Best Buy Hospital

These considerations underlay the Best Buy Hospital, which was introduced on the basis of an acute inpatient provision of two beds per 1,000. It was assumed that patients would stay a minimum of time necessary in hospital and that there would be full supporting services in the community.

Almost independent of the community services, the South East Thames Regional Health Authority has introduced an acute bed norm based on 2·4 beds per 1,000 population for the region as a whole. Within this breakdown, however, an age specific norm had been calculated for each specialty which takes into account the national discharge rate for each age group and also their mean duration of stay. It was also assumed that there would be a mean turnover interval of 2·2 days apart from those specialties in which the national turnover interval is already less than that—that is, gynaecology and dentistry, where the figure of 1·8 was used.

For mental handicap the Cmnd. paper[6] recommended specific provision for both hospital inpatients and local authority places. The South East Thames Region[7] has proposed that the run down in the hospital inpatient provision from 15·3 beds for children and 93·7 beds for adults per 100,000 population to 13 and 55 places, respectively, will coincide with the proposed build-up of the local authority services—from 5·6 places for children and 14·5 places for adults to 12 and 75 places respectively in the community per 100,000 population.

One could also argue that in the geriatric service and the services for the mentally ill and psychogeriatric cases, similar account should be taken of the community day and residential service in calculating the number of inpatient beds required. Unlike the position with acute beds there has been very little change in the last few years in the discharge rate and duration of stay in geriatric accommodation. Only a very small proportion of the elderly population are in inpatient accommodation at any one time, and perhaps resources would be better used not to increase the inpatient provision but rather the day patient and community services.

In providing maternity beds there are even greater difficulties. Ideally these should be based on the fertility rate (the number of births per 1,000 women between the ages of 15 and 44). Nevertheless, like the crude birth rate, even this is changing dramatically, while there have been considerable changes in the pattern of stay in maternity cases. Even allowing for every woman to be confined in hospital and considerable seasonal fluctuations, there is still much spare capacity in the country.

One aspect of the more efficient use of hospital beds that is often discussed is the development of day hospitals and day surgery facilities. But it must be remembered that a secondary effect of the development of these services is to increase the level of dependence of those patients that require admission. Every inpatient will then be at the level of either medium or high dependency and therefore many more nurses will be needed for any given bed than when there were also some low-dependency patients in the wards. Hence it will become more difficult to run efficiently the same number of beds.

Will this continual trend in the reduction of beds affect the quality of care for patients? Probably not—certainly as regards acute beds. A study in Finland[8] has shown that regardless of the number of beds that are available urgent cases are still admitted to hospital at the same rate. Since available hospital beds will always be used, a ceiling must be set if the other aspects of health care are to develop properly. Too often admitting a patient to hospital has been used because the services are deficient elsewhere.

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What Could the G.P. Treat at Home—with Proper Support?

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Despite the Government's good intentions the proportion of money spent on general practice has gradually fallen over the years, while hospitals have taken an increasing share of N.H.S. funds. Since general practitioners and their teams cope economically with 90% of an illness in the community it is difficult to see what large savings they could effect. Nevertheless, many practices give some of their time each week to non-practice matters—such as clinical assistantships, industrial appointments, etc. Some of these jobs are essential to the community, but they should always be allowed for when assessing the total practice work load and not be undertaken to the detriment of patients under care. Practice audits will guide doctors in the best way to apportion their time. Since the reorganization of general practice there have been several assessments of work loads by general practitioners confining their scope to primary care. These have shown the possibility of larger work loads than were formerly considered consistent with good practice. If this pattern continues it would seem wiser to give general practitioners more support to treat cases at home than to increase list sizes.

Without any major changes the general practitioner could at present cope with most of the follow-up of patients discharged from hospital. He should be the doctor of first contact in almost all casualties. Now that the principle of item-of-service payments is becoming more acceptable much minor surgery and other procedures could be done on this basis. Doctors must be encouraged and expected to complete medical assessments of most patients themselves with the good access to diagnostic facilities now enjoyed by most practitioners. When asking for specialist advice or admission to hospital they should be more critical of what they can expect. Such changes in attitudes and skills are expected from vocationally trained general practitioners if their training is to mean anything. Badly trained, they will increase rather than decrease demand on the hospital services.

What is needed is careful community studies of projected forms of treatment before expensive facilities are provided. We have seen this done in Cleveland during the last few years, in myocardial infarction, surgery of hernias, the care of stomata, and family planning. Local management teams should insist on such evidence and ensure they get value for money. For example, our community survey on myocardial infarction in Cleveland showed that many cases could be kept safely at home.[1] It was then possible to plan what was necessary and practicable in terms of community care.

The general practitioner's team is gradually being increased in size, and, used wisely, is adding to the quality of primary care. A serious omission is the lack of provision for nursing or "guardian care" for patients who need more than a few minutes attention each day. Many hospital admissions could be averted if the general practitioner had more substantial support and could call on members of his team to give this care.

More facilities for general practice mean proportionately less for hospitals no matter how the sums are done. This makes sense only if priorities are evaluated on a community basis.

[1] To be published.

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Can the Community Cope with Patients Discharged Early from Hospital?

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As a consultant psychiatrist my brief must be the consideration of early discharge of *psychiatric* patients. I would like to beg the question at the outset by asking "Do we need to admit patients to hospital?"