Proc. R. Coll. Physicians Edinb. 1998; **29**:432-434

Book of the Quarter

HOSPITAL POLICY IN THE UNITED KINGDOM

Anthony Harrison and Sally Prentice, Transaction Publishers. 1998, pp 229

I. A. D BOUCHIER,* 8A MERCHISTON PARK, EDINBURGH EH10 4PN

The 1962 Hospital Plan for England and Wales, with appropriate modification for Scotland and Northern Ireland, was the first attempt by central government to outline an acceptable standard of hospital services across the United Kingdom. The plan proposed the creation of District General Hospitals (DGH) which would serve communities of between 100,000 and 150,000 people and which would accommodate a wide range of clinical services on site. Also included in this blueprint were provisions for a higher tier of hospitals with wider catchment areas providing such specialties as neurosurgery and radiotherapy, and a category of smaller hospitals in the more sparsely populated and isolated parts of the country.

Since then a number of reports and documents on hospital provision have been published but, after 1980, government has published no general statement about the form and content of District General Hospitals: Regional Health Authorities have been left to form their own strategies. Inevitably, therefore, the present pattern of hospital provision is very different from that anticipated in 1962. In *Hospital Policy in the United Kingdom* the authors (Anthony Harrison, who has extensive experience in government, and Sally Prentice, an economist) attempt to answer two questions: is the concept of the DGH still valid? and if it is, how should the DGH relate on the one hand, to the more specialised hospitals which provide a 'tertiary' service and, on the other, to primary care and other community services?

The authors have set themselves a difficult quest for a variety of reasons which become apparent to the reader, who is left to decide whether the authors have answered the questions posed. I suspect that clear answers are not given because there are too many variables and unknowns for there to be an all-encompassing and universally applicable blueprint for a DGH. Inevitably, reliable methods are lacking to assess critically and to measure the quality of hospital care; seductively simple indices such as crude mortality rates or waiting lists are of limited value and are too readily liable to political manipulation, while Health Technology Assessment (HTA), which promises much, is poorly understood by many and consequently is often used incorrectly. The latter discipline has yet to make an impact on hospital services and it remains to be seen whether HTA will deliver the long-awaited reduction in hospital costs.

Despite the book's title, the authors have confined their assessment to the DGH service in England and Wales claiming, probably correctly, that the hospital service which is in operation in Scotland is broadly similar. They do, however, make use of Scottish hospital statistics. A constant theme is a lament for the lack of firm, critical data that relate to the structure, function, use and role of DGH. Therefore, Harrison

*Emeritus Professor of Medicine.

and Prentice are forced to rely heavily on information derived from the North American health care scene with all the hazards that this extrapolation introduces; they also frequently refer to the strategies developed in Oxford and South East Thames.

Unfortunately much of the information that is available is conflicting and this undoubtedly reflects the diversity of the service, the varying practices of the medical and surgical specialties as well as demographic and social variations. Many of the current concepts of the provision of medical care in general, and the hospital service in particular, also reflect the philosophy of the recent Tory administration, and the authors base many of their arguments and predictions upon attitudes prevailing during the first half of the 1990s. Times have changed! Britain is now under a 'New Labour' administration which has yet to make much of an impact on the NHS, but the 'purchaser-provider' concept has already been revised, the philosophy of an 'internal market' is being reassessed, hospital trusts are being amalgamated, general practice fund-holding has been abolished, and many other new, subtle influences are being brought to bear on the NHS.

Despite these difficulties, *Hospital Policy in the United Kingdom* serves a useful function in providing a thoughtful, carefully argued and wide-ranging analysis of the many and varied influences which are brought to bear upon the DGH, and determine their possible form and function.

Intuitively, it might be thought that the DGH would have a tactical advantage by providing a clustering of services - (scope) with an appropriate medical staffing - (scale). However, when the available evidence is reviewed, there is no simple relationship between scope and scale, and the quality of services provided. For example, there is evidence to suggest that concentrating vascular surgical services in a few centres leads to better outcomes; but an analysis of data for 'cure' rates of breast and colon cancer surgery gives conflicting results with no undisputed advantage being shown to be enjoyed by the larger units. What emerges is that the quality of a service frequently depends more on the individual clinician and his/her team than on the scope or scale of the hospital base. It is worth reflecting that most of the studies have covered the surgical services and there is little information relating to the outcome of care of complex non-surgical problems.

The cost of the service and the access of patients needs to be considered when deciding on the function of a hospital. It might be possible to disperse a wide range of hospital activities around smaller hospitals or even into primary care (general practice) or other community-based services, but it is not established whether this would be advantageous for either incurred costs or patient access. However, concentrating services on one site is not necessarily cheaper and might also lead to difficulties in access (such as the costs and time taken for patients to reach the hospital). Regrettably, many hospital planners and local authorities do not take patient access into their planning considerations. The basic requirement for motor car accessibility is often ignored, despite the fact that most patients and visitors will travel to hospital by car, though the inevitable lack of parking on hospital premises and public transport routes do not always relate conveniently to the hospital.

The acute general hospital should provide three main functions: emergency care, elective surgery and outpatient consultations. The authors acknowledge the difficulty of identifying minimum costs or highest quality care for all these elements, they accept that different specialties will serve different categories of patient and thus there will be clustering and concentration of work, staff and patients within a hospital. Furthermore, Harrison and Prentice accept that it is not possible to determine the combination of

specialist services which would form the ideal template for the acute hospital in the twenty-first century.

The increased pressures on the DGH, for example, the unremitting increase in emergency hospital referrals and admissions, the introduction of new diagnostic and therapeutic technology, and the wider roles given to nurses and laboratory technicians, all pose new challenges to the medical staff. The Audit Commission Report of 1995 is highly critical of many of the current practices of hospital doctors, particularly of senior staff, and demands that changes must be made to ensure that the work and training of junior staff is even more efficient. The full impact of the Calman Report (1993) remains to be experienced, but it is already abundantly clear that work practices in hospitals must change: more flexibility is essential, consultants should undertake work previously performed by juniors, and more time should be devoted to teaching and supervising training of junior doctors. This is all very well, but most consultants are already fully extended under the present system, which now includes a newly-introduced load of administration. It is easy for the authors to claim that 'the scope for competitive response through innovation is large', but there will be many who fear that in the process the more subtle aspects of undergraduate and postgraduate training will be sacrificed, sound traditions of high-quality practice will be eroded, group loyalties so essential for an effective service will be lost and, importantly, the fundamental influence of the role-model in medical training will disappear. Medical education has evolved from a rigid system based on a teaching hospital to one which now directly involves the DGH as well as primary care and the community services. Inevitably this trend will influence how the DGH functions.

It is now common knowledge that despite, or possibly because of, changes in primary care, emergency referrals to hospitals have increased steadily. Harrison and Prentice believe that the reasons for this have been insufficiently researched. It is easy to blame disinterested or ill-trained general practitioners, but it is also possible that a highly-trained primary care workforce alerted to the potential for early diagnosis or therapy will refer more and not fewer of their patients to the DGH, resulting in better care albeit at increased cost.

Changes in demography and patterns of disease, varying access to hospitals, differing patient preferences, rapidly evolving technologies, pressures on medical and nursing training programmes - all of these and more must impact on the function of the DGH. It comes as no surprise that Harrison and Prentice conclude that it is impossible to predict the future role for the general hospital and perhaps this is the most important message of their book for planners.

Hospitals are complex social organisations which are inevitably subject to evolutionary pressures. These will be both internal, such as the variety of services that can and should be offered or the aspirations of staff; or external, for example demographic, social and political. As with any evolving system it would be foolhardy to predict the future shape of the hospital service. The AIDS outbreak, the re-emergence of tuberculosis which is often multidrug-resistant and the burgeoning demand for interventional cardiology services demonstrate how hazardous it can be to predict service demand. Perhaps the planning principle that should be adopted is an acceptance that there can be no one blueprint for all DGHs; rather any programme should be simple and flexible, permitting a hospital to adapt and change according to its particular environment and catchment area.