PRACTICE OBSERVED

Practice Research

Are general practitioners in inner Manchester worse off than those in adjacent areas?

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An editorial in the *BMJ* that appeared shortly after the publication of the Acheson report on primary health care in inner London began with the assertion,

"Britain's inner cities have some of the worst social and medical problems combined with some of the poorest primary care services. This has been known for a long time..."¹

The results of a survey among general practitioners in five health authorities in Greater Manchester, reported in the *BMJ* recently,² suggested, however, that inner London may be unique in the diversity and intensity of its problems of medical manpower. Contrary to popular belief, there is no concentration of isolated, elderly, single handed doctors with small lists and no lack of health centres and purpose built premises in the Manchester-Salford inner city partnership area. But there is a striking concentration of doctors who qualified overseas and a below average proportion of young doctors. Although valuable for manpower planning, information about general practitioners' characteristics tells us nothing about how well or how poorly the services are organised.

This paper, therefore, considers whether the primary health care services in the Manchester-Salford inner city partnership area are in general less well staffed, less well equipped, or less well organised than services in adjacent "outer" areas. Like the previous paper, this one draws on data obtained from interviews conducted with 485 general practitioners in five health authorities in Greater Manchester in 1981.³ Firstly, the paper compares

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practices in the inner and outer areas on certain organisational criteria that general practitioners control—that is, the employment of practice staff, clinical records and equipment, and the use of appointments systems and deputising services. Secondly, it examines links between general practitioners, community nurses, and hospitals, which are not controlled by general practitioners.

Inside the practice

STAFF EMPLOYED BY PRACTICE

Inner city practices may be less well staffed than practices elsewhere.⁴ Although virtually all practices in both the inner and outer areas in Greater Manchester employ some staff, practices in the Manchester-Salford inner area employ a narrower range of staff than practices in the adjacent outer area (table I). In the inner area a high proportion of practices employ clerical staff only and a correspondingly low proportion have practice managers—defined as someone who takes responsibility for any aspect of practice organisation other than reception, filing, and correspondence—and practice nurses.

TABLE I—Range of practice staff employed*

Staff	Inner area (%)	Outer area (%)	Total (%)
Medical assistants	13	17	15
Practice managers	11	22	16
Practice nurses	35	44	37
Clerical only	60	41	52
None	2	3	3
Total No of practices	89	93	182

* Percentages add up to more than 100%, because it was possible for general practitioners to give more than one answer.

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One might suspect that the low proportion of practices with practice managers in the inner area reflects the concentration of practices in health centres with administrators employed by health authorities. But in general this does not seem to be the case since 60% of the 38 practices in health centres claimed to have a practice manager. Practices in health centres in the inner area were less likely to have a practice manager, however, than those in the outer area, 11 out of 23 compared with 12 out of 15.

One might also suspect that the concentration of health centres employing community nurses who work some of the time at least in the surgery in the inner area would partly explain the relative "shortage"—by national as well as local standards—of practices employing their own nurses. (A recent survey by the Office of Population Censuses and Surveys showed that 27% of practices in England employed a nurse.)⁵ But the evidence does not support this either. Even though health centre practices stand a better chance than other practices of having a community nurse who works some of the time at least in the surgery, they are as likely as other practices to employ their own nurse as well. This suggests that some practices do not employ their own nurses as a substitute for community nurses, as Cartwright and Anderson reported.⁶ The dearth of practice employed nurses in the inner area compared with the outer area may be related to differences in the accommodation available for practice nurses or differences in the attitudes of doctors and nurses in the two areas.

In addition to practice managers, nurses, and clerical staff a few practices in both the inner and outer areas also employ general practitioners as assistants. Although the numbers are small, these proportions may surprise those who believe that there has been a decline in the number of assistants in the past decade. (A national BMA survey conducted in 1969 showed a similar proportion of practices employing assistants.)⁷

CLINICAL EQUIPMENT AND RECORDS

The "inverse care law," which states, "in areas with most sickness and death (doctors) have least equipment..."⁸ suggests that doctors practising in inner cities will have less equipment or inferior equipment than other doctors. Doctors' replies to questions about the amount and type of equipment they had, however, contradicted the "inverse care law." On average, doctors in both the inner and outer areas owned a similar amount of equipment—three items. There is much variation among doctors in both the inner and outer areas in this respect (table II). At one extreme five doctors said that they did not have any equipment, while at the other extreme more than one in 10 have five or more items.

The three most widely owned items are vaginal speculums, proctoscopes, and peak flow meters. At least two out of three

doctors in the inner and outer areas owned each of these items. Less than one in four doctors in either the inner or the outer area owned any of the other five items of equipment listed. On average, general practitioners in health centres do not have any more items of equipment than other doctors, but they are more likely to have an electrocardiograph and a peak flow meter.

One might also suppose that inner city doctors lag behind other doctors with regard to the number and type of clinical records they keep. To investigate this doctors were shown a card on which 12 ways of improving clinical records were set out. These included modifications to the clinical records—for example, changing to A4 records—and using disease registers and age-sex indices. On average, doctors in the inner area claimed to keep more of the listed records and registers than doctors in the outer area—3.2 compared with 2.5. But, again, there is much variation among doctors in both inner and outer areas (table III).

When one examines the ways in which doctors have improved their records, although more doctors in the inner than the outer area claim to keep each of the records and registers that were listed, 56% of doctors in the inner area compared with 38% in the outer area claim to have age-sex registers, a striking contrast. This reflects an even more striking contrast between health authorities: in one health authority 63% of doctors had age-sex registers compared with 17% in another. Family practitioner committees are in a strong position to encourage general practitioners to install age-sex registers if they so wish.

APPOINTMENTS SYSTEMS

In the past 20 years there has been a great increase in the use of appointments systems. In 1977, 75% of practices were using appointments systems compared with 15% in 1964.⁹ Data from my study show that inner city doctors have lagged slightly behind doctors in the outer area in this respect. In the inner area 78% of doctors used an appointments system for all or some surgeries compared with 87% in the outer area. Thirteen per cent of doctors in the inner area and 17% in the outer area used a partial system where some patients were seen by appointment and others by waiting in turn. A parallel study will show whether different types of appointments systems work equally well in the inner and outer area, and whether or not they discourage use by people who live in the inner city, particularly from social classes IV and V.

The results of other studies suggest that there is a gradient across the social classes in the average amount of time a general practitioner spends in each consultation.¹⁰ Although there is no direct evidence about this from my study, the intervals between appointments that doctors report are made for them (table III) suggest that there may be little difference among the doctors in the inner and outer areas in this respect.

TABLE II—Length of appointments list

Length (min)	Inner area (%)	Outer area (%)	Total (%)
No appointment system	22	13	17
1	53	66	53
2	21	20	20
3	17	13	15
Total No of general practitioners	171	195	366

DEPUTISING SERVICES

In inner London reports of the extensive use of deputising services by general practitioners have caused much concern. As the Acheson report¹ noted, however, there is very little information about the extent and the nature of general practitioners' use

of deputising services or how they operate. Virtually all the doctors in the inner and outer areas of Greater Manchester—96%, and 98%, respectively—claimed to make some use of a deputising service. (No attempt was made in this survey to differentiate between the use of deputising services to handle telephone messages and to see patients.) These levels of use are much higher than those reported by Cartwright and Anderson in 1977 that 44% of doctors in England and Wales used deputising services¹¹ and by Smith in the same year that 80% of doctors in conurbations were doing so.¹²

The information in table IV contradicts the belief that inner city doctors are more likely to use a deputising service regularly than doctors in adjacent parts of the conurbation. Like doctors

TABLE IV—Use of deputising services

	Inner area (%)	Outer area (%)	Total (%)
Weekdays before 11 pm	18	7	13
Used—normal	15	17	16
Used—screened	3	10	7
Not used	82	83	82
Weekdays after 11 pm	44	22	33
Used—normal	41	24	30
Used—screened	3	10	7
Not used	55	66	60
Weekends	37	24	30
Used—normal	34	24	29
Used—screened	3	10	7
Not used	63	66	64
Evening	21	18	19
Used—normal	21	18	19
Used—screened	0	0	0
Not used	79	82	80
Total No of general practitioners	171	195	366

in the outer area, nearly all inner city doctors usually use a deputising service on weekdays after 11 pm, two out of three do so at weekends, and nearly half do so over holidays. Only on weekdays evenings before 11 pm do many more doctors in the inner area than in the outer area use a deputising service. As the Acheson report suggested,¹ before 11 pm and at weekends inner city doctors' use is related to the distance between a doctor's home and his surgery. But the differences between doctors who live less than two miles and more than five miles away from their practice are small.

Whereas the overall levels of use of deputising services among doctors in the inner and outer area at specified times are similar, doctors in the inner area are more likely to say that they usually screen or filter calls before passing them on to a deputising service. If this is considered to be good practice then the inner area may be said to be "better off" in this respect than the outer area.

Outside the practice

COMMUNITY NURSES

To discover whether there is a concentration of practices working in isolation from community nurses and health visitors, the first doctor interviewed in each practice was asked which of six types of nurses listed on a card were "attached to their practice—that is, you don't employ them but they usually work with you." The replies to this question do not, of course, indicate formal attachments or the extent of team working. But they do suggest that the inner area is no worse off than the outer area in the proportion of practices that have regular contact with both health visitors and district nurses—which some might consider to be the minimum primary care team (table V). Having said this, a sizeable proportion of practices in the inner and outer areas—19% and 16%, respectively—reported that they had no regular contact with both health visitors and district nurses, which may be cause for concern. In the inner and outer areas health centre practices were most likely and non-

TABLE V—Regular contact between practices and community nurses*

Range of nursing staff	Inner area (%)	Outer area (%)	Total (%)
None	8	7	7
Health visitor or health visitor and district nurse	11	6	11
Health visitor and district nurse	20	11	15
Health visitor, district nurse, and midwife	30	41	36
Health visitor, district nurse, midwife, and 1 or more nurses	30	32	31
Total No of practices	89	93	182

* See text for question asked.

health centre practices likely to have regular contact with both health visitors and district nurses. In the whole area 92% of health centre practices compared with 80% of non-health centre practices report regular contact with health visitors and district nurses.

In the inner and outer areas health centre practices also reported contact with medical community nurses than non-health centre practices. This raises the question of how community nurses are allocated within the different health authorities. But no confident conclusions may be drawn about the amount of nursing help different practices receive, since how much time nurses devote to each practice was not reported.

HOSPITAL LINKS

In inner London there has been concern about the great divide between doctors working in prestigious teaching hospitals and those working in general practice in the surrounding areas and about the difficulties in communication that may occur when patients are discharged from hospital.¹³ To find out whether doctors in the Manchester-Salford inner area had fewer or less satisfactory links with hospitals than doctors in the outer area we asked doctors about their access to a range of support facilities, the collection of specimens by hospitals, and communication between them and hospitals.

As a whole, the evidence from this survey suggests that if there is any division between general practitioners and hospitals in the Manchester-Salford inner area it is no greater than that in the outer area, and in some respects may be smaller. Table VI, for example, shows that access to physiotherapy services is much better and access to electrocardiographs slightly better in the inner than in the outer area. Access to contrast medium x-ray examination is almost as good. But the variations in table VI conceal substantial differences among health authorities—for example, in one authority 61% of doctors have access to physiotherapy services compared with 8% in another.

A range of other facilities—for example, microbiology, cytology, biochemistry, x-ray examination, and haematology—is also available to all doctors in the inner and outer areas. But more than 10% of doctors in both the inner and outer areas were unaware that one or more of the facilities was available. Thus there is some scope for improving communication about the facilities that are available.

TABLE VI—Access to support services*

Services	Inner area (%)	Outer area (%)	Total (%)
Physiotherapy	52	25	38
Electrocardiograph	76	73	74
Contrast medium x-ray	75	80	78
Total No of general practitioners	171	195	366

* Percentages in this table add up to more than 100%, because it was possible for general practitioners to give more than one answer.

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Similarly, more doctors in the inner area than in the outer area have the advantage of a hospital collection service for specimens sent to the laboratory.¹⁴ But, again, comparing the inner and the outer areas conceals even larger differences among health authorities, 76% of doctors in one authority having specimens collected and 9% in another.

When questioned about communication between themselves and hospitals there was no clear indication that doctors in the inner area thought that this was any better or any worse than doctors in the outer area. But doctors in both areas were more critical about communication when patients were discharged than when admitted.

Discussion

Like the previous paper,³ the selected findings of the survey reported here show that the reality of general practice in the Manchester-Salford inner area diverges from the popular image in several ways that are considered to be important. Contrary to popular belief, there is no concentration of practices in the inner area without employed staff and no concentration of doctors who lag behind their colleagues in outer areas in terms of acquiring clinical equipment, improving their records, and introducing appointments systems. Furthermore, the Manchester-Salford inner area as a whole does not seem to be noticeably worse off than adjacent areas with respect to the level of doctors' use of deputising services, regular contact between practices and community nurses, and general practitioners' links with hospitals.

On these measures of practice organisation the broad similarity, rather than the dissimilarity, between general practitioner services in the Manchester-Salford inner area and in outer areas is striking. This is despite the pronounced concentration of doctors who qualified overseas and the relative scarcity of young doctors in the Manchester-Salford inner area—factors that are sometimes cited as barriers to implementing desired changes in practice organisation.

The broad similarity between certain characteristics of the organisation of the services provided by general practitioners in association with health authorities and local authorities in the inner and outer areas of Greater Manchester may be reassuring to those who aim at achieving an equal input or uniform approach to primary care in different areas. To those who aim at other kinds of equality—for example, equality of access, equality of treatment, or equality of outcome—the similarity between the organisation of the services in the inner and outer areas of Greater Manchester may provide little comfort. The fact that general practitioner services are staffed and organised along similar lines in two contrasting areas does not guarantee, of course, that the services are equally accessible or that those who use the services receive equal treatment for equal need.

Conclusions

Interviews conducted with general practitioners in five health authorities in Greater Manchester in 1981 show little general difference between the staffing and organisation of general practices in the Manchester-Salford inner city partnership area and adjacent areas. The level of use of deputising services and the lack of reported contact between general practitioners, community nurses, and health visitors throughout the five authorities will, however, cause some concern.

Although the findings may be reassuring to those who favour adopting a uniform approach to primary care, similarities in the way the services are organised may conceal important differences in access to the services and in the treatment provided. Further research into these aspects of the services and into the effects of differences in practice organisation in the Manchester-Salford partnership area and adjacent areas is recommended.

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Provision for maternity leave

We are a group of doctors and medical students interested in the provision for maternity leave for principals in general practice. Classified as self employed, general practitioners are not covered by the existing regulations for maternity leave and provision varies according to the contract individually negotiated on joining a practice. In some cases this may be favourable, but on occasion it may mean financial disadvantage either for the doctor concerned or for the practice as a whole. Financial help to pay for locums from the family practitioner committee under the present regulations is seldom available.

We would be interested to hear from general practitioners about their experiences of maternity leave, both positive and negative. All information will, of course, be treated confidentially.—PENNY SCOTCHELLO, ANNE M. JOHNSON, Newcastle Branch of Women in Medicine, 1 Kimberley Gardens, Jesmond, Newcastle upon Tyne NE2 1JH.

Physiotherapy: palliative or panacea?

General practitioners are invited to a seminar on 21 May at the London Hospital, Whitechapel, to learn about developments in physiotherapy. A group from the Chartered Society of Physiotherapy have organised talks, discussions, and demonstrations on spinal problems, respiratory conditions, sports injuries, and control and management of pain. The seminar is approved under section 63, and there are places for 200 general practitioners. To apply, telephone Miss F. Harris, MSCP, 01-548 2559 or Mrs J. Morris, MSCP, 01-449 7755.

TABLE III—Clinical equipment owned by general practitioners and number of records kept†

	Inner area (%)	Outer area (%)	Total (%)
No of items of equipment owned†			
0	2	4	1
1	5	1	1
2	27	27	27
3	38	34	36
4	22	27	24
5	14	12	13
No of records kept			
0	14	32	23
1	27	27	27
2	19	11	15
3	14	11	13
4	18	12	15
Total No of general practitioners	171	195	366

† Percentages add up to more than 100%, because it was possible for general practitioners to give more than one answer.