

# Understanding the role of community hospitals

An analysis of experiences in five countries



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**Ellen Nolte**, Jennie Corbett, Giovanni Fattore, Marja Kaunonen,  
Celine Miani, Emma Pitchforth, Ingrid Sperre-Saunes, David Steel, Eleanor Winpenny



# Why is this study relevant?

- Countries focus increasingly on moving health care closer to people's homes
  - concerns about health systems' dependence on hospital-based delivery and the efficiency of such services given the changing disease burden and associated demand for services
  - perceived high costs of hospital care
- Potential role of *community hospitals* in delivering more integrated care at local level, but models and approaches differ across countries

## ***Aims***

- To explore the nature, scope and distribution of service delivery models that can be considered comparable to community hospitals in England to better understand:
  - the policy drivers behind the implementation or advancement of related models
  - their function and role within the wider system of service provision
  - the degree to which community hospitals contribute to enhanced integration of service delivery and benefit the population.



# What is international comparative health policy and systems research for?

- Marmor et al. (2005) distinguish three principal purposes of comparative analysis in health policy
  - learning **about** national health systems and policies
  - learning **why** they take the forms they do and
  - learning **from** other countries for potential application of policies elsewhere
- Scarcity of documented developments around community hospitals in different settings
- Need to first establish evidence that explores the evolution and general trends of related policies as a foundation for further analytical work
  - Methodological approach is at its core descriptive, principally drawing on documented evidence and key informant interviews to explore observed developments and policies
  - Approach principally allows for drawing lessons to inform policy learning elsewhere but remains a first step for further analytical work



# Our approach

- Part of a larger study that also including scoping reviews about the evidence of the effectiveness and cost-effectiveness of community hospitals and case studies of selected models in a small number of countries
- International comparison considered : Australia, Finland, Italy, Norway, Scotland
  - selection informed by (i) our previous work on providing care outside hospital, (ii) a preliminary review of the published evidence, and (iii) our detailed understanding of health systems in high income countries
- Data collection: (i) review of the published and grey literature, (ii) interviews with key informants (KI)
  - Up to 8 KI per country, considering representatives from provider and professional associations, regulators, funders and patient associations (final selection determined by the specific system context)
- Analysis based on detailed country reviews principally using a thematic approach



# What is a 'community hospital'?

- '[A] hospital where the admission, care and discharge of patients is *under the direct control of a general practitioner* who is paid for this service through a bed fund, or its equivalent' (Royal College of General Practitioners 1990)
- 'A service which *offers integrated health and social care* and is supported by community-based professionals.' (UK Department of Health 2006)
- 'A *local hospital, unit or centre community based*, providing an appropriate range and format of accessible health care facilities and resources [...] include[s] inpatient beds and *may include outpatients, diagnostics, surgery, day care, nurse led, maternity, primary care and outreach services* for patients provided by multidisciplinary teams.' (Community Hospitals Association 2008)
- '[T]ypically has 50 beds or less and *provide[s] basic diagnostic services, minor surgery and care for patients who need nursing care* but not the facilities of a district general hospital.' (McKee & Healy 2002)
  - *A community hospital (i) provides a range of services to a local community; (ii) is led by community-based health professionals, and (iii) provides inpatient beds.*



# Principles of governance of the publicly funded system vary ...

	Population (density)	Sources of funding (% THE)	Spending (% GDP)	Governance of the publicly funded system
<b>Australia (2012)</b>	23.6 million (3 per km <sup>2</sup> )	General tax: 67.6% VHI: 8.9% OOP: 19.9%	8.8%  (3,866 US\$ PPP)	<b>Fiscal and functional responsibilities divided between Australian government and six states/two territories</b> ; federal government funds and administers Medicare and PBS, regulates much of the health system; states administer public hospitals and regulate all hospitals and community-based health services; public hospital funding is shared between the states and federal government.
<b>Finland</b>	5.6 million (18 per km <sup>2</sup> )	National & regional tax: 61.0% NHI: 14.3% OOP: 18.5%	8.6%  (3,442 US\$ PPP)	Shared by centre and 313 self-governing municipalities; central government has mainly steering function; <b>municipalities are responsible for provision of health and social care services</b> and organise primary care; they also fund specialised care through 20 hospital districts that are responsible for the provision of specialised healthcare.
<b>Italy</b>	61 million (200 per km <sup>2</sup> )	National & regional tax: 77.1% OOP: 18.8%	8.8%  (3,077 US\$ PPP)	<b>Highly decentralised</b> : central government provides legislative framework for healthcare and defines basic principles and objectives for the national health service; 20 regions are responsible for organising and funding healthcare, with considerable variation in how they exercise autonomy.
<b>Norway</b>	5.3 million (13.5 per km <sup>2</sup> )	General taxation: 75% NHI: 10% OOP: 14.6%	8.9%  (5,862 US\$ PPP)	<b>'Semi-decentralised'</b> : many functions delegated to the regions and municipalities; 4 regional health authorities are responsible for planning, organisation and provision of specialist care, 429 municipalities are responsible for the organisation of primary care, public health services, and provision of and access to emergency care.
<b>Scotland</b>	5.3 million (69 per km <sup>2</sup> )	General taxation: 83.3% VHI: 3.5% OOP 9.9% (UK figures)	8.5%  (3,235 US\$ PPP)	Scottish government is responsible for healthcare, providing strategic leadership for public health, the NHS and social care; planning and delivery functions are delegated to 14 regional NHS Boards, seven Special NHS Boards and one public health body. From <b>2016 Integrated Joint Boards</b> , formed by health boards and local authorities, will have overall responsibility for the planning, resourcing and delivery of all integrated health and social care services



# ... as do the principles of service provision: hospital care

	Categorisation of hospitals	# hospitals #acute beds/1,000	CH a hospital?
Australia	<ul style="list-style-type: none"> <li>Principally: acute care hospitals, psychiatric hospitals; and day hospitals or centres.</li> <li>'Peer groupings' (shared characteristics) : principal referral hospitals, acute hospitals, small hospitals; women's and children's hospitals; psychiatric hospitals; subacute and non-acute hospital; outpatient clinics</li> </ul>	<ul style="list-style-type: none"> <li>1,347 hospitals (55% public)</li> <li>3.4/1,000</li> </ul>	Yes
Finland	<ul style="list-style-type: none"> <li>20 hospital districts cover 50,000-1.2m each; responsible for organising and providing all inpatient and outpatient specialised healthcare within a region</li> <li>Most hospital districts have central hospital, at times supplemented by small regional hospitals</li> </ul>	<ul style="list-style-type: none"> <li>263 hospitals (2012)</li> <li>2.3 beds/1,000</li> </ul>	Yes
Italy	<ul style="list-style-type: none"> <li>Basic hospital (catchment population 80,000-150,000; emergency services and some specialist services; Level I hospital (150,000-300,000; host first-level A&amp;E, large number of specialties available on call - 24/7); Level II hospital (600,000-1.2m; hospital trusts, university hospitals and IRCCS; Level I ++)</li> </ul>	<ul style="list-style-type: none"> <li>1,152 hospitals (2012)</li> <li>2.8 beds/1,000</li> </ul>	No
Norway	<ul style="list-style-type: none"> <li>Regional or university hospital (1 per region); Large acute care hospital (60-80,000 population; emergency care, surgery, several specialties); acute care hospital (emergency care, elective surgery, some acute surgery)</li> <li>Hospitals w/o acute care functions (elective surgery only)</li> </ul>	<ul style="list-style-type: none"> <li>21 hospital trusts (&gt; 100 sites) (2012)</li> <li>2.3 beds/1,000</li> </ul>	Some
Scotland	<ul style="list-style-type: none"> <li>General hospitals, Long stay hospitals, Mental illness hospitals, Psychiatry of learning disabilities hospitals, Maternity hospitals, Dental hospitals, Other, Clinics, Community hospitals</li> </ul>	<ul style="list-style-type: none"> <li>287 hospitals</li> <li>2.6 beds/1,000</li> </ul>	Yes

**Italy:** [A] structure with a limited number of beds (15-20), managed by nurses, in which medical care is provided by general practitioners, paediatricians or other medical staff contracted by the Italian NHS



18 beds

**Norway:** Cottage hospitals (Sykestue); Small general hospitals; Municipal acute care beds; Local medical centres



22 beds

**Finland:** Inpatient wards in municipal health centres (erveyskeskusten laitoshoido), commonly referred to as 'health centre hospitals'

**Australia:** Varies across states but most commonly refers to a small (district) hospital in rural and remote areas

**Scotland:** A community hospital is a healthcare facility undertaking patient care with typically less than 60 beds



9 beds



40 beds





# Diversity of community hospitals has to be set in the context of the delivery structure (1)

- Some regions in *Norway* have long history of operating cottage hospitals as core component of health service delivery
  - deliver health care in rural areas, have overnight inpatient beds and typically provide a selection of specialist outpatient services
  - 2012 Care Coordination Reform introduced municipal acute care beds (KAD) to complement or potentially substitute the traditional cottage hospital model
    - address the needs of patients with acute but manageable conditions, who need 24-hour supervision
    - all municipalities in Norway are required to provide municipal acute care beds from 2016
- *Scotland*: many community hospitals pre-date the formation of the NHS in 1948
  - traditionally: general practitioner hospitals (~ 3% of hospital beds by 1980)
  - strategic move from mid-2000s to strengthen community-based, primary care-led services
    - New models of community hospital to operate as ‘local community resource centres’ for the provision of ‘more holistic and integrated services quicker and closer to home’
  - 2012 Community Hospitals Strategy Refresh: community hospitals to act as community hub for health and social care services



# Diversity of community hospitals has to be set in the context of the delivery structure (2)

- *Finland*: 1972 primary care reform established municipal health centres
  - municipal health centres evolved in part from small local or district hospitals and as a result they offer a wide range of services, including GP-led inpatient units
  - newly established municipal health centres that were not linked to a former local hospital also established inpatient wards
    - primarily to address the needs of dependent older people, who do not require hospitalisation but who cannot be cared for in their own homes
  - 1993 payment reform made municipalities responsible for all secondary and tertiary care costs
    - “[community hospitals] lost much of their professional attraction and gradually became long-term care facilities for the elderly, especially those with memory disorders” (KI-F05)



# Diversity of community hospitals has to be set in the context of the delivery structure (3)

- *Italy*: Community hospitals established from the mid-1990s onwards
  - response to the changing needs of an ageing population but mostly because of national policies seeking to focus hospitals on acute care provision and reduce the length of acute hospital stay
  - provide a ‘protected place’ for patients and solution to the threat of hospital closures through repurposing of existing local hospitals
    - “So we save the small local hospital, we keep it over there. We try to name it hospital ... its written in big [letters] ... so they [patients] feel comfortable to go there, but I mean no expert would ever name it a hospital.” (KI-I01)
- *Australia*: tradition of small, rural hospitals (‘bush hospitals’) covering large geographical areas and considered indispensable in remote communities
  - “Rationally, they can’t operate [...] and the occupancy rates is so low, it’s very hard to argue that they’re operating efficiently and it’s increasingly evident that it’s hard to operate things safely, for anything with fairly low security levels.” (KI-A05)
  - investment in re-development of small rural hospitals into so-called ‘multipurpose services’
    - designed specifically to address the needs of small rural and remote communities
    - may or may not include inpatient beds



# The range of services provided varies but there are common features

- Most commonly provision of sub-acute, post-acute and/or intermediate care; rehabilitation; palliative care
  - GP acute medical inpatient care; obstetric care; minor surgery; selected outpatient services (Australia, Scotland, Norway [cottage hospitals only])
- The local GP usually holds clinical responsibility and has oversight of the medical care provided, as well as admission rights
  - reflects general function with community hospitals sitting *“in the middle of the patient journey between home and the district general hospital”* (KI-S03).
- Service delivery typically involves multiprofessional teams
  - nurses, healthcare assistants, and allied health professionals (most commonly physiotherapists and occupational therapists)
  - social care workers may form part of team or are co-located
- Involvement of medical specialists varies
  - on-site in Finland and Italy (‘house of health’ co-location)
  - visiting specialists from the acute care hospital (Scotland, Australia, Norway)



# The benefits of community hospitals remain difficult to demonstrate

- Robust empirical evidence of some degree of impact available for Norway and Finland only
  - evidence of reduced service utilisation (readmissions, community services use)
  - early evidence for municipal acute care beds in Norway: small, but significant reduction in acute care admissions
- Challenges in demonstrating evidence of impact
  - *“there is a great deal of belief so you end up with this knowledge gap which is a challenge when we try and protect the funding of smaller services”* (KI-A03)
  - anecdotal evidence and presumed benefits (*“Based on just my past experience and talking to people”* (KI-A02))
    - size and proximity to people’s homes: important for places characterised by geographic dispersion of the population, and for older people
    - Scotland: potential role in facilitating service integration locally (an *“integrator”* of services and as a locale for the development of a *“single point of access to integrated services”* (KI-S02))



# Concluding observations and implications

- Community hospitals and related structures provide a wide spectrum of health services
  - continuum between serving a ‘geographic purpose’, typically rural populations, to a specific population focus, mainly older and frail people
- A ‘fluid’ concept: flexibility to respond to local need
- Potential to occupy a niche within the local service delivery structure
  - a locale for service integration locally (Scotland: ‘local integration hub’) => component of locally integrated health and care services (Finland, Italy, Norway)
- Challenge: attracting suitable staff and maintaining a diverse skillset
- As delivery systems are evolving, boundaries between services provided by community hospitals and those offered elsewhere locally might blur or overlap
  - impact on the effectiveness and efficiency of service delivery
  - potential to undermine their value



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