helped us in the project, and in particular to Mr. John Davies, group medical records officer, United Oxford Hospitals, and Mr. Griffin and Mr. Eddy, of the Organization and Methods Division of the Oxford Regional Hospital Board. Finally, we are most grateful to our secretarial staffs for their considerable help.

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Scientific Basis of Clinical Practice

The Future of Community Medicine

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British Medical Journal, 1971, 4, 670-673

Since 1 April 1948, when the National Health Service came into operation, there have been major developments in the practice of medicine, and at the present time we are in a period of transition and some uncertainty. Most people dislike and are suspicious of change, and doctors are no exception. Nevertheless, changes are inevitable and will occur both in the practice of medicine and in the structure of the National Health Service.

Basically there are three major matters which compel us to re-examine both our present position and the future development of a comprehensive health service: a shortage of medical manpower; the redistribution of population; and a change in the incidence and treatment of disease.

Medical Manpower

Before the war three-quarters of the medical profession were in general practice, but since then as a result of an expansion in the hospital sector and its related specialties the proportion of general practitioners in the Health Service has steadily declined, to about slightly less than half of all doctors today. Between 1964 and 1968 their absolute numbers also fell (Table I).

TABLE I—Doctors in or Entering General Practice

Year	Total New Entrants	Net Gain or Loss	Total
1960	981		19,928
1961	971	+260	20,188
1962	1,017	+138	20,326
1963	1,021	+23	20,349
1964	910	-103	20,246
1965	870	-219	20,027
1966	877	-183	19,844
1967	884	+5	18,894
1968	964	+121	18,970
*1969	531	+151	20,121

*1969—figures for 9/12 only.

Dudley, Worcestershire

G. M. REYNOLDS, M.B., D.P.H., Medical Officer of Health

In 1957 the Willink Committee¹ suggested that student intake into medical schools should be reduced. This recommendation was accepted by the government of the day and implemented for a period. This may well explain, at least in part, the decline in the number of doctors entering general practice in the 1960s. Training medical students is, however, only a part of the picture as medical manpower is affected by migration. The Willink Committee did not foresee the loss by emigration of British trained doctors, but Seale calculated that in the five years up to 1960 the rate of emigration of British doctors was equivalent to one-third of the annual output of the medical schools in Great Britain and Ireland. This figure was disputed but probably the net loss by migration from Great Britain of British and Irish born doctors was 350 for each of the years 1965-6 and 1966-7. The present rate of net loss is about 380 to 400 a year—that is, about one-fifth of the total output.

IMMIGRANT DOCTORS

Immigrant doctors have also played an important part in the medical manpower of this country. Initially, overseas doctors practised mainly in the hospital service, but in recent years the number entering general practice has increased. During the middle 1960s the proportion of recruits to practice with United Kingdom or Irish qualification fell from 96% to 80%, while that of recruits with Asian medical degrees rose from 4% to 18%.

Towards the end of 1970 overseas doctors formed 33.2% of all hospital staff in England and Wales. They constituted one-eighth of all consultants, one-fifth of the senior registrars, just under three-fifths of the registrars, and just over three-fifths of the senior house officers. They formed 48% of all doctors in the training grade posts in the hospital service. One general practitioner in eight was overseas-born, but over a quarter of the new general practitioners joining the Service were overseas-born.

The shortage of doctors is worldwide—in May 1971 it was reported that the United States, with an active doctor population exceeding 294,000 in 1967, with a quarter of its junior hospital posts unfilled, appeared to require annually about 7,000 doctors to replace deaths and retirements alone.² A total of 16,000 new doctors was required annually—the output in 1967 was 7,500, in addition to 2,000 U.S. nationals

who qualified overseas—that is, 9,500 trained for 16,000 posts. The developing nations have an even greater need than more advanced countries. For us in Britain the need is not only for more doctors but for a better deployment of those we already have, as our requirements are not likely to be met in the immediate future.

Population Changes

In a period when there has been a shortage of general practitioners, the population has increased (see Figure). In addition, the age and sex structure of the population has changed. At the beginning of the century only 6·2% of people were of retirement age and over, whereas at present this figure is

16%. The sex ratio has also changed and, for every 1,000 women aged 45 and over, there were 866 men in 1901—but only 813 by 1971. In the main women make more demands on the general practitioner's time than men. Moreover, these patients are not only increasing in number but are also better informed about medical matters than they have ever been. Thus patients now expect higher standards of care from their personal doctor.

Changes in Incidence and Treatment of Disease

In the earlier parts of this century the major health hazards were those associated with infectious diseases, such as diphtheria, scarlet fever, rheumatic fever, whooping cough, and tuberculosis (Table II). There was also a high infant mortality rate—almost 140 per 1,000 live births in 1901, compared with 23 in 1968. Today the position is quite different and the commonest causes of death are ischaemic heart disease, cerebral vascular

TABLE II—Frequency of Some Infectious Diseases Earlier in This Century

Diseases	Cases	Deaths
Diphtheria 1916-25 (average) ..	51,573	4,214
Poliomyelitis 1947 (peak) ..	7,776	707
Tuberculosis (all forms) ..	52,576	19,088

disease, pneumonia, bronchitis, and carcinoma of the bronchus and of the breast. In addition to these, there are many conditions which cause serious handicap. We know that there are 100,000 blind people in Britain, 70,000 spastics (and about 1,000 born every year), 20,000 with muscular dystrophy, 40,000 with multiple sclerosis, about 5,000,000 with osteoarthritis, and over 1,000,000 who need a hearing aid.

The major health problems today are the killing and crippling diseases of the middle-aged and elderly and those of the very young, who now can survive congenital and early handicapping conditions because of improved medical treatment. In addition there are the increasing problems of the mentally ill and the mentally subnormal. Before the 1930s improvement in the national health was mainly the result of public health measures, education, better nutrition, and better housing. Since then, however, personal medical care, both hospital and community, using the new tools of medicine—sulphonamides, antibiotics, antidepressive drugs, and new and advanced technical services in hospital—has played a major part in improving the health of the nation, and the demands on the time and skill of doctors have correspondingly increased.

Nevertheless, other factors than those affecting the doctor-patient relationship will determine how medicine is to develop in the future. These concern administration and organization and we already know enough about them to give a fairly good indication of the way medicine will develop in the next two decades.

Administrative Changes in the N.H.S.

THE CONSULTATIVE DOCUMENT

The damaging effects of the tripartite system under which the N.H.S. is organized have been obvious for a very long time, and there can be few doctors who do not see the advantages of a unified service. This does not mean that an administrative change will cure all ills, but it does mean that an attempt is being made to use our present resources to the best advantage.

The Consultative Document³ lays great stress on management and confines itself to a discussion of the administrative structure of the service. The future service as outlined by the Secretary of State is based on two tiers, with overall control remaining with the central department.

(1) The smallest unit of management will be the area health authorities, which will have the same boundary as the new local authorities—that is, the new counties and metropolitan districts. There will be 70 of these in England outside London, with responsibilities for the planning, organization, and administration of a comprehensive health service within their areas. The chairman of the area authority will be appointed by the Secretary of State and the members, about 14, will mainly be appointed by the regional authority after consultation with interested organizations, including the main health professions.

(2) The regional authority will be responsible for the general planning of the National Health Service, allocating resources to the area health authorities, and co-ordinating their activities and monitoring their performance to ensure that national and regional objectives are achieved, and that the desired standard of service is provided. Unlike the proposals in the second Green Paper, regional authorities will now have substantial powers and will be responsible for the building of major projects. The area of the regional health authorities will be based on the present 14 regional hospital boards, except that the present Sheffield board will be divided into two regions, one based on Nottingham and the other on Sheffield. There will, therefore, be 15 regions and the chairman and all the members of these regional authorities will be appointed by the Secretary of State.

(3) Overall control will remain with Government, and the Central Department will have the ultimate responsibility for the quality and effectiveness of management and for monitoring performance. The Central Department will determine national objectives, priorities, and standards, and will allocate resources to the regional authorities.

(4) In addition, it is proposed that area health authorities will be required to set up community health councils for their constituent districts, which the area health authorities will have to consult on the development and operation of the health services.

Hence, with the appointment by Government of the chairman and all members of the regional authorities, and the chairman and most of the members of the area health authorities, the Central Department will be in a position to exert strong control and direction—and it would be quite unrealistic to suppose that it should do otherwise, since the finances for all of these services will come from Central Government.

THE DISTRICT GENERAL HOSPITAL

The concept of the district general hospital providing for all the acute general specialties, put forward in 1956,⁴ envisaged the provision of treatment and diagnostic facilities for inpatients and outpatients, including a maternity unit, a short-stay psychiatric unit, a geriatric unit, and facilities for the isolation of infectious diseases.

Provision was to be made for all other ordinary specialties but a few specialties such as radiotherapy, neurosurgery, plastic surgery, and thoracic surgery were considered to need a larger catchment area than would be provided for the ordinary general hospital. This new hospital would provide 6-800 beds and would serve a population of 100-150,000, though some district general hospitals would be larger. These hospitals were to be located in or near the centre of the population of the area which they were to serve, but there were also to be smaller hospitals (though rarely would these contain fewer than 300 beds) to provide for the needs of the mentally handicapped, elderly, long-stay mentally ill patients, and maternity services.

It was considered that the district general hospital offered the most practical method of providing the full range of hospital facilities—a consideration that far outweighed the disadvantages of long travel for some patients and their visitors. Most, though not all, district general hospitals would contain a fully developed accident and emergency department.

In 1969 the Central Health Services Council published a booklet on the functions of the district general hospital (the Bonham Carter report⁵). This report stated that district general hospitals in the large cities and conurbations could each serve 300,000 or more people and that most of them should be planned to serve at least 200,000. They accepted that in the more sparsely populated areas of the country there would have to be some compromise between specialist staffing and accessibility, and in these areas a district general hospital might have to serve fewer than 150,000 people—and in a very few places even less than 100,000.

Hospital and community health services are interdependent, and in looking at the need for a full range of medical services to a community these two services should be planned together. Whatever the developments in the hospital services, therefore, these must affect the community services, and the domiciliary team of doctors, nurses, medical auxiliaries, and social workers. There should be continuity of care between both services.

Health Centres

In 1920 the Dawson Committee recommended that general practice would best be conducted from health centres "where are brought together various medical services, preventive and curative, so as to form one organization."⁶ Since then general-practitioner and local authority services have developed along their own separate lines and only in recent years have they started to come together.

There is now an increasing interest by general practitioners in health centres and at present 287 are in operation, with a further 63 planned for the next two years. These will serve 4,573,500 patients, with 1,902 doctors—a relatively small but

ever-growing number. How much real interest there is among general practitioners in working from a centre it is difficult to say, and I suspect that many are now in health centres because surgery premises have become obsolete or because their premises have been demolished in town-centre development or in road-widening schemes. Financially, too, if a doctor is considering moving into new premises, a purpose-built health centre with an agreement with the executive council is a better proposition than a privately arranged seven-year lease or the purchase of new buildings.

On the whole it has taken family doctors a long time to overcome their reluctance to work together with statutory authorities. There has been an understandable resistance by general practitioners and the attitude of many local health authorities has not been in the least bit helpful. Doctors have thought that their practice would lose its individuality, or that the doctor/patient relationship would suffer, or that there would be some form of clinical direction, or even that withdrawal from the National Health Service would be more difficult. Whatever the reason given for not practising from a health centre, it shows a reluctance and a fear by general practitioners which, though in my view not justified, are real enough to the doctor himself.

I do not think it matters very much whether doctors practise from a health centre or from group practice premises, provided that they have clinical freedom and are fully supported by the nursing, medical auxiliary services, and the social services of the local authority. Most general practitioners practise from private accommodation, either owned or rented. Some have a tenancy arrangement with local authorities and practise from surgeries which are situated in local authority clinics. In my own borough 25% of the doctors for whom the executive council is responsible practise in this way, and for all practical purposes they work as if they were practising from health centres. The clinics are all postwar, purpose-built, and arrangements are already being made for an extension into centres.

Local Authority Services

The "Annis Gillie" Committee Report in 1963 pointed out that the development of the health and welfare services of the local authority was bound up with the future of the general practitioner service, that the one would interact with the other, and that both in future should be considered together.⁷ It went on to say that full co-operation could be secured best by the attachment of fieldworkers—nurses, midwives, and health visitors—to individual practices and that this must become general.

In 1956, the medical officer of health for the City of Oxford attached on a full-time basis a health visitor to a partnership of three, and by 1965 all nurses were attached to practices. Because of the success of attachment with health visitors, this was extended to district nurses and midwives and, though the great advantages of attachment were shown early on in this scheme, there has been a certain unwillingness by other local authorities and general practitioners, as well as by nurses, to accept the change. Recent studies have, in fact, shown that local authority nurses have had surprisingly little contact with general practitioners, and I suspect also with hospitals, and that general practitioners are often ignorant of the services which these highly skilled nurses can offer.

Where an attachment or liaison scheme works well there is a more comprehensive coverage of patients' needs, resulting from a closer working relationship between the general practitioner, the health visitor, the district nurse, and the midwife. There is also a continuity of care and treatment which can only result in an improved service. Attachment does not necessarily make the work of the general practitioner less difficult: in some cases unmet needs are discovered and it may actually increase his work. Nevertheless, whatever happens it is the patient who should benefit, and the service is not designed to overcome the difficulty of medical manpower.

Social Services Departments

As a result of the Local Authority Social Services Act, 1970, a new Social Services Department was established in every county borough and county council in England and Wales on 1 April 1971. These departments are under the direction of a director of social services and, broadly speaking, the services to be administered by the new department are those formerly dealt with by the children's department, by the welfare departments, and by the mental welfare section of health departments, with the addition of the home help service and the supervision of day nurseries and child minders. This means that the social aspects of residential care and boarding out of children and the adoption of children, as well as services for the care of the elderly and physically handicapped, the blind, the deaf and homeless families, and mental health, have now been firmly taken outside the medical field. There is now a unified profession of social workers, and it is hoped that eventually they will have a common training. We should appreciate the motives and aspirations of social workers, who have since the publication of the Seeborn Report⁸ worked hard for the unification of their service. This development was sensible and inevitable, and now that they have an integrated service they will work it successfully, despite initial difficulties and the restrictions imposed by staff and financial shortages.

Unfortunately in 1974 social services departments will remain with local authorities, while the Health Service will be unified into local area health authorities. This means that these two services, which should work closely together, are going to be administered by two separate authorities. How much better would it have been to have one authority responsible for all medical, nursing, and social work.

This removal of social services from under the general direction of doctors is an indication of likely developments in other services. I am thinking particularly of the nursing service, which has become more management conscious. Hospital management committees have recently been reorganizing their senior nursing staff along management lines as recommended by Salmon,⁹ and the local health authorities' nursing services are being planned along similar lines, following the publication of the Mayston Report.¹⁰ Nursing will then be a profession which will manage itself. It will be less dependent on doctors for administrative and managerial skills and it will inevitably become more independent and more specialized in keeping with the trend in other professions.

Conclusion

In most areas of the country general practitioners are now much less suspicious of the services being established by local health authorities. Nowadays there is a great deal of co-

operation in addition to the services which I have already mentioned. In my own area we provide radio telephones for certain nursing staff and social workers and these services are also made available at a very low rental to general practitioners working within the borough. Like most authorities we started a screening service for cervical cytology in our own clinics, inviting women to come along for this simple procedure. But we have now moved away from organizing the service in this fashion and are co-operating much more closely with general practitioners so that patients on their lists are invited to come to see them by appointment and they carry out the smear testing in their own surgeries. The administrative arrangements, sorting out names, and sending out letters over the general practitioner's signature are carried out by the health department in co-operation with the practice secretary/receptionist.

Similarly, we are hoping soon to start a scheme of this kind with vaccination and immunization. Our acceptance rates at present are very high and most of these procedures are carried out in clinics, but again I feel that it would be better for the general practitioner to offer this service for his own patients and it is relatively easy for a health department to make all the administrative and clerical arrangements in co-operation with the practice.

These are some of the major changes which are likely to occur when, in less than three years' time, we shall see another radical reorganization of the Health Services. Many doctors will view them with dismay, occurring as they will 26 years after a major upheaval in the National Health Service. Nevertheless, no system can remain static, and it is essential that its evolution and development should keep pace with the rapidly changing needs and expectations which it has to meet.

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This article is one of the Birmingham series of lectures under the heading "Scientific Basis of Clinical Practice" (see B.M.J., 27 November, p. 510).