TALKING POINTS

A lifeboat for inner cities

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Inner cities have been declining since 1918. Most dwellings there are over 100 years old, redevelopment has been mainly in commercial property, and the remaining buildings are now substandard dwelling houses. The young, the successful, and the self-sufficient have moved to the redeveloped areas and postwar housing estates, leaving mainly the elderly, the disadvantaged, and the homeless. Meanwhile the problems of providing medical care have mounted.

Much of the medical care between the wars depended on local authorities but it had a temporary boost in the late 'thirties from the arrival of mid-European doctors, refugees from Hitler, many of them doctors of high academic standing and grateful to have the opportunity of continuing to practise medicine. At that time the doctors practising in these areas were not completely socially isolated: the clergy lived by their churches, solicitors often resided near their offices, and the local university was developing, with many of its staff living locally. But the war came and the environmental decay, already well advanced by the late 'thirties, was accelerated by Hitler's bombs; then the postwar redevelopment raped the city centres and moved people and their work places to the suburbs and the new towns. But a crisis in medical care was again avoided, with young men who had gone to the war as fledgling housemen returning as experienced doctors. There were more applicants than posts in the revitalised hospital service. Some doctors emigrated but many opted for general practice and brought their experience in "getting things done" to the deprived communities. In the early 'fifties we were still suffering from the effects of the privations of the war and from the backlog of disease. The introduction of the National Health Service resulted in queues outside consulting rooms. GPs saw anything from 50 to 100 patients daily, home visiting was at the patient's behest, the working day was practically non-stop for 12 hours, and uninterrupted nights were an exception. The social services were rudimentary, and everyone had "rights"—whereas it seemed that only the general practitioners had responsibilities. The GPs may not have published learned articles in medical journals but they kept abreast of medical advances through their professional societies and managed to cope with the community's demands. From time to time they threatened to rebel; grateful governments threw them another crust and promised better things to come. Somehow medical standards were maintained and until the early 'sixties there were still more applicants than partnership vacancies in NHS general practice.

During the past 15 years, despite improvements in general practice that owe much to the Family Doctor Charter,¹ it has become more difficult to attract young doctors to inner city areas. The 30th anniversary of the NHS has now passed and in my area 20% of the GPs are over 65 and half will probably retire in the near future. Large areas of residential accommodation have been demolished; some have been redeveloped with less dense housing and many with commercial properties, while other areas are still barren, waiting for the planners to make

up their minds. Though the average list size has fallen GPs' patients are elderly, more disadvantaged, and need ever-increasing medical and social services. Ideally a young and eager partner should be introduced to help with the work load and build up the practice with a view to eventual succession. But this is economically impossible, for list sizes cannot be increased when the population is declining.² The high social indices mean a heavy work load and the large proportion of itinerants results in increased commitments with, paradoxically, a fall in practice income. The national average for annual consultations per patient per doctor can be exceeded in the first six weeks after acceptance of a patient, who then moves off again before his registration qualifies the practice to receive a quarter's capitation fee.

When the aging general practitioners in these socially deprived areas retire or die, the Medical Practices Committee may be committed to filling the vacancy, even though it considers none of the applicants wholly suitable. And so the decline in standards of service not only continues but increases its rate. The new entrant to general practice finds that suburbs and new towns, with their more stable populations, purpose-built premises, and attached ancillary staff, are professionally and socially more attractive. Medical journals offer such openings weekly; many have, as added attractions, opportunities for part-time hospital and community health appointments.

Solutions

The areas at risk are easily identified and are defined in recent Department of Employment legislation. The Department of Health and Social Security has a 10-year strategic plan for the NHS. But this problem is too urgent to be solved by strategic or operational planning: the crisis in medical care for these areas is on us and a lifeboat rescue is required.

New premises are needed to attract the young doctors. Many of the present general-practitioner premises are unsuitable for providing up-to-date primary health care. Doctors may wish to modernise but often cannot do so because the area may be scheduled for redevelopment or because the doctor does not own the premises and the landlord will not rebuild or renovate. Where the property belongs to the local authority this may be unwilling to help because of other, more urgent housing needs. Buying new premises is beyond the financial capability of either the incumbent doctor or an incoming partner. The area health authorities plan to develop health centres but in my own area the time from decision to build a centre to opening it to patients is about four years, the cost in 1979 being around £600 000. No longer do we have the time for such luxuries, so what can be done?

In the immediate postwar housing crisis homes were designed to be quickly and cheaply created. Is it not possible to design a standard, easily assembled building to accommodate, say, five general practitioners, with space for reception, record keeping, and consultation rooms? Such a unit need not have a life span of more than 20 years, particularly as it is hard to foresee the pattern of medical services so far ahead. If economic conditions improve modifications or extensions could be planned as necessary. Local and area health authorities own many empty

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properties and vacant sites. Why cannot some of these be developed into health care centres, which are then rented or leased back to GPs? Surely there is a case for the General Practitioner Finance Corporation, with its experience and expertise, to be invited to contribute in these matters, so allaying the profession's fears of having a monopoly employer who is also the monopoly landlord.

Doctors of ability and experience wanted

People are more important than buildings so how do we attract doctors to these inner city health care centres? Those who come to tackle the formidable problems need to be men and women of considerable ability and experience. Any renaissance of medical care in the inner cities calls for the active co-operation of family practitioner committees, area health authorities, local authorities, and university departments of medicine. The suggestion in the new charter for GPs³ that the capitation fee for new patients should be substantially increased in the first year on the doctor's list might help to compensate both for the increased work load and for the high turnover of patients. FPC administrators know of many older doctors who are only too willing to retire but cannot afford to do so in the present financial climate. Surely a way could be found of helping them financially to make way for a younger man—for example, by offering an older general practitioner special payments to encourage him to take in a younger man.

Many of our vocationally trained new entrants to general practice have hospital experience as registrars. On entering general practice the trainee would not wish nor should he be allowed to abandon his special skills. To attract such doctors to our deprived areas, health authorities must increase the opportunities for sessional work in district general hospitals. The present exercises in cutting costs and increasing efficiency without curtailing service to the sick will not succeed while the problems outside the hospital are ignored. Improving community services is in the health authorities' interest. By raising the standard of primary health care and so enabling more

patients to be treated in the community they would leave hospitals with more time and resources to concentrate on those patients whose treatment requires expensive institutional care.

Universities can help in two ways. Firstly, they should offer part-time posts on their teaching staff to the incoming general practitioner, both in undergraduate and in postgraduate teaching programmes, and the new practices could be recognised as preceptor practices for undergraduate teaching. This would help to attract the type of doctor urgently needed. Secondly, university research departments should again examine our Health Service to see whether we are deploying our resources in the most advantageous way and what the right balance should be between primary, secondary, and community health care. Medical schools that do not have active departments of general practice and community medicine are not well placed to do this necessary research and cannot expect to attract to their communities doctors with the professional enthusiasm needed to revive city centre medical care. By all standards these areas are deprived, with the longstanding medical decline rapidly worsening. I know that our young entrants to general practice welcome a challenge and do not lack enthusiasm, idealism, and knowledge. Our inner cities need them now. Political, administrative, and professional inertia, sadly typified by the Normansfield affair,⁴ must be overcome to ensure that they can take up this challenge.

References

- 1 British Medical Association. *Charter for the Family Doctor Service*. London: BMA, 1965.
- 2 Mersey Regional Health Authority. *Report of Committee of Inquiry*. January 1978.
- 3 General Medical Services Committee. Report of GP Charter Working Group. *Br Med J* 1979;iii:1236-9.
- 4 Committee of Inquiry into Normansfield Hospital. *Report*. London: HMSO, 1978.

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Importance of DHSS SH3 returns for radiotherapy work-load statistics

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When the word "new" is used to describe a patient with cancer it can have three different connotations depending on the type of data collection. For DHSS Hospital Activity Analysis (HAA) the patient is new each time he attends for an episode of treatment but the data refer only to inpatients. For the OPCS National Cancer Registration Scheme the patient is new once only—on the date he first receives treatment or, if he is not treated, on the date of his first hospital consultation. Patients treated for a recurrent cancer are not reregistered. For DHSS annual SH3 returns the patient is new once for each continuous course of treatment, whether it is for a previously untreated cancer or for recurrent cancer.

SH3 returns state the number of new patients treated and the total number of treatment attendances. Both statistics are subdivided into inpatients and outpatients. It is not surprising,

therefore, that confusion sometimes arises in assessing radiotherapy work loads, since a patient may be considered new several times in any one year, once only in a series of treatments extending over several years, or once a year for several years. But, for a specialty such as radiotherapy in which the outpatient load always exceeds the inpatient load, often by a factor of two, and in which treatment of recurrent cancer accounts for at least one-third of the load, HAA and cancer registrations cannot provide an accurate estimate of the annual work undertaken by a radiotherapy and oncology centre. SH3 returns are the only regularly collected data which can provide such an estimate.

Methods and results

To show the usefulness of SH3 radiotherapy treatment statistics which are in Part 3E (a, b, c, and d) of the returns, data relating to the 16 largest radiotherapy centres in London during 1971-8 were studied. London was arbitrarily defined as that area within a radius of some 15 miles from Charing Cross and not a combination of the NHS Thames Regions, which have