Middle Articles

GENERAL PRACTICE OBSERVED

Health Centres and the General Medical Practitioner*

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The Dawson Report‡ on Medical and Allied Services, which in this country first gave the clearest expression to the idea of health centres, was published only four years before Morris died. History does not record his reactions to the report's proposals, but we can safely assume that he would have commended the idea of providing buildings "... wherein are brought together various medical services, protective and curative so as to form one organization..." thereby enabling the general medical practitioner to practise medicine under optimum conditions.

Nearly 20 years elapsed before the first trickle of health centres appeared—in Bristol, London, and Edinburgh. Even now, almost 50 years later, the trickle has grown into little more than a stream. Yet in the last year or so we have had a glimpse of the pent-up demand which, given the right encouragement from the Government, could develop into a broad, freely flowing river irrigating the desert of general medical practice and nourishing the growth of a co-ordinated medical service.

In my view, we should regard the health centre as: a field base, functionally designed for a group of professional people with varied skills working together as a team whose objectives are the prevention of illness, the early detection of individuals with physical or mental ill-health, and the speedy restoration of the sick to as sound a state of health as possible. This definition has certain implications. Firstly, the provision of a fine building is not an end in itself, but merely a means to achieve a better health service. Secondly, the main objective is orientated towards the primary and secondary prevention of sickness. Thirdly, and perhaps most importantly, that the satisfactory pursuit of this objective should be by a team with varied skills, some of which may be "non-medical."

In Bristol we are moving forward slowly towards these objectives with two health centres functioning well, a third being built, and three more agreed on with money available for their erection. Progress could be speeded up dramatically by the redesignation and reorganization of work within 12 existing clinics provided the Government makes possible the payment of more realistic rents by executive councils to local health authorities. Thirteen other groups of doctors in Bristol are keen to work in health centres. Indeed, with a capital expenditure of somewhat under half a million pounds spread over the next five years and a vigorous building programme it is probable that the needs of the vast majority of general medical practitioners could, in fact, be met. Compared with hospital capital costs this is a bargain price to pay for providing the opportunity

to rejuvenate general medical practice and co-ordinate the health and social services at field level.

Staffing of Health Centres

As I have already indicated, the provision of a well-designed and well-equipped building will, alone, not meet present-day and future needs. Quality of service is dependent upon the skills of well-trained staff being made properly available to their patients. In existing health centres there is still a considerable gulf between what is done, what could be done, and what should be done if the ideal health centre concept is to be fulfilled. Changes are needed in the training of staff and in the way their skills are used in the interests of the client. Many of these changes are fundamental and will take time to bring about, but the more health centres there are the quicker the changes will come.

In a country which provides such a wide variety of community health and social services and in which an increasing number of psychosocial problems are becoming apparent, the need for improved training of the medical student in the preventive, psychological, and social aspects of medicine should be self-evident. Unfortunately medical schools seem to be slow learners in this respect. In consequence many social workers are beginning to regard themselves as more competent to deal with psychosocial problems than most of the doctors. If new social work departments are formed by local authorities and field consultation bases are provided for the social workers there could be a disastrous divorce of the social and psychological aspects of medicine from the work of the general medical practitioner. Social workers need to be based at health centres and work in the general-practitioner team.

The health visitor, home nurse, and midwife should also be members of the team and be based at the centre. There is a need, however, for doctors to be better taught about how these workers are trained and the kind of skill they can be expected to bring to bear on a case. There is a possible danger that the new training of the health visitor could transform her into an amateur social worker, and it might be interesting and useful to combine some of the home nurse and health visitor training to produce a "community nurse" who would be based at the centre and have lesser-skilled staff such as assistant nurses and welfare assistants to help her with her work.

Health visitor and home nurse general-practitioner attachments have made but slow progress for several reasons. Post-war population movement in towns has led to a criss-cross pattern of general medical practice. The work of the health visitor and home nurse covers a limited geographical area, and in any one area there may be as many as 30 to 40 general medical practitioners, each with a small number of patients. There are not enough health visitors and home nurses to redeploy them to general practices as at present organized. There is undoubtedly

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‡ Report of the Future Provision of Medical and Allied Services, 1920, H.M.S.O., London.

a need for general practitioners to group together in health centres and to streamline their practice areas. Attachment schemes will then follow more easily. In the meantime, however, basing health visitors, midwives, and home nurses at health centres does improve enormously their working relations with doctors, even though not wholly attached to the practice.

The clinical public health doctor could become a member of the group practice, working as either a paediatrician or a geriatrician. Routine child health clinic work can be undertaken by the general practitioner.

Health Centres in Practice

How are health centres working in practice? I can speak only from knowledge and experience of the two health centres in Bristol. Every health centre has to be unique in the sense that its organization and functions are in no two cases precisely similar. One of ours—the William Budd, which is the oldest in the country—covers only branch practice, and the five partnerships represented are all separate. At the other—St. George Health Centre—only two group practices of three and five doctors respectively are represented, and the bulk of their patients at risk are seen at the centre. The practice populations covered are 13,000 and 20,000 respectively.

Experience shows that the health centres neither attract nor repel a greater proportion of patients than any other kind of practice and that doctors can work amicably and constructively together and with other health workers in the absence of financial group-partnership arrangements. With the help of the health centre staff the doctors undertake all their own antenatal, postnatal, and routine child welfare work in association with the health visitor and domiciliary midwife. Case notes have been simplified and conflicting advice to the patient no longer happens. The local authority maternal and child welfare doctor can be withdrawn. The need for organized minor-ailment clinics for schoolchildren also disappears. The patient has the advantage of one "consulting" point in a good environment, and the appointment system (75% effective) cuts waiting-time to a minimum. There have been no complaints from patients that the service becomes impersonal. Vaccination and immunization, the collection of pathological specimens by the nursing staff (for example, blood, sputa, urines, swabs), nursing treatments for ambulant patients, and the organization of diagnostic screening tests are greatly facilitated. With a well-trained clerical staff, family folder-filing for patients' records, age-sex registers, morbidity registers, and the compilation of operational statistics of general medical practice all become possible to organize.

The local health authority can widen the range of health services available to the general practitioner and his patients—for example, chiropody, relaxation and parentcraft classes, physiotherapy, speech, and child-guidance and family-guidance clinics. Provided the co-operation of the regional hospital board is given, consultant obstetric and psychiatric sessions can be organized. Through morbidity registers the organization of new kinds of health education—for example, for groups of bronchitics or diabetics—becomes possible. By using the services of an assistant medical officer of health, health retirement clinics can be organized. If, as we do, the local health authority employs a nutritionist and an almoner, their services can also be made available to tackle some of the dietetic and social problems met within general practice.

Through simple administrative machinery—a joint advisory committee composed of a few representatives of the executive council, local health authority, local medical committee, and health-centre doctors; and a house committee of the health-centre doctors, the medical officer of health, and the clerk to the executive council—the centres function smoothly and efficiently, with no interference from the local authority or

executive council and no disturbance of the doctor/patient relationship.

Opinions differ about the sort of person who should be "in charge"—whether professional or lay. Rightly or wrongly, we chose centre superintendents who are qualified health visitors, with a good knowledge of the whole range of health and social services available and how to get them. Perhaps qualifications count for less than the personal qualities which make for a good administrator, for as Sir Robert Aitken (1966) has said: "Administration is the art of getting men to work happily and effectively together . . ." and this, above all, is what is needed if the health centre is to function effectively and the patient reap the benefit of an improved service.

Further Developments

Section 21 of the Act permits the development within health centres of a pharmacy, Part IV as well as Part III dentistry, and hospital outpatient facilities, but not hospital beds as was envisaged by the Dawson Report.

The need for these additional services is not essential at present, though health-centre sites should, wherever possible, be large enough to provide for them at a later date. The essential need *now* is to provide for the general-medical-practitioner team. It may be desirable, but it is not essential, to provide for Part IV dentistry in health centres. Good dentistry can be practised in relative isolation; it does not need to be integrated with other health and social services, but integration is vital for good general medical practice.

I leave open the question of hospital/health centre relationships and the role, if any, of the general medical practitioner in hospital. Many general practitioners (some authorities have estimated 80%) do not wish to practise in hospitals, though this may not always be so. But one suspects that the hospital will become more and more the centre for complex medicine which can be practised only by highly specialized staff. For this reason (though there are many others) the medical undergraduate (and in years to come the postgraduate following a vocational course in general medical practice) should receive a proportion of his training in a typical general practice health centre. Most of a general medical practitioner's patients are referred to hospital for diagnostic assistance, not for inpatient care, and it is not too much to hope that diagnostic aids for many disease states will be developed at cheap cost and be capable of use by relatively less specialized personnel in health centres.

Conclusion

The development of health centres has been disappointingly slow since 1948, but experience is showing that through their wider development and use we have a very good chance to rejuvenate general medical practice and provide an integrated health and social service at field level. My conception of the ideal health centre is: a field base, functionally planned, for a group of professional people with varied skills working together as a team and whose objects are the prevention of illness, the early detection of persons with physical or mental ill-health, and the speedy restoration of the sick to as sound a state of health as possible.

Present health-centre practice falls short of this ideal. It is suggested that some of the principal needs for its realization are:

1. The redeployment of field staff, such as the health visitor, the home nurse, the midwife, and the family social worker on a functional general medical practice instead of on a geographical basis.
2. The assimilation of practice patients and doctors into more compact geographical areas wherever possible.

3. Health centres should form a base for main and not just branch practice and for all the field workers (including social workers) operating in the local community.

4. Modifications to training curricula so that: (a) The medical undergraduate is given more teaching in the social, preventive, and psychological aspects of medicine; the community services he can use for his patient. He should also know something of the training followed by his team mates and the kind of problems in which they can help. (b) Instead of a separate health visitor and home nurse in towns there should be a "community nurse" with a new kind of training course. These community nurses should be able to deploy less skilled staff to meet the simpler needs of patients.

These suggestions are not impracticable. They involve expenditure, but at a fraction of the cost of the hospital services; they might give a shift in the emphasis of medicine towards prevention, and the existing health and social personnel would be used to better purpose. To give the proposals effect will mean above all a change of attitudes—of the general practitioner against his traditional isolation and towards team-work; of the medical officer of health against the preservation of his empire; of those responsible for training a wider view which will take into account twentieth-century needs of co-operation and co-ordination; of local government councillors that health centres are not for subsidizing general medical practice, but to

give a better service to the people; and, crucially, of the central government, that if the National Health Service is to work really effectively they should give every incentive to the rapid development of a nation-wide health health-centre programme.

Summary

Health centres to facilitate the integration of local health services were suggested almost half a century ago, but until recently demand for health-centre practice has been small. Interest is now quickening, but the provision of a well-equipped building is only the first step towards co-ordination. There is a concomitant need for rationalization of practice areas and the redeployment of health visitors, home nurses, midwives, and social workers on a functional, instead of geographical, basis. Changes in the training of medical and nursing staff are suggested in order to meet present and future community health problems. Health centre experience and future plans for Bristol are described.

REFERENCE

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IS THERE AN ALTERNATIVE?

The possibility of decentralizing the administration of the Health Service has often been raised. In this article Professor Colin Clark deals with the general question of decentralizing organizations and some of the criteria for deciding when an administrative machine has become over-large.

Decentralizing Administration

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Of all the free-market economists—that is, those who contend that all transactions should be settled by free bargaining between buyers and sellers, without Government intervention—the most drastic and dogmatic is probably Professor F. A. Hayek, from Vienna. It is of particular interest, therefore, to note those transactions in which he thinks Government intervention is necessary—namely, those involving children, certain types of town-planning regulation, the control of the monetary system, and finally that which concerns us here, of meeting the full cost of treatment of serious illness or accident. The latter is likely to be beyond the resources of a great many families, however prudent and thrifty, so that some form of organized insurance is necessary. So, of course, is insurance for third-party risks in driving cars. Nevertheless, like car insurance, medical insurance can be abused. Common sense tells us that the most efficient type of insurance and least open to abuse is that encountered in America—which requires the patient to meet the first 50 dollars or 100 dollars (in some schemes as much as the first 500 dollars) of the costs of any illness or accident himself, before he has recourse to insurance. The insurance should then be able to meet the costs of really serious or chronic illness—a liability from which American insurance has often run away.

The above expresses my own idea of how medical service should be provided. Many well acquainted with the problem, however, may contend that insurance—however well organized—will not suffice, and that substantial provision of medical service by public authorities is necessary. They may well be right; and in any case I do not wish to debate this point further. What I do want to say, as emphatically as possible, is

that if there have to be public authorities providing medical service they should be local or regional, not national. There are strong objections to unduly large-scale organizations, in this as in other fields.

First, however, it may be necessary to dispel the illusion, if any readers of the *B.M.J.* still cherish it, that it is possible to have a national organization whose control will be "divorced from politics." If you expect Parliament to provide the money, of course Parliament will control the organization. Members of Parliament will point out, quite rightly, that they are failing in their duty to their constituents and taxpayers if they provide public funds without supervising the manner in which they are spent. For some years people have been quoting the universities as an example of organizations which can receive Government funds without being subject to Government control. Those who believe this had better come and take another look at the stealthy but inexorable process by which Government control over universities in this country is steadily being tightened.

Regional Authorities

By similar reasoning we must also conclude that a genuine decentralization of responsibility for running hospital and medical services will be possible only if we have regional authorities spending their own funds, obtained from taxes or fees collected from the inhabitants of the region. If we expect them to live on grants from the central Government this will

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