Making a virtue of necessity

After reading Hospital Services: the Future Pattern of Hospital Provision in England, health authorities may not be much the wiser about what to do with the plans for their long-awaited 800-bed district general hospitals. The paper, recently issued by the Minister for Health, Dr Gerard Vaughan, marks an official move away from the concentration of hospital services on to one site that started with the Hospital Plan of 1962 and developed throughout the 'sixties. It proposes that centralisation should now give way to dispersal “to allow for the retention of a wider range of local facilities.”

Though Hospital Services is officially a consultation document, Dr Vaughan has already reviewed 66 plans in the light of it (he approved 50). Indeed, in announcing his paper, Dr Vaughan seemed unsure whether it represented a major change in policy or merely a sensitive tinkering to reflect the financial climate and current disinclination with large institutions. The policy of the ‘sixties has not in fact produced great concentration: many district general hospitals are a mixture of old and new buildings on several sites, over half of England’s hospitals have fewer than 100 beds, and only about 30 general hospitals have more than 800. Health authorities have had to modify plans for centralised hospitals (or never made them) simply because the money never matched their aspirations.

The arguments against large hospitals and in favour of small ones outlined in Dr Vaughan’s paper will be familiar to those who have tried to close small hospitals in the face of local opposition: large hospitals are expensive to run, difficult to manage, hard to get to, and impersonal; smaller hospitals are easier to staff, more personal, easier to get to, and derive more support from their community. While emphasising the need for different patterns of service to meet different needs, the paper specifically recommends a main hospital of 450 to 600 beds (with a further 200 or so in teaching hospitals or for regional specialities) with an accident and emergency service, medical and surgical beds, the children’s unit, some maternity beds, a small psychiatric unit, and 30% of the geriatric beds. Local hospitals might provide geriatric and psychiatric services, some outpatient clinics, day surgery, and a casualty service “preferably run by general practitioners.”

Hospital Services acknowledges that a review of policy was necessary for financial reasons—health authorities will have to maintain existing facilities because there is little capital to reorganise them—but it does recognise some of the difficulties of dispersal. These include the expense of running two hospitals rather than one, the greater costs of medical staffing, and the problem of deploying and training nurses: “Such a policy could therefore result in a lower overall quantity of clinical service for a given level of revenue than would be possible with a more concentrated service.” Such a policy is unlikely to be welcomed by authorities trying to maintain levels of service with less money than before. At best Dr Vaughan’s paper merely recognises what health authorities are already doing in the face of lack of capital and delayed plans. At worst it is a dishonest response to the real problem of hospital provision in England: a persisting lack of capital investment in the NHS.

Genital herpes

Genital herpes has recently been described as the most important sexually transmitted disease. It has a higher prevalence than other sexually transmitted diseases and a tendency to recur; we have no effective treatment or vaccine; and there is an association between recurrence and sexual problems and a link with subsequent carcinoma of the cervix. Sexual transmission can take place in the absence of symptoms or signs, and a baby may be infected during delivery, sometimes with catastrophic results, though this seems to be a more of a problem in the United States than in Britain.

Gardner found that genital herpes accounted for 13-5% of cases of all sexually transmitted disease in his private practice in Houston, Texas. Figures for Britain are hard to obtain: only the cases seen in clinics for the treatment of sexually transmitted diseases are notified, and many must be seen elsewhere without notification. One survey suggests that in about 60% of cases notified from these clinics the diagnosis is soundly based on clinical observation supported by the results of viral culture; but in units such as dermatology and gynaecology departments the diagnosis is less likely to be supported by the results of viral culture.

Genital herpes was first noticed as a separate disease by the sexually transmitted disease clinics in Britain in 1971, when 3671 new cases were recorded, or 12.2 per 100 000 population. By 1976 the total had doubled, to 7547; and by 1978 the provisional total was 8957, or 28.8 per 100 000 population. The disease is now about twice as common as syphilis, for which the provisional number of new cases (of all forms) was 4802 in 1978. Genital herpes is thus much commoner than primary syphilis, from which it must be differentiated; the clinics report about one fresh case of primary syphilis