TALKING POINT

Who does what, and how much in the preschool child health services in England

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Introduction

The Royal College of General Practitioners has recently proposed that child health surveillance in England should be carried out by general practitioners.¹ It has become apparent, however, from personal communications from district medical officers in certain areas that there is already considerable variation in who does what, and how much in the child health services in different districts. For example, from initial inquiries it was apparent that 73% of child health clinics in the Oxford district were carried out by general practitioners, 91% of child health clinics in East Suffolk were carried out by health visitors, whereas in Croydon 100% of child health clinics were carried out by clinical medical officers.

An initial pilot survey from several further districts confirmed this variation and it was therefore decided to undertake a fuller study covering as many districts as possible in England.

The original aims of the survey were to try and understand, for each district:

(1) How many preschool medical sessions were carried out relative to the preschool population.

(2) Who, among clinical medical officers, general practitioners, and health visitors, were responsible for doing such sessions.

Method

Questionnaires were sent to the district medical officers of 178 districts in England, asking:

(1) The 1981 preschool (0-5) population.
(2) The total number of child health clinics for 1981.

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(3) The number of 1981 child health clinic sessions done by:

(a) clinical medical officers; (b) general practitioners; and (c) health visitors.

Only 178 out of a possible 193 questionnaires were sent because not all the names and addresses of district medical officers in the Mersey and North Western regions were available at the beginning of the survey.

In order to provide a ratio that was comparable between the different districts the total preschool child population was divided by the number of child health clinic sessions held. At the same time, the percentage of child health clinics held by clinical medical officers, general practitioners, and health visitors alone were analysed for each district.

After this information was collected the Department of Health and Social Security was contacted to see what comparable information was available for the same year from its forms LHS 27/2.

Results

138 districts out of the 178 contacted provided adequate information for analysis. The

ratio of the total number of preschool children per child health clinic sessions for all these districts was 9.1, with a standard deviation of 3.3. Fifty three (38.4%) had figures above this mean. As a result of the enormous variation in the ratio between the districts, rather than presenting all the results we have presented the 10 districts that have the lowest ratio—that is, have the highest number of child health clinics per head of preschool population (table I) compared to the 10 districts which have the highest ratio—that is, have the lowest number of child health clinics per head of preschool population (table II). The comparable ratios worked out from the DHSS's figures (LHS 27/2) are also presented. Given that the sets of figures were collected entirely independently, the correlations, with some exceptions, are on the whole good. What is most notable from these figures is that there seems to be a six to sevenfold difference in the density of the preschool child health services between districts.

Information about the number of sessions in each district carried out by clinical medical officers, general practitioners, and health visitors was also collected. This again shows enormous variation so we have given the 10

TABLE I—Districts with the lowest ratio of preschool population per session

District	Preschool population (000s)		Child health clinic session		Ratio	
	Study	LHS 27/2	Study	LHS 27/2	Study	LHS 27/2
Paddington and North Kensington	6.3	6.1	1768	2248	3.6	2.7
Brighton	7.8	14.7	1907	1959	4.1	7.5
Wirral	22.1	22.6	4819	5817	4.4	3.9
Newhaven	14.8	15.9	3198	1754	4.7	9.1
Bromley	16.1	16.2	3426	3555	4.7	4.6
Frenchay	13.6	13.3	2860	2860	4.7	4.6
Salisbury	5.1	7.1	1093	1056	4.7	6.7
Tower Hamlets	9.5	10.7	1995	2255	4.8	4.7
Isle of Wight	5.5	6.0	1127	584	4.9	10.3
Camberwell	13.6	13.8	2601	2678	5.2	5.1

TABLE II—Districts with the highest ratio of preschool population per session

District	Preschool		Child health clinic session		Ratio	
	Study	LHS 27/2	Study	LHS 27/2	Study	LHS 27/2
West Berkshire	27.6	26.1	1250	2195	22.0	11.9
Somerset	20.7	22.0	1191	1027	17.4	21.4
Scunthorpe	12.0	12.5	689	1485	17.4	8.4
Barnsley	14.5	13.9	882	1759	16.4	7.9
Huntingdon	11.0	8.6	697	697	15.8	12.3
Central Birmingham	14.0	13.4	889	1070	15.6	12.5
Portsmouth	30.1	31.0	1924	3087	15.0	10.0
Bradford	27.3	26.6	1789	1821	14.9	14.6
North west Herts	8.8	15.9	592	1900	14.9	8.4
West Cumbria	8.3	8.7	558	713	14.7	12.2

TABLE III—Districts with the highest and lowest participation of clinical medical officers

Highest			Lowest		
District	% study	% LHS 27/2	District	% study	% LHS 27/2
Victoria	100	90.6	Airedale	4.8	4.8
Croydon	100	93.6	East Suffolk	8.5	7.2
Harrow	96.1	95.7	West Suffolk	13.7	10.9
Hampstead	86.1	82.9	Somerset	11.0	6.2
Enfield	96.0	94.0	Oxford	16.8	16.8
Leeds Eastern	92.9	72.9	Southend	20.2	15.9
Harrogate	92.8	92.8	Hull	23.7	32.2
Gateshead	92.3	92.7	Sandwell	28.2	38.3
North west Surrey	91.8	71.9	Huntingdon	29.7	29.7
Haringey	90.0	90.9	Wakefield	32.0	29.0
Hillingdon	89.5	88.1			

districts with the highest and lowest participation of clinical medical officers (table III), the highest and lowest participation of general practitioners (table IV), and the highest and lowest participation of health visitors (table V).

Table VI shows all the districts in which child health clinics were carried out by medical staff other than clinical medical officers or general practitioners. These were all hospital staff of either senior house officer or registrar grade.

The ratios of child health clinic services relative to preschool population for regions were arrived at by taking an average of the sum of the district figures in that region. These are shown in table VII. Here, interestingly, no distinct pattern emerges and therefore the enormous district variation evens out when looked at on a regional basis. Equivalent figures arrived at from forms LHS 27/2 are shown on the same table. Table VIII shows figures for clinical medical officer, general practitioner, and health visitor participation in the clinics, on a regional basis, along with the DHSS's figures.

Discussion

Within the National Health Service it might be supposed that there should be some agreement as to what form child health surveillance should take. The recent discussions on the subject, however, have highlighted the fact that this is obviously not so, and is clearly reflected in the district variation demonstrated here.

It is reasonable that some districts might need more child health clinics relative to their population than others, dependent on such factors as degree of urbanisation, percentage

TABLE VII—Ratio of preschool population per child health clinic session by region

Region	Preschool population (000s)		Child health clinic session		Ratio	
	Study	LHS 27/2	Study	LHS 27/2	Study	LHS 27/2
Northern	130	188	18	23	7.3	8.2
Yorkshire	207	217	22	24	9.2	9.0
Trent	259	270	27	34	9.5	7.9
East Anglia	84	118	1	11	8.9	10.7
North west Thames	166	206	2	28	8.1	7.4
North east Thames	184	226	26	31	7.0	7.3
South east Thames	254	202	23	30	10.9	6.7
South west Thames	145	169	17	22	8.2	7.7
Wessex	81	157	11	19	7.0	8.3
Oxford	137	152	14	16	9.4	9.5
South Western	123	172	15	21	8.0	8.2
West Midlands	255	320	28	37	9.0	8.6
Mersey	82	149	12	25	6.7	6.0
North Western	84	246	1	37	8.3	6.6

TABLE VIII—Percentage of child health clinic sessions held by clinical medical officers, general practitioners, and health visitors by region

Region	Clinical medical officer		General practitioner		Health visitor	
	Study	LHS 27/2	Study	LHS 27/2	Study	LHS 27/2
Northern	59.1	60.8	18.2	15.9	22.6	22.6
Yorkshire	61.3	60.0	11.7	12.2	27.0	26.3
Trent	43.5	43.9	17.4	15.7	38.4	41.4
East Anglia	35.4	31.3	10.6	9.9	54.0	51.8
North West Thames	78.0	74.6	3.9	3.9	18.1	18.9
North east Thames	59.9	56.4	8.6	8.2	31.5	34.2
South east Thames	53.6	59.5	22.1	17.6	24.2	24.2
South west Thames	79.1	72.6	4.3	6.2	16.6	21.7
Wessex	60.0	51.8	6.3	3.5	33.5	39.5
Oxford	38.2	39.2	33.2	32.3	28.6	27.7
South Western	50.0	41.4	7.2	6.4	42.8	44.5
West Midlands	54.8	55.2	15.2	15.4	30.0	29.8
Mersey	44.4	41.0	3.7	14.5	41.9	38.5
North Western	80.0	57.2	6.3	16.2	9.4	27.5

immigrant population, higher rates of unemployment, higher incidence of social class IV and V, etc. From superficial examination of our figures, however, no clear patterns emerge.

Furthermore, the variations between districts are not only as to how much surveillance is carried out but also as to who actually does it. Therefore, it must be asked:

(1) Why is there so much variation? Is a district policy on child health surveillance simply dependent on the whim of those administratively responsible, or is it based on such sound data as is available?

(2) Do we have any evidence that the policy, say, in East Suffolk, which runs relatively few child health clinic sessions per head of preschool population and virtually all done by health visitors, provides any worse child health surveillance than, say, Salisbury which provides three times as many child health clinics per head of preschool population and over 60% of which are done by doctors?

(3) Given that health visitors are already more concerned than general practitioners in child health surveillance—if there is to be less participation by clinical medical officers—should not their work be undertaken by health visitors rather than general practitioners?

We would therefore suggest that all those concerned—the Royal College of General Practitioners, the British Paediatric Association, the British Medical Association, the Faculty of Community Medicine, and the Health Visitors Association, should meet and jointly agree on a national policy of child health surveillance, based on such evidence as is available at the moment, and that such a policy should be continuously evaluated.

Reference

- Royal College of General Practitioners. *Healthier Children—thinking prevention*. Report from general practice 22. London: Royal College of General Practitioners, 1982.

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TABLE IV—Districts with the highest and lowest participation of general practitioners

Highest			Lowest		
District	% study	% LHS 27/2	District	% study	% LHS 27/2
Oxford	72.7	72.7	Essex	0.4	0.4
Hull	57.5	48.3	East Suffolk	0.6	0.4
Hastings	42.3	27.7	South Cumbria	1.1	3.5
Sandiwell	41.8	39.6	North Herts	1.2	0.4
Rotherham	38.6	35.4	West Essex	1.7	1.5
Tower Hamlets	38.0	31.0	Basildon	1.7	1.5
Sunderland	36.2	32.6	Frenchay	1.7	1.7
Islington	36.0	29.4	Kettering	1.6	1.6
Bromley	36.0	29.4	Blackburn	1.9	1.8
			Merton and Sutton	2.6	5.0

TABLE V—Districts with the highest and lowest participation of health visitors

Highest			Lowest		
District	% study	% LHS 27/2	District	% study	% LHS 27/2
East Suffolk	90.9	92.4	Hillingdon	1.5	1.9
West Suffolk	86.3	89.1	Grimsby	1.6	26.1
Airedale	90.5	90.5	Tower Hamlets	2.6	4.6
Somerset	72.8	59.3	City and Hackney	3.3	1.7
Mid-Essex	68.9	74.8	Hampstead	3.9	6.5
West Birmingham	64.4	62.5	Harrow	3.4	4.3
Wakefield	64.0	66.9	Islington	4.1	3.4
Newham	62.5	27.8	Camberwell	4.7	2.8
Central Nottingham	60.5	26.9	North West Herts	4.9	19.7
Frenchay	60.4	60.4			

TABLE VI—Districts in which child health clinics were also done by hospital staff

Highest			Lowest		
District	% study	LHS 27/2	District	% study	LHS 27/2
Hull	9.3	10.6	North Lincoln	3.8	3.5
South east Staffs	6.5	6.3	York	3.0	3.0
South Lincolnshire	4.8	3.0	Rotherham	1.9	5.2
Tower Hamlets	4.4	3.1	Dartford	1.2	1.2