake defibrillation in the absence of a doctor (Liddell et al, 1990, p.322). Generally, however, the literature suggests that flexibility and a willingness to go beyond traditional roles were a clear strength. Teamwork was much in evidence and the relationship between doctors and nurses was "fundamental not hierarchical". As a result, the Royal College maintained, "nurses are held in high esteem not only by colleagues but by the local community" (Royal College of General Practitioners, Ibid, p.4). But this shared responsibility and non-traditional pattern of working was not unproblematic. As Wilce concluded, in her book on the Lambeth Community Care Centre

"It takes a certain courage and a definite commitment to step out of a clearly defined role, to accept blurring at the edges" (Ibid, p.55).

Other positive features of staffing in small hospitals are said to be loyalty and commitment, low turnover and high morale. Cavenagh's study of general practitioner hospitals in England and Wales showed that:

"None of the hospitals surveyed had been subjected to any industrial dispute or unrest and, with few exceptions, morale was uniformly high" (Cavenagh, 1978, p.35).

Where there were occasional problems of low morale this was attributed to the uncertainties caused by health authorities in planning the futures of the hospitals.

One drawback of stable staffing, however, may be a lack of professional stimulation and professional isolation. The problems of ensuring adequate educational standards and professional updating in remote rural areas are serious ones. General practitioners now have a financial incentive, through their educational allowances, to update their skills but the same incentives do not necessarily exist for other staff. Although there are no data on the numbers and motivation of nurses in small hospitals, it was suggested by some interviewees that they are likely to be older staff who only wish to work in the one hospital and who have no career aspirations. The desire to acquire further education or training may, therefore, be lacking and some external stimulus has often been required to ensure professional growth development. Some hospitals have developed in-service training for both qualified and unqualified staff, but this is only one part of a solution. The UKCC's PREPP proposals on post registration education and practice should, however, make an important contribution here. The PREPP report recommends that nurses should spend at least five days every three years in continuing education. Furthermore, it has been argued that, because small hospitals have been vulnerable to closure for so many years, they have become adept at innovation. In a small hospital, with little bureaucracy and short chains of command, changes in professional practice can be implemented in days instead of the months or years which it can take in large NHS hospitals.

Small hospitals, however, do not seem to be universally popular with nursing and other staff, especially where they have the option of working elsewhere. Haynes and Bentham's study showed that the most popular size of hospital amongst different staff groups had between 100 and 300 beds. Physiotherapists, occupational therapists and radiographers, in particular, preferred larger hospitals. They felt that they had more variety in their work in a larger hospital, more opportunities to use and enhance their experience and better access to modern equipment.

On the other hand, they felt that good staff relationships were often a feature of small hospitals as was the likelihood of getting to know patients personally. A very high proportion (87%) of staff who expressed strong preferences for either large or small hospitals had experience of working in a hospital of that size themselves (Haynes and Bentham, 1979, pp68-74).

Both the Royal College of General Practitioners and the House of Commons Health Committee recommend additional training for medical and nursing staff working in small hospitals. The Royal College suggests that GPs need to know "when to admit a patient to a general practitioner bed, or to a specialist bed, and when not to admit at all" (Royal College of General Practitioners, 1983, para 4.2). In addition, staff in small hospitals need to understand that they are part of the system of primary care and what that means. The House of Commons Health Committee saw education as a way of stopping the "deskilling" process in obstetric care. It argued that obstetric training should focus much more on normal births, should involve the training of GPs by midwives and should be more community oriented.

8.7 Primary care and social care

A central debate in the discussion about small hospitals has been whether they are 'mini-DGHs', peripheral outposts of larger hospitals replicating their services, or whether they are one element in a range of primary care services. There is little dispute amongst those who run and work in small hospitals that they are very clearly the latter, but there is no overall unanimity on the issue. Within the small hospital sector the definitions of the role and functions of community hospitals, set out by Rosemary Rue and her colleagues in Oxfordshire in the early 1970s, are essentially the 'gold standard' and there is broad support for their philosophy. In her view, community hospital care should be understood as "a style of care" and "an approach to patient management" (Rue, 1974, p.4), rather than simply a residential facility providing a range of in-patient services. The style was to include close collaboration with social services, voluntary organisations and other local agencies. It was the primary care team which was to have responsibility for patients and the service was to be based around "the expansion of responsibility and potential among the domiciliary team, rather than a dissipation of the strength of the specialist teams" (Ibid, p.5). Rue argued that "Logically there should be no differentiation ... between nursing or other paramedical staff by defining limited spheres of work either in the hospital or in the homes" (Ibid, p.5).

There has been a deliberate attempt, in many small hospitals, to break down the traditional

boundaries between health and social care and to provide services which are sensitive to the needs of individual patients and their families. Community hospitals are at their most successful where they have achieved this blurring of roles and functions. It makes evident good sense in many areas to look at who can do what best rather than at who manages the budget or employs the staff. In any case, it is often an accident of history which determines who provides services such as respite care or day care and not an act of deliberate forethought. Many of the most exciting initiatives in small hospital care have taken place at the interface between health, social services and housing, as some of the Scottish Health Boards have demonstrated. Lothian Health Board's plans to re-use old hospital buildings for in-patient care, day care, sheltered and mainstream housing are just one example.

Small hospitals cannot aspire to be District General Hospitals and it would be a mistake to do so. In isolated areas with poor transport they may, however, provide a more traditional acute hospital service than in areas where accessible alternatives exist. However, in many cases, the notion that they are essentially community resource centres, with their roots in primary and social care, is more appropriate.

8.8 The access/equity trade-off

Although most health authorities in Britain subscribe to the principle of equity in health care as a core value, this goal has never been achieved. If equity is to be understood as equal treatment for equal need and equal access to treatment in cases of equal need, the contribution of small hospitals poses a dilemma.

Some would argue that the role of the small hospital is to smooth out inequalities of access to acute, elective and emergency care by providing local services where suitable alternatives are absent. Others have suggested that small hospitals subvert the principle of equity by giving isolated communities a service which equally needy patients in urban areas do not get.

The case of the small hospital indicates that principles of equity and access may, in practice, be irreconcilable and that a choice between them must be made. For advocates of local

services tailored to local needs, the question of access has become paramount and the eradication of gross disadvantages in rural areas a primary concern. Much of the literature, however, suggests that although small hospitals may be substituting for DGH services they are not providing the same kind of care. Baker et al, for example, show that the 10 community hospitals in the Oxford Health District reduced the demand upon District General Hospitals. However, as we have shown above, these hospitals were regarded firmly as a primary care resource providing a different service from that available in DGHs. Furthermore, in this particular case there is evidence to suggest that community hospital patients got more of the service than their counterparts who were reliant on DGH or community care. The survey showed that utilisation rates were higher in each age group for community hospital patients than for other comparable population groups (Baker et al, 1986, p.120).

The development and promotion of small hospitals puts local access as the highest priority, at the expense of equity. The grounds for this seem strong, but the case needs to be argued.

9. Future trends

In looking to the future of health services in Britain and the future role of small hospitals three broad themes should be considered. Each poses difficult and - to some degree - unanswerable questions. The first centres upon changes in demographic patterns, the location of populations, the likely shape of economic and social life and the impact these changes will have upon access to health care. The second theme is concerned with the ways in which changes in technology and in professional values will lead to different ways of delivering health services, particularly at the interface between the NHS and Social Services. The third set of questions focuses upon small hospitals in the marketplace and the opportunities and threats which current trends in policy present. These themes are discussed in turn below.

9.1 Social change and access to health care

In looking at past, current and future roles of small hospitals three particular issues have arisen. First, it was argued that the growth of cottage hospitals took place, in part, because of the movement of women into the industrial labour force in the middle of the nineteenth century. As long as women were available at home to tend the sick, the problem of providing medical care for family members was contained to some degree. When the place of work moved from the home to the factory there was growing pressure to provide alternative care. Second, the growth of the older elderly population in Britain (over 80 years) creates new and particular demands for health care. By 2031 the number of over 80 year old people is projected to be 3.4 million, 60% more than in 1990. Similarly, the under 16 age group which has been declining in numbers in the last two decades is projected to increase steadily, peaking at 12.6 million in 2001 (Government Statistical Service, 1992, p.27). It is clear that those most in need of health care - young people, older people, poor families and women - are less likely to possess a driving licence and less likely than all other groups to have the use of private transport. Their ability to secure access to the health services they need is thereby limited. Third, the population of Britain has been steadily moving out of metropolitan areas and more urban non-metropolitan counties, where health

facilities are concentrated. A continuation of this trend will raise questions about the future location of health services and access to them.

These three issues raise important questions for the future. The pressures on women in the 1990s to both participate in paid work outside the home and to continue caring for dependent family members in their own homes are very strong. The 1989 General Household Survey showed that the proportion of over 16 year old women in the labour force in Great Britain increased from 60% in 1973, to 62% in 1983 and to 72% in 1989 (Government Statistical Service, 1989,p. 58). If this trend continues, as it is predicted to do, there may be major consequences for the care of dependent people, even though women show few signs of shedding their responsibilities for family care as their labour force participation increases. It may be that small hospitals have a key role to play in replacing and supplementing family care, as the pressures on women intensify. The expansion of so-called 'community care' may lead to increased demands for services (especially for elderly dependent people) which are local, sensitive, personal and flexible. The contribution of small hospitals in providing respite care, rehabilitation, convalescent care and terminal care may increasingly replace and, to some extent, improve upon care which was provided at home by women. If they come to be seen as community resource centres, instead of conventional hospitals, they will become an important locus of care for a range of local activities which will cross the divide between health and social care.

Since the creation of the NHS a number of factors have served to reduce the accessibility of some parts of the health care system. In the 19th century, hospitals were built in centres of population where many of the patients who used them could easily reach them on foot. Although relatively cheap forms of private transport have enabled more distant users of health services to gain access to care the benefits have not been universal. The growth of car ownership has been accompanied by a decline, especially in recent years, in public transport. Furthermore, car ownership is unevenly spread across the population with those groups with the highest morbidity least likely to have access to a car. In 1989 33% of people in England did not have the regular use of a car; the figure for Wales was 30% and for Scotland 45%. In the United Kingdom as a whole 35% had no car. In Social Classes I and II access to at least one car (and often two cars) was common, whereas 45% of semi skilled manual

workers, 57% of unskilled manual workers and 56% of retired people had none (Government Statistical Service, 1992,p. 225). Health services, particularly hospital services, have been centralised in large centres in urban areas. Those local facilities and small hospitals which have survived have bucked the trend. The increasing number of people living into old age has created pressures on health services from the groups in our society who are the least mobile. If this problem is recognised by taking more services to patients, instead of vice versa, and through the strengthening of community care and primary care as seems likely then small hospitals may flourish as accessible local facilities. They provide opportunities for more out-patient diagnostic and treatment clinics in those specialties most required by older people and for the expansion of other mobility enhancing services such as chiropody and physiotherapy.

9.2 At the crossroads of care.

There is little dispute that a number of trends set in train in the 1980s will persist until the end of the century

- Shorter lengths of stay and higher throughput in acute hospitals
- A reduction in the size of acute hospitals
- An increasing emphasis on community care and primary care
- A strengthening of the power of the General Practitioner
- A blurring of the boundaries between health and social care
- More day surgery and day care
- More mobile technology

It is very clear that each of these trends bears directly upon the future of small hospitals and creates a greater potential for their development than we have seen in Britain for a hundred years. If small hospitals are to take advantage of this tide flowing in their favour they will need to enhance their profiles and identify clearly where they fit into the burgeoning area of non-acute hospital care. They will need to demonstrate that they are at the crossroads of primary/secondary, statutory/voluntary and health/social care activities and not at the margins. They will need to contribute to a changing culture of care in which purchasers look to them first, and not last, for respite care, rehabilitation, post-operative care, terminal care and so on.

New models of care for the future should have a number of characteristics:

- Facilitation of early discharge from acute care
- Provision of flexible, good quality post-operative care
- A greater emphasis on rehabilitation, particularly to enhance mobility
- Improved communication between primary and secondary care
- Clear understanding of roles and responsibilities in primary and community care, within the health service and between the health service and other agencies. Avoidance of both duplication and gaps in services.
- Flexible, sensitive and appropriate support for families and carers.

It is unlikely that small hospitals will have it all their own way in cultivating the area at the crossroads of care. 'Patient hotels' and 'Hospital hotels', for example, which are well established in Sweden and being introduced slowly to Britain, will see themselves - to some extent - as being in the same territory as small hospitals. Their focus is upon the provision of postoperative and convalescent care and accommodation for patients having investigations, day surgery or prolonged treatment such as radiotherapy (Davies, 1990; Warner, 1992;

Yarrow, 1992). Glasgow Western Infirmary is building a 64-bed 'patient hotel' and South Glamorgan plan an 80-bed unit in Cardiff. Another interesting initiative has taken place in Doncaster which has a ten bed unit to which community nurses (as opposed to GPs) can admit patients for respite care (Hughes and Gordon, 1992,p.30).

The 'hospital at home' and 'home care' schemes which are being developed around the country may also threaten the viability of small hospitals unless collaborative ventures can be established (Marks,1991). They too are at the boundaries of care between the primary and secondary sectors and between statutory and voluntary agencies. There is good potential here for strong and complementary partnerships if demarcation disputes can be avoided.

Small acute hospitals in the private sector have, in the last decade, been in a different market from those in the NHS. All of them have operating theatres and most are primarily engaged in elective surgery. However, for some while they have been under pressure to diversify their activities. Many of them have now introduced rehabilitation services, particularly physiotherapy, and they are conscious of the need to develop post-discharge services. In the long-stay sector private nursing homes and residential care homes have rapidly filled the gaps in residential services for elderly people and convalescent care which have been left by the public sector. Small hospitals may need to reclaim some of the shorter stay activities from the private sector if they are to progress.

Small hospitals vary greatly in their ability to spot trends and market niches and to respond to them quickly. In some cases the constraints are financial or staffing problems but in others it is a failure of imagination. These hospitals are in a prime position to respond positively and flexibly to virtually all the trends described in the opening paragraph of this section and it is clear from earlier sections that, in many areas, there is the management support for them to do so. The small hospital of the 21st century may be, indeed should be, a different creature from its 19th and 20th century counterparts but it has a key role to play.

9.3 Small hospitals in the marketplace

The introduction of an 'internal market' in the NHS, after the passage of the 1990 National Health Service and Community Care Act, has turned the spotlight onto small hospitals. Their future now depends not so much upon the good (or ill) will of District managers but upon their ability to survive in a competitive market. A much greater responsibility than ever before rests upon the hospitals themselves, and their managers, to define their own role and potential contribution. Business planning and the contracting process have meant that hospitals have begun to sharpen their image and to identify their market niche. At the same time, potential purchasers - particularly Health Authorities and GP fund holders - have given more attention to the question of what services they wish to buy and in what quantity. While the outcome will be painful for some small hospitals it may be preferable, in the longer term, to the patronage or benign neglect which has characterised their relationships within some Districts in the past.

The process of redesignating many small hospitals as NHS Trusts should identify clearly the strengths, weaknesses, opportunities and threats which exist. The culture of small hospitals in many areas in recent years has been one of threat, but the application for Trust status creates the potential for a more confident, aggressive stance which focuses instead on opportunities. Not all hospitals will survive the process, either because of ignorance of what they have to offer or because what they offer is not what purchasers wish to buy. Some will have a considerable task in changing the images which some purchasers have harboured - that they are outdated, anachronistic, low quality and expensive institutions. Nevertheless, they have more power than ever before to determine their own futures and to promote themselves positively.

In the last two years, four particular developments have created opportunities which highlight the need for locally responsive services tailored to individual needs. Small hospitals are well placed to meet these needs.

The publication of the Patient's Charter in 1991 set out nine national Charter Standards on items such as privacy and dignity, access, information, waiting times and discharge

arrangements. Many small hospitals would claim to be meeting these standards already and those which are not should find that, because of the limited size of their organisation and relatively low patient throughput, they have an edge over their larger competitors. The Patient's Charter is designed to empower patients in a number of ways, through better information and more extensive consultation about their service needs. If the consultation process is actually meaningful and feeds through into purchasing plans and contracts, it is almost certain that the pressures in favour of local services and small hospitals will intensify.

The Health of the Nation, which was published in 1992, contains a number of messages and new opportunities for small hospitals if they can respond imaginatively. It emphasises the importance of local developments and local solutions, within broad national guidelines and targets, it underlines the importance of "healthy hospitals" and acknowledges the need to engage with local authorities and voluntary organisations in meeting targets. The small size of hospitals, their intimacy with local populations and their already developed role in health promotion and inter-agency working mean that they have a key contribution to make in meeting Health of the Nation targets. Many small hospitals may find it necessary to reorientate themselves to focus upon 'health', instead of 'health services' and 'ill health', but their local focus and the commitment and enthusiasm of the surrounding community may give them a captive audience which few other health service agencies enjoy to the same degree.

The third recent development which is relevant to small hospitals is the implementation of the community care element of the NHS and Community Care Act in April 1993. This represents both an opportunity and a threat. The threat is that restrictions on Local Authority budgets for the purchase of long stay residential care for elderly people, the decline of Local Authority Part III provision and the volatility of the private sector long stay market may lead to extensive 'bed blocking' throughout the NHS. Small hospitals will need to become light on their feet if they are not to become both victim and cause of bed blocking at other points in the system. Although many small hospitals are designated as 'GP beds', 'medical beds' or 'surgical beds' rather than 'elderly beds', the reality is that many of them are occupied by patients over the age of 65 years. If residential care outside the NHS becomes more scarce, small hospitals may find their role in intermediate care (between primary care and acute hospitals) becomes unsustainable and they will transform themselves, de facto, into

long-stay hospitals for elderly people. On the other hand, their ability to work closely with community staff (both health and social services) and local agencies may avert this situation before new patterns of care become too rigid. The majority of small hospital patients will be discharged to their own homes. Some imagination and resourcefulness will be required to place the rest in appropriate accommodation.

Finally, the shift towards primary care and community care is now being endorsed at both Regional and National level. Since the 1960s most small hospitals have been clear that, despite their anomalous funding situation, they 'belong' to primary care rather than to the acute hospital sector. Some of them are now taking this argument further and redesignating themselves as 'community resource centres', rather than hospitals, providing support for a range of health and social care activities. As 'hospital at home' schemes and similar initiatives in domiciliary care become more common, small hospitals can play an important role as a focus for interdisciplinary working.

The introduction of market forces in the NHS has not been comfortable for small hospitals or for many other health care providers. The contracting process, as it evolves, will almost certainly identify small hospitals which should go out of business, either because they make poor use of resources or because standards are low. On the other hand, those which survive will be strengthened and have a *raison d'être* which may not have been self-evident previously.

10. Three key requirements

The essential messages from this research can be encapsulated very briefly. If small hospitals are to fulfil their potential and play a central role in primary and community care in the next century three key requirements must be met. It is clear from the literature, and from other evidence, that small hospitals only succeed where patient selection by referring doctors and other staff is accomplished skilfully. This involves a clear definition of what the patient needs and what the hospital can offer. The responsibility lies with both doctors and hospitals to ensure a close match. The second key requirement is appropriateness. The services offered in small hospitals should be appropriate to the resources available, in relation to both staffing and facilities. Small hospitals will not succeed if they promise - or attempt - too much, but nor will they succeed if they lack the imagination to do more of the things which they are poised and equipped to accomplish. Third, it is clear from this and other research that the active support of General Practitioners is necessary for small hospitals to flourish. At a time of fragmentation and diversification in general practice this cannot be guaranteed, but it is an essential ingredient if small hospitals are to play their part in the primary and community health services of the future.

Appendix 1

THE FUTURE OF SMALL HOSPITALS
IN BRITAIN

*supported by
King Edward's Hospital Fund for London
and the
Milbank Memorial Fund, New York*

**Joint Health Policy Review
Hospitals and Health Services
into the Next Century**

ID No. _____

1. In your opinion what is the minimum number of beds required for a viable in-patient, acute hospital? (Please circle)

6 Beds 10 beds 20 beds 30 beds 40 beds 50 beds Other _____

2. Which of the following services are, in your opinion, essential services that should be maintained in a small hospital? (Circle all that apply)

- | | |
|-------------------------------|---------------------------------|
| 1. Birth/Labour/Delivery Room | 10. A and E Department |
| 2. Ultrasound | 11. Pharmacy |
| 3. ITU | 12. AIDS In-patient care |
| 4. Orthopaedic surgery | 13. Outpatient surgery |
| 5. Outpatient services | 14. Primary health care nursing |
| 6. Convalescent care | 15. Respite care |
| 7. Physiotherapy | 16. CT scanning |
| 8. Speech therapy | 17. Pathology |
| 9. Diagnostic X-Ray | 18. Other _____ |

3. What are the greatest barriers or problems facing small hospitals today?

4. What will those barriers or problems be in the year 2000?

5. Do you think that the successful small hospital in the future will be:
(Circle one)

1. A diversified, independent hospital that provides a wide range of services on site
2. A member of a group of small hospitals with common management
3. Part of a health care system centred in larger hospitals
4. Other _____

(Please explain)

6. **What do you feel Doctors working in small hospitals expect from them?**
(Please rank your selections, with 1 being the highest)

- ___ (a) Collegueship
- ___ (b) The opportunity to earn additional income
- ___ (c) A place to provide continuity of care
- ___ (d) A place to maintain clinical skills
- ___ (e) Access to more complex diagnostic tests
- ___ (f) Other _____

(Please specify)

7. **What should local communities expect from small hospitals?**
(Circle one)

1. High technology care equivalent to a general hospital
2. Quality care with some limitations on available technology
3. A more personal environment with reasonable quality.
4. Short term care or a different level of care with appropriate referral to a large in-patient facility
5. Other _____

(Please specify)

8. Either a) **If you are a purchaser, what kinds of services do you expect to buy from small hospitals in the next 5 - 10 years**

- or b) **If you are a provider, what kinds of services do you expect to sell from small hospitals in the next 5 - 10 years.**

**9. Who do you think is the key actor for change in small hospitals?
(Circle one)**

- | | |
|------------------------------|--------------------------|
| 1. District Health Authority | 4. Department of Health |
| 2. Regional Health Authority | 5. General Practitioners |
| 3. Trust Board | 6. Local Community |
| 7. Other _____ | |

10. Do you think that the importance of the small hospital to the local community extends beyond the provision of health care? If so, please say how.

11. Do you wish to add any further comments about the future of small hospitals?

Thank you for your assistance in filling in this questionnaire

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