A COMPREHENSIVE SURVEY

OF

HEALTH CENTRES IN ENGLAND AND SCOTLAND

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CHAPTER 1

INTRODUCTION AND ACKNOWLEDGMENTS

The National Health Service has now been in operation for eleven years and it will be recalled that in the early days much of the enthusiasm with which many General Practitioners welcomed its inception was due to its promise of Health Centres. It was felt that owing to the tripartite administration of the medical services these would facilitate the co-ordination of the three branches, General Practitioner, Hospital and the Local Health Authority, and make greater co-operation possible.

Unfortunately only a few health centres have been built so far and it is true to say that very little is known about even those. I have always been interested in health centres and thought that the time was now opportune to make a survey of those in operation, and this has been made possible through the generosity of the Medical Practitioners Union. A sub-committee was set up to consider the scope of the survey. The Assistant Secretary, Mr. Derek Lancaster-Gaye was instructed to help me in any way possible and I would like to record the tremendous help I received from him in preparing the questionnaire and in dealing with the numerous problems which presented themselves from time to time.

It was decided that I should visit all the health centres set up since the appointed day; a questionnaire was prepared which was intended to collect statistical information as far as possible;

It was hoped that I would meet the G.Ps. and other medical staff at the centres and discuss with them how far and in what ways their family doctor services had been affected by working at the health centres. From the material collected a report was to be prepared which would try to evaluate the work these services are doing and to formulate principles on which development of health centres in the future might be based.

The survey has now been completed. It has been thought useful to include a chapter on the history of health centres and shows quite clearly that the profession has given a good deal of time and thought to their study.

It remains for me to express my sincere gratitude to the Medical Practitioners Union whose financial assistance made the survey possible. My thanks are also due to Prof. R. Wofinden, Medical Officer of Health for Bristol, for his help in preparing this report, and to Miss Duncan, Statistician to Bristol Local Health Authority for many valuable suggestions; to my G.P. friends and colleagues, to Medical Officers of Health and their Deputies for their kindness and patience in face of my seemingly endless questions; to the secretaries of Local Medical Committees and others who have written to me giving information regarding current opinion on health centres.

CHAPTER II

WHAT IS GOOD MEDICAL CARE?

It has long been argued in articles and correppondence in the medical press and elsewhere that the G.P. services of the country could be greatly improved by better organisation. Further, a considerable body of informed medical opinion has suggested, as will appear in chapter 3, that the ultimate aim of such reorganisation namely, the provision of good medical care for the population can best be realised by the establishment of Health Centres and Group Practices. It seems important that a survey like the present one should first of all discuss what is meant by good medical care.

Until comparative recent years very little was known about general practice because the family doctor worked for the most part on his own and no attempt had been made to study him at his work. The first serious investigation of general practice and its standards of service was conducted by Dr. Collings,[1] an Australian graduate with some experience of general practice in New Zealand. His method was to visit a fairly large number of practices in England and Scotland to attend surgery sessions and to accompany the G.P. on visiting rounds. About a year later an inquiry on somewhat similar lines was carried out by Dr. S. Hadfield[2] an assistant secretary of the B.M.A., and a further and more detailed survey was made by Dr. S. Taylor[3] at the same time.

It is an understatement to say that Dr. Collings was greatly disturbed by what he saw, and his report caused a good deal of comment and discussion. While not attempting to minimise the gravity of Dr. Collings' charges or to deny that in some practices standards were very low, the two later surveys tended to present a more balanced overall picture. Nevertheless, they were agreed that there was room for considerable improvement. The general impression was that about 25% of all G.Ps were giving first class service, 50% good service which could be better, and that the services given by the rest were very inferior. Included in the last 25% was a small group, about 5% who gave very bad service indeed. It is of course true that surveys of other professions would show a similar state of affairs. There are bad lawyers, priests and schoolmasters, and it would be indeed strange if there were not also bad doctors in the community. In medicine where health and even life itself may be at stake, the greatest possible care should be taken to keep their numbers at the minimum.

In assessing standards of service the criteria adopted in the three surveys were similar and they included not only the clinical approach but also types of surgery premises, equipment, ancillary help and so on. It was observed that inferior medicine could be practised in very good surroundings and conversely good work was being done under adverse conditions. On the whole it was

agreed that for good medical practice there were certain minimal requirements in the way of premises and equipment. Dr. Taylor deals with this in very great detail in his book. Yet we are still left with the following questions.

What constitutes good medical care? What makes a good doctor? Is it one who follows the commercial slogan that the customer is always right and surrenders to every whim and fancy of his patients without question or investigation? Or is it one who treats them on the basis of what Dr. Balint calls the apostolic function[4] with certain fixed ideas as to how sick persons should behave or, one who regards every patient as a separate problem and takes the time and trouble to listen to his story rather than dismissing him as quickly as possible with the inevitable E.C.10?

At the present time there are two schools of thought concerning the role of the G.P. in the National Health Service within our modern so-called Welfare State. There are those who maintain that with the rapid advances in medicine over the past 20 years or so it is impossible for any one G.P. to deal adequately with all the problems which arise in a patient and his family. Such persons hold that the family doctor should treat only minor conditions himself and refer all those requiring even simple investigations to the appropriate out-patient department, surrendering all clinical responsibility and interest in so doing.

In this way the G.P. could be held responsible for many more patients than the present maximum of 3,500 whilst treatment for the most part would be based on hodpitals and consultants. The surveys showed that there were quite a number of G.Ps. who were content to receive their capitation fees under the N.H.S. for being what might be called basic doctors or signposts to the nearest out-patient department.

On the other hand there are those who utterly reject this concept. They consider that modern methods of diagnosis and treatment present a challange to the G.P. to exploit to the full the skills in which he has been trained and so enable him to fulfill his true function and satisfy his sense of vocation. The new drugs and techniques and those concerned with social welfare e.g. Health Visitors, District Nurses, Home helps and so on, enable him to treat at home or in his surgery many cases formerly sent to hospital. We can no longer separate preventative from curative medicine and the G.P. should ultimately be responsible for most, if not all, of the clinical work at present regarded as coming within the scope of the Local Health Authority. He cannot do everything himself but as patients come to him in the first instance he should be the co-ordinator of all these services, and his should be the position of ultimate responsibility. His spheres of activity would increase rather than decrease and with the diminishing incidence of many infectious diseases there will be more time to devote to the increasing problems of our day now grouped very

loosely under the term, psychosomatic disease. Despite the vast amount of literature on this subject we are at present only on the threshold of our inquiry into the working of the mind and we know very little about its influence in producing disease. As. Dr. Balint[5] puts it "Which is the primary, a chronic organic illness or a certain kind of personality? Do sour people get peptic ulcers or does a peptic ulcer make people sour?" The approach to the patient so well described in this book offers a new horizon of immense interest and importance to the G.P. All this is included in what I understand by good medical care and it is suggested that the majority of G.Ps would prefer to belong to this second group if conditions of service made it possible.

The three surveys and the discussion which followed their publication had a stimulating effect on the profession generally and compelled recognition of the fact that standards were not as good as they might be. One of the more immediate results was the formation of the College of General Practitioners in 1952 and another, the inspection of surgeries. A full discussion of the reasons for the unsatisfactory state of affairs in general practice is outside the scope of this study but two important contributory factors are generally recognised. Firstly, the absence until comparatively recently of any instruction on general practice in the medical curriculum and secondly, the unsatisfactory conditions under

which a good many general practitioners work. Two methods have been suggested for dealing with these factors. They are:

1. The establishment of General Practitioner Teaching Units at medical schools. They would be staffed by G.Ps. and here the future G.Ps would gain an insight into general practice in its broadest aspects. In addition to its clinical side they would see that nowadays family doctoring is essentially team work and they will learn how to co-operate with the various preventive medical and social agencies organised by the Local Health Authorities and other bodies. It is hoped that this will go a long way to educate the student towards a proper appreciation of these agencies and do much to remove the ill feeling and lack of co-operation which unfortunately still exists. between the G.Ps and the L.H.A.

2. The provision of Health Centres for those already established in general practice. Most doctors who enter general practice do so quite soon after qualifying, retaining in their mind the ideals with which they began their studies and which were reinforced by their teachers and their experiences during their student years. Unfortunately, in the course of time and sometimes quite soon in the case of a young doctor who quickly finds himself in possession of a large list, these ideas tend to become rather blurred. This is because many G.Ps find themselves submerged as it were, by the pressure of adverse working conditions, large numbers in their surgeries and the competitive element in general practice.

The best type of doctor does not need much encouragement, he will give of his best under any circumstances and maybe the poor sort will only be little affected by improved working conditions. It is the remainder who constitute the majority of G.Ps who would respond to the challenge of Health Centres. These would provide better facilities for patients, secretarial and nursing help which, by relieving the doctor of all the non medical work, would buy time for him which he could more usefully devote to his patients. They would provide the opportunity for co-operation with the Local Health Authority workers and by close association with his fellow G.Ps. stimulate him to raise his standards of service.

The present survey was undertaken in an effort to discover what contribution the existing Health Centres had made towards these ends but before turning to the survey itself it has been thought worth while devoting a chapter to the definition and history of Health Centres.

References. 1. Lancet 1950 I.555
2. B.M.J. 1953 2.683
3. "Good General Practice by S. Taylor,O.U.P. 1954
4. "The Doctor, his Patient and his Illness" by Michael Balint, Pitman, London, 1957, p216.
5. Ibid. p.255.

CHAPTER III

THE HISTORY OF HEALTH CENTRES

General

The concept of Health Centres is not new. Rene Sand, in his book 'The Advance to Social Medicine'[1], traces the way in which the idea was developed in different countries throughout the world from the early years of the present century to modern times. He describes how, in America, it was realised that the various institutions concerned with health would work more cheaply and efficiently if contained in one building. In 1910 two multiple clinics were founded, the Irene Kaufmann Settlement Health Center in Pittsburgh and the Kirby Memorial Health Center in Wilkes-Barre. This was followed by others in 1913 and 1916 and the Rockefeller, Commonwealth and Milbank Foundations encouraged the spreading of the idea throughout the world.

Professor Sand gives France the credit for being the first in the field with an Infant Welfare and Maternity Centre in 1901 in a district in Paris, and goes on to describe their later development and spread to other towns in France.

The commission appointed to draw up plans for a National Health Service in South Africa also proposed setting up a network of Health Centres and, up to the time the book was published, twenty of these were functioning. In Australia, too, Health Centres are

preferred and in South America under the Interamerican Co-operative Health Program sixty-four Centres have been opened in the past five years. In the U.S.S.R. the medical services are also grouped round Health Centres and Polyclinics.

There is great variation in the facilities offered at the Health Centres described by Professor Sand but in all of them the guiding principle is the same, namely, that the curative and preventive aspects of medical care cannot be separated and it is simpler, more efficient and economic to join them together in one service under one roof.

Since the publication of this book Health Centres have been built all over the world, even in the remote Arctic as was described in an account of a Norwegian Health Centre[2].

Health Centres in Britain

The term 'Health Centre' was first used in Britain by the Dawson Committee as long ago as 1920. In their Report[3] a Health Centre was defined as "An institution where are brought together various medical services, preventive and curative, so as to form one organisation." The Committee suggested two types of Health Centre to be built and maintained at the expense of statutory authorities and called 'Primary' and 'Secondary'. The former was to be a simple organisation supplying, for the most part,

domiciliary, or what we would now call family, medical services; the latter more specialised services.

The Primary Health Centre would be "An institution equipped for the services of curative and preventive medicine to be conducted by the G.Ps. of the district in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists..... the patients retaining the services of their own doctors." The importance of the G.P. was recognised and his sphere of activities was to be spread very wide in the field of preventive and social medicine.

A group of Primary Health Centres should, in turn, be based on a Secondary Health Centre to which difficult cases or those requiring special treatment would be referred. The Secondary Health Centre would contain more extensive equipment and would be staffed mainly by consultants and specialists. These Secondary Health Centres, in turn, should be brought into relation with a Hospital or be merged with a teaching hospital where one existed.

The Primary Health Centres described by the Committee were planned on a scale different from any which have been built in this country and would correspond more nearly to what one would call General Practitioner Hospitals. In addition to the G.P. suites they were to contain wards of varying sizes including maternity

wards, operating theatres, X-ray and pathological facilities and physiotherapy equipment. The design also included a common room which was to serve as a meeting place for the G.Ps. of the district and act as the intellectual centre of the doctors at that unit. The Committee recognised that G.Ps. work mostly in isolation and hoped that these centres would bring them together in a spirit of co-operation with great advantage to the health service.

The design for Secondary Health Centres differed very little in principle from that of the Primary, the functions would be the same, curative and preventive, but with a staff of consultants and specialists. There would also be facilities for post-graduate study and the training of nurses. The Secondary Health Centres would receive cases sent from the Primary Centres by reason of difficulties in diagnosis or because specialised treatment was necessary. They would have all the resources of a hospital and, in many cases, would act as one.

A reading of the detailed recommendations of the Report shows the Dawson Committee to be the source of many of our current ideas on health care. Unfortunately, although it was presented as an Interim Report as a matter of urgency, no action was taken.

During the following years there were published a series of study on future health policy. The B.M.A. Report on "A General

Medical Service for the Nation" was issued in 1930 and a revised version was later published in 1938. Its main recommendations were to improve and expand the Health Service on its existing foundations rather than build an entirely new structure. One interesting suggestion was the setting up of local medical centres for treatment only.

This report did not envisage the provision of Health Centres but is here mentioned because it was, in a sense, the fore-runner of the much more comprehensive Draft Interim Report of the Medical Planning Commission[4] published in 1942. For those interested in Health Centres this is the best and most detailed account of the Health Centre concept as understood today.

Experiences of the health services during the war and the Emergency Medical Service showed that there would be need for considerable changes in the future medical services. The profession early realised this and one of the first steps taken was the setting up of the Medical Planning Commission in August 1940. This body consisted of seventy-three members representing the B.M.A., the Royal Colleges and the Royal Scottish Corporations and its members were drawn from all branches of the medical services. It has been described as "probably the most representative body ever established by the medical profession."[5] This Commission was divided up into five sub-committees with a co-ordinating committee

and the recommendations set out in their Report represent the broad principles on which full agreement was reached. Its terms of reference had been "to study war time developments and their effects on the country's medical services present and future."

The Commission had before them the Reports of the earlier B.M.A. Committee 1930-38 and adopted as their main objectives those set down by this Committee. These were:

(a) "To provide a system of medical services directed towards the achievement of positive health, the prevention of disease, and the relief of sickness."

(b) "To render available to every individual all the necessary medical services, both G.P. and specialist, domiciliary and institutional."

The Commission considered that the recommendations of the earlier Committee were not sufficiently comprehensive and were of the opinion that if they were adopted too many of the faults of the existing system would be retained. They recognised that a service part salaried and part private to serve certain income groups would lead inevitably to two kinds of service determined by ability to pay. They also commented unfavourably on competition for patients and stated "co-operation between G.Ps. in any locality is essential for efficient general practice under modern conditions."

It had long been recognised that there was too much diffusion of responsibility for the country's health among a number of statutory authorities both local and central and the Commission were of the opinion that -[6]

> "each family or individual should be under the care of a Medical Practitioner who shall be concerned not only with diagnosis and treatment but also with the prevention of disease. It involves integration of the preventive and personal health services, it also involved radical changes in the country's administrative machinery and in the training of medical students. It assumes that fusion of public health and other forms of practice will result in practitioners in every field working in close contact and accord not only with each other but also with dentists, nurses, midwives, sanitary inspectors and other auxiliaries."

The Commission suggested that for general Practitioner services Health Centres, as defined by the Dawson Committee, would be the means of achieving these ends and in this regard make the following recommendations:-

1. Health Centres should be provided and maintained by statutory authorities and not by the doctors themselves. They would replace the doctors' private surgeries.

2. There would be free choice as between doctor and patient.

3. The family doctor would be the key figure and provide the link between the various medical and social services concentrated at the Centre.

4. Doctors would work together as groups, preferably in partnership. Modern conditions of medical practice made it inadvisable to "continue individualism into an age where division of labour and co-operation are essential factors in social service."

5. The doctors would have nursing and clerical assistance to enable them to devote more time to their patients.

6. The Centres would be provided with X-ray apparatus and pathological and other diagnostic facilities which would be under the supervision of consultants. This would bring about closer association between the general practitioners and hospital consultants.

7. The Commission rejected the idea of a salaried service for G.Ps. working at Health Centres but recommended instead payment by capitation.

8. A model Health Centre was described. It was proposed that it would contain suites for six G.Ps., each with separate waiting rooms, consulting and examination rooms.

The Report of the Medical Planning Commission was an Interim one intended for discussion by the profession and was considered by the Annual Representative Meeting in London,

September, 1942. After considerable discussion it was accepted and a motion "approving in broad outline the plans for Health Centres as set out in the Report" was approved.

It is worth noting the objections raised at the A.R.M. to the principle of Health Centres. These were, general practice in a Health Centre would become impersonal and tend to resemble a hospital out-patients' department; there would be too much clerical work, and the centres would be too costly for general application.

Nineteen forty two also saw the publication of the Beveridge Report[7] and the acceptance in it of the main recommendations of the Medical Planning Commission. Assumption B states "It (Social Security) covers a national health service for prevention and for cure of disease and disability by medical treatment; it covers rehabilitation and fitting for employment by treatment which will be both medical and post-medical." The report continues - "The first part of Assumption B is that a comprehensive national health service will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary or institutional, general, specialist or consultant, and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents.....Restoration of a sick person to health is a

duty of the State and the sick person, prior to any other consideration. The assumption made here is in accord with the definition of the objects of medical service as proposed in the Draft Interim Report of the Medical Planning Commission of the British Medical Association."

The Beveridge Report insisted, that all these facilities be open to the whole population as against the 90% entitlement suggested by the M.P.C.

Following this Report discussions took place among representatives of the B.M.A., the Royal Colleges, Voluntary Hospitals and Local Government Authorities and ultimately, in February 1944, the Coalition Government produced the White Paper entitled "A National Health Service."[8]

In the White Paper the proposal for G.P. services followed in the main the recommendations of the M.P.C., stressed the importance of close collaboration amongst G.Ps and recommended group practices in Health Centres. It also recommended that in such Centres competition would be undesirable and G.Ps. should be paid on a different basis.

"It seems fundamental that inside a Centre the grouped doctors should not be in financial competition for patients. All the practical advantages of the centre - the use of nursing and secretarial

staff, record keeping, equipment, the availability of young assistant doctors in particular will be under a system of a salaried team, at the disposal of the group in whatever way they like collectively to arrange; it is the whole idea that they should arrange their own affairs together in this way. But if individual remuneration is based on mutual competition for patients, complication will enter into any attempt of the group to allocate and share these services - for the more any one individual is able to draw on the ancillary helps of the Centre (and particularly on medical assistants) the more he will gain and his fellows lose in the contest for patient lists. There is therefore a strong case for basing future practice in a Health Centre on a salaried remuneration or on some similar alternative which will not involve mutual competition at the Centre."[9]

In an attempt to discover the opinions of the profession, the B.M.J. then issued a questionnaire based on the recommendations of the White Paper and in August 1944 the results were published. Of the doctors who replied the majority were opposed to the main recommendations of the White Paper. Sixty per cent of the G.Ps were in favour of Health Centres but only 32% were in favour of salaried service at Health Centres, the majority preferring either basic salary plus capitation fees, or capitation fees only.

The National Health Service Act was passed in November, 1946, and section 21 declares: "It shall be the duty of every local health authority to provide, equip, and maintain to the satisfaction of the Minister premises, which shall be called "health centres", at which facilities shall be available for all or any of the following purposes:-

(a) for the provision of general medical services under Part IV of this Act by medical practitioners;

(b) for the provision of general dental services under Part IV of this Act by dental practitioners;

(c) for the provision of pharmaceutical services under Part IV of this Act by registered pharmacists;

(d) for the provision or organisation of any of the services which the local health authority are required or empowered to provide;

(e) for the provision of the services of specialists or other services provided for out-patients under Part II of this Act; or

(f) for the exercise of the powers conferred on the local health authority by section one hundred and seventy-nine of the Public Health Act, 1936, or section two hundred and ninety-eight of the Public Health (London) Act, 1936, for the publication of information on questions relating to health or disease, and for the

delivery of lectures and the display of pictures or cinematograph films in which such questions are dealth with.

(2) A local health authority shall to the satisfaction of the Minister provide staff for any health centre provided by them;

Provided that a local health authority shall not employ medical or dental practitioners at health centres for the purpose of providing general medical services or general dental services under Part IV of this Act." Similar duties are laid upon the Department of Health for Scotland.

There is no intention of associating Health Centres with a salaried service for G.Ps. and this was subsequently reaffirmed in the Amending Act of 1948.

The passing of the National Health Service Act 1946 was followed by a period of intense activity and discussion in which the intentions of the Government with regard to Health Centres were clarified in a series of Ministry of Health circulars.[10] The Health Centres were to be provided by Local Authorities, one to every ten to fifteen thousand of the population and were to contain suites for six to eight G.Ps and surgeries for dentists. They would contain the Local Health Authority Clinics as out-lying Clinics of the hospital services. They would develop team work

and enable G.Ps to specialise amongst themselves. They would be convenient for the public and relieve the over-worked G.Ps and their wives.

Early in 1947 in a series of articles entitled "Health Centres of Tomorrow[11]" the future of the general practitioner services is discussed and two lines of development are considered. The first holds that what the G.P. needs most of all is access to special diagnostic methods carried out on his behalf by experts. The other method chiefly seeks better facilities for the practitioners use, it wants to increase his usefulness by sparing him non medical tasks and by promoting more co-operation with his fellow G.Ps and other health workers.

The author prefers the second method and considers that this can best be applied in group practice at Health Centres. This will in no way affect the doctor patient relationship, on the contrary the author considers that the G.Ps responsibility to his patient will be increased not diminished. Specialization in general practice is also discussed but not favoured. It is thought that where a G.P. becomes proficient in any special branch of medicine the logical thing is for him to become a specialist. G.Ps must be truly general practitioners.

Finally the series concludes "...the new National Health Service must not be considered just another method of payment for the G.Ps services. It must give him new advantages, enlarge his capabilities and restore some of the opportunities which general practice has - with the advance of medicine - been lately in danger of losing. To do this it will be necessary to explore to the full the conception of group practice in Health Centres."

Unfortunately, the situation in the building industry made any general development of these plans impossible and in 1948 a Ministry of Health circular asked Local Authorities to postpone, for the time being, their schemes for Health Centres. Moreover it was considered that study was necessary before embarking on any ambitious programme and the Central Health Services Council was asked to set up a committee to investigate this matter. This view was also shared by the profession when a motion at the Annual Representative Meeting of the B.M.A. in July 1948 requesting that Health Centres be treated as a matter of urgency was amended in favour of a more cautious and experimental approach. The whole matter was then referred to the B.M.A. Sub-Committee on Health Centres which had begun working in 1947.

The published reports of these two bodies[12,13], were based on fairly extensive investigations into varying types of general

practice throughout the country, both urban and rural, single handed and partnerships, and is evidence that a good deal of time and thought was given to the question of Health Centres.

Although they differ in certain particulars their conclusions and recommendations follow similar lines. It is interesting to note that, when these were discussed at the B.M.A. Annual Representative Meetings over the next few years, the members of these committees maintained their support for Health Centres while the opposition to Health Centres in principle from other representatives was on grounds very little different from those already mentioned.

Discussing its report in two articles,[14] the B.M.A. stresses the importance of experimental planning of Health Centres especially in new housing estates. The recommendations are still the same except that it is suggested that x-ray and pathological services should not be provided at Health Centres but at hospitals and that G.Ps should have direct access to all these facilities.

This led to some thinking and discussion on how best to relieve the pressure on hospital out-patients departments and also on how best to provide diagnostic facilities in the new towns where as yet there were no hospitals. The Nuffield Provincial

Hospitals Trust were greatly interested in these matters and it is mainly through their initiative and generosity that the diagnostic centres at Corby (1954), Harlow (Bentham House, 1958), and Edinburgh (1959) were built.

In their recommendations on health centres both the Dawson Committee and the M.P.C. referred to the training of medical students. As about half of all medical graduates enter general practice it seems logical that the curriculum should contain some instruction in general practice by G.Ps. No doubt thinking on these lines influenced in some measure the setting up of the G.P. Teaching Health Centres at Edinburgh in 1951 and Manchester in 1954.

One of the first Health Centres to be built under the act was the William Budd in Bristol which began working in July 1952. In their article[15] recording the event Drs. Parry and Wofinden discuss the financial aspects of Health Centres. Although it had been considered that provision of Health Centres would be an expensive undertaking no information was as yet available. (The report of the London Local Medical Committee was not published until 1956). The William Budd was a modest building costing about £16,000 and it was estimated that the running costs would be about £10,000 per annum. If similar centres were to be provided for all the Bristol G.Ps between thirty and forty would

be required and this would place a heavy burden on the rates. The authors go on to discuss other methods of assisting G.Ps to improve their surgery accommodation.

In a second article[16] written after the William Budd Had been running for two years the estimate of running costs is confirmed but the financial implications are put in their proper perspective. The running costs are made up of loan charges and the salaries of personnel working at the centre. As the Local Health Authority are bound to build and maintain clinics and employ staff surely it would be better to have them fully employed in Health Centres than in clinics which may be idle for some part of the day. They also argue that the cost of Health Centres must be considered in relation to the services rendered to the community and this aspect they compare very favourably with other branches of the Health Service.

During this period the country was still in financial difficulties and the building of further Health Centres could not be contemplated.

In 1954, as an interim measure, the Government set up the Group Practice Loan Fund to stimulate the formation of group practice. The fund provides interest free loans to enable groups of doctors to establish central surgery premises from which all the

doctors concerned would practice and where the bulk of their work would be done. It was also hoped that, wherever possible, the Local Health Authority services would be contained in the same building and in this way bring together the two branches of the service. The conclusion of the B.M.A. Sub-Committee 1949 was "that the most satisfactory form of practice at present or in the immediate future is partnership practice from a common surgery" and further "the logical future development will be the provision of specially designed Health Centres from which both G.P. and the present Local Authority Health Services can be provided."

The first Health Centre to be built in Britain by a statutory authority under the National Health Service Act was opened at Woodberry Down in 1952, and this was followed in the course of several years by all those included in the present survey.

The Surveys undertaken by the B.M.A. revealed an increasing tendency for doctors to abandon single-handed practice and come together in partnerships working from a communal surgery. In some cases they had the assistance of midwives and health visitors provided by a Local Health Authority for their ante-natal and infant welfare sessions. Even where no partnerships or groups existed the G.Ps tended to organise themselves into rota systems for emergencies, night calls and holidays.

At the present time it is true to say that much of the enthusiasm for Health Centres aroused by the Medical Planning Commission's Report has diminished. This has been due to a number of factors, some of which are discussed in the Report of the Central Health Services Council 1954.[17]

This Committee noted that Health Centres had aroused a good deal of controversy, especially on the grounds of expense and policy and described some of the practical difficulties met by G.Ps and Local Health Authorities in their efforts to set up Health Centres. For example, in many cases the G.P. was reluctant to give up independent practice in his own premises for premises owned by the Local Authorities who must, of necessity, exercise some control and this it was thought might lead ultimately to a salaried service. There were difficulties too in the drawing up of contracts and the unwillingness of the G.P. to commit himself to a new experiment such as a Health Centre without knowing in advance the terms of service, rental, control, power of dismissal and so on. Moreover fears were also expressed as to the effects such a move would have on his practice, especially if some of the G.Ps with whom he was in competition elected to stay in their own surgeries. Efforts to persuade the Ministry of Health to declare such an area closed had failed on the grounds that such action would

be too controversial. The G.Ps also feared that in the event of there being an unoccupied suite at a health centre a practice vacancy would be declared and advertised by the Local Executive Council. The Ministry has gone as far as admitting that this would be undesirable but has been unable to agree to ban it completely.

The Local Authority for their part could not proceed with any plans for a Health Centre until they knew for certain that the G.Ps. would practice there.

Great difficulties were encountered in drawing up comprehensive agreements between the three participating bodies, G.Ps., Local Health Authorities and Local Executive Councils. The model form of contract drawn up by the General Medical Services Committee in 1949 is rather a formidable document.

The question of rental was found to be exceedingly difficult. If the G.P. had to pay an economic rent, this would be too expensive and if the Local Authority agreed on low rents, this would be objected to by the doctors outside - as rate payers they would be subsidising doctors with whom they were in competition. Difficulty in reaching agreement on this question alone has been responsible for the abandonment of Health Centre projects in some instances.

All these difficulties are discussed at length in this report and the committee goes on to make recommendations whereby they might be overcome.

Other factors responsible for the lessened interest in Health Centres have been the restriction on capital development imposed in 1948 and later because of building and financial difficulties and during recent years to the preoccupation of the profession with other problems of organisation and especially remuneration.

Now that the financial position of the country has improved and that the Royal Commission on Remunerations is about to publish its Report interest in Health Centres may be revived.

The literature on the subject of Health Centres has only briefly been mentioned in this chapter but for any group of G.Ps or Local Health Authorities who are considering settling up Health Centres in their locality a close study of this subject is essential. This would show them how, from the simple beginnings described by Professor Sand, that is the acceptance of the fundamental principle that prevention and cure of disease are indivisible, the Health Centre idea has spread and been developed throughout the world. We have gone a long way from the humble Centre in a Parisian suburb to the comprehensive Health Centres and the Polyclinics in the U.S.A. and U.S.S.R., but the underlying

intention is the same. A Health Centre is not an end in itself but only a means towards improving the medical services and the health of the people.

At this point it will be useful to summarise the main recommendations of the various committees mentioned and also list what are considered to be the main disadvantages and advantages of Health Centres.

Recommendations regarding Health Centres in Britain as extracted from the various Committees' Reports.

Dawson Committee - (a)

Medical Planning Commission - (b)

B.M.A. Committee, 1949. - (c)

Central Health Services Council, 1954. - (d)

1. Preventative and curative methods of medical care must be gathered into one building containing G.P. and Local Health Authority services. (a)

2. There must be complete freedom of choice as between doctors and patients. The G.Ps who form a group must do so by mutual consent. (c)

3. Health Centres still being in the experimental stage, those set up should be the subject of close attention to see how they work and what their effect is on the efficiency of the health services.(c)

4. There is no reason why the clinical work at present regarded as being the province of the Local Health Authority Medical Officers should not be done by the G.Ps. themselves. The Local Health Authority Medical Officers likewise could participate in general practice. This would encourage integration of these two branches of the Health Service. (c) and (d)

5. The doctors concerned should practice solely at Health Centres and in order to encourage them to give up their other surgeries they must be protected by the restriction of entry of other G.Ps. into the neighbourhood and be allowed to give up leases on their houses without financial loss. (c)

6. In new towns and on new housing estates it is recommended that Health Centres be provided concurrently with schools and other public services and that doctors' houses with surgery accommodation should not be provided. "If the opportunity was not grasped and doctors were allowed to establish themselves in independent practice it would be many years before the lost ground would be re-gained." (d)

7. When it has been decided to establish a Health Centre in any locality the G.Ps. and the L.M.C. should participate in the discussions from the very beginning. (c)

8. Although the Dawson Committee recommended the provision of beds and wards for in-treatment of patients, these views have not been supported by the other committees. There are those who consider that G.Ps should have diagnostic facilities at the Health Centre such as X-ray and some pathological services, these departments to be under the supervision of visiting consultants. (a) and (b).

9. On the other hand, the contrary opinion holds that these facilities should be concentrated as far as possible in hospitals with completely open access to G.Ps. (c) and (d).

10. Similarly there are opposing views as to the presence of consultants at Health Centres. Instead it is recommended that arising out of special experience there would be partial differentiation of functions amongst the G.Ps. themselves. It is suggested that liaison between G.Ps. and hospital consultants could best be effected by frequent meetings at the Health Centre for discussion of cases seen in domiciliary visits and associating the G.Ps. with the staff of hospitals wherever possible. (d)

11. It is important, therefore, to have a staff room for discussions.

12. There should be a separate treatment room for injections, dressings and minor surgical procedures. (b) and (c)

13. The G.P. suites should consist of a consulting room, examination room and waiting room, which could be shared between two doctors. Large waiting halls are not favoured. The Centre should have its own permanent nursing and secretarial staff appointed in consultation with the G.Ps. (c)

14. The size should be such as to serve a population of a minimum of ten thousand and a maximum of twenty thousand. This would probably require four to eight G.Ps. who should preferably be in partnership. (c) and (d)

15. The rental paid by the G.Ps. can never be an ecomonic one but should compare reasonably with what it would cost to provide themselves with adequate facilities and services in the particular district in which the Health Centre is located. (d)

16. The doctors should live in the area in which they practice.

17. The site of location of the Health Centre deserves careful consideration and would be influenced by local factors such as ease of access and population requirements.

18. Pharmaceutical services should be provided only where indicated by local needs. (b) and (c)

19. Dental services should be provided at the Centre.

20. Only physiotherapy requiring little or no apparatus should be provided. (d)

21. There should be adequate telephone arrangements or a caretaker to ensure that patients can contact their own doctor when the Centre is closed.

22. A Social Worker should be appointed to a Health Centre to help the G.Ps. with the social medical aspects of their work. (d)

23. A Hospital Dietician could, with advantage, hold sessions at the Health Centre. (b) and (c)

24. There should be professional committees which include the G.Ps., Dentists and representatives of the M.O.H.

25. There should be someone in over-all charge of the Health Centre. (d)

26. "There is clearly a danger that if a number of doctors work at a Health Centre as individuals, this might lead to competition as between these doctors for patients. Lack of mutual confidence might then develop which would prevent the co-operation and interchange of knowledge and experience which a Health Centre is intended to foster, and would certainly prejudice the changes of forming the type of group practice described in paragraphs 61-64 above." (d)

27. "We wish to put on record our opinion that the use of Health Centres and the doctors practising therein could be most valuable as part of the education of medical students in the field of general practice." (d) (71)

Disadvantages of Health Centres

The disadvantages put forward are that Health Centres are too costly and would impose a severe strain on the country's finances and on the G.P. if the rent was excessive.

The Centre would, by its impersonal nature, destroy the close doctor/patient relationship and convert the doctors' private surgeries into something more like a hospital out-patients department.

Some doctors feel that their independence and security might be affected by the conditions of practice in a Health Centre owned by Local Authorities.

Opinions also differed over the question as to whether Health Centres might lead to a salaried service and whether this would be advantageous or not.

Under the Act the Local Authorities have to provide the Health Centres and use the facilities and this means that they would be in control to some extent and G.Ps. have serious misgivings about being subject to the control of Local Authorities.

Advantages of Health Centres

Once the principle has been accepted that preventive and curative medical services are at one, it is sound business efficiency to have them under one roof. As Professor Sands puts it, the first American Health Centres were organised on the same business methods as the multiple department stores. The immediate result would be a saving in capital expenditure.

The Health Centre would provide a natural meeting place for all those working in the health services in the neighbourhood and would bring about close integration and co-ordination amongst the G.Ps., Local Health Authority Workers and Consultants. This would be greatly increased in consequence of the G.Ps working in a group. There would be no wasteful competition for patients but close co-operation and rotas for holidays and night calls. They would work in close association with the mid-wives and nurses on the staff of the Centre and be able to meet and discuss cases with all the visiting ancilliary health workers. This close association would greatly enlarge their sphere of interest and give them the opportunity of practising preventive medicine. They would be meeting and getting to know these various personnel and this would make for greater efficiency by avoiding overlapping of services. It would also make for improvement in personal

relationships which are recognised to be less harmonious than they ought to be.

Provision of these services and adequate secretarial help would buy time for the G.P. and enable him to devote more time to his patients and provide him with opportunities for study and attendance at hospital lectures, courses and the like.

If some diagnostic facilities were also provided these would tend to keep the G.Ps. proficient in the skills they had learnt at medical schools and the attendance of medical students would also stimulate them to keep up to date.

The doctor would also benefit in his private life because "the majority of doctors' wives would prefer the home to be right away from the surgery; the irregularity of meals in a doctors' home, the constant interruptions of family activities and the disturbed nights are enough for any woman to endure without the extra work she cannot avoid if she lives in a building to which come all the patients and messages and 'phone calls." (d)

Although all the advantages here mentioned would accrue to the doctors there is no doubt that it is the patients who would ultimately benefit from the resulting improvements in the medical services, and this is as it should be.

It ought to be emphasised that most of the recommendations listed here were available for consideration long before any of the present Health Centres were built and the Survey will show how they were applied.

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CHAPTER IV

ANALYSIS OF THE QUESTIONNAIRE

SCOPE OF THE SURVEY

Four types of Health Centres were visited, their titles, addresses and references are given in full in Appendix 1 and are referred to throughout by the names of the towns in which they are situated.

1. Those established by statutory authorities -

   (a) In England by Local Authorities under Section 21 of the National Health Services Act -

   Aveley

   Bristol

   Cheltenham

   Coventry

   Farringdon

   Harold Hill

   Nottingham

   Sunderland

   Swindon

   Woodberry Down

   (b) In Scotland by the Department of Health -

   Sighthill

   Stranraer

2. Group Practice Health Centres -

Harlow

Lichfield

Oxhey

3. Diagnostic Health Centres -

Corby

Edinburgh

4. G.P. Teaching Unit Health Centres -

Edinburgh

Manchester

During the course of the Survey I visited Stoke-on-Trent and saw the temporary surgery accommodation made available by the Local Authority to G.Ps whilst negotiations are proceeding with regard to the proposed Health Centre. I met the doctors concerned and had an opportunity of discussing the situation with them. At his kind invitation I visited the County Medical Officer of Health at Stirling and heard an account of his plans for Health Centres at Bannockburn, Bonnybridge and Kilsyth.

By discussion with colleagues and correspondence from secretaries of Local Executive Councils and others some account of opinion has been obtained regarding Health Centres at Exeter Glasgow, Hull, Leeds, Sheffield, Middlesborough, Cardiff and Liverpool.

It has been thought useful to include for comparison two group partnerships where, from personal knowledge of the doctors, the G.P. services given were of a high standard. One is in Yorkshire and the other in Bristol.

For the sake of convenience this chapter follows much the same order as the questions in the questionnaire (Appendix II). Wherever possible the information collected has been tabulated (Appendix III)*. Harlow, being an unusual project is described separately in Chapter V.

SECTION 1 : H I S T O R I C A L

(I) Centres built by statutory authority

All these were established in response to a definite local need and for the most part this was a new housing estate with no resident doctor, poor surgery accommodation for the visiting doctors and inadequate facilities for Local Authority Medical Services. The exceptions were Swindon, where the Local Authority took over the old Great Western Railway Health Centre in the middle of the town on the "appointed day", Faringdon where the Cottage Hospital was about to close because of staffing difficulties and Bristol where it was intended to build a Health Centre in a fully built-up area on a Housing Estate which was built between the two wars.

* In separate folder at end of book.

There was abundant evidence during the tour and from correspondence received that Local Authorities and Medical Officers of Health everywhere took the recommendations of the National Health Service Act with regard to Health Centres very seriously and were, in most cases, the prime movers in discussion towards their establishment. Many of the L.As had prepared master plans for the re-housing of the population in new housing estates and these included the provision of Health Centres in the areas for which they were responsible.

The schemes the L.A. had in mind were laid down in Ministry of Health circulars and these in the main follow the recommendations of the Medical Planning Commission Draft Interim Report of 1942 and other B.M.A. Committees on Health Centres. The essential points were that the Health Centres should be the sole surgery premises of the doctors and not branch surgeries and that the G.Ps should work as a group in close association with the L.A. Medical Services.

Unfortunately, in some cases the relationships between the doctors concerned and the L.A. seem to have been very bad indeed. It was the feeling of the G.Ps at these Centres that they were not consulted at an early stage in the proceedings. In some

cases it was stated that the project was at an advanced stage - on paper that is - before they were told anything about it. The site had been chosen without reference to them and was often thought to be unsuitable nor did they have much say in the design or finally in the choosing of the staff.

This gave rise to bad feeling on both sides. The G.Ps for their part felt that the Local Health Authority wanted to go ahead with their schemes with or without their co-operation, that they were mainly concerned in establishing the L.A. clinics with the G.P. suites as appendages as it were. This was because it was only in this way Ministry consent for their clinics could be obtained and also that they could build much bigger premises. They felt too many political factors were involved.

Another cause for suspicion was the fear that the Health Centres might be the thin edge of the wedge towards a salaried service. (Occasionally a G.P. was found who expressed a wish for a salaried service). It had also been suggested to them that if no local G.Ps were willing to go into the Health Centres practice vacancies would be declared and advertised to doctors outside the city.

The result was that the G.Ps felt they were being blackmailed into joining the Health Centres solely in order to protect their practices.

In one city the bad relationship between the G.Ps and the L.H.A. arose from the slow rate of progress of the actual plans for the Health Centre. One was to be built on a new housing estate and when first proposed found general agreement amongst the G.Ps concerned. Unfortunately, by the time the final plan was accepted the situation had changed completely. The houses had all been built in the meantime and most of the people had chosen doctors on the periphery.

In another city the circumstances were similar except that the fault lay in poor liaison between the Health Committee and the Housing Committee. This resulted in permission being given to the building of a doctor's house with surgery near enough to the site of the proposed Health Centre to prejudice its chances of success right from the start.

In yet another the G.Ps while agreeing to the Health Centre in principle, objected to the plan on account of its size and siting.

It was emphasised that, in all cases where differences of opinion existed, the G.Ps. made their objections known to the L.A.

and in one case went as far as to send a deputation up to the Ministry. It was a further cause of resentment that their objections were ignored and the plans proceeded.

The L.A. for its part had a statutory duty to perform and they felt that in many cases the doctors were unaware of this. In the areas concerned there were no clinics, or housed in unsuitable premises. They felt that here was an excellent opportunity to put into effect the recommendations of the doctors themselves as embodied in Section 21 and were exasperated at what they considered the stubborn attitude of the doctors. They were the duly elected representatives of the people acting on the advice of their technical staff and their's was the responsibility. They had to take the long term view and wanted to build comprehensive centres whereas in many cases the G.Ps. only wanted branch surgeries.

In some cases the position was aggravated by disagreement between the G.Ps who intended to work at the Centre and their representatives on the L.E.C. and L.M.C. with whom they and the L.H.A. had to negotiate. Whereas the G.Ps. wished to participate in a Health Centre the L.M.C. objected very strongly to Health Centres in principle.

They maintained that the area was adequately served and if the G.Ps. wanted better surgery facilities they must provide them themselves and not place an additional burden on the rates.

In most of these Centres it was emphasized that the dispute lay between the G.Ps. and the L.A. The M.O.H. was usually regarded with sympathy as being in a difficult position in no way responsible for the difficulties which arose.

This was the background to the establishment of some of the Section 21 Health Centres.

At others however, the history is much happier. All the people concerned in the project were fully consulted in the beginning and all the way through to the opening of the centre.

Even under favourable circumstances the projects were not completed without a good many difficulties. The Health Centre was a new idea and there were no precedents to act as guides. The question of rental was a source of anxiety to many G.Ps but much more important was their deep-seated distruct of the Local Government. It was quite an effort for many of them to give up surgery premises which they controlled and become the tenants of the Local Authority. Matters were not helped by the slow rate

of progress, even at Bristol where there was goodwill among all concerned, the doctors, the L.H.A. and the L.M.C. it took 3 years from the time disucssions were begun until the opening of the William Budd Health Centre. At others it took much longer.

Such them is the historical background of the Health Centres built by Statutory Authorities visited. In those towns where no Health Centres are being planned the reasons given are that the L.M.C. has been opposed to Health Centres in principle or to the actual plan put forward by the Local Authority; or that the areas concerned were adequately served by G.Ps. and there is no need for any Health Centres.

(2) Group Practice Health Centres.

Here the initiators were the G.Ps. themselves in partnership as at Oxhey and group practices as at Lichfield who were dissatisfied with their surgery premises and wished to improve them. Their first preference was for Section 21 Health Centres but, unfortunately, their plans originated during the period of financial restrictions and their requests were not granted. Ultimately they obtained group practice loans on condition that the buildings contained accommodation for L.A. Medical Services. Their difficulties were due mainly to the number of different parties involved and the lack of a suitable site.

The Partnership Practices are purely private ventures and there were no special difficulties. It is worthy of note that they improved their premises in order to give better service to their patients at increased cost to themselves and this was followed by an increase in the rates.

(3) Diagnostic Centres

There are two such in the country. One opened at Corby New Town in 1954 and the other in Edinburgh on 1st June, 1959. The Edinburgh Centre was established to provide direct access for G.P.S. to diagnostic services and thus relieve the increasing pressure on hospital outpatient departments. It resulted from the joint efforts of all the medical bodies in Edinburgh, University, L.M.C., and Department of Health of Scotland, and was made possible by the generosity of the Nuffield Trust.

The problems of Corby were firstly those of a rapidly expanding new town whose nearest hospital outpatient facilities were at Kettering and Northampton, 8 and 25 miles away respectively at a time when the financial situation and other considerations of policy made the provision of any local hospital unlikely for some years to come. Secondly, it was stated that a good deal of feeling had been aroused locally by the publication of the Collings and Hadfield Reports and it was felt that something ought

to be done to raise the standard of the G.P. Services. The Centre was established in order to provide the population with outpatient facilities and it was hoped that by giving the G.P. access to diagnostic facilities and opportunities for meeting the Consultants, the standards of medical care would be raised. It was a joint effort initiated by the Nuffield Trust and proceeded with the close co-operation and goodwill of all the Medical Bodies concerned and also Stewart and Lloyds who contributed financially as well.

(4) General Practitioner Teaching Units

Reference has already been made in Chapter III to the recommendations of the M.P.C. and other B.M.A. Committees regarding the role of Health Centres in the teaching of medical students. Both Edinburgh and Manchester Medical Schools proposed to initiate centres wherein would be found all the usual family doctor and Local Health Authority services and, in addition, G.P. teaching units with the G.Ps themselves as the teachers. The Centres would be under the direction of a member of the staff of the Medical School. The Edinburgh project had the support of the Rockefeller Foundation which also helped to establish the Manchester Unit in association with the Nuffield Trust.

Dr. Stopford, Vice-Chancellor of Manchester University, was the prime mover at the Darbishire House project with Dr. R. Logan, Reader in Social Medicine as the Director. At the Edinburgh Teaching Unit, the task of organisation was given to Dr. Scott, also a Reader in Social Medicine and in addition actively engaged in General Practice, having a N.H.S. list of his own.

All the interested bodies were consulted right from the beginning. At Manchester a meeting organised by the Vice-Chancellor was attended by about 40 G.Ps. and the main principles of the project were outlined. It was to be a group practice Health Centre sponsored by the Medical School and the G.Ps. at the Health Centre would participate in the training of medical students. Hopes were also expressed that it would become a meeting place for the G.Ps. in the neighbourhood for clinical discussion and other forms of medical activity. Six G.Ps. were required who would join the Centre under certain conditions which would also safeguard them against loss of income. At first only three came forward but subsequently a fourth joined them and these constitute the present group practice. Further progress was not achieved without some difficulties. The M.O.H. welcomed the proposals and gave every assistance but, unfortunately, the L.E.C. and the L.M.C. opposed the whole scheme in principle. As there were local difficulties because of slum clearance and population

drift many G.Ps. felt it unfair that any group of G.Ps. should be specially protected against loss of income.

Two of the G.Ps. were sent on a tour of the Health Centres then in existence and, no doubt, saw much that was useful to them, but all the same the goup did not enter the Health Centre without certain misgivings. All were established G.Ps. with their own adequate surgery premises and it was quite a bold step for them to give these up and join in the experiment. As strong individualists and comparative strangers to each other they now had to work as a group. Moreover, from being accustomed to dealing with patients entirely on their own they had to accept students in their Consulting rooms. As family men they naturally were anxious about the financial side and as they were, for the most part, of a friendly disposition, they were not happy about the dispute with their colleagues on the Local Medical Committee.

The G.Ps. insisted on having their own small x-ray unit and this proposal was met by strong opposition from the Consultant Radiologists. However, they stood firm and got their x-ray unit. On the other hand there was every co-operation from the Pathological Department of the Manchester Royal Infirmary.

In Edinburgh the antecedents of the unit were much happier.

The advent of the N.H.S. meant the closing down of all the Dispensaries formerly maintained by Charitable Bodies. Prof. F.A.E. Crew of the chair of Public Health and Social Medicine saw in this an excellent opportunity for setting up a field laboratory to be used by the medical school for research and teaching in social medicine. Although his original ideas have been considerably modified it is freely and gratefully acknowledged that his inspiration led to the establishment of the unit. His senior lecturer, Dr. Scott was seconded to one of them, the Royal, with the intention of developing it as a centre for the study of the many problem families in the district and later this was developed into the teaching unit. He took the precaution of going round all the G.Ps. in the neighbourhood explaining very fully what his intentions were and reassuring them that he was not in competition with them for patients. He thus established himself on terms of goodwill with his neighbours and one result was that they began to send him all their problem patients. Later, as the project developed, he was able to choose his own colleagues and partners and when circumstances made it possible Livingstone House, about a half a mile away, was added to the unit.

SECTION II : F I N A N C E

(1) The Statutory Health Centres in England were financed out of public funds provided by Local Councils with the assistance of direct grants of 50% from the Ministry and this means they have to be paid for and maintained partly out of local rates. In Scotland the financing of Health Centres is the direct responsibility of the Department of Health under the Secretary of State for Scotland and is thus wholly derived from central funds. Both these bodies retain ownership of the Health Centres and are responsible for the salaries of staff, maintenance of the buildings and running costs.

The G. P. suites are let in the first instance to the Local Executive Council which in turn rents them to the individual G.Ps. or partnerships. The question as to what rental ought to be paid by the G.Ps. was a very difficult one and in some cases they moved into the Centres before this was decided. At the Section 21 Centre at Aveley there is, even now, no final agreement and at the group Practice Centre at Lichfield when visited, although the Centre was now open, negotiations were still proceeding with the M.O.H. to decide what rental ought to be paid for the Local Authority part of the Centre. At all the other Centres it was understood that the original rental was only provisional and would

be reviewed after a period of some years subject to agreement between the G.Ps., L.E.C. and L.H.A. There have been increases at half the Centres and no suggestion of an increase at any of the others. These increases have been slight, except at Bristol where the original low figure of £75 per annum was doubled in agreement with the G.Ps. The L.E.C. collects the rental by deductions from the quarterly cheques for capitation fees.

The Group Practice Health Centres were built with the assistance of interest free loans from the Group Practice Loan Fund which have to be paid over a period of years. The G.Ps. are themselves responsible for the maintenance, staffing and running costs of their own part of the Centre and the L.H.A. is responsible for that part which it rents from the G.Ps.

One of the private practices enlarged and improved its premises out of its own capital resources before the war, while the other obtained a Group Practice Loan a few years ago to enable the partnership to be enlarged to admit a further partner. No details are available of the running costs of these two practices but they are stated to be quite heavy.

The capital costs of the Daignostic Centre at Corby were met by generous grants from the Nuffield Trust which is also

contributing towards the running costs for the first few years. There are also contributions towards running costs from Northamptonshire County Council and Corby Urban District Council as well as from Stewart and Lloyds. Ownership is here vested in the Nuffield Trust but at the end of the first five year period Northamptonshire County Council will have the opportunity of acquiring the Trust's part in the Centre, Oxford Regional Hospital Board is responsible for the capital cost, maintenance and staffing of the X-ray Unit, Physiotherapy and Pathological services and the Consultants and Specialists use the same suites as the G.Ps., for which services the Board pays rent to the Trust. The G.Ps formerly paid fees for the use of these suites but they are now free.

The Diagnostic Centre at Edinburgh was established with funds from the Nuffield Trust and running costs for the first three years will be shared between the Trust and the Department of Health for Scotland. As at Corby all the facilities are available to the G.Ps without charge.

The funds for the Manchester Unit were provided by the Rochefeller Foundation and Nuffield Trust. Manchester University is responsible for financing the teaching of medical students and research at the Centre and the City Corporation pays for maintenance

and the salaries of the non-medical staff. As this is not a Section 21 Centre it is not eligible for any grant from central funds so that the whole of the Corporation's contribution is a charge on the rates.

The Edinburgh Teaching Unit was established by the University in 1948 and later received financial assistance from the Rohhefeller Foundation to extend its activities. The Unit is regarded as a section of the University's Department of Public Health and Social Medicine which has the financial responsibility for maintenance and running costs. The G.Ps working at the unit pay no rental, they are salaried members of the teaching school and all fees collected from the Local Executive Committee and so on are retained by the University. A few figures are set down in Table 1.

It is quite impossible to form an exact comparison of the cost of the various centres because many authorities have different methods of presenting their accounts. The figures given for capital costs do not always tell the whole story because in a few Section 21 centres the site value is not included as it is part of a large housing site. Nor were the Architect's fees because the design and plans were mainly the work of salaried officers of the Local Councils. Even the private ventures failed to take account of the cost of the premises vacated by the G.Ps and their subsequent loss of value.

For all that the figures obtained give a fairly good idea of the financial aspects of the centres. The running costs however do not always give a complete picture. Many of the centres offer a wide range of services by consultants and others attending part-time whose salaried would come under a different authority or department, but what the doctors pay for the facilities they enjoy are at least definite figures.

An attempt was made to relate costs to the number of patients on the doctors lists but this was found not always possible. So many of the centres were branch surgeries only and exact figures could not be obtained and in others the G.Ps were reluctant to disclose the size of their lists. Nor was it always possible to relate them to surgery attendances or treatments as some centres kept no records at all. It is interesting to note that it is unusual for the whole population at immediate risk to a health centre to be on the lists of the G.Ps. working there and this is true only of Stranraer, Lichfield, Swindon and Oxhey where all the G.Ps. in the district staff the health centres.

A glance at the table will show immediately that even where the rental is fairly high it is never an economic one and for the most part is heavily subsidised.

When it is appreciated that the rental paid includes in addition to accommodation, staff, nursing attendants, heat, light and power, cleaning, and in some cases telephone and headed notepaper it must be recognised that the G.Ps get a fair return for their money and this they freely admit. (Table II).

SECTIONS III - VI

General Description

Faringdon, Manchester, Edinburgh and Swindon are all buildings converted or adapted for use as Health Centres. At Nottingham temporary premises have been provided by adapting a block of two pairs of semi-detached council houses which, when the permanent Health Centre is built, can readily be restored to their original use. Apart from the doctors' name-plates on the doors, from the outside they are identical with other council houses on the estate. All the other Health Centres are new, specially designed buildings. For the most part the general plan is the same so that from the outside they all tend to resemble each other, Aveley and Harold Hill having been built from the same Architect's plan.

Size varies from the very large Woodberry Down and Sighthill to Nottingham which is the smallest. All the others are of medium size except Sunderland, and those built by Statutory Authorities are larger than the Group Practice Health Centres or private practices and are, on the whole, better appointed. In this context it should be remembered that, as the former were built by Local Authorities, the intention was that as well as being functional they were to be regarded as a source of Civic pride in the same way as other public buildings.

The new Health Centres are built on modern conventional lines, very light and airy with plenty of window space. The free use of glass has been rather extensively applied at Lichfield in the waiting hall and some concern was expressed that heating in cold weather might be a problem. (The wide glass doors at Cheltenham had been responsible for a nasty accident and are now covered up with strips of adhesive!)

Much thought had been given to planning the interior layout but in the larger Centres such as Woodberry Down and Sighthill there was considerable space wastage and too many corridors.

Interior decoration in all was very pleasant, paintings and furnishings in good taste with no suggestion of any hospital or institutional atmosphere.

Sighthill was especially attractive with its beautiful staircase in the entrance hall.

Lichfield has Venetian blinds of coloured plastic material instead of curtains and this was said to be more economical; it would last longer and requires no attention.

The Corby Diagnostic Centre is a new building specially designed on economical lines so as to provide diagnostic facilities at a reasonable cost. The central entrance hall gives an air of spaciousness to the whole building and any institutional appearance is considerably minimised by the very pleasant colours used in the decorations and furnishings. This is an extremely well designed building and the only complaint was of a shortage of cubicle space for some surgical and ante-natal sessions.

Faringdon Health Centre, which had been an old cottage hospital built in 1891, looked a charming picture in the afternoon sunshine. Lack of finance has prevented any alterations to the interior and here too much of the corridor space could well be given to the small and rather cramped waiting rooms and surgeries.

Swindon Health Centre is a grimy building of typical Victorian design, built in 1892 by the Great Western Railway to provide medical services for their employees: the G.Ps were formerly salaried officers of the Company. Very little has been done in the way of renovations and alterations since the appointed day. The general impression of vastness produced by the large and tall common waiting room for all the G.Ps. and is not particularly reduced by the grouping of seats round each doctor's consulting suite.

At Manchester there have been considerable alterations to an old building which had formerly served as a students' hostel. Nothing could be done to the exterior which was rather unprepossessing but within the limits of the original structure and considering its rather awkward layout, the architects have done an excellent job. The free use of light pastel shades of paint and light furniture have done much to minimise the institutional character of the building.

The Edinburgh Teaching Health Centres at Royal Dispensary and Livingstone House are likewise old buildings and little money has been available for their internal improvement. Livingstone House also contains a Diagnostic Centre and this part of the building has been extensively altered and decorated in a most effective manner with free use of pastel shades of paint and wall paper.

Siting

Most centres are well sited with good bus services or within easy walking distance for the patients. Unfortunately, the housing estate at Woodberry Down is divided by a large reservoir and a large park so that patients on the far side have quite a distance to travel. At Manchester there were said to be complaints by

patients who found they had to travel further than before. The Corby Diagnostic Centre is not particularly conveniently sited but, of course, is much nearer than Kettering Hospital.

The area served by Bristol was declared restricted when the centre was opened. Sunderland was formerly open but is now restricted and so also are Swindon, Oxhey, Corby and Edinburgh. Sighthill and Manchester are open and all the others intermediate.

Accommodation and Services Provided

Apart from the Diagnostic Centres all the health centres provide G.P. and Local Authority Medical Services and in all except Bristol each occupies its own separate part of the building and in some cases the entrances are separate. Even where there is a common entrance the two parts are separated by a door or a corridor and are usually some distance apart. In some each has its own reception office and secretarial staff.

At Bristol the G.Ps. hold their surgery sessions in the mornings and evenings and the Local Authority use the same suites for their clinical sessions in the afternoons. The nursing and secretarial staff is shared by the two services.

A. GENERAL PRACTITIONER

1. Accommodation

The accommodation provided at each centre is indicated in Table III. Points worthy of note are absence of treatment rooms and staff rooms at some centres and provision of separate staff rooms for each service at Sighthill and Woodberry Down. At Corby the G.Ps share the suites with the Consultants and at Cheltenham, Faringdon, Harold Hill and Sunderland the suites are shared amongst the G.Ps. but at all the others each G.P. has a suite for his own exclusive use and this also applies at the private practices.

Accommodation is considered adequate for the size of lists but at most centres there was said to be overcrowding in the waiting rooms during the busy seasons and this was especially the case where all the surgeries were held at the same time. Exceptions were Cheltenham, where patients were seen by appointment Nottingham, which in only a minor branch surgery of the G.Ps concerned, Coventry, where only two of the firms between them do the majority of the surgery sessions and Sunderland, where only 42% of the available surgery sessions are in use. There was no complaint of overcrowding at the larger centres.

All the G.P. suites are on the ground floor and at most centres these included separate waiting room, consulting and examining rooms for each doctor. At Faringdon and Oxhey waiting rooms are shared between two doctors and at Aveley and Harold Hill two of the G.P. suites also share a waiting room. There are waiting halls at Lichfield, Coventry, Corby and Swindon.

At some centres there is an extra door to each consulting room so that patients can go out without having to pass through the waiting room.

All the G.P. suites are well furnished with chairs or benches in the waiting rooms or halls. At Coventry the waiting hall has built-in bench seats very well arranged to create a separate small hall round each G.P. suite.

The consulting rooms contain the usual furniture of desk, doctor's chair, chairs for patient and attendant, instrument cupboard, small sterilizer in some centres and wash hand basin. All the rooms were of convenient size except those at Woodberry Down and possibly Sunderland which could have been smaller.

The examination rooms contained examination couch and in some a fixed wall sphygmomanometer and in some an extra wash hand basin.

Where there was no separate examination room, as at Edinburgh Teaching Unit and Lichfield, the examination couch was in the consulting room screened off by a curt ain. At Lichfield there was also two extra examination rooms available if required.

At Woodberry Down it was stated that the original intention was to have two examination rooms so that one patient could be examined while another was preparing for examination or dressing.

At Cheltenham there is a couch in the consulting room as well as in the examination room.

Most G.P. suites are arranged adjacent to each other but at Stranraer each consulting room is across the corridor from the waiting room and this makes the consulting room more private. At Bristol two waiting rooms are adjoining so that by opening the door between them a large waiting room can be obtained for clinics.

The accommodation at the Private Practices compares favourably with the Health Centres. The toilet facilities at all the Health Centres are considered to be adequate.

2. Services

Apart from the Diagnostic Centres all provide full range of G.P. services and each G.P. is responsible for his own list.

There is no sharing of patients, except at Oxhey, where it was stated that many of the patients indicate no preference for any particular doctor.

At Bristol the G.P. sessions overlap slightly mornings and evenings so that, with the Local Authority using the suites for their Clinic in the afternoons, the Centre is kept fairly busy throughout the day. At Cheltenham patients are seen by appointment at specially fixed sessions throughout the day. At the remainder the surgery sessions are held by G.Ps. at times which overlap at some but are concurrent at others mornings and evenings and for most part of the day the suites are unoccupied. Overlapping facilitates the work of the nursing and secretarial staff and reduces crowding of entrance halls and waiting rooms in the busy season.

Satisfactory arrangements exist at all the centres whereby the patients can get in touch with their doctors during the hours in which the centre is closed. There are resident caretakers at some, including the private practices, and at the Bristol centre the night porters can summon the nursing staff who live nearby to attend to casualties as required. There are no resident doctors at any of the centres and on the whole most of them live quite near but in Swindon and Manchester they live a few miles out of the town.

3. Nursing Assistance

The G.Ps. have no nursing assistance at Swindon, Cheltenham, Lichfield and Nottingham, at Oxhey the receptionist is a fully qualified nursing sister. At Manchester, Queens Nurses assist on a rota during surgery hours. At all the other centres there are full time nurses and at Bristol these also assist at the Local Authority sessions.

4. Records and Secretarial Help. (Section X)

At most centres the patients records are kept in filing cabinets at the reception office and taken down a few at a time to the consulting rooms by the clerks as the patients arrive. At many places there is a letter box in the consulting room door so that cards may be inserted without disturbing the doctor. At Lichfield the cards are handed to the patients to take with them as they go to see the doctor. At Nottingham and Sunderland the case records are kept in the consulting room.

Secretarial help at the centres is considered adequate. Some doctors who previously had none admitted that it took them some time to get used to it. Full use of the secretarial help is made at Bristol, Manchester and Edinburgh. At Bristol the secretaries save the doctors an immense amount of time by typing out the hospital letters, attending to correspondence, arranging appointments, filing the records and attending to the telephone.

For the most part the reception offices are adequate but at Manchester and Stranraer they are considered to be awkwardly placed and too small for their needs. At Aveley, Oxhey, Coventry, Harold Hill, Swindon, Sunderland and Woodberry Down, the G.Ps. and L.H.A. each have their own reception office and staff. There is no reception office at Nottingham.

5. Treatment Room

Where there is a treatment room this is used quite extensively for dressings and minor ops. and is said to save a good deal of this work being sent to hospital. A fully equipped operating theatre had been provided at Sunderland but as this was never used the equipment had been removed and it is now functioning as an extra suite. All treatment rooms are easily accessible on the ground floor except for Manchester which is upstairs.

A nurse is always on duty either throughout the day as at Bristol or Coventry or at surgery sessions only as at the other centres. At Coventry there is a well organised appointment system for treatment so that patients can attend at their convenience outside surgery hours.

Where there is no treatment room the examining room or the consulting room is used and the treatments are done by the

doctors themselves. At Swindon all patients requiring treatment are sent to the local hospital across the way. The numbers of treatments given annually are indicated in Table V . The gaps mean that no records are kept.

At Stranraer and Lichfield all the doctors are on the staff of the local hospitals which are close by. They act as surgeons, anaesthetists and radiologists and the senior members of the Oxhey and Bristol partnerships are also part time anaesthetists. The G.Ps. at the other centres hold no outside appointments. Private Practice is permitted at most but is negligible in amount.

6. Medical Staffing

In all cases the G.Ps. in the neighbourhood were circularised by the L.E.C. and invited to transfer their practices to the centre. Some Local Authorities had suggested that this invitation should be restricted to the doctors in the immediate neighbourhood but the L.M.C. were of the opinion that all G.Ps who wished it should be given accommodation at the centre. All who applied were accepted except at Woodberry Down where a ballot was necessary.

For the most part there have been few changes of personnel except for a death or retiral vacancy. At Sunderland a few

doctors withdrew from the Health Centre when they discovered that not enough of their patients attended to make it worthwhile.

At Swindon, Faringdon, Stranraer, Manchester and Edinburgh and the Group Practices, the G.Ps. practice solely at the Health Centres and at the other centres some of the G.Ps. practice solely at the Health Centre and for the others it is a branch surgery.

At Faringdon one of the practitioners in the town elected to stay in his own surgery premises adjacent to the hospital for personal reasons. The Group Practices had surgery premises which were not very convenient so these were very glad to move into the health centres.

In the new health centres on housing estates those G.Ps whose main or branch surgeries were near enough simply moved in when the centre was opened. Some of these G.Ps. had been established in the district for many years and as their patients moved out to the new housing estates they continued to attend them and in some cases established branch surgeries in temporary premises. Others were new G.Ps. who, with the assistance of an Initial Practice Allowance had been encouraged to settle in the district originally in temporary houses and later in doctors' houses specially built for them and rented on a long lease.

Although health centres had been included in the plans for the housing estates negotiations were so protracted that by the time they were opened the doctors had fairly well established themselves either in their specially built houses or in their branch premises. Moreower, many of the residents on the periphery of the estate had registered with G.Ps. whose main surgeries were too far away to enable them to transfer all their work to the Health centres even if they wished to do so, as many of them did.

The proportion of main to branch surgeries at each centre varied tremendously from a half to a fifth and even less at Cheltenham where the centre is only a very minor branch surgery for the many G.Ps practicing there.

At some centres the G.Ps. admit that it would be possible for them to practice solely from the health centres but they feel they must have an alternative in case of dispute with the Local Authority and they wish to vacate their suites. Moreover, at Aveley and Harold Hill where they had houses specially built for them they could not give up their leases without financial loss. Further, they were reluctant to vacate their homes or branch surgeries unless they had a firm assurance that these would not be given to other doctors.

The Bristol doctors would prefer to work solely at the health centre but this is not possible because they are in partnerships whose main surgeries are widely dispersed.

Consideration of the last few paragraphs explains why the numbers on the lists of the G.Ps. at the health centres is usually less than the population at risk to the Local Health Authorities. The figures are set out in Table V. Many of the people on the lists of the outside G.Ps. attend for the Local Health Authority or other special services and at Woodberry Down these are estimated to cover a population of a quarter of a million.

The existence of branch surgeries on new estates shows the presence of population drift and this problem in its relation to general practice is worthy of careful study. At many of these centres the G.Ps. in the outlying districts were perturbed by the decrease in the size of their lists as the result of extensive slum clearance schemes as at Stoke and extensive new building of bombed Cities as at Coventry.

The result of this was that on the one hand senior established G.Ps. found their lists greatly reduced and on the other fairly recently qualified G.Ps. found themselves with full lists and

more very rapidly and in some cases had to take on assistants or partners. This , by the way, refutes the claim that the size of a list is always a reflection of the ability of the doctor.

In all the centres round London, including Harlow, there is stated to be considerable ebb and flow of the population as noted in the removals from and additions to the G.Ps. lists rising to about 20% in Avely and Harold Hill.

B. LOCAL AUTHORITY

The Local Authority Medical Services are also located on the ground floor at most centres but are upstairs at Nottingham and Swindon. The accommodation is similar in most of them comprising reception office, waiting room, a fair sized hall for clinics, cubicles for expectant mothers, Health Visitors' room and consulting rooms for Local Authority Medical Officers. All have treatment rooms for minor ailments. Some have physiotherapy rooms and dental suites for priority cases, that is to say children and expectant mothers; only occasionally is there a full time dentist under contract to the L.E.C. Except for Nottingham the entrance hall or one of the Local Health Authority rooms can be used for lectures, if required, but on the whole this was not common.

There is a wide range of variation in the Local Authority Services at the different centres from the simple facilities at

Bristol and Nottingham to the comprehensive array at Woodberry Down and Sighthill. The L.A. provide infant welfare, ante natal, simple physiotherapy (wall bars, radiant heat, U.V.R.) minor ailments clinic, welfare foods and dental services as indicated in Table IV and the services are, of course, available to the patients of all doctors in the locality.

At all the health centres there have been considerable reductions in the attendances at the Local Health Authority Clinics and this is due to several factors. At the Bristol Centre and private practice and at Edinburgh the G.Ps. hold special ante natal and infant welfare sessions for their own patients only without extra fee as part of their general service, in this they have the assistance of mid-wives and health visitors. A Local Health Authority Medical Officer conducts sessions for those patients on the lists of the outside G.Ps. At Manchester by arrangement with the M.O.H., the G.Ps. conduct the ante natal and infant welfare sessions both for their own patients and others on the lists of the G.Ps. of the district and are paid sessional fees. The expectant mothers who attend these clinics are also in the care of their own doctors who collect their fees in the usual way on E.C.20. At Cheltenham too all the G.Ps. conduct the Local Authority infant welfare clinics for which they are paid

sessional fees. Attendances at these sessions is for advice only, where treatment is necessary the patient is referred to his own doctor. These arrangements are said to work well and cause no difficulty between the health centre G.Ps and those outside.

At Lichfield negotiations with regard to G.Ps conducting the Local Health Authority's clinics are still proceeding. At all the other centres there is no participation whatever by the G.Ps in the Local Health Authority Medical Services and in some of them the patients are actually discouraged from attending these clinics.

For the most part the L.H.A. provide their own medical and nursing staff for the various services carried out at the health centres. When, because of sickness or holidays, a Local Authority M.O. is not available for clinics at some centres the policy of the L.M.C. insists that a G.P. from a distant part of the City may act as a Locum and not one of the health centre doctors.

The health visitors based on the centres assist at the clinic sessions and in addition there is usually some time in each day when they are available for consultation with the G.Ps if required. A school nurse is on duty in the minor ailments room during school hours.

Contracts with L.E.C.

At Bristol there are definite contracts regarding tenancy and rental charges but at most of the other centres the G.Ps. were very vague about their terms of service but did not appear to be particularly concerned. Enquiry, however, showed that for the most part they had security of tenure and an agreement whereby the rent would be reviewed at certain intervals of years. At Sunderland the tenancy is for a minimum of 12 months.

Dental Services

Bristol, Cheltenham, Coventry, Edinburgh, Lichfield, Manchester and Nottingham have no dental services. At all the others the dental suites are in a separate part of the Centre, usually on the first floor. Except for Faringdon all are very well equipped with modern dental furniture, X-ray apparatus and dark rooms. Owing to staffing difficulties most provide priority services only.

Pharmacy

Swindon and Edinburgh Teaching Unit had pharmacies when they were taken over and these have been retained. There are also pharmacies at Sunderland and Sighthill. The Swindon pharmacy is said to be run at a handsome profit. None of the others have

pharmacies and this is L.E.C. policy.

Swindon and Sighthill and Manchester have syringe services.

Consultant Services.

At Bristol there is a Consultant Obstetrician session weekly at which are seen cases referred by midwives and outside doctors. The Consultant will also see the centre G.Ps. cases at any time during their pregnancy and always at their request. The Sighthill doctors had asked for similar facilities but this was refused.

At Corby there is, of course, a full range of consultant services and at Sighthill a consultant in physical medicine and a psychiatrist. At Stranraer there are visiting consultants to the hospital adjacent. At Faringdon there is a Consultant Chest Clinic and Opthalmic sessions. Swindon provides a room for the Regional Medical Officer to see cases referred to him under National Health Insurance regulations. Apart from these special facilities there are no Consultant services at any of the Health Centres.

Diagnostic Facilities

Manchester has its own small x-ray unit with part-time Radiographer and dark room and at the moment they are negotiating for an E.C.G. They also have good laboratory facilities, some of

which are run in association with Manchester Royal Infirmary nearby. Bristol has a small side room with B.S.R. and an E.C.G. Faringdon has a screening unit for the chest consultant only. Woodberry Down has a microscope, B.S.R. apparatus and a photo electric colormeter. Apart from urine testing apparatus there are no diagnostic facilities at any of the other Centres. For their x-ray requirements most G.Ps. send their patients to the nearest hospital or mass x-ray, in some cases a few miles away. Pathological specimens are sent either by hand or through the post. Bristol is included in the daily carrier service which does a round of all the Local Authority Clinics and this delivers specimens to the hospital laboratories and collects reports when they are ready. All the G.Ps. at the centres have direct access to the diagnostic facilities of their nearest hospitals.

Bristol and Coventry had requested further diagnostic facilities, especially x-ray units, from the Regional Hospital Boards without success. At Coventry this refusal was on the grounds that it was too dangerous for them because of the risk of x-ray burns and also that it was not the policy of the Regional Hospital Board to provide x-rays units at health centres.

The Diagnostic Centres

Although the two diagnostic centres are considered together

there are certain important differences. Both contain a full range of diagnostic services which except for some highly specialised procedures are directly accessible to the G.Ps. They include x-rays with radiographer and dark rooms, E.C.G. Pathological laboratory services with limited bacteriological facilities, nursing, secretarial assistance and almoners to help with social problems. The G.P. reserves a consulting suite at the centre by telephone, attends his patient there by appointment, conducts his examination and initiates any investigations necessary. Neither centre deals with casualties or emergencies.

Corby has a treatment room for the G.Ps. which is rarely used except when a patient is attending for a special investigation. There is also an orthopaedic treatment centre with gymnasium and all the physiotherapy apparatus of a modern hospital, only this unit is not directly available to the G.Ps. who must refer first their patients to the consultant in physical medicine who is in charge. (The same applies to the department of physical medicine at Sighthill)

Corby also has a full range of consultant sessions. Medical, Surgical, Obstetrics and Gynaecological, Paediatrics, Chest diseases, Psychiatric, EN.T., Radiologist, Dermatologist, Opthalmic, Orthopaedic, and those are freely available to all the Corby doctors.

The latter are all on the staff of the hospital and are officially regarded as unpaid clinical assistants. They formerly paid fees for the use of the suites but these are now free.

At Edinburgh the centre is for G.Ps. only. IF further advice is required a consultant appointment at the hospital is made by the doctor in the usual way. The x-ray unit is under the supervision of a consultant radiologist who attends at a weekly session and one of the Edinburgh consultants acts as honorary medical advisor to the unit as a whole. As a precautionary measure until it is known what the demand will be, the services of the unit for the present were restricted by a ballot to 35 of the 100G.Ps. who applied.

As the Edinburgh unit has just been opened no statistics are available. Here are the Corby figures.

Record of attendances

	1956	1957	1958
G.Ps.	2108	1779	1893
Consultants	12555	13616	13848

It will be seen that consultants see about 7 patients for every one the G.Ps. see.

Student Training

At Manchester and Edinburgh student training is an important part of the work of the units. The programme at Manchester is to

be found in Appendix IV. Woodberry Down and some of the others see an occasional student but at Bristol there is more student participation. The Consultant Obstetrician often brings students with him and about four years ago Bristol Medical School began sending out final year students to spend two weeks with specially selected G.Ps. and they too visit the centre.

Research Projects

Apart from Manchester, Edinburgh and Bristol none of the G.Ps. at the Health Centres are concerned in any research projects, nor is there any literature published at the others apart from notices in the medical press when the centres were opened.

At both Manchester and Edinburgh a good deal of research has been directed to the social problems of general practice. At Bristol there has been an enquiry into anaemia in General Practice and at the moment the centre is engaged on a Survey of Women's Preference for place of Confinement.

Bristol has also been used to try out several experiments which have been so successful that they have been followed all over the City. Most important of them is the provision of facilities at the L.A. clinics for the G.Ps. to hold ante-natal sessions for their own patients, at which services of the nursing

staff and health visitors are available free of charge. This has resulted in very close co-operation between the G.Ps. and midwives so that whichever one an expectant mother sees first informs the other. It was formerly a source of irritation to G.Ps. that a patient on their list could be attended at a clinic throughout pregnancy, be delivered and the first intimation a doctor had of the event was the appearance of the mother with the E.C.1 of the new baby. The G.Ps. are not paid sessional fees, they collect their fees in the usual way on the E.C.20. Other experiments have been the provision of a Psychiatric social worker and Nutritionist.

Annual Reports

Only Manchester, Bristol, Stranraer and Sighthill publish annual reports which are available on application.

Administration

The Statutory Authority Centres are, the responsibility of the Local Authority through the M.O.H. and the G.Ps. themselves are responsible for the Group Practice Health Centres. At Corby, Bristol, Woodberry Down, Faringdon, Sighthill and Sunderland there is a fully qualified nursing sister who is responsible for the day to day running. At some of the others it is usually one

of the doctors or a lay secretary (Swindon) and in some cases no-one is specially in charge, the centre is said to run itself. The two teaching units are under the supervision of Drs Logan and Scott respectively.

There is usually a House Committee or Staff Committee composed of all the G.Ps. who work at the Centre with a representative of the M.O.H. At Edinburgh there is a weekly staff meeting, at Manchester a monthly one, at Bristol two or three times a year and at all the others only occasionally when there is something special to discuss - for the most part this means their Committees seldom meet.

Edinburgh has an external advisory committee containing representatives of the medical school and at Manchester and Bristol the external advisory committee members are representatives of M.O.H., L.M.C., and L.E.C.

SECTION VII

Relationships and Co-operation

(a) Among the G.Ps. themselves. At Edinburgh there is a daily meeting of the G.Ps. at which all the work of the previous day is discussed and at Manchester a weekly clinical meeting is held but there are no clinical meetings at any of the others;

the G.Ps. meet only casually. Although all willingly attend each other's patients in an emergency second opinions are usually restricted to partnerships. There is said to be a very friendly feeling among the G.Ps. themselves at all the centres and this had only developed since they had come to work at the health centres. Previously they had been more or less strangers working in isolation and in some places not on particularly good terms with each other owing to the competitive element inherent in the present system of general practice. Now they feel this hardly exists as at most centres there is enough work for all; transfers are few and only by mutual consent.

At some centres new patients with no special preference are allocated on a numerical or day of the week basis. At others they are shown a list of G.Ps. and have to make their own choice. At Stranraer there is a rota for temporary residents.

(b) With the M.O.H. Relationships with the M.O.H. and L.H.A. personnel vary a good deal. At Bristol, Manchester and Edinburgh all are on excellent terms, co-operating fully in their work with midwives and other ancillary staff so that there is very little overlap. This is especially true of the health visitors about whom the G.Ps. had previously known very little. They now

realise that these highly trained nursing sisters have special experience in social problems and are very glad to have their help in such cases. At Bristol there is also close co-operation with the Local Health Authority Medical Officers. It is felt at these Centres that the staff room plays a very important part in promoting this state of good feeling and co-operation. It is in constant use throughout the day and provides a natural meeting place for discussion over cups of tea amongst all those working at the centre. (There are staff rooms at other centres but the impression was that they were very little used by the G.Ps. who declared they had very little time to spare.)

At all the other centres there is very little co-operation with the L.A. services and to all intents and purposes two separate services exist in the same building. At a few the situation can best be described as one of open hostility.

When questioned about lack of participation in Local Health Authority work the G.Ps. admitted that they would like to undertake this work but with the present size of their lists this was not thought possible. The Medical Officers of Health were, for the most part, quite agreeable to handing over their clinical work to the G.Ps. It was noted that where bad feelings exist no steps are being taken to initiate discussions in an effort

to improve the situation. Where relationships were good this was often found to be due to the enthusiasm of one or two G.Ps. who were in favour of health centres in principle and determined to make the venture a success. At no centre was there any suggestion whatever of interference or control by the Local Authority in the work of the G.Ps.

(c) Relationships with outside G.Ps. For the most part the neighbouring G.Ps. are not interested in health centres and rarely use the services available, except for those provided by the Local Authority. At Bristol, however, free use is made of the treatment room for casualties, dressings, and injections. All the G.Ps. in the district are on excellent terms and meet socially at Sherry Parties in the centre or one of the other L.A. clinics. Others guests on these occasions have been health visitor's, midwives, District nurses, Probation officers, Children's Officers, Public Health Inspectors and the Head Teachers of the schools in the district. Meetings are planned between G.Ps. and the Head Teachers to discuss methods of co-operation and dealing with problems of mutual interest.

Where the rental is highly subsidised it was stated that some of the outside G.Ps. still feel resentful at contributing as

rate payers towards the cost of facilities enjoyed by G.Ps. with whom they are in competition. At Stranraer, Lichfield, Oxhey and Cheltenham there is no competition as all the G.Ps. in the district work at the health centre.

There was no evidence that G.Ps. at the centres increased their lists at the expense of the outside G.Ps. Experience at Bristol shows that patients living quite close to the health centre will travel some distance to the surgery of their own doctor. They prefer to take a bus direct to a distant surgery rather than walk to a health centre which is nearer. Where there have been increases in lists this is due to local population increase in which all doctors share.

Appointments System

At Cheltenham all patients are seen by appointment and one doctor at one other centre has an appointments system. At Edinburgh patients were seen by appointment at their own request. Appointment systems had been tried at Manchester but discontinued because it was said the patients did not like it. Enquiry as to the method of running an appointment system showed a good deal of variation.

Rota Systems

Manchester, Swindon and Edinburgh are best organised in this respect and in all the others there is a wide variation. Rotas for night calls, week ends and so on are usually restricted to partnerships. Some of the G.Ps. in the larger towns are in rota groups with other G.Ps. not working at the Centre. All appeared to be satisfied with their arrangements.

SECTION VIII

Obstetrics

Except at Woodberry Down where only one G.P. does maternity work all the doctors are on the Obstetric lists and do a fair amount of midwifery. At Bristol, Manchester and Edinburgh and the private practices all the doctors hold special ante natal sessions with the assistance of the nurse and more rarely the midwife. For the latter it was explained that, owing to general staff shortage she could not find time to attend the G.Ps. ante natal clinics as well as her own.

At the other centres there are individual variations amongst the different doctors in the way they conduct their ante natal sessions but at Nottingham, Stranraer, Oxhey, Faringdon and Swindon these were conducted in the ordinary surgery hours or at the patient's homes.

At Bristol, Stranraer and Lichfield the G.Ps. have access to beds in G.P. Maternity units but at all the others, hospitals are available for special cases only. The only attempt at specialisation in general practice was seen at a few centres where the ante natal and infant welfare sessions were conducted by one or two members of a partnership.

SECTION IX

There are no consultative committees on which the patients are represented nor is there any way in which patients' views can be obtained except casually. At one or two housing estates there are tenant's associations which would forward any complaints or suggestions but on the whole these have been few and concerned mainly with the novelty of the centre. For the most part all are now accepted and the patients appreciate the fact that they have only one place to go to for a good many of their medical services.

It is difficult to assess the effect most centres have on hospital referrals but on the whole it is thought to be slight. At Manchester it was stated that their records show that there has been a reduction of one-third in referrals to hospital both in-patients and out-patients as compared with practices in Manchester generally and this is estimated to save the public purse some £12,000 per annum. At Bristol there is certainly a

saving on the hospital casualty services and the E.C.G. dispenses with the need of many appointments to the Cardiologist. Corby has considerably reduced the referrals to Kettering Hospital and it is hoped that Edinburgh Diagnostic Centre will lessen attendances and admissions to the Edinburgh Hospitals.

General

At Manchester the G.Ps consider themselves fully employed at their G.P. and Local Health Authority Services and have recently taken on an Assistant to help with the work. As this was a temporary arrangement only they felt they might have to reduce their lists which average 2,700 each.

At Enginburgh the four G.Ps. had only 4,000 or 5,000 patients under their care but here too they were fully occupied. It must be pointed out that this is a special type of practice in that it contains an unusually large number of problem families as well as patients at the other end of the social scale. In addition a good deal of research is being carried on and the doctors take an active part in the work of the medical school.

At Lichfield, Stranraer, Oxhey and Swindon, the G.Ps. do not participate in the Local Health Authority work, they consider themselves fully occupied with their lists and do not think they

could take on the additional work; in any case, as at all the centres where there was no G.P. participation in Local Health Authority work, this matter had never been discussed.

At all the other centres where only some had their sole surgeries and others branch surgeries the position varied a good deal, but the opinion was expressed that Coventry, Nottingham, Sighthill, Woodberry Down and Sunderland were not working to full capacity from the G.P. point of view.

The G.Ps. are quite convinced that working at health centres has not had an adverse effect on the doctor/patient relationship. They feel that, they give a higher standard of service than at their former surgeries. In some cases, where home surgeries are retained, they prefer to send cases requiring special examination to the health centre because of the better facilities in the way of nursing attendance. They also feel they have more freedom in their home lives and save their wives a good deal of the work they had to do formerly. This applies, of course, mainly to those G.Ps. who work solely at the health centres, and giving up their home surgeries has enabled them to move out to smaller houses in more pleasant surroundings.

The overall feeling of the G.Ps. is in favour of working at health centres rather than ordinary surgeries.

CHAPTER V.

THE HARLOW HEALTH CENTRES

There are five health centres in Harlow. To complete the picture of the health services of this new town it is thought useful to include in the list which follows the County Council special clinics, the Industrial Health Centre and Bentham House which is a hospital consultant outpatient unit built as a temporary measure until the new hospital is completed.

1. Nuffield House. Opened 1954. Cost £24,000.

   Comprises, three G.P. suites, L.H.A. section and suites for two dentists with dental laboratory, X-ray and dark room.

2. Sydenham House. Opened 1954. Cost £24,000.

   Comprises four G.P. suites, L.H.A. section and suites for two N.H.S. dentists and one L.H.A. dentist.

3. Osler House. Opened 1954. Cost £12,000.

   Comprises, suites for two G.Ps. and L.H.A. section.

4. Keats House. Opened 1958. Cost £32,000

   Comprises, six G.P. suites, L.H.A. unit with suites for two dentists, three suites for N.H.S. dentists.

5. Edinburgh House. Opened 1958. Cost £18,600

   Industrial Health Centre.
   Comprises two consulting rooms, treatment room, waiting room, recovery room, an X-ray and dark room and ancillary offices, a gymnasium and physiotherapy room.

6. Addison House Group. Opened Oct. 1958. Cost £84,000.

Comprises (a) Addison House - four suites for G.P., suite for L.H.A. medical services, suites for three dentists in N.H.S. practice and L.H.A. dental unit for two dentists.

(b) Chadwick House - contains the Essex County Council health authority special clinics, eye, orthopaedic, physiotherapy.

(c) Galen House - contains the Essex County Council education authority Child Guidance Clinics.

(d) Bentham House - contains three consulting suites, X-ray unit and Path. Lab. Eleven consultant sessions weekly as follows:

General Medicine
General Surgery
Orthopaedic Surgery
Obstetrics and Gynaecology
Paediatrics
Psychiatry
Thoracic Medicine
Neurology
Dermatology
Ear, Nose and Throat surgery
Radiology

Parent hospital is St. Margarets, Epping. Is run by the Epping Hospital Management Committee under the N.E. Metropolitan Regional Hospital Board.

Historical

The Health Services at Harlow are part of the master plan of the new town which emanated from the decisions of the Harlow Development Corporation established in 1947. The full story of the health centres to date has been well written and references may be made to the various publications listed at the end of this chapter. The excellent "Guide to Harlow" gives a picture of the development of the town as a whole.

The suggestion that there should be health centres and not individual surgeries in this new town came from two local doctors, Dr. C. Taylor and Dr. Huntley, and the ideas were subsequently developed in association with Dr. K. Cowan, then M.O.H. for Essex, and Dr. Stephen Taylor. It is freely acknowledged that Lord Taylor has been the driving force behind the development of the centres.

Before any building of the health centres was begun a good deal of study was given to the project and this included visits to health centres already built. The proposals were first of all sent to the Ministry of Health which could not accept them because of financial difficulties. They were then submitted to the Nuffield Trust which agreed to finance a small experimental

health centre at Haygarth House and the success of this venture encouraged the Trust to proceed with the others. It was decided that the centres were to be run on sound financial lines and that the G.Ps would pay an economic rent. This was an important factor in the building and furnishing of all of them.

All the Medical Bodies concerned were consulted from the very beginning and negotiations proceeded for the most part in an atmosphere of good will. There was some opposition on the part of one or two G.Ps. who had established themselves in the old town of Harlow and would have preferred to stay in their surgeries. All the doctors in the district, however, were invited to join in the project and all accepted.

Each centre was regarded as an essential service in the new town and was built concurrently with the houses and other main services and as a temporary measure where required the doctors were given accommodation in ordinary houses. Keats House is an illustration of good planning. There are two unoccupied G.P. suites in this centre as that part of the town is not yet completed. Some blocks of houses had just been built and were awaiting tenants.

Finance

The capital cost of all the centres has been provided by the Nuffield Provincial Hospitals Trust and ownership is retained by the Nuffield Health and Social Services Fund. Each centre is run as a separate economic unit and is said to be self-supporting through the rentals paid by the G.Ps. and the Local Health Authorities. The rental varies in each according to the cost of the building and the accommodation required and is calculated on a basis of 6% of the capital cost. It is nowhere less than £200 per annum. Each is rented as furnished premises with heating of the waiting hall, light and power included but the tenants are responsible for heating the surgeries, interior decorating and the replacement of furniture, cleaning and rates. One or two of the G.Ps. thought the rental was rather high for the services received.

Buildings

All the centres are new buildings, one storey except for Bentham House and part of Keats which is to be used as a flat for caretaker or district nurse. They are of similar design on modern conventional lines, small and compact with little space wastage. The interiors are light and airy with plenty of Window space and very pleasant colour schemes and general decoration.

The G.Ps. were allowed to choose their own furnishings within a certain budget limit.

The centres are well sited within easy walking distance for all and each serves a well defined area of the town. The patients are perfectly free to register at whichever centre they choose.

Reception Offices are well spaced and considered adequate for the duties they perform. At Addison House one of the G.Ps. retains his own receptionist and at Keats House there are two quite separate G.P. wings each with separate reception office. Although both share the same waiting hall. Keats House is intended to contain two Group Practices. Patients medical records are kept in files in the reception offices.

Waiting Halls are to be found at all the other centres, they are not very large and the space effect is minimised by arrangement of chairs and tables. The waiting halls are also used for Local Authority Services. The Dental suites have separate waiting rooms.

Each G.P. has the exclusive use of his own suite comprising a consulting room and an examination room and there is a couch in each of these rooms.

There are no other rooms at any of the centres and a treatment room only at Addison House and the Industrial Health Centre. A District Nurse assists during the morning sessions with dressings and so on and for evening sessions the G.Ps. employ their own nurse/secretary.

The Local Health Authority occupy their own part of each centre and the services provided vary, with Chadwick House providing the most extensive range as seen on page 97

The Local Authority sessions are held mostly in the afternoons and at Nuffield and Addison House centres health visitors are in attendance daily between 9 and 10 a.m. for consultation.

Medical Staffing

All the G.Ps. practising in the district were invited to join in the health centre and all accepted and constitute the present staff. As the town developed and more doctors were required the G.Ps. either took in partners or a practice vacancy was declared and filled in the usual way. There have been no withdrawals.

All the G.Ps. in Harlow work at the centres which are their sole surgeries, and this is a condition of entry to the health centre. They are in group or partnership practices except for a singlehanded G.P. at Addison House. There is no private practice. Some do a session at the Industrial Health Centre for which they are paid and the patients seen are treated only if they remain at work otherwise they are referred to their own doctors. The G.Ps. also do the L.A. ante natal and infant welfare clinics for their own patients at the centres by arrangement with the L.A. and they are paid sessional fees for the latter. Some give the dental anaestetics.

Patients are seen at the usual surgery sessions morning and evening and at one centre only by appointment. (This appointment system is said to work satisfactorily). Except at the lunch hour secretaries are available from 8.30 a.m. to deal with any enquiries, requests for calls and so on.

There is a well defined and strict contract between the G.Ps and Harlow Corporation. Its main provisions are:

1. Consulting rooms (with the use of all other necessary facilities) are let to individuals or partnerships.
2. Lettings to partnerships are made "jointly and severally" (This is to enable partners to continue to practice from the centre in the event of a dissolution).

3. Before a tenancy to a partnership is granted, or extended, the partnership agreement must be approved by the Nuffield Trust. (To ensure that there is no exploitation of assistants or junior partners).

4. The agreement shall also be approved by the Medical Practices Committee, and a certificate obtained under Section 35(9) of the N.H.S. Act (1946).

5. Leases to principals or partners shall be for 21 years (or less if they wish), with the option to renew for a further 21 years (or less), the rent on renewal to be subject to negotiation.

6. Leases of consulting rooms for assistants shall be for one year; with possibly two annual extensions. When an assistant becomes a partner, a long-term lease is granted.

7. Two doctors may occupy only one consulting-room, whether as principals, assistants, or locums, in emergency or temporarily, or after written permission from the Trust, such permission not to be unreasonably withheld.

8. Long-term tenancies of more than one consulting-room will not be granted to a single doctor.

9. A doctor practising from a health centre shall not conduct a regular surgery or exhibit a plate or board elsewhere in the area of the new town served, or to be served, by one of the Trust's health centres.

10. If a partnership fails to grow to meet the medical needs of an area, the Nuffield Trust retains the right to let vacant consulting rooms to doctors not in partnership with those already in a health centre.

There are no consultant sessions or diagnostic facilities at any of the centres. There is direct access to all facilities at the nearest hospital seven miles away but in the Addison House group, Bentham House contains a full scale outpatient service as listed, with the x-ray and laboratory services directly open to the G.Ps. As this has only been in operation for some months there are no statistics available. There are no doctors or nursing staff resident at the health centres but as the town is small all live fairly near. None of the G.Ps. had considered requesting any further facilities at the centres except that a G.P. Maternity Unit for the district was very much desired.

Administration

The administration of the Harlow group of health centres is in the hands of Mrs. Long at the Information Centre in Harlow but there is no one personally in charge at any of the centres which are autonomous and run themselves. There are consultative house committees whose membership consists of doctors and dentists with representatives from the L.E.C. and L.H.A. and Harlow

Development Corporation who act as agents for the Nuffield Trust. These meet twice a year but there are no formal meetings of the G.Ps. themselves either for administrative or clinical purposes. Neither the L.A. or Harlow Development Corporation interfere or attempt to control the work of the G.Ps. in any way.

Partnerships and Co-operation

The G.Ps. for the most part, are on good terms and discuss cases with each other casually but second opinions and rota systems are limited to within partnerships. New patients must choose a doctor and the few transfers which occur are by mutual consent but at some centres an element of competition for patients exists. The G.Ps. are very pleased with their new premises and say that their patients, most of whom have been re-housed from London, like it very much. They are quite sure there has been no adverse effect on the doctor/patient relationship. Relationships with the M.O.H. and L.H.A. are said to be good. The assistance of the health visitor is especially appreciated.

Maternity Work

All are on the Obstetric List and do their ante natal at special sessions at the centres with the assistance of L.A. midwives and health visitors. There are no G.P. maternity units

and there is said to be difficulty in finding hospital accommodation even in special cases. There is a flying squad based at Epping Hospital.

General

All the doctors increased their lists and this is due to local population increase.

There is a community association which would deal with any complaints about the centres but so far there have been none.

There are no pharmacies at any of the centres and this is an act of policy.

At the Industrial Centre there is a register of patients seen and treated but none of the centres keep any records of attendances or treatments.

There have been no research projects at any of the centres but the Harlow G.Ps are now engaged in a Survey under Lord Taylor and Mr. S. Chave on the effects living in new towns have on mental health.

It was difficult to discover if there had been any decrease in the numbers sent to the local hospital and it is too soon to estimate the effect of Bentham House. The laboratory there does

not receive many requests from the G.Ps. and as a result the attendances of their technician have been reduced.

There is no tendency towards specialisation in the Group Practices except that the Infant Welfare clinics are usually restricted to one or two G.Ps. in a group.

The Harlow G.Ps. feel that the Health centre enables them to give a higher standard of service than they gave at their former surgeries and all of them prefer to work at the centres. They appreciate the value of working in close association with midwives, health visitors and dentists.

References - Lancet 1952, I. 255. 1955, II. 863. 1958, II, 1055
1959. I. 933. Proc. Roy. Soc. Med. Aug. 1958.

CHAPTER VI

DISCUSSION OF THE SURVEY

When the Medical Planning Commission produced its plans for health centres these were welcomed by the majority of doctors because not only did they envisage better working conditions for G.Ps. but also the implication that their sphere of activities would be increased captured their imagination. Although the N.H.S. began in an atmosphere of dispute with the Ministry many G.Ps. welcomed it for its promise of health centres. In the years following, the surveys of general practice by Collings, Hadfield, and Taylor showed that many G.Ps. worked under conditions which are far from satisfactory. Thus side by side existed evidence of the need for improving working conditions and a method showing how this could be achieved namely by the provision of health centres. Yet the survey shows that, apart from an exceptional G.P. here and there, the initiative towards the establishment of health centres came from Local Health Authorities through medical officers of health and correspondence suggests that this is also true in some areas where schemes were suggested to the G.Ps. but were not accepted.

In all of them those in favour of the health centre in principle and willing to co-operate in every way had to overcome

the traditional suspicion and hostility of their colleagues towards the L.H.A. and the M.O.H. So far they have been successful in Bristol, Harlow, Edinburgh, Manchester and Cheltenham only. At some of the remaining centres the feeling is one of indifference and at others one of open hostility.

It is not intended to go into detail on every dispute or mention any centres or individuals by name. Where tension exists that is well-known to the people concerned. It will be more profitable to enquire into its causes and see what can be done to remove them and also suggest methods whereby they can be prevented in the future.

The survey showed very quickly that considerable differences existed between the L.H.A. concept of health centres and that of the G.Ps. The former through the M.O.H. wished to put into effect as far as possible the recommendations of the Medical Planning Commission to help the G.Ps. raise their standards of service whereas the latter on the other hand saw little beyond the provision of better surgery accommodation though both agreed that the two services could be housed more economically under one roof. The G.PS. were surprisingly ignorant of much that had been written about health centres whereas the M.O.H. on the other hand was usually much better informed.

Occasionally also there was a good deal of imagination and vision on the part of the L.H.A. as for instance at Nottingham where the original intention was to use the centres as a means of establishing new entrants into general practice. These were to be appointed to the centre under the supervision of an experienced G.P. carefully chosen, who would act as a senior partner and in effect educate them into good standards of general practice. The phrase coined by a friend and colleague 'Wise men of general practice' is a good description of what was intended. Unfortunately, this plan was not adopted owing to objections by the L.M.C. At Sunderland, too, the original scheme was for a comprehensive centre with 5 G.Ps. who would have no other surgeries. The G.Ps. on the other hand, because of a good many factors, were more anxious that these should be branch surgeries. It is interesting to note here that the contracts at Harlow insist that there be no outside surgeries.

Unfortunately, sufficient account was not taken of the long standing opposition and hostility general practitioners have towards Local Authorities. It is worth while examing the causes of these, they apply not only to G.Ps. at the health centres but are fairly general throughout the country.

It must also be remembered that many of the G.Ps. were still resentful at having been compelled to enter the N.H.S. against their will and tended to regard suggestions of the L.H.A. with grave suspicion if not actual hostility before any discussion of the merits of any particular scheme took place. It is understood that many G.Ps. who felt this way were members of Local Medical Councils and Local Executive Councils and although often not involved themselves they were in a position to exert influence on policy discussions on health centres.

Fir st of all there was found to be a tremendous ignorance of the statutory obligations put by Parliament on to the Local Health Authority Services between the Wars. Most G.Ps. consider that the M.O.H. is mainly concerned with expanding and maintaining his 'empire' and see him continuing in competition with them as it were by maintaining clinical services, most of which they now consider unnecessary since every one has, in theory, his own doctor. They do not realise that these services were provided to fill a gap which existed in the medical services for many years before and between the two wars. Thus arose school clinics (1908) the maternity services (1915), minor ailment clinics and many of the other activities carried out on the preventive aspect of medical care. Nor do they know that, when the Act came into being

it was at first intended that these services should pass into the province of the G.P. It was realised, however, to do so would put an intolerable strain on to the G.P. services so they were retained in the third branch of the Tripartite Administration.

There was also fear of the Local Authority encroaching on their sphere of activities with consequent loss of prestige. This is hard to reconcile with the eagerness with which many G.Ps. make use of the Local Authority Services, e.g. minor ailment clinics which do a good deal of the work they ought to be doing themselves.

There is also a considerable resistance to facing up to the full meaning of preventive medicine as understood by Local Authority medical services and considerable irritation at what they consider interference from health visitors and school medical officers. They are not aware that a health visitor has to visit every new mother to give advice concerning the new baby and that her usual practice is to advise the mother to attend the nearest L.A. clinic. G.Ps. vary tremendously in their approach to child care, some being quite indifferent to its many problems and the health visitor has no way of knowing who is interested and who is not. To most G.Ps. health visitors are complete strangers and they

have not the least idea of their functions nor do they know that she is always a highly qualified nursing sister.

It is true to say, also, that in the course of building up their services the more energetic and enterprising M.O.Hs. had built up considerable clinical services which offered, for the most part, better waiting room facilities and consulting rooms than the average G.P. could afford to maintain and thus drew away many people who would otherwise attend the G.Ps. This naturally aroused a good deal of resentment and a tendency to belittle the achievements of the Local Authority medical services. It must be made clear that this problem only existed in the spheres of maternity work, infant welfare and school clinics. There are many other activities of L.H.A. which do not conflict in any way with the G.Ps. duties and responsibilities.

The G.Ps. also felt that the Local Authorities tended to be influenced by political factors, but members of Local Councils are there because of their interest in politics and they must behave politically whether they be Conservative, Labour or Liberal. They were, for the most part, trying to put into effect a political programme which was an all party measure and on the whole their intentions were laudable. They were responsible to the electorate

and naturally anxious to claim the credit if they could, being well aware that if things went wrong the blame would also fall on them. Unfortunately, too many G.Ps. could not see this.

The G.Ps. also felt that the Local Authorities were more concerned with using them as a means whereby they could build better clinics and thus gain in prestige value but there is nothing wrong with this, it could be equally well used the other way around. In Bristol, for instance, the G.Ps. were very glad that the Local Authorities were about to build a clinic and they could join with them and make it a health centre.

The profession as a whole is aware that these feelings exist and is trying to improve the relationship between the local health authority and themselves but it is only recently that there has been some success in this direction.

The reluctance to co-operate with the local authority was also due to fears that this might be the thin edge of the wedge towards a full salaried service.

The M.P.C. Report does not recommend a salaried service and the amendment to the Act makes it quite clear that there is no intention of instituting one. Where this question has been studied

fairly extensively it is considered to be impracticable for many reasons. With regard to salaried service it is interesting to record a change in the attitude of some G.Ps. to this question. Whereas formerly they were unwilling to consider the idea at all and reacted very violently to any suggestion of it, now they have modified their views to the extent that it might be worth while examining it afresh. This view is, for the most part, held by the younger doctors but also by an occasional established practitioner who formerly was in violent opposition. The survey showed that nowhere has there been any attempt to force the G.Ps into a salaried service at health centres.

Even in places where the G.Ps. as individuals, were willing to co-operate with the Local Authorities, their intentions were often frustrated by their colleagues on the Local Medical Committees. These bodies are mainly advisory to the statutory body, the Local Executive Council, and it is true to say that most G.Ps. are very ignorant of medical affairs and do not know the difference between the two bodies. The L.M.C. is a duly elected body representing the G.Ps. in each town or district by annual election, but such is the apathy that these elections are very poorly attended - rarely by more than 18% of the electorate -

and, indeed, at some L.M.Cs. there are vacancies because they cannot find enough doctors to fill their quota.

The Local Medical Committees are, for the most part, so taken up with day to day matters of administration that they have very little time for constructive thinking on new lines of general practice and doctors are in any case notoriously resistant to new ideas. Any one who is a member of medical committees knows that most of the work is done by a few individuals who take the trouble and time to interest themselves and become informed on medical affairs. Most members are, on the whole, uninformed and matters are often discussed and decisions taken without their being fully aware of their implications and consequences. As Sir Frank Newsome observed "the future of general practice is largely being determined by default"[1].

In the course of conversation with M.O.Hs. it was revealed that many proposals for health centres had been made by L.H.As., to L.M.Cs. but these were opposed in many cases on the grounds that a particular district was already well served by G.Ps. This may will be the case but one cannot but condemn such an unprogressive attitude. For many years the correspondence columns of the medical press have contained complaints about the lowered status of the G.P. since the 'appointed day.' Authoritative medical committees

had declared themselves in favour of health centres as a means of raising the standards of G.Ps. and yet here there were G.P. representatives through L.M.C. and L.E.C. advising against their establishment.

The L.M.C. felt that as health centres would be heavily subsidised out of local rates they themselves would be helping towards the expenses of their competitors and while this point of view should be regarded as extremely unimaginative it must be recognised as being firmly held in those centres where the G.Ps. do not pay an economic rent. This however, is more an argument against the method of financing health centres and against competition in principle rather than against the health centres themselves. Surely if the G.Ps. on these committees did not wish to work in health centres themselves, then at least they need not have hindered those who were anxious to do so. They might have shown more sympathy with their colleagues who were willing to undertake this unusual experiment in general practice.

The G.Ps. now living in specially built doctors' houses on new housing estates have also cause for complaint as they cannot understand why these were ever built, if it had always been the intention of building a health centre on the estate.

The Local Authority might have gained much goodwill by allowing those of them who wished to practise solely from the health centres to terminate the lease on their houses without financial penalties. At the same time by arrangement with the L.E.C. they could have ensured that no other G.P. was allowed to establish a practice in the vacated premises. Housing committees could have assisted by refusing branch surgery premises or building permission near enough to a health centre to jeopardise its chances of success. The partial failure of the one centre is largely due to the presence of a practice with a resident doctor in opposition to the G.Ps. at the health centre and more conveniently sited for the people on the estate.

Another problem not envisaged by the local authority when plans for health centres were being drawn up was the dispersal of practices as a result of slum clearance and re-housing programmes. The amount of overcrowding in some areas was only realised by G.Ps. when, as new houses became available, they found their lists shrinking and this was more common in many an old established practice. This point has already been mentioned in the survey, and, explains why in many cases the G.Ps. were unable to concentrate all their work at the health centre.

The Local Authorities were, in many cases, between two fires and often whatever they did was wrong. If they acceded to the wishes of the G.Ps. that the centre should be used as branch surgeries they were afraid that the centreewould not fully justify itself. If they persisted with their plans in spite of the opposition of the G.Ps. then the result was mutual suspicion and a very unhappy feeling at the centres.

In one or two places it would have been far better to have abandoned the proposals for health centres and build clinics only but have them so planned that they could be converted into health centres when the climate of opinion was more favourable. As far as the G.Ps. were concerned it would be then their own responsibility to find premises on new housing estates and in this they could have been given all the assistance possible from the housing authorities.

All the foregoing help to explain why relatively few health centres have been built and show that this has very little to do with those already in existence. The truth is that G.Ps. working in one health centre know very little about what is happening in others. There is little written about their experiences and no attempt to get together to pool information and experiences. There are two health centres quite near each other in which the

problems in both were exactly similar, yet no-one has taken the initiative in calling a meeting to discuss, even amongst themselves, what can be done to remedy the situation. The tasks would not be easy but in the light of discussions with all parties it is felt that if a determined effort was made with goodwill and patience on both sides matters would improve considerably. It would be a good idea if some body could arrange a meeting to which would be invited G.Ps. and local health authority representatives from every health centre. They would be interested to discover that their difficulties were very similar and might be able to devise some methods of dealing with them.

The trouble with most of the health centres in the survey lies mainly in the fact that one of the important recommendations listed in Chapter III mentioned frequently in discussions on health centres at the General Medical Services Council has not been adopted. Namely, that they should be regarded as being experimental in nature. P32.3. Some one should have been appointed to hold as it were a watching brief and visit each centre from time to time to inquire as to progress. Did the G.Ps. like working together in the same building?; did they consider joining in partnerships or group practice?; were they finding secretarial and nursing assistance useful and enabling them to spend more time on their

patients? Were they co-operating with the L.H.A. and making full use of the health visitors?; did they think that the L.A. clinics should continue as before or would they prefer to do this work themselves as part of their terms of services for their own patients. Did the patients like the centres or would they prefer to attend their family doctors in their own home surgeries? Unfortunately, only at Edinburgh, Manchester, Bristol and Harlow was this experimental attitude adopted. In these centres, there is someone in overall charge of the project watching carefully how it is developing and initiating research to discover the effects on patients and doctors and also ready to experiment with new ideas.

Harlow provides the best illustration of the experimental approach. The first health centre was a small one carefully supervised and from its success emerged all those which now serve the new town. From the very beginning they were all the subject of careful planning with the co-operation of all concerned, and the main recommendations listed in Chapter III were closely followed. In order to do this the planners had to exercise strict control over conditions of entry into the health centres and this is shown in the contract offered to the G.Ps. Most important is the condition that the centres must be the sole surgeries, no one can engage in general practice in Harlow except from a health centre.

This has always been recognised (P 33.5) as essential to the full concept of health centres and cannot be too strongly emphasised especially while health centres are still in the experimental stages. The project is too important to allow any outside competition to have an adverse effect on it and experience of the other centres shows how necessary this is. Harlow is however unique it is a new town and fortunate in being under the wise and imaginative guidance of Lord Taylor and his colleagues.

At Stranraer, although conditions are ideal for the application of these principles, the doctors have for so long regarded the hospital as their main focus of interest that the health centre is of secondary importance. Yet by building it as anextension of the hospital to which it is joined by a corridor the whole unit comes very close in structure to a Primary health centre described by the Dawson Committee and with much closer association between the G.Ps. and the L.H.A. this is what it could be. The situation here is worthy of careful study as a pattern for the family doctor services in towns of similar size and situation. At Litchfield, the situation is somewhat similar. The G.Ps. are on the staff of the local hospital but this is some little distance away from the health centre, and time will

show the way in which the G.Ps. regard their new health centre. Faringdon presents a challenge in its interesting potential of being converted into a real health centre round which could be grouped all the family doctor services of the surrounding countryside. A small X-ray unit would be justified here in view of the distances involved but all this of course would require outside financial aid. For the present any development is unlikely here in view of the fact that the senior G.Ps. are near retirement age and it is unreasonable to expect them to be interested in new ventures. In all the others the G.Ps. have been provided with better surgery facilities and seem to be content to leave it at that except that here and there an occasional G.P. expressed himself as feeling dissatisfied. They had hoped for group practices, their work to be much more interesting with more co-operation with local health authorities personnel and consultants but none of these aspirations have been realised.

To sum up, the antecedents of most of the health centres visited showed that nearly all of the difficulties encountered were the result of lack of vision at L.M.C. level and poor personal relationships between G.Ps. and L.H.A, and faulty planning and inability to profit from the recommendations laid

down by the various medical committees, which had considered health centres over a period of years. In fairness to all concerned it must be recognised that in some centres solution of these difficulties depend on factors outside the control of the people concerned and that in all cases they were unable or unwilling to exercise strict supervision of development as at the Harlow Centres.

FINANCES

One of the arguments against health centres has been that they would be too expensive. These criticisms are directed for the most part against the large comprehensive type such as Woodberry Down, Sighthill and to a lesser extent Sunderland. Table I shows that apart from these three, the health centres in the survey were built at a modest cost as compared with the vast amounts of public money spent in other directions. Comparison of costs between the various health centres is not possible because of the many different factors involved, but the overall impression was that there was little difference in actual cost whether the centre was built by local authority, privately or the Harlow Corporation. The capital costs cannot be criticised except against the background of the services provided. All the Harlow centres were provided at a total cost of just over $\frac{1}{4}$ million pounds. This must be compared

with the cost of the future Harlow hospital estimated to be somewhere in the neighbourhood of £2m.

All the same it is immediately recognised that even the cheapest centre would be beyond the means of little towns like Faringdon if some of the finances have to be provided out of local rates. Where the G.Ps. have provided their centres themselves or from the group practice loans this has placed quite a strain on their resources. Some anxiety was expressed at Lichfield and Oxhey because not all the accounts had, as yet, been presented and little was known about running costs. It was felt that if these proved to be too heavy the local health authority might be asked to take over the centre.

The running costs are not comparable because here again so many different factors are involved. Time and space does not allow full details of the annual budgets of every centre to be included here but the Bristol one is a fair example (Appendix V). It is seen that the staff salaries account for the major portion of the cost, and from personal knowledge the Bristol centre is not over-staffed allowing for holidays and time off. It must also be remembered that if there was no health centre much the same personnel would be employed at local health clinics which would be idle for some part of each

day, whereas they are fully employed at the health centre. It is not possible to make an exact comparison with the costs of running a L.A. clinic but it is estimated that the extra cost of the Bristol Centre is more than justified by the services supplied to the people of the district.

The Harlow Centres are stated to be self-supporting from rentals but these only take account of the building and maintenance. The G.Ps. have a high rent to pay and in addition have to pay for secretarial help likewise the local health authority has to pay the salaries of its personnel and the expenses of equipment and so on. At the statutory centres the facilities provided for the G.Ps. in secretarial and nursing help are, it is thought, better than at the other centres so they are bound to cost more.

The advantage in owning the health centre is that after the loan has been paid off there is something of capital value which can be realised on retiral. It does, however, place a strain on a new partner who would have to find the money to pay for his share as well as a house in which to live. This would mean incurring a total debt of £6,000 to £7,000 i.e. £3,000 to £4,000 for a house and say £3,000 for a share in the health centre. This would bring back one of the disadvantages the Act

was intended to abolish. Also there is bound to be considerable reluctance to develop the centre because any extension of diagnostic facilities or ancillary help would have to be paid for by the G.Ps. who cannot recoup themselves by charging fees to their N.H.S. patients. Further it is reasonable to assume that the G.Ps. who would have the imagination and initiative to engage in such projects would only be found among the 25% of really good G.Ps. For these reasons it is doubtful whether this way of financing health centres will be widely applied. So far out of a total of 322 applications for group practice loans only two have been used to build health centres.

Health centres can never be regarded as an economic proposition and must be classed with clinics and hospitals as part of the essential medical services. The return they give is incalculable in terms of improving the health of the country. Further, since the medical profession has accepted the N.H.S. i.e. accepted the proposition that it is the responsibility of the nation to pay for the health services and it is true to say that many accepted the N.H.S. with enthusiasm because of the promise of health centres provided out of public funds, the G.Ps should not be expected to pay for them. Consultants and specialists do not pay for the far greater facilities they enjoy

at hospitals.

Where health centres are established these should be paid for entirely out of public funds from the Exchequer with no local rate contributions. It will immediately be argued that this is impossible because if universally applied the costs to the country would be very high. This might well be true, but the centres would be built gradually over a term of years and also the costs must be balanced against the costs of running a much greater number of smaller units, i.e. doctors surgeries and L.A. clinics each with its own limited facilities. It is true, of course, that the latter would be paid for by the G.Ps. themselves but the G.Ps. expenses are only a very small part of the cost of the N.H.S.

Comparison must also be made between the services they give and it is suggested that in the long run there would be a saving of public money by running a more efficient organisation of the G.P. and L.A. services.

It will be seen that with the single exception of Bristol all the centres contain separate premises for L.A. and G.P. services.

A glance at the Local Executive Council lists of doctors' surgeries in any town will show that, for the most part, doctors

are to be found in their consulting rooms for about 2 - 4 hours of each day, and for the rest of the day their premises are empty. Regarded on purely business lines this is gross capital wastage.

When the Bristol centre was being planned, this simple fact was grasped and discussed with the G.Ps. concerned. It was immediately realised that the building would be smaller, more compact, the rental and the runnings costs lower if the rooms served for both services, i.e. G.P. and L.A. - the G.Ps. having the use of them mornings and evenings, and the L.A. in the afternoons and some evenings.

The design allowed for communicating doors between two adjoining waiting rooms so that a large room was available for clinics, if required, but no other special facilities were thought to be necessary. Further, it was hoped that in time the G.Ps. would take over most of the L.A. work for their own patients at any rate. When this was discussed during the course of the survey it was quite obvious that the doubling up of the two suites of premises had not been considered except in the case of Stirling where it is the intention of the M.O.H. to apply this principle to the health centres planned in his area. It is interesting to recall that this principle was also favoured by Mr. McLeod when Minister of Health.[2]

"I very much agree with what was said, that these local health authorities and others who have difficulties in this field should consider a study of the Bristol centre which provides both suites for the general practitioners and at the same time accommodation for local health authority clinics when the G.Ps. are not using it. It may be that some of our problems can be solved along those lines."

Other G.Ps. with whom these proposals were discussed were at first inclined to insist that each G.P. must have his own surgery for his exclusive use because it in some way reflected his personality. It is suggested that there is more emotion than reason behind this argument. When it was pointed out that the changeover was effected at Bristol without the least disturbance and alteration so that the G.P. was unaware for the most part that there had been any use of his premises only a few moments before, it seemed that many of them thought they had missed an opportunity of saving money.

Certainly public bodies are not along in wasting money. At Lichfield it seemed extravagant to provide seven separate surgery suites for seven doctors in two partnerships of three and four respectively. Capital costs could have been less by reducing the number to four, or perhaps five, with one of them slightly adapted for L.A. work, and by spreading out surgery

sessions to ensure that there would have been a doctor present and available for most of the day. This would also prevent overcrowding at busy sessions and lessen the strain on the secretarial staff. It is well known that for a large part of the day many doctors are not easily available, being out on their rounds. In the larger cities this does not matter very much. In the case of emergencies dialling 999 will provide immediate transport to hospital, but this is not so easy in the smaller new towns and housing estates and in any case hospital and ambulance services are expensive and often used unnecessarily by the public.

If the G.Ps. staggered their surgery sessions morning and evenings and the L.A. clinics were held in the afternoons, then the district would be covered for most of the day by there being a doctor or nurse present at a health centre nearly all day. This was put into effect at Bristol with the results anticipated. The centre is small, compact and costs much less than the average to build, and the running costs compare very favourably with others when it is considered what facilities are provided for the doctors and patients.

It is well known that the hospital services constitute by far the most expensive part of the medical services to the nation.

It is submitted that a good deal of the public money would be saved if the G.Ps. did more for their own patients and were not required to send them to hospital.

Where there were treatment rooms it was considered these did a good deal of the casualty work which would otherwise have gone to the hospitals. Further at Manchester where statistics are available there is considerable saving in the demand on out-patient and in-patient facilities.

As has been said modern methods of treatment and diagnosis enable G.Ps. to treat at home or in their surgeries many cases they used to send to hospital, and with the provision of simple diagnostic facilities as at Manchester this could be extended greatly, certainly on the medical side and to a limited extent on the surgical as for example suggested by Farquharson[3]. This and other methods of co-operation with the hospital consultants could reduce considerably the bed occupancy rate in this country which is the highest in the world. It is not intended that the G.P. should try to do the consultant's work - his approach to patients is quite different. Except for Stranraer and Lichfield none of the G.Ps. expressed any desire to have G.P. hospital beds apart from those required for maternity cases.

Now that every citizen in the country has his own doctor, the time will surely come when most of the family clinical services provided by the L.A. will come to be the responsibility of the family doctor. Many of the M.O.Hs. realised this and were prepared to enter into discussion with the G.Ps. If certain changes could be made in the arrangements for school medical services there is no reason why these also should not be within the scope of the G.P.

The G.Ps. for their part, were disposed to consider this favourably even though it was suggested that they should expect no special fees for these services to patients on their own lists, as it was absurd to regard preventive medicine as being a sort of speciality requiring a special fee. The G.Ps. objection was that they just did not have time to do all this work in addition to their own. This brought home very clearly the fact that the survey could not be considered strictly within its terms of reference wide though these were. There were so many outside factors which affected the attitude of the G.Ps. to their work, and most important of these was the size of their lists. Any recommendations with regard to health centres cannot ignore this important factor. If their lists were reduced, and the G.Ps. did all the preventive work many wished to do, there would be in the long run a great saving of public money.

Many assistant M.O.Hs. could either become G.Ps. because there would be a great need of additional G.Ps. if lists were reduced, and those who did not wish to enter G.P. work could become administrators because more administrators would be also needed. Certainly much of the reduplication which is one of the worst features of the Tripartite Administration and one which adds considerably to the cost of the services, would be reduced.

Further saving could be effected by re-examing the services already provided. The value of much of the physiotherapy apparatus found at many of the health centres is debatable. In their annual reports the Manchester G.Ps. seem to place little value on theirs regarding it more in the nature of a placebo.

It is further submitted that with proper organisation treatments could be carried out better and more quickly so that less time would be lost in getting people well and back to work. Regular clinical meetings something like those held at the Teaching Units would be of great value in this respect. At these meetings there would be case discussions, and any difficulties with regard to treatment or diagnosis would be discussed, and the combined experience of the G.Ps. might enable them to deal with many problems which would otherwise have been referred to outpatient departments of hospitals.

These meetings could also take over the duties of the Regional Medical Officer. Patients would have the right to appeal to another body and this might well be at a more distant health centre.

To sum up at this point, it is submitted that, by keeping the building small, making the suites serve dual purposes with the G.Ps. doing all the routine clinical work formerly done by the L.A. Medical Officers there would be a great saving of public money.

THE BUILDINGS

Little criticism is offered of any of the new buildings. No doubt the minor deficiencies and drawbacks have already been appreciated by the doctors themselves. Sighthill, Woodberry Down and Sunderland are far too large. In the first two named one tends to get lost in the endless corridors and this militates against the establishment of co-operation amongst the G.Ps. working there with L.H.A. personnel and consultants. Centres should be small, about the size of the Bristol or Harlow centres.

Manchester and Edinburgh Teaching Unit have done their very best within their financial and physical limits, but it does not need a time and motion study to realise how awkwardly they are designed. By the time the cost of the alterations are met and

consideration of the repairs in the future it may be found that it would have been cheaper and more effective to have built new centres. Lack of finance was no doubt a limiting factor.

It is ironical to contrast these grimy buildings with the splendid departmental stores and blocks of offices springing up all over the country. Napoleon's jibe is certainly true today. Neither of these centres are worthy of great cities like Edinburgh and Manchester.

The Swindon health centre has acquired a tradition in the town on account of its long years of service but it too is a very awkward place to run. As the hospital opposite is due for demolition there will have to be some thinking about its future. It is hoped the authorities will have the courage and vision to demolish the centre as well and build two smaller ones in its place.

The authorities might have been a little less generous with the equipment provided. The personal equipment of the G.P. such as a sphygmo. and other instruments ought to be his own responsibility. There is no need to have a wash basin in both surgery and examination room. Further, a couch in both surgery and examination rooms is quite unnecessary and bad psychologically, giving the impression that patients are being put on to a

conveyor belt system.

GENERAL

Evan at the centres where there was no actual contract there was security of tenure and no evidence of anxiety about tenancy. The only anxiety expressed was about possible increases in rent. Nor was there any evidence of any attempt at interference with their work, even where relationships with the L.H.A. were very bad. There had been some fears expressed that health centres would lead to regimentation, loss of personal factor and interference with work but the fears voiced many years ago at the A.G.M. 1942 were found to be quite baseless.

Without exception the G.Ps. preferred working at the centres. They liked having secretarial and nursing help and had lost the feeling of isolation. Mere proprinquity with their colleagues had a very good effect on their relationships.

It also explained why they all felt they gave a better service. Working in the centre where from time to time there was the possibility of their standards being open to criticism by their colleagues had a stimulating effect. Also they did have the opportunity of meeting and getting to know each other, even if only casually.

Certain circumstances, however, worked against them getting to know each other very well at some centres. At Woodberry Down and Sighthill it was size. At Cheltenham the very large number of doctors prevented any feeling of being engaged in any new enterprise.

At this centre there was a very pleasant staff room, but little evidence that it was ever used, and a glance at the surgery timetable showed the reason. The G.Ps. would scarcely have time to do more than their work and be off again. It is pertinent to inquire why it is necessary for all of them to attend, and why they had not formed themselves into groups so that the responsibility for the housing estate could be restricted to six of them. Cheltenham is the negation of the health centre concept, it is really little more than a call office or very minor branch surgery for the doctors who use it.

In some cases there was no staff room where all the personnel could meet and discuss any problems which arose from time to time. This is a serious omission, it is not enough to use the reception office or one of the consulting rooms. This would mean choosing a convenient time when there were no patients to be seen, and this would often be at a time when the G.Ps. were anxious to be off on their rounds. There ought to be one staff

room available at all times for cups of tea and discussion. It should bea pleasant room on the ground floor and so placed as to be easily accessible and not tucked away in some odd corner. There was found to be a close relationship between the presence of a staff room, the use made of it, and the state of harmony of all those working at the health centre.

At far too many places there was no one special in charge. No one easily available at all times, either personally, or by deputy, to whom any complaints could be referred, or suggestions made re the running of the centre.

The good relationship among all doctors at Bristol owes much to the personality of the Sister in Charge.

It is suggested that the person in charge should be a highly qualified, actively working, nursing sister with a deputy and not a lay administrator and is essential that the appointment should be made in full consultation with the G.Ps.

There is no doubt that at the Teaching Units the overall supervision of Drs. Logan and Scott respectively give a sense of purpose and direction to the centres, while at Bristol much is owed to Prof. Wofinden for his constant interest and encouragement.

Lord Taylor's influence at Harlow has already been emphasised.

At Edinburgh, through the kindness of Dr. Scott an invitation was accepted to sit in at one of their meetings for a short time, and this was a very inspiring experience. Listening to the discussion the patient emerged as a living being, complete in his home background of which the G.Ps. had intimate knowledge and always treated with great sympathy, and not just a collection of signs and symptoms. There is no doubt that these meetings are extremely valuable and apart from its benefits to the patients, it helps to keep the G.Ps. together as a coherent unit. The fact that at other centres they are not in partnership or groups should not prevent the establishment of similar meetings. If there are no meetings at all the centre will remain dead, and never produce anything. No matter what facilities are provided at the health centres they must not be regarded as bigger and better surgeries than before.

Again the main objection the G.Ps. had to these suggestions was lack of time and the same reasons are given in answer to any question of research. This is a comparatively new idea for G.Ps. although many original contributions have been made by them in the past, and here must be mentioned Dr. William Budd 1811-1880

and his investigations into typhoid and other diseases in 1849. There are also others such as Dr. Fry and a good deal of work is being done under the aegis of the College of G.Ps. and published regularly in their Research Newsletter.

There is no doubt whatever about the value of research in General Practice. At the Edinburgh Teaching Unit research (unpublished) has shown that in all the patients who attend for social reasons the commonest single factor is poverty. This is a surprising finding in these days of the Welfare State but it is not restricted to the Edinburgh practice as a recently published pamphlet shows.[4] Even the simple investigation of haemoglobin[5] levels in a random series of women at Bristol showed a wide prevalence of unsuspected iron deficiency anaemia. It demonstrated the fact that whatever else many of these women required in the way of treatment, they certainly got iron in addition.

There was no tendency to specialise and that is understandable. General practice is a speciality in its own right, G.Ps. must remain truly general doctors.

MATERNITY

The Survey showed that there was a considerable variation in

the standards of maternity services as expressed in G.Ps. attitudes to ante natal care. The Cranbrook Report[6] had recently been issued and it is true to say that only one or two of the doctors had even heard about it far less read it and most were unaware that the recommendations for an Obstetric list were only a small part of the main Report and should only be considered in their proper context.

This recommendation was resented by many of the G.Ps. but some on the other hand consider that the Report offers a wonderful opportunity of converting the maternity services into a G.P. speciality and this could be best organised at a health centre with only some of the G.Ps. doing all the midwifery of the group with a corresponding reduction in the numbers of patients for whom they are responsible.

Provision of all the services considered necessary for good ante natal care would, of course, be at the Centre and a visiting Obstetrician, as at Bristol would supply the connecting link with the hospitals.

There was everywhere a desire for more maternity beds for G.Ps. and provision of these is strongly recommended by the Cranbrook Report. This of course is a long term measure and

in the meantime it might be worth while experimenting along the lines of the Bradford[7] or Bristol[8] suggestions.

PHARMACY

At Swindon there had been a pharmacy and at two of the new ones one was provided. At some of the others this had been discussed but decided against by the L.E.C. Firstly because it would increase the size and cost of the building but much more because the health centres would be in a neighbourhood which would contain shops and there would always be a Chemist there. Also in any case L.E.C. are always reluctant to interfere with established commercial practices.

APPOINTMENT SYSTEMS

There were few appointment systems and little evidence that any had been tried generally. It is quite understandable as this is a revolutionary idea in general practice. For too many years patients have been accustomed to waiting for hours in their doctor's waiting rooms and it is surprising that they have not revolted long ago. An appointment system would avoid overcrowding in busy seasons and remove the need for large waiting rooms. There should be separate waiting rooms which could be shared by two doctors rather than a large waiting hall for all the doctors.

The thought of crowded surgeries in the winter days must have a bad effect on the G.P. in his consulting room and it is high time this sort of thing was abolished. G.Ps. ought to be able to spread out their surgery attendances.

In practices where appointment systems exist no special difficulties have been experiences and they ought to be tried out more extensively. Of course, it is essential to have adequate secretarial help for this purpose.

INCREASE IN LISTS

There was no evidence of any increase in lists at the expense of the outside G.Ps. This is the reply to those who thought that the advantages enjoyed by the centre doctors in their subsidised premises would result in a mass transfer of patients to the G.Ps. at the centre.

The chief gainers are the patients, and that is as it should be.

DENTAL SERVICES

Where there were these services they were much appreciated. The difficulty was that owing to the general shortage of dentists

it was only possible to provide priority services in most cases.

The salaries offered compared very unfavourably with what most dentists could earn outside and this explains why, at some centres, there were dental suites but no dentists.

Until there are more dentists in the country the health centre should not include dental suites but the plans should allow them to be added when dentists become more plentiful.

G.Ps. working at most centres seemed adequately covered for time off and emergencies but none of them had the full advantages of a complete rota system, except where there was a partnership. Where some partnerships had to employ locums for holidays it was thought that they were under-staffed and mainly for financial reasons.

It was surprising how the doctors reacted to questions about what the patients thought about health centres. This was something they had not considered but they were sure patients were happy to attend at the centres. Their former premises were so inadequate by comparison that they had not the slightest doubt about it. There was no instance given of any patient leaving a practice solely on account of its moving into a centre.

For all that there ought to be some way in which patients' opinions are collected. Hospitals are always asking their patients' views on the treatment and attention they receive and centres ought to do the same. Some useful suggestions might result.

The over-all picture of the health centres is one in which the G.Ps. felt they give a better service then they did before, and even where there was little co-operation with the local authority services they much preferred the health centre to their previous surgeries.

DIAGNOSTIC FACILITIES

The survey showed that apart from the Diagnostic Units and Manchester few health centres possessed any diagnostic facilities while the side rooms were used for minor purposes only. In most cases the G.Ps. used the nearest hospital facilities, although on enquiry many of them would have preferred to have them at the centres if they also included a technician. Yet at Bentham House the technician felt he was not being given enough to do by the G.Ps. and at Corby the facilities available were used far more by the consultants than the G.Ps. Whereas Corby is some distance away from most of the practices,

Bentham House does not suffer from this disadvantage. It is adjacent to one of the health centres and not very far away from all the others in Harlow new town. At most centres the impression was that the G.Ps. had not considered further extension of daignostic equipment and seemed to be satisfied with the services available. At Manchester the facilities are all on the premises and this explains why they are used so much.

Corby. With the constant complaint of lack of time it is too much to expect G.Ps. to make a special visit to another consulting room in order to examine a patient. It is easier to conduct the examination in one's own surgery and if in doubt send directly to a consultant. The exception to this is the mass x-ray service for chests or in the case of pathological specimens which can be taken by the patient directly to the hospital or sent through the post.

The Corby centre was disappointing. The G.Ps. did not use it as much as had been hoped for. Few of them took full advantage of the facilities for examining their own patients there an preferred to send them direct to the consultants as the figures show. There was also an impression that association with the consultants was limited to a few keen G.Ps.

It is not without significance that, although the centre has now been running for several years there has been nothing written about it. There was certainly no evidence that the G.Ps. felt they were engaged in something new and interesting in general practice.

There was no doubt as to its success as a hospital out patient department. Obviously the patients preferred coming there to making the much longer journey to Kettering. All the same it may be asked if, had that been its main purpose a free bus service for patients to the main hospital would not be much cheaper.

It is too soon to comment on the Edinburgh diagnostic unit but time will show how much the G.Ps. use the excellent facilities provided. There are no consultant sessions, it is for G.Ps. only and this is something new and important.

At Coventry and Bristol there had been a good deal of discussion on the question of providing X-ray units at the centres. The Regional Hospital Board were against this in principle while the L.M.C. objected on the grounds that the health centre was being subsidised enough already and if the G.Ps. wanted x-ray units they must provide them themselves.

The Manchester doctors got their x-ray unit in the face of strong local opposition and their annual reports show the use they make of it. The machine is in use mornings only, five days a week and reports are received within two days. The 1957-58 report shows that chest x-rays account for nearly 80% of the total x-ray examinations and it must be emphasised that this is the one x-ray examination which is directly and easily available to G.Ps. everywhere through mass x-ray units. A good deal of thought has been given to this question and it is felt that, while it would be desirable to have such units at health centres, it is not a practicable proposition on grounds not only of cost but also owing to the shortage of qualified radiographers. The same objections apply to full scale laboratory facilities. It is more important that G.Ps. at health centres and outside be given direct and easy access to all diagnostic services and for this reason there will be more support for the Edinburgh experiment. If this is successful then there may be further diagnostic centres established apart from hospitals and reserved solely for G.Ps.

Some simple diagnostic aids should be provided at the health centre. At Manchester the photo electric calorimeter is found to be invaluable while at Bristol the E.C.G. saves many an

appointment with the cardiologist. The nursing sisters very quickly learnt to use the machine and the reading of the graphs is done by one of the junior colleagues whose opinion so far has always coincided with that of the consultant to whom they are sent as a precautionary measure.

TREATMENT ROOM

Where treatment rooms were provided they were found to be of great value in "buying time" for the G.Ps. by the nurses doing all dressings, ear syringing and inoculations as well as urine testing. They also save the district nurses many a home visit and patients many attendances at hospital outpatient departments. If second attendances are apread throughout the day and by appointment as at Coventry the work is made much easier.

The treatment room should be downstairs and accessible to patients without having to call at the office and while under treatment the records could be kept there. One piece of equipment sometimes forgotten is an incinerator for disposing of soiled dressings. There is no need for separate treatment rooms for the G.Ps. and L.H.A. one could serve both and this would help in promoting co-operation. At Oxhey the G.Ps. have no treatment room yet are unwilling to use the one in the L.H.A. part of the centre,

in fact they had never got as far as discussing this with the M.O.H. Comment is unnecessary.

RECORDS AND RESEARCH

At Manchester, Edinburgh and Bristol full records are kept and there are research projects on problems in general practice. It was rather disappointing to find record keeping regarded as being of little value at the Harlow centres. This is a most unusual experiment in town planning and one which should call for full documentation. At Swindon in the Secretary's office there is a chart showing every item of service rendered by the G.Ps. since the appointed day. This could be the subject of a most interesting paper. Treatments are not included as these are done at the hospital across the way.

INDUSTRIAL HEALTH CENTRES

The subject of occupational health services is occupying a good deal of thought and discussion nowadays but only a brief acount may be made here.

This is a pleasant and well equipped little unit but it is suggested that it is an example of the unnecessary re-duplication of medical services, this time by private enterprise. Industrial medicine is now established as a speciality and ought to be the

responsibility of full time medical officers appointed maybe to a group of factories, or of one G.P. part time to one or two. At Harlow the sessional G.Ps. were seeing their own patients for the most part and were thus being paid twice for their services. An Industrial centre should be a first aid room only under the chargeof a qualified nurse with provision for dressings, injections and treatment of casualties, but no medicine except maybe some asprins and stomach powders. The real consulting room of the factory doctor is the factory itself, and he should concern himself with the investigation of special industrial hazzards and accident proneness. There was no suggestion that any such investigations were being conducted here.

TEACHING UNITS

Taken as general practice the teaching units at Edinburgh and at Manchester were excellent. There is no doubt that the patients enjoy a very high standard of service at both. At Edinburgh the lists are much smaller than the average and the G.Ps. felt they were much freer to treat their patients without worrying about any possible affects on their lists.

They were salaried full time doctors and thought it was better that way. The Manchester doctors felt that their lists ought to be reduced for all the work they were doing.

At Edinburgh it was early realised that the practices at the Royal Dispensary and Livingstone House were exceptional so the students are encouraged to visit outside G.Ps. In 1956 eight local G.Ps. were appointed to take part in the teaching programme on a part time basis and similar arrangements exist at Manchester. Perusal of the programmes at Edinburgh[9] and Manchester (Appendix IV) show that the course if fairly extensive. Is there not a danger here that it may place a further strain on an already overloaded curriculum and further is not the final year much too late?

By that time the medical student is already conditioned by several years of hospital work, and regards "patients" from the hospital "angle" which is quite different from seeing them in a G.Ps. surgery or in their own homes. The people he has seen so far have been patients with established diseases, organic or functional, and it is quite a surprise for him to see how different and difficult the clinical picture is at the beginning of an illness. Also this is rather an anxious time for him because he is far too pre-occupied in mind about his

forthcoming examination to derive the full benefit of his experience.

Surely it would be much better for him to learn about general practice at the beginning of his clinical studies? As he signs on for his various clinics he would at the same time be apprenticed to a G.P. for the remainder of his medical training. The details of this apprenticeship could provide a fruitful subject for discussion. Something may be, in the nature of a weekly or fortnightly surgery attendance followed by a round of visits, or the range of experience might be widened during the holidays by occasional sessions with other G.Ps. in different districts or in rural practice. In this way the newly qualified doctor would be better equipped to enter general practice as many of them do, while for those who go on to specialisation or higher qualifications, the broader outlook would be of great value to them. Incidentally, there would be no need for the trainee practitioner scheme, and thus further public money would be saved.

It is a cliche to say there are fashions in medicine and, unfortunately, in the changes which occur from time to time much that is good is lost. There is nothing original in the suggestions put forward, for up to comparatively modern times the

usual entry to medical practice was by way of apprenticeship as well as examination, and it is a great pity that the former was ever abolished. There can be no doubt that by reintroducing an apprenticeship even for so short a period as one academic term these two units are doing valuable work in the field of medical education. An inquiry at Edinburgh in 1956[10] amongst former students and graduates showed that the majority who responded to a questionnaire sent them were firmly of the opinion that they had derived considerable benefit from attending the course. Whereas up until then their experiences had been wholly in wards and outpatients they were now 'looking in' on family practice in all its aspects. They were being shown that this is essentially team work in co-operation with health visitors, midwives, district nurses and other social workers and that there was a strong emphasis on preventive medicine. They were seeing a host of conditions not normally met with in hospital practice and learning to appreciate the difficulties of general practice. The results can only bee good because at these units the student is seeing general practice at its best and it must influence him to set up and maintain the same high standards himself. There is surely a case for the establishment of similar units in medical schools throughout the country.

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3. E.L. Farquharson. Lancet, 1955, II, 517.

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7. Home on the Second Day; The Bradford experiment by G.W. Theobald. B.M.J. 2. 1364.

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CHAPTER VII.

SUMMARY AND CONCLUSIONS

What has the survey shown? How do the facts elicited compare with the recommendations set out in pp 32 - 36? What advantages have accrued to doctors and patients at the health centres and what about the disadvantages?

To take the last named first it has been shown that these are none existent and the fears baseless. There is no evidence of any deterioration of the doctor patient relationship and the patient still sees the doctor of his choice in the privacy of his consulting room.

At the new centres at any rate the institutional atmosphere is absent and in the old buildings it has been minimised as far as possible. There was no evidence of complaint by patients on this account.

There is no attempt whatsoever at control, direction or interference by the L.A. nor any suggestion of imposing a salaried service on the G.Ps.

The financial aspects of health centres have been fully discussed and it has been ~~shown~~ suggested that apart from Woodberry Down,

Sighthill and to a lesser extent Sunderland the Capital expenditure has been modest compared with the vast sums of public money spent in other directions.

Next, the recommendations as numbered on pp 32 - 36.

1 & 4. It is true that the G.P. and L.H.A. services are to be found in the one building at all the centres but there is still a great gap in co-operation between them. Full co-operation is to be found only at Manchester, Edinburgh, Bristol and the Harlow centres.

2. There is complete freedom of choice as between doctors and patients at all centres.

3. Only at the Harlow group, Bristol, Manchester and Edinburgh is there any application of the experimental method and supervision over the progress of the centres.

5. Only at the group practices, Edinburgh and Manchester do all the G.Ps. work solely at the health centres.

6. This principle has been applied only at Harlow.

7. At some centres there is a conflict of opinion on this point. On the one hand the G.Ps say they were not consulted right from the start but this is not accepted by the L.H.A.

8 & 9. There was no desire for beds or wards for in-patient treatment and except in one or two centres further diagnostic facilities were not considered necessary.

10. The question of having consultants at the centres was nevercconsidered, except at Sighthill where a request for a consultant obstetrician session weekly had not been granted and Bristol which had asked for a consultant physician and this too had been refused.

11, 12, 13 and 14. Not all the centres had treatment or staff rooms. Where these were absent the reasons were either on account of costs or that they had not been considered necessary. Apart from this accommodation is considered adequate.

15. Except for Harlow the rental paid by the G.Ps. is not economic.

16. The G.Ps. live in the area in which they practice.

17. The centres on the whole are well sited.

18. Pharmacies are to be found in three centres only.

19. Owing to the shortage of dentists it has been difficult to provide other than priority dental services.

20.. The physiotherapy apparatus is usually simple in nature .

21. There is adequate telephone cover at all the centres.

22 - 25. Only at Bristol, Manchester and Edinburgh are these requirements met while the Harlow group are under the overall care of Lord Taylor.

26. The G.Ps. say that they do not feel that they are in competition with each other for patients even though at most centres they are not in partnership.

27. Two teaching units have been established and there is no doubt that both are doing valuable work in the field of medical education.

As to the advantages there are considerable and enjoyed by both patients and doctors. The former are receiving a much more efficient service by having only one place to attend for many of their medical needs in surroundings which are for the most part very pleasant - a point of considerable therapeutic importance. Where there are treatment rooms and adequate nursing assistance they are saved many a visit to hospital casualty and outpatient departments and where there is close co-operation between the G.Ps and L.H.A. workers they feel they are being looked after by a team and not by a number of individuals.

The doctors for their part derive the most benefits where conditions most nearly approach the true concept of a health centre and this is true of Manchester, Edinburgh, Stranraer, Harlow and even although Bristol is a branch surgery for most of the G.Ps. working there it too represents a successful approach to this ideal. At all of them the G.Ps. prefer working there to their previous surgeries and are quite sure that they give a higher standard of service than formerly. The provision of nursing and secretarial help enables them to spend more time on their patients and where relationships with the L.H.A. workers are good they have learnt to

appreciate the value of co-operating with them. Competition for patients has virtually disappeared and what few transfers there are occur by mutual consent. Even though at some centres the doctors only meet casually relationships between them are everywhere good. By taking their surgeries out of their homes they have more freedom in their private lives.

All the same it would be idle to deny a feeling of disappointment at some of the facts revealed by the survey although these have nothing to do with the merits or otherwise of health centres. Too often the issue has been clouded by the longstanding hostility between G.Ps and L.H.A. nor has it been helped by the innate conservatism and resistance to new ideas of many Local Medical Committees. Too many mistakes of the same kind have been made and many valuable opportunities on new housing estates have been lost. In some of these new residents have all been registering with doctors round the periphery while the plans for the health centre are still on the drawing board.

Yet on reflection perhaps too much was expected in too short a time. It is not enough to propound new and rather revolutionary ideas in medical practice, provide facilities for putting them into effect and then expect results almost immediately. Ingrained habits and attitudes of mind have also to be considered and much more time is needed. There is also need of a restatement of the

main principles of health centres.

Of all the centres visited Manchester stands out as an example of what can be achieved even under adverse conditions. It has been referred to so often in this report because it comes nearest to the true concept of a health centre as described in chapter II. Here were four ordinary established G.Ps. each with his own separate practice yet they had the courage to join in this unique experiment. From being strong individualists they now work as a group and from working completely alone they now teach medical students in their consulting rooms. From hardly knowing anything about health visitors and other L.H.A. personnel they are now working in close co-operation with them. There is no need to go on, the Manchester G.Ps. have expressed themselves fully in their published reports and they are in no doubt as to the success of their experiment. It has enriched their professional lives, given a much higher standard of service to their patients and incidentally they claim to save a good deal of public money.

At Edinburgh, the fact that the unit was set up under much more favourable conditions than at Manchester does not in any way detract from its undoubted success. This is undeniable even if it is considered simple as a general practice but it is more than this. It is a centre for research in general practice by G.Ps. themselves and this is only possible with the small lists they have.

Their case record system is worth close examination and any visitor to the unit ought to sit in at a morning case conference; he will surely feel that this is general practice at its best.

The Harlow centres, although not oficially regarded as true health centres, fulfil most of the requirements and represent the highly successful results of careful and intelligent planning and if the Bristol doctors could concentrate all their practices at the centre it too would come nearer the ideal. At Stranraer all that is required is more co-operation with the L.H.A. and more emphasis on preventive medicine.

It is doubtful if the centres at Woodberry Down, Sighthill and to a lesser extent Sunderland will ever justify their high capital expenditure although it is felt that there is scope for considerable increase of general practice at all three.

At all the others the most that can be said is that the G.P. and L.H.A. services are under one roof and apart from Swindon, in better premises than previously. Yet despite the lack of co-operation the patient is very little affected and for the most part enjoys a better service than before.

Where difficulties still exist it is suggested that the G.Ps. initiate discussions with their colleagues on the L.H.A. in an effort to remove them and see what can be done to realise

to the full the true functions of their health centres. Given frankness on both sides, goodwill and the determination to succeeed there is every possibility that these centres will ultimately justify the hopes and expectations of those whose ideas and imagination were responsible for them being built.

APPENDIX I

LIST OF HEALTH CENTRES

Aveley Health Centre, South Ockenden, Nr. Romford, Essex.

William Budd Health Centre, Leinster Avenue, Bristol, 4.
Lancet 1952. 1. 1297; B.M.J. 1954. 1588; Med. World Newsletter. 1954. Med. World 1954, July and March; Lancet 1956, 2.555.

Hesters Way Health Centre, Cheltenham, Glos.

Tile Hill Health Centre, Coventry.

Faringdon Health Centre, Faringdon, Berks.

Harold Hill Health Centre, Romford, Essex.
Lancet, 1954, II. 866.

John Ryle Health Centre, Clifton, Nottingham.
Medical Officer, Nov. 1952.

Sighthill Health Centre, Calder Road, Edinburgh,11.
B.M.J. 1953, I. Supplement P.254.

Stranraer Health Centre, Stranraer, Wigtownshire, Scotland.

Alderman Jack Cohen Health Centre, Sunderland.

Swindon Health Centre, Milton Road, Swindon

Woodberry Down Health Centre, Stoke Newington.
Lancet 1952, II 772.

The Harlow Health Centres, Harlow, Essex.
Lancet 1952, I. 253; 1955 II, 863; 1958 II. 1055; Proc. Roy. Soc. Med. Aug. 1958.

Red Court House, Health Centre, Lighfield, Staffs.

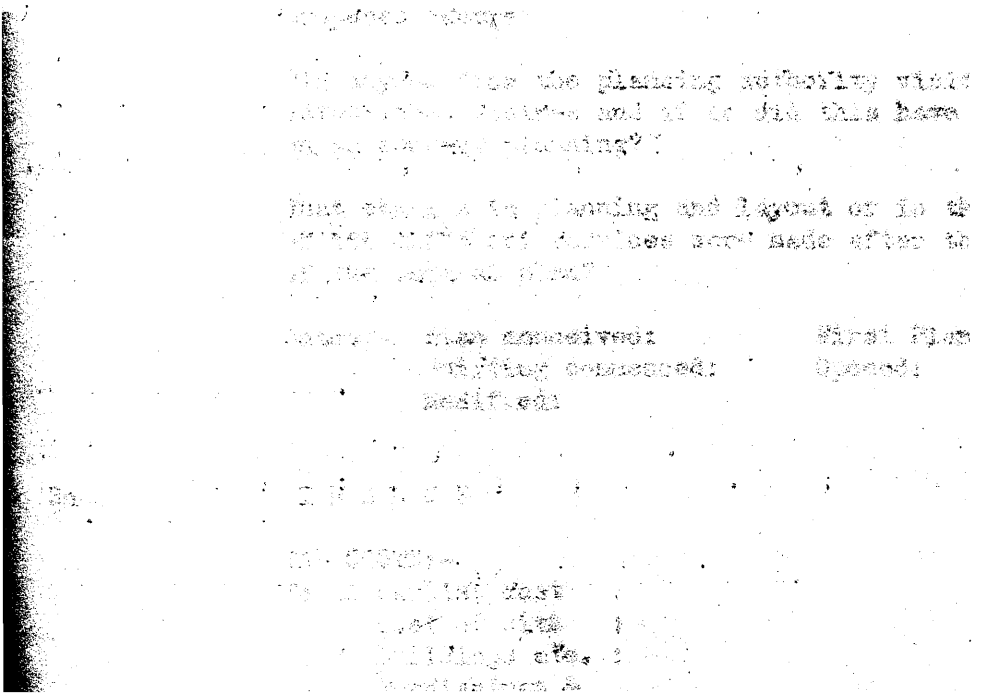
Oxhey Health Centre, Oxhey, Herts.

The Nuffield Diagnostic Centre, Corby, Northants.
Lancet 1954, I. 871.

Family Doctor Centre, Livingstone House, Edinburgh, 1.

Edinburgh University Teaching Unit, Livingstone House,
Edinburgh, 1.
Edinburgh Med. Journal, 1950, 454; Journ. Med. Educ. Sept 1956.
Res Medica Vol. 1. No. 4. pp. 19-26. June 1959.

Darbishire House Health Centre, 295 Upper Brook Street, Manchester, 13.
Lancet, June 1954; Med World. July 1958; Lancet. Aug. 1958;
B.M.J. II 1220; 1958.



APPENDIX II

HEALTH CENTRES QUESTIONNAIRE

Section 1 : HISTORICAL

1. What local considerations led to the building of the centre?

2. Who initiated the project?

   Was this a combined effort of all services or was the scheme largely the work of an individual? If so, who?

3. Did the Local Executive Committee take any special steps to consult the G.Ps immediately concerned when they considered the proposal for the new centre and was the M.O.H. also brought into these discussions?

4. Were there any difficulties in securing the co-operation of any of the parties to the centre, (i.e. Hospital Boards, L.H.A., L.E.C., etc.,)?

5. Was there any opposition from any local source to the proposed centre?

6. Did anyone from the planning authority visit any of the established centres and if so did this have any effect on subsequent planning?

7. What changes in planning and layout or in the participation of the different services were made after the acceptance of the initial plan?

8. Dates:- Plan conceived: First Plan:
   Building commenced: Opened:
   Modified:

Section 11 : FINANCE

CAPITAL COSTS:-

1. Total capital cost :
   Cost of site :
   Buildings etc. :
   Furnishings & equipment :
   Extensions (total cost) :

2. By whom were the funds provided and in what proportion?

3. If the Centre is <u>not</u> a Section 21 centre, was there any contribution by the G.Ps in the centre?

RECURRENT EXPENDITURE:-

4. Total recurrent cost to the owners per annum £
   Cost per doctor or firm :
   Cost per suite :
   Cost per patient registered :

5. What is the annual rental charge per doctor/firm?
   £. s. d.
   and does this include Staff (receptionist)
   Nursing attendance
   Heat, light & power
   Cleaning
   Telephone & postages
   Others?

6. What is (a) the total number of patients registered at the centre?
   (b) Total patient attendances for the last three years?
   1958 1957 1956

Section 111 : N A T U R E O F C E N T R E

(a) GENERAL DESCRIPTION:-
   New Premises/converted premises/old premises
   Conventional design
   Number of floors
   Lifts
   Unusual features

(b) ACCOMMODATION:-
   G.P. suites (what do these comprise)?
   Treatment rooms (number of treatments annually?)
   Reception office
   Waiting rooms or hall
   Changing rooms or cubicles
   Toilets staff
   patients
   Staff common room
   Patients refreshment room or space

Pram Park
Lecture room
Casualty theatre/minor ops. theatre
Resident accommodation - medical
nursing
caretaker
Car park
Other - please specify?

(c) LOCATION

1. Does the centre serve any clearly defined geographical area?

2. Is the area OPEN/RESTRICTED/INTERMEDIATE/DESIGNATED ?

3. What is the nature of the area in which the centre is situated?
URBAN / RURAL / SEMI-RURAL
Is there a housing estate (pre-war / post-war)?
Is it a development area?
Is it residential or industrial?

4. What is the ease of access to the centre by the patients?

(d) MISCELLANEOUS

1. Where part of the premises are owned by the G.Ps what is the agreement of user in this case?

2. Are the G.Ps given the exclusive use of the premises allocated to them? Does each firm have the exclusive use of the premises allocated to it? If not who else uses the surgery and when?

(Does this arrangement have any effect on the assessment of the rental?)

3. Number of consulting suites :
Number of firms (showing number in each firm) :
Are the consulting suites proportionate in size to the firms to which they are allocated?

Section 1V : M E D I C A L S T A F F I N G

1. How were the doctors recruited to the centre and by whom?

2. Were all G.Ps who applied accepted?

3. Did anyone withdraw after acceptance? If so, why?

4. Was the centre offered as an alternative to existing accommodation or were the G.Ps given no alternative?

5. Has any other G.P. entered the centre since it was opened and have any applications for inclusion in the centre been made?

6. How many doctors work in the centre and what is their relationship with one another; are they in partnership with each other or with others outside the centre?

Doctor	Firm	List size
A		
B		
C		
D		
E		
F		
G		
H		
I		
J		

7. How many surgeries in the centre does each firm provide and at what times?

8. Do any of the doctors attend external clinics elsewhere, and which of these is the principal clinic?

9. Do any of the doctors man the L.A.clinics; if so how are they paid?
If not, why not?

10. What is the reaction of G.Ps in the area to the conduct of L.A. clinics in the centre by the centre G.Ps?

11. Do any of the G.Ps attend external surgeries of their own and if so which of these is the principal surgery? (i.e. centre or outside surgery?)

12. If the answer to '11' is 'yes' what is the proportion of the lists to the inside and outside surgeries?

Doctor	Inside%	Outside%

13. What other medical commitments are undertaken by the G.Ps in the centre? (i.e. medical boards, clinical assistantships, etc.,)?

14. What are the main terms of the contracts held by the G.Ps in the centre?

15. Do any of the G.Ps sleep at the centre? Alternatively, do any of the G.Ps live near the centre?

16. Is there any form of private practice carried out at the centre?

17. What non-G.P. medical services are provided in the centre?
Hospital consultative sessions
R.M.O. Schools M.O. etc., etc.

Section V : N O N M E D I C A L S T A F F I N G

The following attend the centre in the capacity shown:

No	Grade	Full or Part	Perm or Visit	No	Grade	Full or Part	Perm or Visit
	MIDWIVES				RECEPTIONISTS		
	NURSES S.R.N.				CLERKS		
	NURSES SEAN				PORTERS		
	DISTRICT NURSES				CLEANERS		
	RADIOGRAPHERS				DRIVERS		
	LAB.TECHNICIANS				ADMIN OFFICER		
	SPEECH THERAPIST				CHIROPODIST		
	PHYSIOTHERAPIST						
	NUTRITIONIST						
	PROBATION OFFICER						

Section VI : N O N G.P. M E D I C A L S E R V I C E S

1. What other services are provided in the centre?

Midwifery	Child Welfare
Home Helps	Dental
P.S.W.	Social Welfare
Speech Therapy	School Clinics
Welfare Foods	Pharmacy
Physiotherapy	Home Nursing Equipment
Chiropody	Others:-

2. What diagnostic facilities exist in the centre and by whom are they provided?

X RAY E.C.G. PATHOLOGY

3. What is the proximity of the nearest hospitals, what are they and what out-patient facilities do they provide?
(i.e. casualty dept., x-ray, pathology etc.,)

4. Are these facilities directly available to the G.Ps in the centre?

5. Does the centre provide at 24 hour casualty service? Are minor operations performed in the centre and is there a separate casualty theatre for this? If so, by whom is the unit staffed?

6. Is the treatment room fully utilised?

7. In the light of experience has there been discontinued or is it now desired to discontinue any existing service provided by the centre or to introduce any new service and why? (Whether or not funds are available)

8. Has the centre increased the service to the patient to a standard higher than he would have received under the original system?

9. Are the services of the centre available to G.Ps outside the centre?

10. Is there any competition from G.Ps outside the centre and how many other G.Ps are there in the area?

11. Are any of the nursing staff resident?

Section VII : R E L A T I O N S H I P S & C O O P E R A T I O N

1. Who is responsible for the day to day running of the centre?

2. Is there any governing body within the centre and how often does it meet?

3. What liaison committee exists within the centre
   (a) between the G.Ps and the L.A. officers?
   (b) between the G.Ps themselves and do they hold regular meetings for
      1. administrative purposes?
      2. clinical purposes?
   (c) between all the authorities participating?

4. Is there any external advisory body and if so, what is its membership?

5. Is the co-operation due largely to the efforts of one individual, if so who?

6. Is there a staff common room and if so, is this used and by whom?

7. Is there full co-operation between the staff and the authorities responsible for the centre and are there any special points of merit or otherwise regarding this relationship?

8. Is there a tendency towards specialisation amongst the G.Ps in the centre and if so is this by mutual agreement? (particularly with regard to obstetrics).

9. Is there a free exchange of clinical opinion amongst the G.Ps in the centre? (i.e. do they seek 2nd opinions).

10. If the answer to '9' is 'yes' has this tendency developed only since the centre was opened.

11. What system controls the allocation of new patients to the lists of G.Ps working in the centre where the patient makes no express choice of doctor? and is there any transfer of patients between the lists of these G.Ps, if so how is this done?

12. Do the G.Ps prefer working in the centre to their old premises?

13. Do the G.Ps operate a rota for the following and if so what form does it take:-
Night calls
Week-end calls
Holidays
Sickness

Section VIII : O B S T E T R I C S

1. How many of the G.Ps in the centre are on the 'Obstetric list'?

2. Do they do all the midwifery?

3. What is the approximate number of maternity cases seen by the G.Ps annually?

4. Do many of the patients from the centre go into
(a) G.P. units?
(b) Specialist hospitals for their confinement?

5. Do the doctors operate their own ante- and post-natal clinics and do they do this work at special sessions or in their ordinary surgeries?

6. Do they receive help in ante-natal care from local midwives?

Section IX : P A T I E N T R E L A T I O N S H I P S

1. Has there been any clear reaction in favour or against the centre by the patients affected?

2. Where a G.P. with an existing list moved into the centre, has that list materially altered and how?

3. Has there been a substantial change in the list sizes and if so has this been due to the proximity of some new housing estate or shift in population?

4. Is there an appointments system? If so, how long has this been in operation and do all the G.Ps in the centre work the system? How does it work and are many appointments missed? Is the system favoured by the patients?

5. In what ways has the centre been 'sold' to the Public?

6. Is there any form of consultative committee in the centre on which the patients are represented? If not, is there any other way in which the views of the patients are represented other than by casual comment?

7. Is it felt that as a result of the services offered by the centre that fewer patients are referred to the local hospitals for examination?

8. Is it felt that the 'personal contact' between doctor and patient has in any way suffered as a result of the centre system? If so, how?

SECTION X : MEDICAL RECORDS & RECEPTION

Some comments:-

Section XI : GENERAL REMARKS

APPENDIX IV

THE WILLIAM BUDD HEALTH CENTRE BRISTOL

It has often been said that general practitioner health centres are costly to run so it might be as well to scrutinise the costs of maintaining a health centre more closely than is usual to see whether this is really true.

Estimate - year ending 31st March, 1960

Expenditure	£	Income	£
1. Salaries, wages, national insurance and superannuation.	6,760	1. Rent - Executive Council	650
2. Laundry allowances	50	2. Rents for hostel (nurses accommodation)	190
3. Repair and maintenance of buildings	800		
4. Fuel, light, cleaning materials and water.	1,030		£840
5. Furniture and fittings.	20		
6. Rent and rates	550		
7. Drugs, dressings and appliances	300		
8. Equipment	150		
9. Clothing, uniforms and laundry	170		
10. Hire of transport	75		
11. Printing, stationery, advertising, postage and telephones.	375		
12. Travelling, subsistence and conference expenses.	10		
13. Insurances	15		
14. Miscellaneous.	10		
15. Loan Charges	1,870		
	£12,185		
less			
16. Recharge to clinics	4,110		
	£8,075		

The £8,075 is supposed to represent the cost of the health centre for G.P. purposes, i.e. roughly $\frac{2}{3}$ of the total cost; the other $\frac{1}{3}$ being for L.H.A. purposes. This basis of 2 : 1 is a very rough and ready approximation in terms of centre usuage either by the general practitioners or by the L.H.A. In practice however the doctors often use the surgeries for only between 1 to 2 hours and never take up the full 3 or $3\frac{1}{2}$ hours of an M & C.W. or School Clinic session. Moreover the health centre has developed into a base for so many local authority health and social workers that the arbitrary fraction now bears little relation to a realistic calculation.

As salaries and wages (1) amount to more than half the total expenditure an effort should be made to decide how much of staffing expenditure is needed for Part IV work only.(General Medical and Dental services etc). In a clinic of similar size but concerned only with Part III services (i.e. services provided by L.H.A) a deputy sister-in-charge and two secretaries would not be needed. To offset this, a Local Authority Health Clinic would be carrying a Clinic Helper, a Clinic assistant and perhaps a second clerk. So, the salary bill is only £800 more for a true health centre than a clinic. The G.Ps. would strenuously assert at this point that the employment of Night Porters was against their advice and wishes; and further that the £1,500

annual expenditure for this service is solely for the purpose of allaying the rears of residents on the estate in regard to medical attention at night. The doctors are firmly of the opinion that they are able to make alternative night telephone arrangements.

Items (3), (13) and (15) relate to the provision and maintenance of the building which would have been required anyway for any type of Local Authority clinic.

Items (4) and (11) - fuel, light, etc., and telephones, are again very difficult to apportion. It is true that lighting is heavy in winter for evening surgeries but it would seem unfair to charge ? of the fuel bill to the general practices when they are in fact using the residual heat from the daytime use.

It can be assumed from all this that it is virtually impossible to decide how much of the maintenance costs would have had to be borne by the Corporation in any case, how much is due to the needs of a community which for so long had no medical centre and lastly what proporation could be set against the rent paid by doctors.

APPENDIX V

TEACHING IN GENERAL PRACTICE IN DARBISHIRE HOUSE

MORNINGS 9 a.m. G.P. Surgery where some 300 patients will be seen in the fortnight.

11 a.m. Home visits to some 100 families in the fortnight.

This programme entails that the greater part of a student's time is spent in close association with one general practitioner. It therefore involves him not only in the intimate observation of patients and families but also in close discussions, often personal and far-reaching, between the student and the doctor about the medical problems in all their aspects.

On one or two mornings in the fortnight a Case Discussion on a sick family by a student guided by the G.P. (The morning when the doctor has no surgery himself but is available for his School Clinic).

AFTERNOONS 2 p.m. - 4 p.m.

First Week

Monday The G.P. in the National Health Service - its economics and evolution with changing disease in a changing society.

The aims of the Darbishire House experiment.

(Each student to have the Annual Report)

Tuesday The work done in and from Darbishire House.
Discussion of X-ray and lab., particularly in watchful expectancy of disease in early stages.
Role of Home Nurses, Health Visitors, and Social Worker.

Thursday Delaying incapacity and the care of the elderly in General Practice. Visit to Dr. Greenwood's Geriatric Department at Withington and to Local Authority Part III Accommodation.

Friday The care of chronic disease and handicaps in General Practice, e.g. Chronic Bronchitis, Peptic Ulcer, Psychoneurosis, Rheutism, degenerative heart disease.

Second Week

Monday Possibilities of presymptomatic detection in G.P. of Chronic Disease, e.g. Tuberculosis, Diabetes, Iron-deficiency Anaemia, Severe Hypertension, some Cancers, Psychoneurosis.
Consideration in G.P. of follow-up, screening as "secondary" prevention, and case-finding.

Tuesday — After-Care in the home, Rehabilitation, Reablement and Training of the Disabled.
The G.P's. use of the Disablement Resettlement Officer, and role of the Regional Medical Officer.
Visit to Industrial Rehabilitation Unit at Denton, and possibly a small factory with a G.P. as its part-time Industrial Medical Officer.

Thursday — Group Discussion with Social Worker, and, if possible, a G.P. on "In 20% to 30% of G.P. patients the dominant aspect is emotional rather than physical ill-health".
The use of listening and counselling by 'care-takers'.

Friday — Open discussion on the fortnight.
How does a G.P. look after the two or three thousand people on his list? Advances in medical treatment providing new weapons for the family doctor but also changing the pattern of age and disease in homes. How is General Practice changing and how can it evolve?
The relation of home, the General Practitioner, and Hospital.

Students with outside general practitioners are invited to attend if free, e.g. on the doctor's 'half-day', and participate in any of the above afternoon discussions or visits.

APPENDIX III

TABLES OF STATISTICAL DATA AS EXTRACTED FROM THE QUESTIONNAIRES.

HISTORICAL

TABLE I.

HEALTH CENTRES	Plan Conceived	Prime Movers	Local Opposition.	Building Begun	Opened	Financed By.
SECTION 21						
Aveley	1951	Essex CC.	-	June 1954.	Dec. 1955.	Essex CC.
Bristol	1949	G.Ps. M.O.H.	-	1951	Sept. 1952.	Bristol L.A.
Cheltenham	1952	G.Ps. M.O.H.	-	1951	1955	Glos. C.C.
Coventry	1954	G.Ps. M.O.H.	L.M.C.	1958	Dec 1958	Coventry Corporation.
Farringdon	1948	G.Ps. M.O.H.	-	Already built.	1948	-
Harold Hill	1948	Essex CC.	-	May 1955	Oct 1954	Essex CC.
Nottingham	1951	M.O.H.	L.M.C.	April 1952	Oct 1952	Nottingham Corporation
Sight Hill	1946	G.Ps. M.O.H.	-	1950	1955	Department of Health.
Stranraer	1948	M.O.H. G.Ps.	-	May 1954	May 1955	Department of Health
Sunderland	1951	M.O.H. G.Ps.	G.Ps.	1954	1956	Sunderland L.A.
Swindon	1948	M.O.H. G.Ps.	-	Already Built	1948	Wilts. C.C.
Woodberry Down	1948	L.C.C.	-	1949	1952	L.C.C.
GROUP PRACTICE HEALTH CENTRES						
Harlow	1947	S.Taylor. G.Ps. Harlow Dev.Corp.	-	See page 96.	See page 96.	Nuffield Trust
Lichfield	1954	G.Ps.	-	Aug. 1958.	May 1959	Group Practice Loan
Oxhey	1952	G.Ps. M.O.H.	-	July 1957	Dec 1958	L.A. and Group Practice Loan
DIAGNOSTIC CENTRES						
Corby	1949	Nuffield Trust	-	1953	1954	Nuffield Trust
Edinburgh	1957	R. Scott & Univ.	-	1958	June 1959	Nuffield Trust etc.
G.P. TEACHING UNIT						
Edinburgh	1948	Prof.Crew. R. Scott	-	Already Built	1948	Nuffield Trust
Manchester	1950	Vice Chan. Nuffield.	G.Ps L.M.C.	Already Built	1954	Rockefeller Foundation Man.University.

4.

FACILITIES INCLUDED IN THE RENTAL

TABLE III

HEALTH CENTRES	WAITING	CONSULTING	EXAMINATION	STAFF	TREATMENT
SECTION 21					
Avelcy	Room	Room	Room	Room	Room
Bristol	Room	Room	Room	Room	Room
Cheltenham	Room	Room	Room	Room	None
Coventry	Hall	Room	Room	None	Room
Farringdon	Room	Room	Room	Room	Room
Harold Hill	Room	Room	Room	Room	Room
Nottingham	Room	Room	Room	None	None
Sight Hill	Room	Room	Room	Room*	Room
Stranraer	Room	Room	Room	Room	Room
Sunderland	Room	Room	Room	None	Room
Swindon	Hall	Room	Room	None	None
Woodberry Down	Room	Room	Room	Room*	Room
GROUP PRACTICE HEALTH CENTRES					
Harlow	Hall	Room	Room	None	None
Lichfield	Hall	Room	None	None	None
Oxhey	Hall	Room	Room	None	None
DIAGNOSTIC CENTRES					
Corby	Hall	Room	Room	Room	Room
Edinburgh	Room	Room	Cubicle	Room	None
G.P. TEACHING UNIT					
Edinburgh	Hall	Room	Room	Room	Room
Manchester	Room	Room	Room	Room	Room

*Separate staff rooms for G.Ps and Nurses.

TABLE III

Secretarial.	Reception	Nursing	Heating Light Power	Telephone	Headed Notepaper
F	F	F	+	+	+
F	F	F	+	+	-
F	F	F	+	+	-
F	F	F	+	Rental only	-
F	F	F	+	Rental only	-
F	F	F	+	+	+
-	F	F	+	+	-
F	F	F	+	+	-
F	F	F	+	+	-
F	F	F	+	+	-
F	F	-	+	+	-
F	F	F	+	+	+
* -	P	P	-	-	-
G.Ps. pay all their own expenses					
G.Ps. pay all their own expenses					
F	F	F	+	+	+
F	F	F	+	+	+
F	F	F	+	+	+
F	F	F	+	+	+

F = Full time. P = Part time.
*Rates are not included.

FINANCIAL

TABLE II

HEALTH CENTRES	COST TOTAL	COST ANNUAL	Total Rental from G.Ps.	No. of G.P. Suites	Rent per Suite.	Rent per Firm	Rent per G.P.
SECTION 21							
Aveley	41,441	9,000	1,000	4	250	250	125
Bristol	15,000	12,185	750	5	150	150	150
Cheltenham	26,264	5,600	960	4	240	87	42
Coventry *	16,540	4,990	750	4	325: 250: 150: 25:	* 325:250: 150:25:	Varies in each
Farringdon	-	1,820	165	2	82.10.0d.	165	55
Harold Hill	45,000	9,500	1,200	4	300	300	170
Nottingham	9,000	2,716	624	4	156	156	Varies according to no.of G.Ps in firm.
Sight Hill	160,000	20,000	2,040	6	300	300	-ditto-
Stranraer	28,000	5,200	1,000	5	200	200	-ditto-
Sunderland +	75,000	Not Available	Not Available	5	+	+	+
Swindon	-	Not Available	3,500	10	380	380	Varies
Woodberry Down	195,000	40,000	2,100	6	350	350	350
GROUP PRACTICE HEALTH CENTRES							
Harlow	See page 96.	Self Supporting.	4,440	19	210 - 260	210-260	Varies
Lichfield	15,000	Not known	-	7		G.Ps own the Health Centre	
Oxhey	21,000	Not known	-	5		G.Ps. own the Health Centre	
DIAGNOSTIC CENTRES							
Corby	47,000	19,000	-	4	Free	Free	
Edinburgh	26,672	8,835	-	5	Free	Free	
G.P. TEACHING UNIT							
Edinburgh	17,000	10,000	-	4		G.Ps are salaried	
Manchester	42,000	14,000	800	4	200	200	200

* G.P. Unit only
\+ Each firm pays 9/4d per surgery session

*750 divided 1:6:10:13 according to number of surgery sessions weekly.

PATIENT STATISTICS

TABLE V

HEALTH CENTRES	NO. OF REG. PATIENTS.	POP. AT RISK TO L.H.A.	ATTENDANCES 1957	ATTENDANCES 1958	ANNUAL TREATMENTS 1958
SECTION 21					
Aveley	14-16,000	20,000	42,375	41,048	15,285
Bristol	11,687	25,000	35,990	34,625	16,000
Cheltenham	11,000	15,000	23,493	24,074	No records kept.
Coventry	8,500 app.	20,000	Records not yet available		
Farringdon	6,000 approx	8,200	No records kept		No Records
Harold Hill	14,000 app	50,000	23,878	23,805	7,300
Nottingham	4,000	25,000	No records kept		
Sight Hill	14,000	Not known	No records kept		7,578
Stranraer	14,000	14,000	39,279	39,962	6,500
Sunderland	7,000	20,000	No records kept		
Swindon	30,000	Not known	Approx 100,000 per annum		No records kept
Woodberry Down	12,000	20,000	26,600	27,150	8,100
GROUP PRACTICE HEALTH CENTRES					
Harlow	44,000 App	44,000	No records kept		
Lichfield	16,000	16,000	Records not yet available		
Oxhey	14,000	14,000	Records not yet available		
DIAGNOSTIC CENTRES					
Corby	See page 84.				
Edinburgh	Records not yet available				
G.P. TEACHING UNIT					
Edinburgh	5,000	Impossible to estimate	35,000 per annum		
Manchester	11,000	Impossible to estimate	36,046	37,447	7521

7.

MEDICAL STAFFING

TABLE VI

TABLE VI

HEALTH CENTRES	NO. OF SUITES	NO. OF FIRMS	NO. OF G.Ps. IN EACH	SHARING OF SUITES	CONSULTING SESSIONS PER WEEK	NUMBER WITH OUTSIDE SURGERIES	G.Ps. SOLE SURGERY AT HEALTH CENTRE.
SECTION 21							
Avelcy	4	4	2,2,2,2,	No	44	6	2
Bristol	5	5	4,3,2,1,1,	With L.H.A.	52	10	1
Cheltenham	4	11	3,3,3,2,2, 2,2,2,2,1,1.	With G.Ps.	62	23	0
Coventry	4	4	3,2,5,1.	No	37	11	0
Farringdon	2	1	3	With G.Ps	19	0	3
Harold Hill	4	7	2,2,2,2, 2,1,1.	With G.Ps.	35	12	0
Nottingham	4	4	3,3,2,1.	No	41	9	0
Sight Hill	6 One firm has two suites.	5	3,3,2,1,1.	No	75	6	5
Stranraer	5	5	2,2,2,2,1.	No	55	1	7
Sunderland	5	9	4,3,3,2,2, 1,1,1,1.	With G.Ps.	37	18	0
Swindon	10	9	2,2,2,1,1, 1,1,1,1.	No	101	0	12
Woodberry Down	6	6	1,1,1,1,1,1.	No	46	5	1
GROUP PRACTICE HEALTH CENTRES							
Harlow	19	8	1,3,2,2,2,2, 1,1.+2 assist.	No	86	0	14
Lichfield	7	2	3,4.	No	59	0	7
Oxhey	5	1	6	No	54	0	6
DIAGNOSTIC CENTRES							
Corby	4	7	4,4,4,2, 1,1,1.	With G.Ps & Consultants	Not relevant		
Edinburgh	5	-	Use restricted by ballot to 35 G.Ps.		Not relevant		
G.P. TEACHING UNIT							
Edinburgh	4	1	4	No	32 (Both practices)	0	4
Manchester	4	4	1,1,1,1.	No	44	0	4

NATURE OF THE AREA

TABLE VII

HEALTH CENTRES	L.E.C. CLASSIFICATION	TYPE OF DISTRICT	SITUATION
SECTION 21			
Aveley	Intermediate	Residential Semi-Rural	New housing estate.
Bristol	Restricted	Urban	Old housing estate.
Cheltenham	Intermediate	Residential Urban	New housing estate.
Coventry	Designated	Residential Urban	New housing estate.
Farringdon	Intermediate	Rural	Old country town.
Harold Hill	Intermediate	Residential Urban	New housing estate.
Nottingham	Intermediate	Residential Urban	New housing estate.
Sight Hill	Open	Urban	New housing estate
Stranraer	Intermediate	Residential Rural	Old country town
Sunderland	Open	Residential Urban	New housing estate.
Swindon	Restricted	Urban	Built-up area
Woodberry Down	Intermediate	Residential Urban	New housing estate.
GROUP PRACTICE HEALTH CENTRES			
Harlow	Intermediate	Urban	New Town
Lichfield	Designated	Semi-rural	New housing estate.
Oxhey	Restricted	Semi-rural	New housing estate.
DIAGNOSTIC CENTRES			
Corby	-	Residential	New housing estate
Edinburgh	-	Urban	Built up area
G.P. TEACHING UNIT			
Edinburgh	Open	Urban	Built up area
Manchester	Open	Urban	Built up area

ADMINISTRATION AND MEDICAL RECORDS

TABLE VIII

HEALTH CENTRES	RESPONSIBLE FOR DAY TO DAY ADMINISTRATION	MEDICAL RECORDS KEPT AT	RECORDS OF ATTENDANCES AND TREATMENTS.	APPOINTMENTS SYSTEM.
SECTION 21				
Aveley	Area M.O.H.	Office	+	-
Bristol	Senior Nursing Sister	Office	+	-
Cheltenham	-	Office	+	+
Coventry	M.O.H.	Office	+	- For treatment only
Farringdon	Matron	Surgery	-	-
Harold Hill	-	Office	+	+
Nottingham	Clerk	Surgery	-	-
Sight Hill	S.R.N.	Surgery	Treatment only	-
Stranraer	Secretary	Office	+	-
Sunderland	Senior H.V.	Surgery	-	-
Swindon	Chief Clerk	Office	Attendances only	-
Woodberry Down	Admin. Officer	Surgery Office	+	-
GROUP PRACTICE HEALTH CENTRES				
Harlow	-	Office	-	-
Lichfield	G.Ps. in turn	Office	-	-
Oxhey	-	Office	-	-
DIAGNOSTIC CENTRES				
Corby	Nursing Sister		+	+
Edinburgh	Nursing Sister	Office	+	+
G.P. TEACHING UNIT				
Edinburgh	Dr. Scott	Office	+	By patient's request.
Manchester	Dr. Logan	Office	+	By patient's request.

MISCELLANEOUS

TABLE IX

HEALTH CENTRES	DIAGNOSTIC FACILITIES.	ANNUAL REPORTS.
SECTION 21		
Avelcy	Urine testing,	-
Bristol	Urine testing, E.S.R. E.C.G.	+
Cheltenham	Urine testing,	-
Coventry	Urine testing	-
Farringdon	Urine testing	-
Harold Hill	Urine testing	-
Nottingham	Urine testing	-
Sight Hill	Urine testing	+
Stranraer	Full hospital facilities.	+
Sunderland	Urine testing	-
Swindon	Urine testing	-
Woodberry Down	Urine testing, E.S.R. Colorimiter	-
GROUP PRACTICE HEALTH CENTRES		
Harlow	Urine testing	-
Lichfield	Urine testing	-
Oxhey	Urine testing	-
DIAGNOSTIC CENTRES		
Corby	Full range	-
Edinburgh	Full range	-
G.P. TEACHING UNIT		
Edinburgh	Urine testing	-
Manchester	Urine testing, x-ray Easy access to hospital.	+