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LONDON HEALTH SERVICES RESEARCH GROUP

London's health services in the 80s

LONDON'S HEALTH SERVICES IN THE 80s

Part 2

Edited by MARK McCARTHY
Senior Lecturer, Department of Community Medicine,
University College Medical School, London WC1

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Jane Jackson is Specialist in Community Medicine, City and East London Area Health Authority.

Ceri Davies is Assistant Chief Architect, DHSS.

Jeannette Mitchell is Secretary, Brent Community Health Council.

Helen Rosenthal is Courses and Training Organiser, Community Work Service, London Voluntary Work Services.

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PSYCHIATRIC SERVICES IN LONDON

Jane Jackson

Nearly one tenth of the total population can expect to be admitted to a mental illness hospital or unit at some time during their lives. Shepherd[1] estimated that 14% of people on practice lists would consult their GPs at least once during a year for psychiatric disorders. Many more attend doctors with emotional problems or psychosomatic ills. In 1976 over 45 million prescriptions for psychotropic drugs were dispensed.[2] About 30 million working days are lost a year through mental disorders in Great Britain and many more because of more vaguely defined symptons like debility. There are one million people with mild mental handicap and 160 000 who are severely affected. About 10% of school children have some degree of emotional maladjustment or behavious problems, and Rutter[3] suggested that in inner London 17% of school children aged 10 - 11 years were so disabled. A Newcastle study found that 6% of elderly people living at home suffered from dementia and a further 22% had moderate or severe psychiatric disorders.[4]

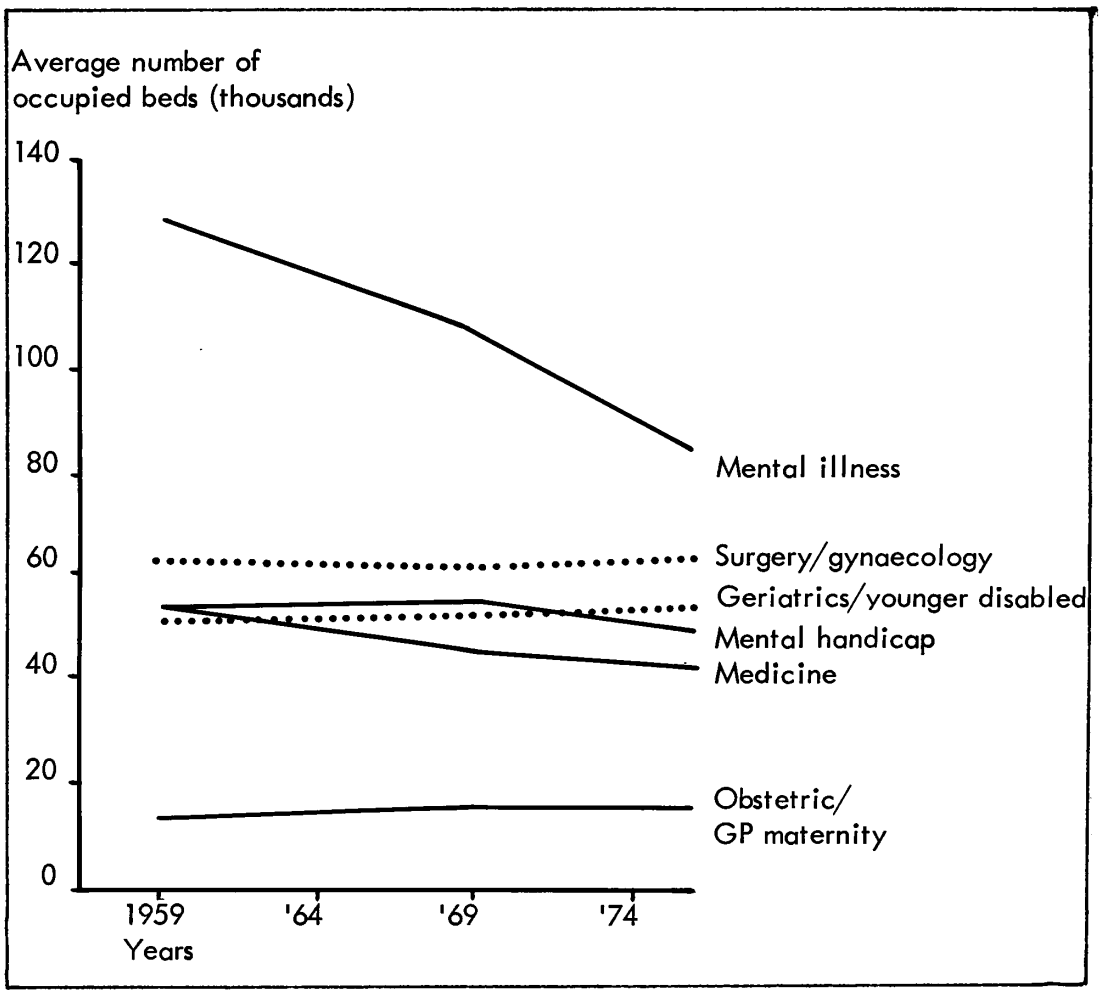
These few statistics serve to remind us of the extent of mental illness and mental handicap amongst us. Given that a large proportion of these problems may be amenable to treatment, how well do our psychiatric services provide for primary and secondary prevention, primary care, specialist care and rehabilitation? Are the services available in London appropriate to London's problems? And what should the future pattern of care be?

There are more hospital beds in Britain for mental illness than any other speciality (Figure 5.1). At any one time 45% of all hospital inpatients are in mental illness or mental handicap hospitals (Figure 5.2), yet only 11% of all hospital consultants are psychiatrists and only 9% of all medical staff work with the mentally ill or handicapped.

Furthermore, while in non-psychiatric hospitals there are on average 122 nurses to 100 patients, in mental illness hospitals there are on average 55 nurses to 100 patients, and only half of them are qualified (Table 5.1).

FIGURE 5.1

NHS HOSPITAL BED USAGE
England 1959-76



Many GPs have no special training in psychiatry. Care is offered to mentally ill and mentally handicapped people from a wide and bewildering selection of formal and informal agencies, many of which overlap or have opposing objectives. It may be pure chance which agency is involved, for instance, in the assessment and treatment of disturbed adolescents; and those with severe problems may not necessarily get the best or most appropriate help.

FIGURE 5.2

NHS HOSPITAL SUMMARY - GB 1975

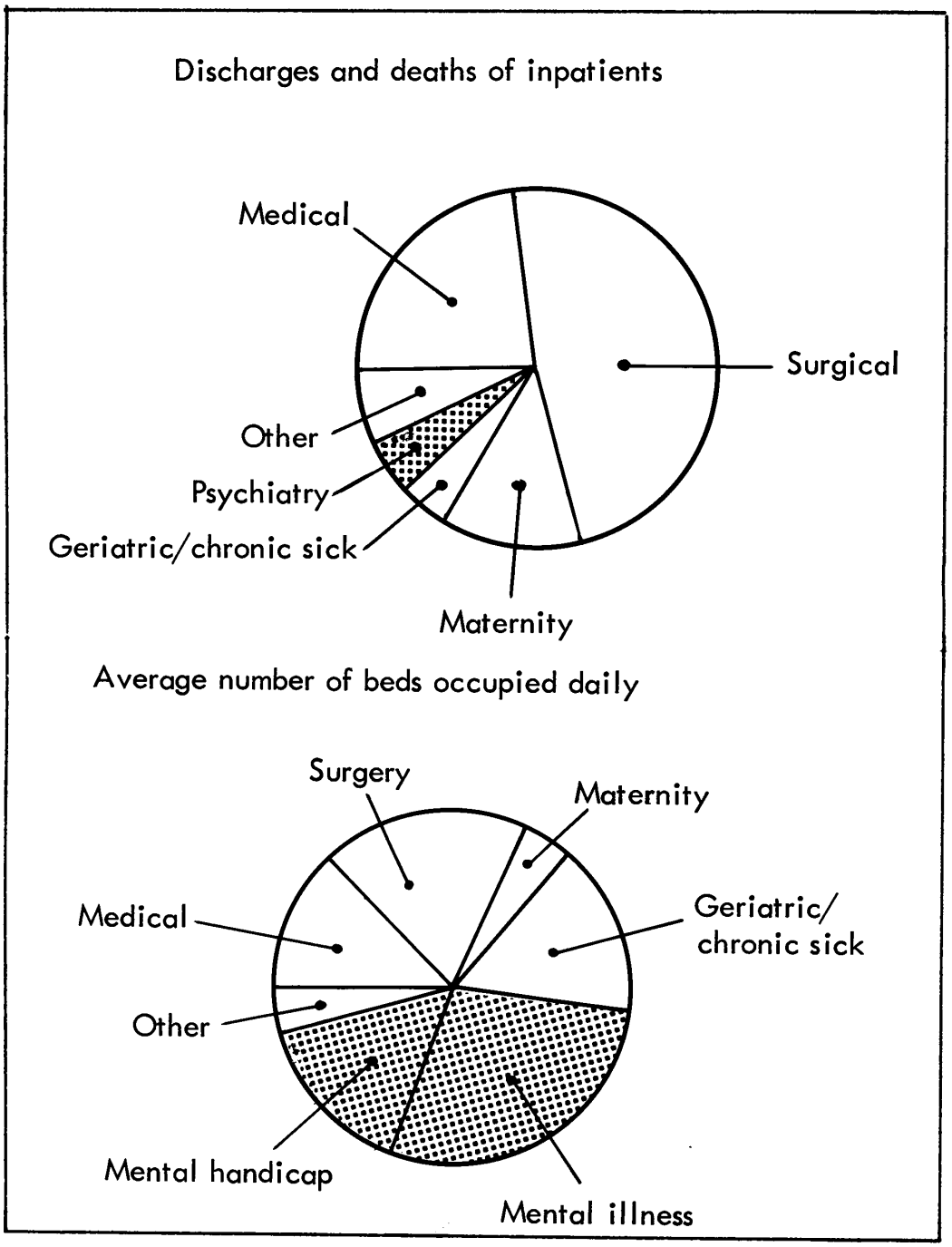


TABLE 5.1

STAFF/PATIENT RATIOS IN CERTAIN MENTAL ILLNESS HOSPITALS (200 OR MORE BEDS) – 1975

PER 100 RESIDENT PATIENTS

HOSPITAL	CONSULTANTS AND OTHER PSYCHIATRIC MEDICAL STAFF	TOTAL NURSES
Horton	1.16	38.3
Shenley	1.10	48.3
St. Bernard's	2.15	40.0
Friern & Halliwick	4.59	57.6
Bethlem & Maudsley	26.79	113.0
NWTRHA average	3.37	49.8
NETRHA "	4.28	55.0
SETRHA "	3.22	57.0
SWTRHA "	2.64	46.1

There are many strange anomalies in the supply of NHS services to mentally ill or handicapped patients, most of them due to historical reasons. In the 18th century bizarre behaviour was tolerated in general in the mainly rural society. Few people required institutional care and most of these were expected to get better and return home soon. Institutional care was in private madhouses run for commercial gain or in charitable hospitals and, later, in the country asylums where "the shattered bark might find the means of reparation and safety". After 1845, however, large boroughs and counties were obliged to build hospitals for their public and while general hospitals were built in the centres of population, mental hospitals were sited out in the country-side, of very large size because that was economically most viable. They became self-contained communities where many patients lived full and busy lives, working in the hospital farm, the laundry or the kitchen, remote from their families and homes.

It was only after the last war that this changed and smaller local district hospital units and community services were developed, helped along with the use of drugs like chlorpromazine, Modecate and Depixol,

which could help people manage at home without long stays in hospital. The change was also assisted by studies such as those of Goffman[5], Morris[6], and Wing and Brown[7] showing the damaging effects of institutionalisation, as well as by public concern about patient care in places such as Ely hospital.[8]

We are still left with a pattern of major hospitals in a ring around London serving city population many miles away, so that catchments may be very complicated (Figures 5.3, 5.4) and the relative supply of hospital beds is distorted (Table 5.2).

FIGURE 5.3

SITES OF MENTAL HOSPITALS
over 400 beds serving London

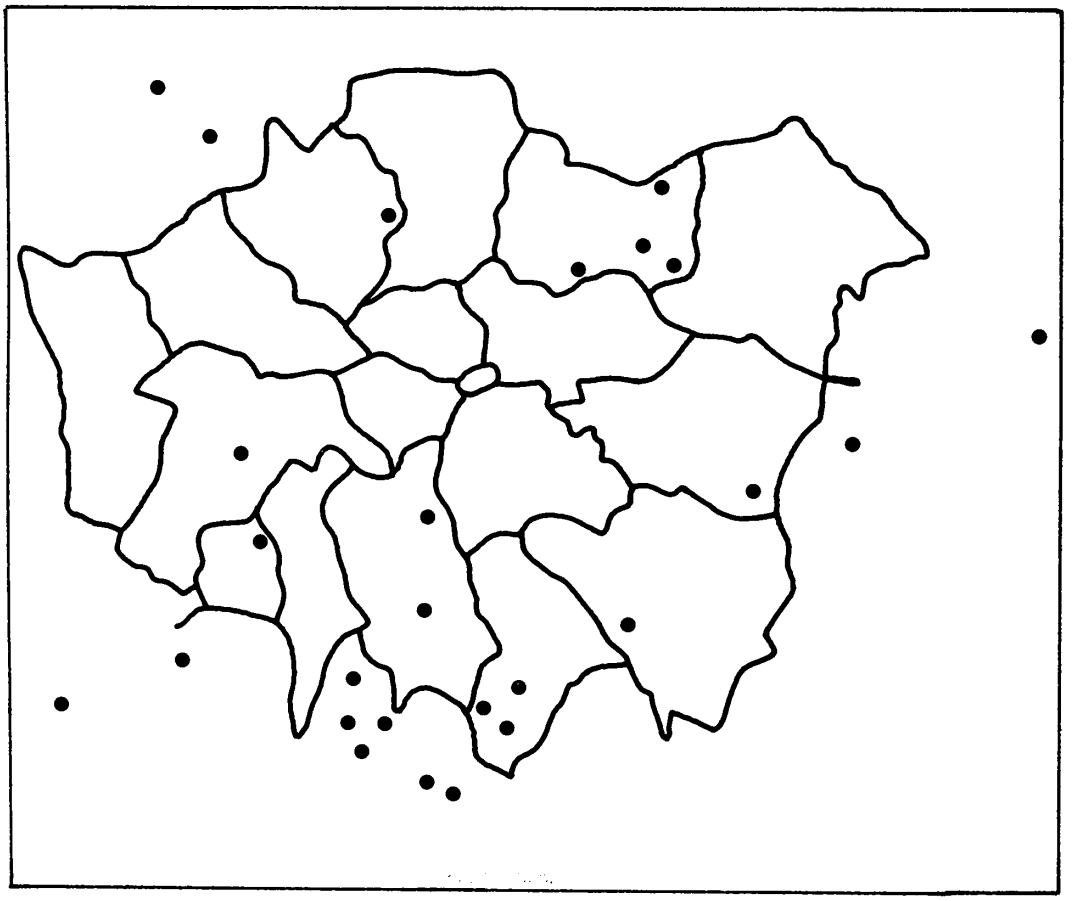
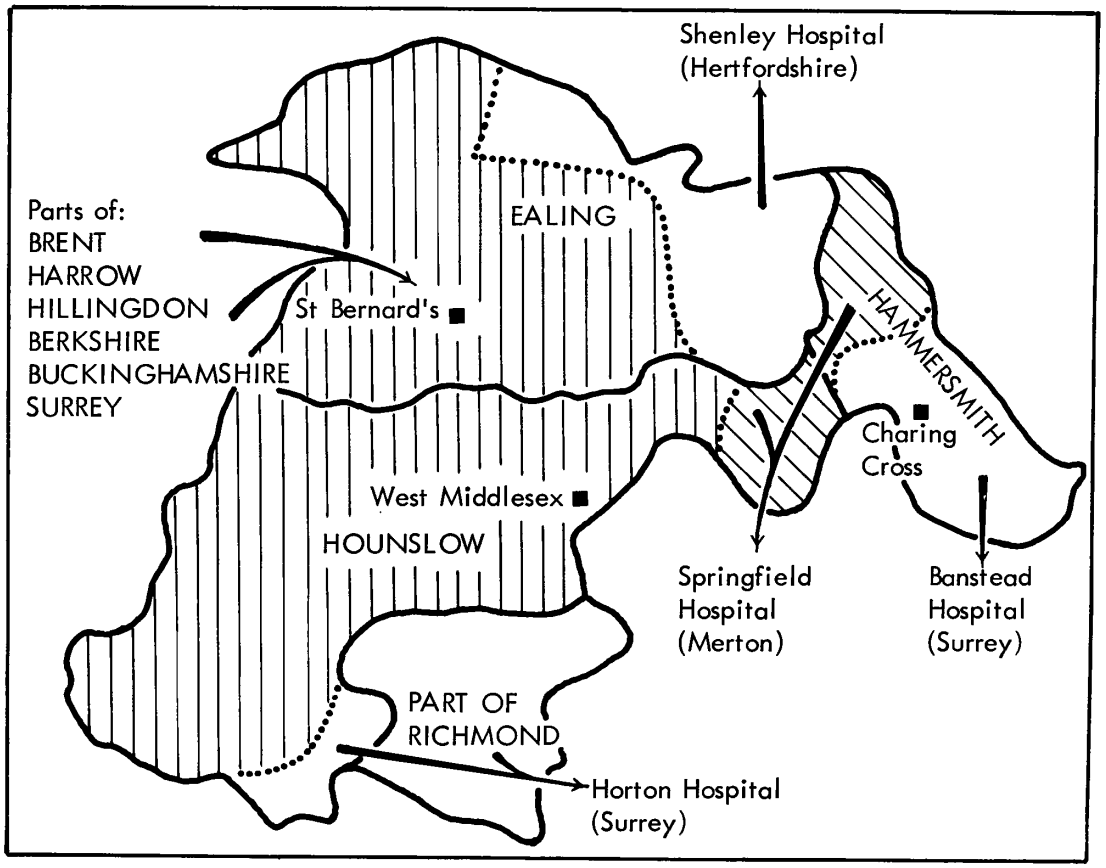


FIGURE 5.4

CATCHMENTS FOR MENTAL ILLNESS HOSPITALS
Ealing, Hammersmith and Hounslow AHA (T)



This has led, however, two districts in City and East London that have no access to beds elsewhere to develop relatively efficient and effective local services, based on one small mental hospital and on a unit in a general hospital.

Does the ring of peripheral hospitals fit the needs of London's population? After all, there has been a marked shift of people to outer London over the last decades. But there is no evidence that people in outer London use the hospital services more. Indeed, admission rates to mental hospitals of outer London residents are lower than for inner London residents (Figure 5.5).

TABLE 5.2

AVAILABLE BEDS BY SPECIALTY (%)

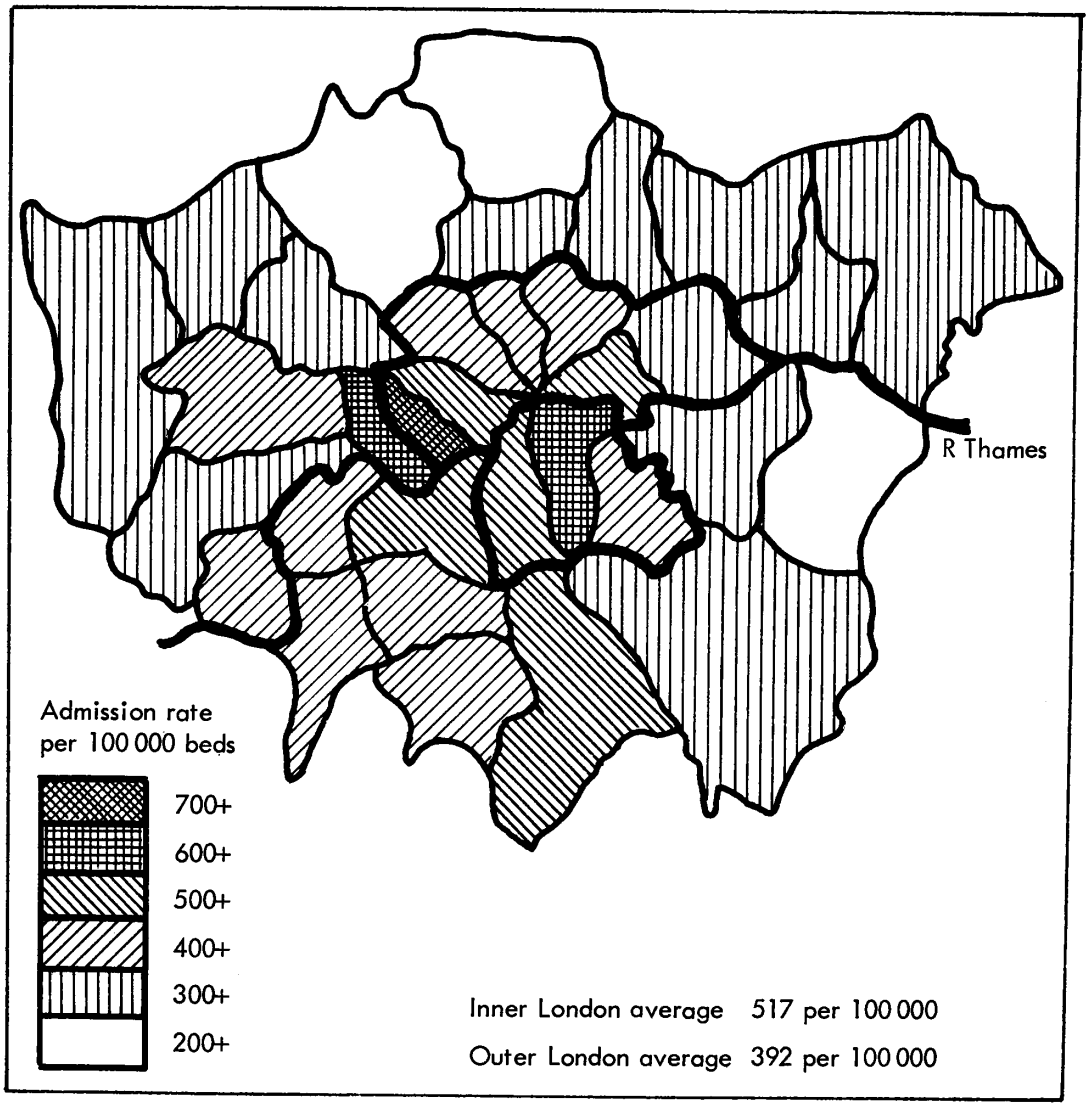
SPECIALTY	ENGLAND 1966	NETRHA 1976	CITY/E L.AHA 1978
	%	%	%
Mental Illness	25	23	6.5
Geriatrics	15	14	15.0
Mental Handicap	14	9	1.0
General Surgery Trauma & Orthop. E.N.T. Other Surgery	18	20	32.0
General Medicine Paediatrics Chest Diseases G.P. Medical Other Medical	16	20	29.0
Obstets/G.P.Mat. Gynaecology S.C.B.U.	9	10	12.5
Pre/Convalescent All other.	3	4	4.0
Total No. of Beds	379,600	31,830	4,736

Perhaps despite this, are there more stresses and strains on people living outside than in the centre of London? This is difficult to judge because mental disorder or distress is associated with all aspects of life, such as family, housing, employment, ill-health or disability, poverty, growing up, separation or bereavement. However, Table 5.3 shows that there is variation in rates between inner and outer London for certain features which may have significant effects upon mental health.

It does not seem likely that the present pattern of care, with the main repositories of NHS psychiatric services in large country hospitals, is the most appropriate one. The London Regional Health Authorities have committed themselves to running them down and building up local

FIGURE 5.5

ADMISSIONS TO MENTAL HOSPITALS AND UNITS
by area of residence 1975



services, though some more wholeheartedly than others (Table 5.4, Figure 5.6). What effect will this have? Copas and others[9] compared treatment settings in a large hospital in Essex with a small unit associated with a DGH in Southend and found little difference in outcome or satisfaction with care, the main problem being access to the relatively isolated large hospital.

TABLE 5.3

VARIATIONS BETWEEN INNER/OUTER LONDON

FACTOR	AHA with Highest Rate	Inner London	Outer London	England & Wales
Population density (persons/hectare 1977)	KCW 110.2	86.0	36.7	3.3
Sulpher Dioxide (mcg/m^3 av-Oct 76-Mar 77)	KCW C/EL 163	132	89.0	N.S.
% Overcrowding (1½ p.p. room 71)	KCW 6.93	5.0	1.99	1.4
% Single person households (71)	N.S.	29.3	19.3	18.2
% Born ex - U.K. (71)	KCW 34.0	20.6	12.9	6.2
% illegitimate births (76)	L.S. Lew. 21.6	19.5	9.9	9.2
Children in care (/1000 pop. 0-14 78)	N.S.	24.3	9.8	9.5
Infant mort.rate 1975-77)	C/EL 17.8	16.4	13.8	14.4
Admission rates to mental hospitals (/100,000 pop.'75)	KCW 636	516	392	378
Deaths from suicide etc.(100,000 pop.'77)	KCW 44	19	13	12.0
Indictable offences (100,000 '76)	N.S.	111.5	46.2	43.5

FIGURE 5.6

NHS PSYCHIATRIC HOSPITAL BEDS
NET RHA 1971-78

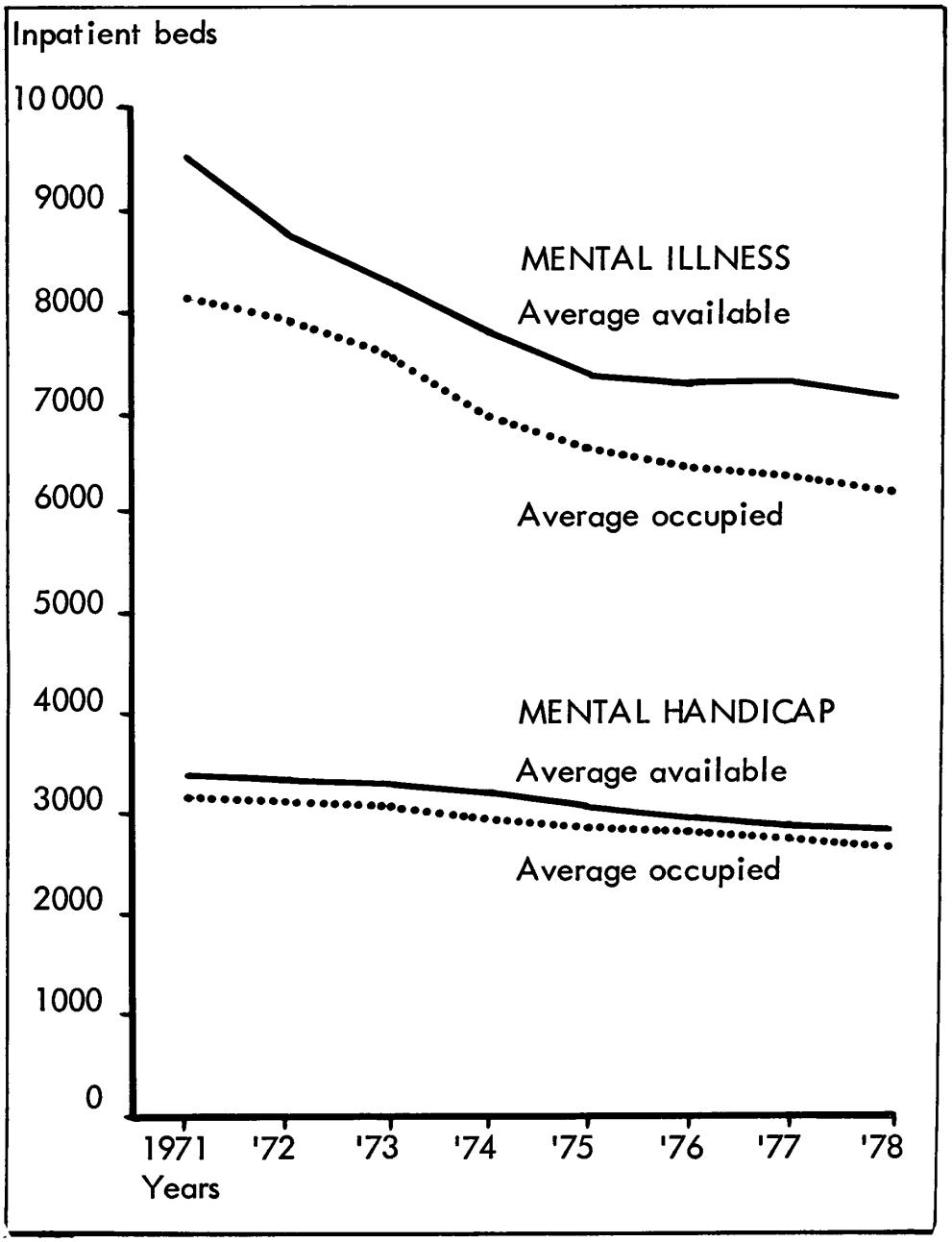


TABLE 5.4

MENTAL HOSPITAL/UNITS
By size and number of patients
NWTRHA 1971-76

MENTAL ILLNESS			
1971	7 large 9 small	(626 – 1820) (5 – 71)	total patients C 9000
1976	7 large 21 small	(484 – 1455) (6 – 65)	total 7190
MENTAL HANDICAP			
1971	4 large	–	total 4543
1976	4 large 2 small	(355 – 1479) (21,65)	total 3894

Abrahamson's recent study[10] of long stay patients in Goodmayes suggests that at least one third are suitable for alternative accommodation, and others might be so after a period of rehabilitation. He thinks that a substantial proportion of the rest, however, are likely to require active treatment, specialist nursing care or supervision in something like the present hospital setting, though for many of them it could be in flats, hostels or group homes developed on campus. Many of these people have been in hospital for a number of years and a large proportion are elderly. Others have suggested that fairly large back-up hospitals will always be required and that specialist units could also be sited there, staff rotating between them and the District units. Many inpatients are likely to have been in hospital for a long time and to be elderly (Table 5.5). For elderly severely mentally infirm people a World Health Organisation report stated:

> . . . . . the size of the problem of mental health among the aged and the rate at which it is growing make it impracticable to consider in terms of hospital beds the care of even the small

> fraction of cases who become infirm or sick or who belong to the marginal group that hovers between sickness and health. But, even if there were an abundance of places, the old person is, as a rule, better off in his own home, unless illness or serious infirmity afflict him. It is both expedient and humane to maintain the aged person in the community or, if he breaks down, to treat him promptly and return him there before his social roots have been finally severed. The emphasis on social environment as a factor in mental health is growing, and so is the realisation that uprooting an individual may be as important as illness in the long run, in impeding his return to the community.

Psychogeriatric patients in hospital may be distrubed, aggressive, subject to persistently confused behaviour or to dangerous conduct at home, or incontinent. Similarly, many people still living at home may have problems as severe as these. Local community health and social services support has to be increased along with hospital day care or short term admissions as required.

TABLE 5.5
LONDON MENTAL ILLNESS HOSPITALS AND UNITS 31.12.75

REGION	IN-PATIENTS		RATE/1000 home pop.		% IN 5 + yrs		% AGED 65+	
	M	F	M	F	M	F	M	F
N.W.T	3609	4696	2.13	2.64	55	50	28	56
N.E.T.	2820	3909	1.56	2.04	56	47	30	58
S.E.T.	2618	3712	1.52	1.97	50	44	31	58
SWT'	3727	5323	2.71	3.54	56	51	33	62
England	37510	49811	1.66	2.09	53	44	33	59

Although people with acute or particularly intractable mental illness or severe dementia may require specialist psychiatric hospital care, this is not appropriate for most people with mental handicap. Except perhaps

for those who are very frail, have multiple handicaps or severe behaviour problems, mentally handicapped people should be given the opportunity for as normal a life as possible in the community. They should have access to all the services and facilities of daily life on a par with the rest of the public, as well as the specialist medical services that are appropriate to their needs. The large isolated institutions should be closed, the sites sold and the money used for jobs, homes and community mental handicap care staff to support individuals in or near their homes.

There has been lip-service to the ideal of community care but, like Titmuss[12] we must be concerned lest that without adequate resources vulnerable people may be left worse off than they were before. There has been a build-up of local authority provision and an encouraging development of the community psychiatric nursing service. There is also a wide variety of other people and agencies involved with the prevention and alleviation of mental problems from counsellors and churchmen to publicans and sinners. In the case of people with special problems such as potential suicides, drug addicts or vagrant alcoholics, the voluntary societies have shouldered a large part of the load.

Yet services are still organised in isolation, and there may be complete lack of communication between agencies in the same area. People with mental illness or mental handicap need high quality general practitioner and specialist services and easy access to a wide spectrum of care and support, based largely within the community.

It should be simple to develop services jointly with housing, social services, voluntary societies, patients' groups and so on, but our present organisation and "territorial aggression" inhibits us.

The promotion of mental health is difficult. We want people to enjoy active indepdent lives yet we must be sensitive enough to recognise when they themselves need help, and when their illness may have devastating effects on others. We must tread a wary path between callous disregard or exploitation on the one hand or over-protectiveness on the other. This challenge requires far more concern from professionals and the public than has been shown so far in the last quarter of this century.

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HOW CAN WE USE BETTER THE HOSPITALS WE HAVE?

Ceri Davies

Existing buildings represent an important national resource, to be linked with other resources of money, manpower and staff, and to be conserved and used imaginatively in planning. Nothing like enough effort has been put into our thinking about our current stock of buildings and how these can help to plan our future. This paper reflects some of the work of the DHSS which is trying to bring new views on this important subject.

In trying to identify what opportunities existing building stock represent for the future we are involved in a battle for both hearts and minds. For the last 20 years, planners have acted in a way which can be described as the "Build new" syndrome. If you have a problem, we'll build you out of the problem. This approach to buildings has been across the range of public and private work. As the central areas of our cities now bear witness, we can look back on an age of the bulldozer. Planners sat in their offices with their felt pens marking down destruction and demolition of large areas of our cities – and yet returning in the evening to their Victorian or Edwardian homes. They knew where the quality was! What was good for society wasn't necessarily good for them.

These last two decades have had a disastrous effect on health service estate. In our madness to build new, we have demolished buildings that still had an excellent future life that we never looked for. But there was also a more subtle force at work. If you were running a hospital, there was an active disincentive to essential maintenance, since the better you kept it the less chance of having it replaced there was. And, because revenue allocations were linked to these new capital schemes, there was equally less chance of expanding your budget. So, you deliberately ran it down. As a result now, hospitals are both not replaced but also run down, and it will take an enormous effort to bring them back up to standard.

In the DHSS, we have been undertaking an exercise which has given us some insight into the extent of these problems, although it was primarily intended to describe the need to improve fire precautions across the country. We chose a 2% sample of the 2300 hospitals in the whole country, and the sample was representative in all respects of the stock as

a whole. In these 45 hospitals, over half were found to have considerable potential for use other than their current use. Also, most of the hospitals are on sites that are far bigger than the hospital needs, and at least half of the sites seem, as far as future planning can forsee, surplus to requirements But, of course, the present machinery for selling off sites and working money back into the NHS is still very poor.

It can't be said that all old hospitals are marvellous, exactly what we want and in the right place. Far from it. But the extreme swing of the pendulum to new building over the last 20 years should be readjusted to a middle position, which takes account of the potential of our current stock to meet at least some of our future needs. Of course we need new buildings. But new ones should be seen as topping up what exists at the moment.

Over the last 20 years planners have grown up in a climate that believed apparently in the replacement of the total hospital stock within a life-time. But the effect, in proportion to the stock as a whole, has been tiny. We have architecture libraries full of books on hospital building, yet what was the effect of our efforts when money was plentiful and there was a strong driving force for new building? We added barely more than 15% to the total stock! In the future decade we must see the futility and danger of thinking in that way. Our new building must be seen to supplement what exists, not to replace it. In developing this view of buildings, we are certain that there needs to be adequate training for people at district level, so that they are aware of the potential of buildings themselves. The buildings that exist must be properly described in terms that the planners and decision-makers understand, rather than in technical jargon understood only by works officers. In our 2% sample survey, we had to spend our first 18 months preparing drawings of the stock – because they didn't exist. Time after time, the only person who would have a drawing was the security man at the gate: and his would be one drawn up in the 1930s.

Beyond description of the stock, we are developing ways in which the information can be presented intelligibly, and then perceiving the potential within it. We need a whole set of new tools, similar to those we have used for new buildings in the last 20 years, but designed to answer current problems much more rapidly.

Over the years, the DHSS has undertaken a number of development projects – for example Greenwich Hospital, Best Buy, etc. But we have never before done a development project on existing stock. We are now working with an Area and District in London. There are three hospitals we'll call them A, B and C. Hospital A, built in the 1850s, has about one hundred geriatric assessment beds, and is on the edge of a common. Property values there are very high – it is a land of film stars and other well-to-do people. Two miles away is a 200 bed hospital, B, which, my friends tell me, has ideal potential for an urban community hospital. A further 5 miles away is a 650 bed District General Hospital, C, There are several other hospitals in the neighbourhood: looking at a plan of hospitals nearby is rather like looking upwards at a starry night. But in our project we are concentrating on just three.

The first change was the move, for medical reasons, of the maternity beds from hospital B to hospital C. It was then thought that it would be possible to transfer the geriatric assessment beds from A to B. But the problem, as so often in apparently simple rationalisation schemes, was that it wouldn't work. In our case, the shape and size of the buildings were wrong but other similar immediate reasons have been found apparently preventing other schemes. The trick is to see hospitals as a chess board. We used a model to see whether it was possible to create a space by moving various functions around within hospital B. And we came up with a satisfactory solution.

What were the financial implications of this move? The capital cost of improving B up to a standard to take in geriatric care is about £135,000. To build a new unit would cost over £1m. The Community Health Council gave their full approval to these changes because they saw that the transfer was to a community hospital rather than to a DGH and not very far from the original site. Hospital A costs £1½m to run and a total saving of just under £0.5m per year is made by the move. And, finally, the District valuer suggests, at a conservative estimate, that the site could be sold off for between £1m and £1.5m.

All this is possible because existing building stock is thought of as a resource to be used imaginatively. It is not constrained by historical use. Limited thinking occurs time and time again within the NHS because the potential is not seen. If we open our eyes to the use of existing stock in imaginative ways, many of our problems of service planning may be solved.

WHAT IS THE PLACE OF COMMUNITY HOSPITALS IN LONDON?

Jeannette Mitchell

Although it is not clear where the term 'community hospital' first came from, it represents a development of the old cottage hospital idea. During the 1960s and the early 70s the Department of Health and Social Security was seeking to phase out such hospitals, and to centralise the services on one site, as the District General Hospital. But in 1974, after an experimental community hospital project undertaken by the Oxford region at Wallingford[1] a circular was issued which renewed support for GP hospitals[2]. Originally this guidance was interpreted as relevant only to rural areas, but more recently the DHSS has indicated that it would not be opposed to the development of community hospitals in urban areas.

This change of policy was in part a political response to the growing resistance towards closure of small hospitals. But the new thinking may well also have been connected with anxieties about the growth of public spending, and the escalating costs of health care in particular. It was gradually being recognised, not just that a substantial proportion of patients needing in-patient care do not need the sophisticated diagnostic and treatment facilities of the DGH, but also that transporting them backwards and forwards can be a costly business.

The 1974 circular has not lead to any dramatic changes in patterns of health care delivery. In rural areas many GP hospitals have been redesignated as community hospitals with little change of function. One or two new community hospitals have been developed in new towns like Milton Keynes. There is not yet, to my knowledge, a community hospital in any of the big cities. But over the last few years there has been growing talk about urban community hospitals. Feeling has run high and an outside observer could be excused for being confused. In some places there have been very strong community campaigns in support of the development of a local community hospital.

Elsewhere local community groups have been opposed to their development. Similarly, some Area Health Authorities have taken initiatives towards setting up community hospitals, whereas other Authorities have been very hostile. While some people are arguing that community

hospitals may have a significant role to play in improving London's health services, in line with the needs of the communities they serve, others are arguing equally vehemently that the interest currently being shown by some AHAs in community hospitals will actually lead health services in London to deteriorate in the coming decade.

If we are to get to the bottom of these apparent contradictions, we need to look at the particular circumstances in which health managers, local doctors and community groups are arguing for or against community hospitals. Arguments about whether community hospitals in urban areas are or aren't a 'good thing' are likely to be very sterile. The important thing is first to try and understand what it is that people feel they have not got and need, in places where there is strong feelings for or against community hospitals. It is only once we have done this that we can begin to sort out the circumstances under which it makes sense for us to support or oppose their development.

Before we get on to the arguments, however, let us briefly look at what a community hospital is. According to the DHSS, community hospitals should complement the DGH by providing accessible outpatient and rehabilitation services, and basic nursing care for inpatients who are admitted and cared for by GPs. There is no additional medical cover and consultants are only involved in the same way as they would be if a person were to be ill at home. Suitable cases for admission include pre-diagnostic patients requiring routine tests, patients primarily in need of nursing care (in particular stroke patients, patients with chest infections and those suffering from chronic illness) or for whom bed rest cannot be obtained satisfactorily at home, holiday admissions and selected terminal care cases. No community hospitals accept psychiatric patients or children. Few have operating facilities, although, recent guidance indicated that the DHSS would not necessarily be opposed to facilities for minor surgery. Most community hospitals accept some post-operative patients where this is agreed between the GP and the consultant. The experiment at Wallingford has shown that community hospitals can also provide a whole range of additional services, from a health centre to a 24 hour minor casualty unit.

Although some community hospitals have long-stay wards (in some cases these are GP wards, in others they are under consultant care) most community hospitals make strenuous efforts to ensure that there is a

continuous turn-over of patients and many set time limits on the length of stay. In one community hospital in Wales [3] the average length of stay is around 14 days and on average two beds are likely to be in use by each GP at any one time.

On first coming into contact with the idea of community hospitals some people may be surprised by the notion that GPs provide the only medical cover. They wonder whether this might lead to substandard health care and cannot envisage how the GPs involved can manage to provide the 24 hour cover necessary. One helpful way of thinking about the first point is to see the community hospital not as an inferior version of the DGH but as an extension of primary care. In order to ensure that their patients have the best possible opportunity to get well, the GP invites them to stay in the community hospital and visits them just as if they were at home. The difference is that in the community hospital they get the kind of full time nursing care they couldn't get at home. Access to beds and cover when the GP is off duty seem to make far fewer difficulties than one might envisage.

So what do community hospitals have to offer urban areas? Doesn't the relative abundance of hospitals in London make the notion of GP beds irrelevant? Given the sometimes poor standards of general practice in London, isn't it madness to extend the role of GPs? Will they cooperate? And as for the provision of accessible outpatient services, surely we in London do not have the same kind of problems as people whose nearest hospital is thirty miles away?

For the past two years community groups in Brent have been compaigning very hard to see a community hospital established on the site of Willesden General Hospital, which was closed as a General Hospital over three years ago. The campaign has been a popular one. Support has come from the Borough Council, general practitioners, the Community Health Council, trade unions inside and outside of the health service, church groups, and a wide range of community groups from Brent Active Pensioners to the Willesden Hospital League of Friends. And it's been going on for a long time with a persistance which the Area Health Authority probably did not bargain for.

The 120-bedded hospital was 'temporarily' closed in 1976 as part of a wider bid to curb the District's overspending — changes that involved closing over 300 acute beds. The AHAs plan was to use it for geriatric patients transferred from other parts of the District. Outpatient, x-ray, rehabilitation and some pathology services were retained. At the moment one ward is being developed for the younger chronic sick and part of the site has been leased to the Council's Social Services Department who are building a day centre. The accident and emergency department has been converted to provide new accommodation for the chest clinic. Two wards are already in use by geriatric patients. The dispute is about what other services should be provided on the site. Those campaigning for a community hospital want two wards of GP beds, a minor casualty unit, a health centre and a health information and action centre. The AHA want to use the two remaining wards for geriatric patients transferred from elsewhere in the District.

On the face of it the argument is not about very much. The total additional cost of the services we are arguing for would be in the range of £½ million. So why has local feeling run so high?

I think the enthusiasm for the community hospital comes from two sources. The first is a very basic anger about the loss of Willesden as a General Hospital. The second is a feeling — increasingly articulated by the more thoughtful and lively community organisations — that there is also something qualitatively wrong with the current provision of health care.

I am sure that our health managers put the anger at the closure of Willesden General down to a sentimental attachment to an outmoded hospital and the failure of local people to understand that centralisation and rationalisation are the key to the development of a modern health service. The closure of the accident and emergency department is a case in point. For them it was irrevelant and unsafe. But in an area where general practitioners do not cater for minor accidents — a bit of stitching or a tetanus injection — and where poor standards of primary care have led people to rely particularly heavily on the casualty department, it makes little sense to expect people to catch a couple of buses to the exceptional busy DGH casualty department where, as a 'low priority' case it may take them hours to be seen.

The problem of access is also crucial for elderly and disabled people and women with young children attending the DGH as out-patients on public transport. It may only be a couple of miles, but it's still a couple of buses, and it may well take an hour or more. Clearly there is everything to be said for centralising those services which require sophisticated technology, and take in patients by ambulance. But it is not acceptable to expect the ill, injured, pregnant or disabled to make a long trek to the DGH for a routine visit; and it especially doesn't make sense if we are conscious of the need to encourage attendance, as in antenatal care.

Local people are also aware that, whatever the administrators say, government norms for the level of acute bed provision do not make sense and that you can't axe 300 beds without a cost. It's not just that poor socio-economic conditions lead to high levels of morbidity, it's also that poor housing, often overcrowded and lacking facilities, is not conducive to home nursing. This means that we not only need more beds, but that a higher proportion of what goes on in these beds will be the provision of basic nursing care. Hence the enthusiasm for GP beds. (It's perhaps important to point out here that the rationalisation of Brent's health services, with the loss of so many beds, has made sense in it's own terms. Waiting lists have not been increased mainly because there has been a higher level of throughput. While this partly reflects developments in medical practice, there is a widespread feeling amongst local people that patients are often being sent home too soon and that some people who would benefit from admission to hospital are not being admitted).

The fight for the community hospital then, is rooted in both the loss of an accessible casualty service for minor accidents and opposition to the new 'high throughput' approach to inpatient care. But the debate about the future of these hospitals is also about the kind of health care we need and the form it should take.

The community hospital is seen as one way of stimulating a badly needed improvement in primary care. It is hoped that the presence of such a hospital would attract younger GPs to work in the area. A study undertaken by Dr Norman Noah, in which he interviewed all the GPs in the Willesden area to sound out their views on the community hospital, indicated not only that a substantial number of local GPs would like

access to GP's beds, but also that these are on the whole the younger and more active general practitioners.[4] It is also hoped that the provision of GP beds would in turn stimulate the development of a health centre on the site. GPs have been very reluctant to move into a health centre in Willesden despite the efforts of the health authority, but a number of local GPs have indicated that they would be interested in a health centre if GP beds were available on the site. This seems very reasonable as the many advantages are obvious.

The second reason that there has been so much positive enthusiasm for the idea of the community hospital is that the struggle to see it established has not just been about the provision of increased resources for health care. To some extent it has also been about how health care should be organised, and in whose interests. The question of control — not just of who should control our health services, but also who should control our bodies — has been a continuing theme wherever there have been discussions about the community hospital. The enormous interest shown in the health courses run recently by the Brent Women's Centre and the Brent Active Pensioners has highlighted that people are becoming less and less prepared to have a passive relationship with their doctors. They want to be in a position where they can be well informed to make their own decisions. And they are not prepared to accept that ill health is inevitable. They are questioning what is making them ill. Although the proposal we are making for a community hospital for Willesden offers no ready made solutions to the weaknesses which local people are identifying, it emphasises the need for more resources for routine everyday health care, and the importance of being actively involved in one's own health. We were all quite happy to answer to the charge of 'barefootism' levelled at us by the Chairman of the Hospital Medical Committee.

Now in Brent, after a year of vigorous campaigning by the Willesden Hospital Action Committee, the Area Health Authority is beginning to acknowledge some of the problems the closure of Willesden as a general hospital has created, and have agreed in principle to the development of a community hospital. There remains the problem of how this initiative should be funded, and the Community Health Council is continuing to press the AHA to argue the case for a community hospital more vigorously than they have done so far. In the meantime we feel that what we have achieved is not insignificant.

We have won a recognition on the part of the AHA that the rationalisation and concentration of health care services is at a cost to health service users and that the AHA has an obligation to meet needs which are currently unmet.

There have been similar campaigns to establish community hospitals at Hounslow and Bethnal Green, both of which have won paper commitment from the AHA but little by way of resources so far. But elsewhere there has been considerable local opposition to the idea of community hospitals. In the Kensington, Chelsea and Westminster AHA, for instance, the Save Paddington Hospital Campaign was very strongly opposed to a suggestion from the Community Health Council that a community hospital should be established on the site of St Mary's Harrow Road once it had closed as a general hospital. Their opposition was based on the fact that the CHC's proposal would still mean an overall loss of beds in the District, further to travel for outpatients' appointments and to visit inpatients, and the loss of a casualty department.

The City and East London AHA proposals to turn a number of existing acute hospitals into community hospitals have also met with resistance. The main basis for objection here has been that the AHA explicity state that such hospitals are to be primarily for the elderly. Reassurances that such hospitals would have rehabilitation facilities and 'dynamic' social work departments have not been sufficient to convince the Community Health Council's concern that such hospitals would not become geriatric "ghettos' offering a second class standard of care. They are also unhappy with the notion that all acutely ill patients would have to travel to St Bartholomew's for hospital care. Their reservations are based not only on the problem of access, particularly to out-patient and casualty facilities, but also on a feeling that, especially where home conditions are poor, the high technology, high throughput style of medicine at St Bartholomew's Hospital is not appropriate to local needs.

Brent CHC has been very active in campaigning for a community hospital, and we believe that the facilities we have argued for are both very badly needed and would be very popular in Willesden. But community hospitals should not be seen as the magic key to the solution of all the health care problems which people living in inner London experience. The most important thing is to look behind the specific demands of any particular

campaign and to try to understand what all the fuss is about. There is actually a unity in what both the people who are fighting for community hospitals and those fighting against them are saying:

1 'Acute' beds in inner London have a crucial role in the provision of basic nursing care. While London may appear on paper to have too many acute beds, we have to analyse the role and function of such beds, especially in areas where conditions for home nursing are poor. Attempting to solve the so called overbedding problem by rationalising the small hospitals with the longer lengths of stay out of existence and concentrating facilities in the Teaching and District General hospitals is unacceptable.

2 The right to reasonable access to health care facilities is not a luxury. We need facilities for treating outpatients, and accidents which are easy to get to and don't involve interminable waits.

3 Hospitals for elderly patients only are not popular, whether these are called 'geriatric', community or 'support' hospitals. Patients don't much like the idea of being admitted to them and staff are reluctant to work in them. Whatever the good intentions of those who want to see geriatrics developed as a speciality and no longer regarded as a cinderella service, people are suspicious that hospitals for the elderly may become more, rather than less, institutionalised.

When we think about "London's health care problems" we are actually talking about two sets of problems. There are the everyday problems, which particularly the people who live in inner London experience, in getting access to and using London's health services. And there are the problems of the people who run the services in the face of growing demand, reducing resources, as well as the competing pressures from the medical establishment and users of, and workers in, the health service. Although these two sets of problems are often conflated as 'London's health care problem', we need to acknowledge that this is to some extent a mystification. We must distinguish between what I would describe as "managerial" solutions and solutions which reflect people's real needs. I have no doubt that where setting up a community hospital means an extension of accessible, everday health care it will be warmly welcomed. But where it represents an attempt to provide health care on the cheap under a fancy name it will be equally strongly resisted.

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NEW APPROACHES TO HEALTH IN THE COMMUNITY

Helen Rosenthal

Earlier this year I was given a grant by the King's Fund to carry out a short survey of what broadly described as "Alternative approaches to primary care in big cities". As I am neither a primary care worker myself, nor a medical sociologist, the circumstances which led up to the commissioning of the survey deserve some explanation. Far from being an academic exercise, the survey arose directly out of the work of a small group of activists on a Community Health Council.

HOW THE SURVEY AROSE

I became a member of City & Hackney CHC in 1977, representing Hackney Trades Council. The CHC was beginning to establish an active role for itself in a borough which has a long tradition of political and community activity, and where the effect of 'rationalisation' by the Resource Allocation Working Party on top of continuous underfunding of the NHS were to have a dramatic impact on health service provision. The CHC quickly developed a style of work which has often been militant e.g. in campaigning for day-care abortion facilities, improved maternity and antenatal care, and more recently against cut-backs in acute hospital provision. But despite the acclaim afforded our popular "Guide to the NHS in Hackney" by both community and local health services, the CHC became concerned that its work was too often responsive in character, defined by the demands made on it by the health service itself or by individuals approaching the CHC with problems and complaints.

We seemed to spend a good deal of time responding to District, Area and Regional plans which were often incomprehensible and frequently bore little relationship to developments forced on the local health services by more immediate economic and political considerations. We had plenty of contact of a limited kind with the public, through casework, through organising stalls and displays at local events and through often packed public meetings. But a connection between this public work, and our comments on District proposals for community hospitals was sometimes hard to see.

Much of the CHC's work was conducted in small working groups which meet to discuss specific issues – mental handicap, women's health, children's health etc. This way of working was adopted in order to involve more people in the CHC in a more active way, but we were aware that we were only succeeding in attracting small numbers of middle-class people. Hackney is a working class borough with all the hallmarks of urban decay and social and environmental deprivation. We knew that the roots of sickness and health lay in the social conditions around us. We also knew that our local health services were poor in contrast to those in more affluent areas, and that there was a higher incidence of every disease and health risk amongst people from social classes 1V and V.

Talking among ourselves in small working groups, producing criticisms of health service plans, or occasionally making our own alternative proposals did not begin to address these problems. We felt that the health and health services of the people of Hackney could only begin to improve when Hackney people themselves were engaged in an informed dialogue with the providers and practitioners of the health and medical services. There was no doubt that local people cared about their health and the NHS. The fact that 2000 Hackney people recently turned out to demonstrate against cuts in acute hospital provision was proof enough. But the CHC had to find new ways of working which would raise consciousness and expectations beyond the level of defending the inadequate health service we already had.

After a visit to the Albany in Deptford, where a small neighbourhood health project had been based for a year, we became excited by the idea that a community development approach to health might provide what we were looking for. Traditionally, community workers have focused their work on housing, environmental issues, nursery provision, etc., but the Neighbourhood Health Project in Deptford was an example of how community development could apply to health issues. By the autumn of 1978, the CHC had prepared a proposal for a small community development project based on a Hackney housing estate, which would focus on health.

The project would employ a lay community health worker, whose work would be guided by a support committee, to work with groups and individuals on the estate to raise health issues. The aim of the project

was to stimulate greater awareness of the meaning of health and the causes of ill health. This, it was hoped, would enable local people to play a more positive part in determining their own health, to make better use of the health services, and to engage more easily in dialogue with the CHC and health services to change and improve them to suit local need.

A year later, our project is to be funded by the Hackney and Islington Inner City Partnership. It was while applying for funds for the Hackney Community Health Project that the opportunity arose to spend some time looking at another initiative related to primary care.

Possible areas for the survey to cover included

neighbourhood or community health projects initiatives by CHCs
patients' associations or committees (in health centres or in general practice)
women's health groups
initiatives in Inner City Partnership and other urban programmes
initiatives by statutory health services which attempt to intervene in particular patterns of morbidity.

These categories overlap to some extent, and I intend to focus only on the handful of community health projects I have discovered. These projects seem to me to be sufficiently wide-ranging in their approach to embrace many of the ideas and ways of working of the other categories.

NEIGHBOURHOOD HEALTH PROJECTS

In 1976, six workers were appointed to work attached to different community organisations in Liverpool, London, Belfast, Sheffield, Milton Keynes and Derry. This was part of a Neighbourhood Health Project initiated by a group called Foundation for Alternatives, funded by the Anglo-German Foundation. The project was designed as an action research project to look at the application of community work methods to health education, and to explore the possibility of a role for neighbourhood health workers. By the autumn of 1978 only the London project, based at the Albany in Deptford was still in existence. But other projects have emerged out of particular neighbourhood needs. Camden Council

for Racial Equality has a worker employed to work with local Asian women on health and dietary issues. Pitt Street Settlement in Peckham and the Waterloo Action Centre each support flourishing neighbourhood health projects, and Inner City Partnership funds are being allocated to two embryonic health projects in Hackney and at Thornhill in Islington.

These projects have certain common features. All employ lay-workers, usually with training and experience in community work, to work on health issues in small, fairly defined geographical areas (often an estate). The workers are usually supported by an advisory or support group of both local people and sympathetic health professionals, who decide collectively on the direction and initiatives the project should take.

Several of the projects use the World Health Organisation definition of health as a primary reference point for their activities – i.e. "a state of complete physical, mental and social well-being and not merely the absence of disease". All of them reject individual and disease-based models of health, recognising that ill health is actually created by society in various ways. They therefore attempt to develop collective, community-based ways of working on health issues, which often emphasise prevention, education, and self-help. Several of them are overtly political, and their activities reflect a recognition of the relationships between social class, poverty and health, and the inequalities in health care provision that exist between deprived and more affluent areas.

Some of the projects have flourished and others have not. Viability, judged by a project's continued survival and the growth of its activities, seems to depend on the degree to which it is rooted in the community. The projects in Milton Keynes and Liverpool apparently collapsed because of the random way the locations were chosen, and the tension that existed between the worker and community, and the distant and irregularly involved management group. By contrast, the three established projects in South London at Deptford, Waterloo and Peckham have all grown out of existing local action or community centres from which a range of other community activities take place. All three have very closely involved support groups made up of largely local people.

THE WATERLOO HEALTH PROJECT

Before considering the achievements of these projects and some of the questions arising from them, it may be helpful to describe in more detail the kind of work that one of them does. The Waterloo Health project employed one worker in 1978, whose work in that year focused mainly on health issues relating to elderly people, women, and advice and information work.

Work with the elderly was a combination of encouraging a regular health input into discussions and activities at old peoples' clubs and groups already in existence in the neighbourhood, and initiating new groups and projects. In one club, a series of discussions were held on topics like relaxation and exercise, diet (a local dietician was invited), uses and dangers of drugs, and massage. Another old people's club was already running a course put on by the local health education unit, and invited the worker to provide follow-up sessions on local health services. There was work on health rights, as part of welfare rights course for old people organised at a nearby Settlement. There were discussions on "going to the doctor", followed by meeting with a local GP at the Settlement sheltered workshop for psychiatrically ill and physically handicapped people. The elderly people who had been involved in these initiatives were the main participants in a public meeting on rheumatism. Arising out of the public meeting a regular relaxation and exercise course was set up at an adult education centre.

Work on women's health developed from a small women's group which met regularly. The aims of the group were to improve women's health by increasing social contact and providing the opportunity for mutual support, enabling a sharing of knowledge and increase in confidence which might in turn lead to the group bringing about changes in factors influencing both health and health service provision.

The women's group itself was not usually attended by more than three or four women. Discussions varied from pregnancy, slimming, smoking, sex, family planning to the estate and bringing up children in flats. The group met a GP to discuss contraception, made bread, saw films on breast examination, the leboyer birth method, and drugs. The group also had an active role in obtaining funding for a local "drop-in" centre for mothers with toddlers and in fighting for provision of playspace for children on the estate.

The women's group stimulated the setting up of a keep fit group at an adult education centre. It also organised a public meeting on "The Menopause", at which a senior registrar from St. Thomas' Hospital and a local health visitor spoke. The interest aroused at the meeting enabled a group for menopausal women to be established. This group met monthly for the women to share their experiences, collect and share information on the menopause and related topics.

Advice and information work

The Waterloo Project's Advice and Information work was carried out in weekly sessions at the Action Centre's advice centre, and in a weekly "drop-in" session in the tenant's association flat. The latter allowed for informal and lengthy discussion of people's difficulties. Both activities were used as indicators of particular health issues and concerns that could be taken up more widely – e.g. the need for a meeting and group work on the menopause was realised after several women had come to the advice centre wanting advice and information. The advice work at the action centre led to an increase in the number of enquiries about health and to other advice workers in turn learning more about health. A health information sheet was also produced which was distributed via the shop front.

Other possibilities explored by the Waterloo Project worker, included visiting inpatients at St. Thomas' Hospital, visiting outpatients at Guy's Hospital to put outpatients in touch with each other for mutual support, forming a support group for diabetics, and work with an adult literacy project.

I have described the work of this project during one year because it is representative of the kinds of approaches that have been made elsewhere. Different projects have different emphases and priorities however, and will develop according to local needs and interests. There is no blueprint for community health projects.

WHAT ARE COMMUNITY HEALTH PROJECTS ACHIEVING?

Perhaps the most important common feature of all the community health projects is the work with small groups of local people. The groups may be already in existence or may be specially set up. Evaluation of this work is usually made by the worker her/himself in discussion with the support group, and takes the form of carefully monitoring the setting up,

attendance, range of discussion and activity of each group. The functions and achievements of different groups in different projects vary and may change with time.

The projects I have seen emphasise mutual support, building up of confidence in the group to discuss individuals' experiences and opinions in relation to the particular health issue, learning how to seek out and use specialist information from medical literature or health professionals, learning the technical skills necessary to produce a pamphlet or leaflet, or to make a video-tape, gaining confidence in seeking the kind of medical help or advice the individual feels is appropriate.

The projects are also important catalysts. They can stimulate local agencies such as adult education centres, schools, health departments and advice centres to set up classes or courses. Their closeness and responsiveness to the local community helps to ensure that such initiatives reflect local needs and interests. They can also help make connections between health and other community issues such as housing, welfare rights, etc.

A greater problem is developing approaches to the health services themselves. The background to our attempts in City and Hackney CHC to establish a community health project has been described already, and makes clear that we see the fostering of better relations with an improvement of local health services as an important consequence of the educational and consciousness raising content of the project. We do not see our community health project as an alternative health initiative, even though we may wish to consider types of health care not usually embraced by western medical orthodoxy, such as acupuncture, homeopathy, etc. The existing community health projects share this view. Yet so far the emphasis of their work has not been directed towards the health service in a major way, with the exception of the Thornhill Project. (This project arose out of a report by community workers on the need for improved primary care in the Thornhill neighbourhood, and has newly appointed a community physician in addition to the community workers).

There are good reasons for this. Attempts by lay-people to address health issues in anything but a voluntary and private way will often be greeted with suspicion by medical and health professionals, or occasion-

ally by attempts to colonise the initiative, and bring it into the safe confines of the health service. A community-based health initiative threatens the traditional monopoly of health held by the medical profession. The threat to its status and value system may provoke hostility which is difficult for the layperson to deal with, and erect barriers to the progress of the project. It is important for the project to become confident and rooted in its community before it attempts to meet the health services themselves more directly.

Another difficulty for workers of community projects in relating to health professionals is the divergence of expectations about what the project should be aiming to achieve. All agree that it is a good thing to improve health, but how you show that you are doing that is the starting point of a seemingly endless debate. For the health professional, this may mean demonstrating that the uptake of immunisation has increased, or that a decrease in the occurrence of a particular illness has occurred as a result of a campaign or particular intervention. It may seem that an estate or neighbourhood where community development work on other health issues is taking place is ripe for an experiment of this kind. But for that community it may not be a priority. Cooperation with a campaign or intervention initiated from within the health service may threaten the autonomy of the project, and inhibit the growth and development of other activities which demand a different style and pace of work, and a more flexible approach.

Nor have the community health projects begun to take up environmental health issues, although lead pollution and health and safety at work are cited in several project reports and planning documents as potential areas of future work. Perhaps these issues have not yet been taken up because they do not have the immediacy of the health problems suffered by the individual. Community workers work where people are, and the people who spend most of their time in the council houses on the estate are women at home with small children, and old people.

The burden of demonstrating the success of community approaches to health falls at the moment on a very small number of projects. For the project workers, a lot of their time may be taken up with the search for funds, and they must be decisive about where to concentrate their

limited time and resources. It is important to be seen to be successful, and in the early days of community health projects, this may mean limiting your areas of work to where you are confident that progress can be made. All three of the south London projects are supporting a number of small groups of local people who are gaining confidence, learning about health issues that are important to them and finding that they have a lot to say about health and health services.

At the same time, community workers from London and elsewhere are coming together at regular courses and meetings on health issues being held at the London Council for Voluntary Service. Many of the local campaigns that are springing up around the country in response to cuts in the health service are different in one important way from the defensive campaigns usually mounted. They are recognising the importance of discussing the causes of ill-health and the need for improved services as well as defending the old and inadequate services.

If the existing health projects are not yet demonstrating measurable improvements in the health of their communities, it is because this is not their intention. What they are doing is playing an important part in creating a climate in which people in the community are finding a voice to challenge professionalism and from which change will come.