Does one size fit all?

Increasingly recognised as an industry standard in the US, in other areas of the world the jury is still out on the 100% single patient room model of care. Our four experts consider when, where and for whom single patient rooms are appropriate

In the Canadian system, existing hospital wards contain an assortment of patient room types, including private, shared and the four-person ward room. But As the US moves towards a private room healthcare model for new construction, does 'one size' fit all? Before this design guideline becomes the industry standard, we must consider the issue from both a medical and a design perspective. Are private rooms beneficial for all patient populations? Will this design concept alter important psychological and social aspects which accompany the process of illness and healing? How will this change the experience of hospitalisation?

Along with private patient rooms, some US facilities now incorporate private pre- and post-operative rooms, in contrast to the larger open spaces which separate patients with curtains. In this new scenario an individual undergoing a procedure might never see, or be in, the same room as another patient. This characteristic of prospective inpatient facilities may enhance the sense of fear and disruption that accompanies the hospitalisation experience. In addition, family zones are now provided in each patient room, but there may not always be visitors there to provide companionship.

More research is needed to explore the impact on various patient populations

For some patient groups, most notably palliative care, geriatrics, and certain paediatric groups, shared spaces can provide social supports for patients and families which are beneficial in the healing process, decreasing the sense of alienation often felt in the wake of medical illness. A cost-effective design solution may be one where smaller private rooms are provided with more area devoted to a variety of social spaces. This need not be limited to designated lounges found at the corridor's end, but benches and alcoves could be provided in the hallway space outside each room to promote interaction, while allowing an easy retreat when isolation or privacy is desired.

Before we accept the private room model for all medical wards, more research is needed to explore the impact on various patient populations. Through the design of flexible spaces to accommodate individual preferences, patients and families can maintain an element of choice for room type. Ultimately 'one size' may not fit all.

Diana Anderson MD, 2008-2009 Tradewell Fellow,
WHR Architects, USA

By now, we've all heard the arguments for and against single-bed wards. Even as this debate wages on, however, much of the world is moving – and will continue to move – toward this patient room model, not only in the US and Western Europe but in Eastern Europe and the Middle East as well.

The arguments, particularly surrounding the heightened risk of infection, continue to stack up in favour of it. Not only that, but as healthcare worldwide becomes an increasingly commercial venture, patients and markets are demanding it.

On the other hand, single-bed wards are not always economically feasible. In many countries, the objective is simply to bring the quality, efficiency and accessibility of care up to an international standard. Even in places where the healthcare system is fully developed, social health services are often better served with more economical solutions that provide a mix of single and multi-bed rooms.

Cultural issues also play a role. In many developing countries, there are conflicting requirements driven by the substantial separation between the very wealthy and the poor; the need for affordable healthcare; and the desire for flexibility to accommodate a large family entourage. For any designer working globally, an understanding of context and culture is crucial to determining the ideal mix.

Single-bed wards are not always economically feasible

Ideally, single-bed wards will grow to become the industry standard in the interest of delivering the best healthcare worldwide. In the meantime, it is our responsibility as healthcare designers to bridge the gap between the two types of rooms, reducing the drawbacks and exploiting the benefits.

Alan Morgan, director, RTKL Associates, UK

The debate about single hospital rooms continues to preoccupy the UK's NHS as it strives towards a model for 21st century healthcare. Whilst some initiatives for change might be compared to rearranging the deckchairs on the Titanic, others – improving infection control, enhancing patient dignity and privacy – are all crucial.

I believe that single patient rooms have major benefits. However, not everyone is convinced. The elderly, in particular, tell us at public consultation meetings that they fear soulless corridors and the prospect of dying alone and unnoticed by hospital staff. Healthcare architects play a key role in persuading potential patients that their fears about single rooms are unfounded.

The US experience offers hope for a patient-focused model of care

The Ulrich model and the US experience offer hope for a model of care which will provide all the benefits of patient-focused care – shorter recovery times, better infection control, more efficient bed management, efficient bedside use of some hospital facilities (physiotherapy, pharmacy, pre-operative assessment) – thereby producing an overall improvement in the patient experience. The capital cost of providing single rooms will, of course, increase as hospitals become larger. As a society, we must decide on the relative merits of increased costs since the rewards are considerable. In the future, if we do achieve a higher ratio of single rooms to wards, we may wonder what the fuss was about.

Some things, with the benefit of hindsight, are obviously worth doing. Then the image of the 'Carry on Doctor' style hospital will be a historic one.

Chris Pye, partner, Watkins Gray International, UK

The Australian health system is one of the best in the developed world in terms of health outcome indicators, and at a cost of approximately 9% of GDP (similar to the UK) offers high quality, equitable and accessible healthcare to the Australian people regardless of age, employment, health status or income. It does this at a fraction of the cost of the US system which costs approximately 15% of GDP – a system that also scores a great deal worse on many of the same health outcome indicators where Australia excels.

Although the debate for and against 100% single rooms for inpatient facilities may be won in the US, it continues without definitive conclusion in Australia. Recent Australian research suggests that although there are many benefits associated with 100% single rooms, there are also significant additional capital and recurrent costs. The question must then be asked whether 100% single rooms is the best way to spend valuable, yet ultimately limited, Australian health dollars or is it possible to accept a lower percentage of single rooms (say 50-60%) and spend the money that is saved on other important health initiatives?

Are 100% single rooms the best way to spend valuable Australian health dollars?

With an increasingly ageing population, greater demands for costly technology, diversification of care from the acute sector into the home and community, plus an increasingly limited medical and nursing workforce, it is obvious that we simply cannot have it all!

The debate is ongoing and the 'evidence' continues to be gathered, reviewed and assessed to support a decision regarding the proportion of single rooms appropriate for the Australian health system. Ultimately, we must spend health dollars wisely to achieve the best possible health outcomes for our population. Our facility-related decisions, such as the proportion of single rooms, must accord with this reality.

Jane Carthey, director of the Centre for Health Assets Australasia (CHAA), Faculty of the Built Environment, University of New South Wales, Australia