HEALTH CENTRES
A REPORT AND DISCUSSION

by

Gail Baker and John Bevan

1971

Reissued 1975

Health Services Research Unit

University of Kent at Canterbury

CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

We are most grateful to a number of people for their contribution to this study; to Dr. K.S. Dawes* of the Centre for Research in the Social Sciences; and Dr. G.R.M. Sichel of the Department of Health and Social Security for help in preparing the report and for bringing to our notice much relevant material, and to several others of our colleagues in the Centre for Research in the Social Sciences for valuable comment on draft of this report; to Angela Lane and her colleagues in the Centre for typing the report (and to Jill Steadman for producing the 1975 reissue).

The study was supported by a grant from the Department of Health and Social Security.

---

* now of the Health Services Research Unit

PREFACE TO 1975 REISSUE

This is a report (originally issued in February 1971) of the first phase of work, carried out at the Centre for Research in the Social Sciences of the University of Kent, into health centres and related aspects of primary medical care organisation. It presents the background in terms of the state of knowledge about health centres for the later studies which were being developed by the group at the University of Kent and became part of the programme of the Health Services Research Unit. Since final reports on these studies are now being completed it seemed useful to reissue the original (1971) report. The issues discussed remain relevant to policy decisions about health centres.

In reissuing this report we have not attempted to update it in any way. Since however the bibliography[1] of health centres, which was originally included, was subsequently extended and published elsewhere, we have confined references in the present version to those cited in the text. We have however included for convenience of reference the proforma used to obtain detailed descriptions of health centres and the activities undertaken therein. This was originally included in the preliminary report to the Department of Health and Social Security (February 1969).[2]

In the body of the text health centres and group practice premises are followed in brackets by the date of opening (or where a change of use of premises was involved when family doctors first commenced using the premises).

Further information on health centres can be found in Brookes' publication (1973)[3] and The Hospitals and Health Services Year Book[4] (the 1975 edition contains names and addresses of health centres by district).

---

[1] Baker, G.E. and Bevan, J.M. (1973) A Bibliography on Health Centres in the United Kingdom. London : Update Publications Ltd. (This covered publications up to December 31st 1972, supplements for 1973 and 1974 are issued by the Health Services Research Unit, University of Kent).

[2] This document was we understand the basis for the design-in-use proforma adopted by the Ministry of Health and Social Services, Northern Ireland.

[3] Brookes, B. (1973) British Health Centres Directory. King Edward's Hospital Fund for London.

[4] London : Institute of Health Service Administrators.

THE AIMS OF BUILDING HEALTH CENTRES

The concept of the health centre has been under discussion for at least fifty years, although it is only recently that health centres as such have been provided. Although the 1946 National Health Service Act empowered local authorities to build centres, for various reasons (described for example by Ryan 1968)[1] centre building did not get under way and by 1966, only twenty one centres had been built by local authorities under section 21 of the 1946 Act. A few centres, notably those at Harlow (1950s) and Witney (1966), had been financed from other funds. However since 1966 there has been a great increase in the rate of building of centres by local authorities. As pointed out in 'Building for Health' 1970[2], "Between 1967-8 and 1969-70, the share of local authority capital expenditure on health and welfare devoted to health centres in England and Wales increased from 5 per cent to 13 per cent".

Precisely what function a health centre should fulfil, and what kinds of medical care should be undertaken in a centre, has not been agreed upon. However a health centre has come to be regarded as a building housing community health services, services that is which are provided by medical or paramedical staff to patients who are resident in the community (and not in hospital). Two areas are obviously open to debate, namely what sort of staff are involved, when drawing a line between medical and social services, and hospital and community staff, and what sort of patients should they be concerned with, when drawing a line between those to be cared for in hospitals and those to be cared for at home. Where these lines are drawn is partly a matter of tradition, and partly decided by the techniques and resources available. For instance, as far as staff are concerned, medical social workers and occupational therapists traditionally are based in hospitals, and not in community health service buildings. Social workers and mental health social workers tend to be based in local authority administrative buildings. Where patients are treated partly depends on social needs, that is whether or not they can be cared for at home, and partly on their clinical condition. The community services provided affect the assessment of where the patient should be, since a patient can be discharged early from hospital, or have follow up treatment at home, if staff and equipment are available in the community. This kind of assessment affects outpatients as well as inpatients and it has been suggested that more supervision could be undertaken by general practitioners of patients who otherwise regularly attend outpatient sessions (Forsyth and Logan 1968).[3]

Given that centres are built to be, as Wofinden (1967)[4] has said, "a field base" for staff in community health services, and that the precise nature of these services is variously defined, there are several aims which have been put forward as being the purpose of health centre building.

i. Provision of purpose built premises for community health services

This aim is implicit in building centres, and by itself could be a justification for a health centre building programme. General practice premises are often unsuitably housed, and local authority clinics have been held in church halls for lack of appropriate buildings. The West Riding of Yorkshire adopted a policy of providing health centres and of letting rooms in clinic buildings to general practitioners, partly to help ccunteract the net loss of doctors in the county, who were not being replaced on death or retirement. Lees and Carr (1960)[5] in their survey for the Ministry of Health concluded that the motives of most doctors in entering centres were material - they wanted better premises. Generally speaking centres are purpose built, although a small proportion have been adaptions of clinic buildings and sometimes of houses.

ii. Professional contact, and less isolation for the general practitioner

The Interim Report of the British Medical Association in 1942[6] emphasized the need for more contact with other practitioners, and single handed practice has been increasingly criticized. The decline of the single handed practitioner is shown in the tendency to form more and larger groups, and this is reflected also in the opinions of medical students, surveyed in 1966 for the Royal Commission on Medical Education[7] (see Tables 1 and 2).

iii. Better organisation

In 1942 the British Medical Association report[6] considered that health centres would give doctors the necessary ancillary help, opportunity for study leave and rota systems for out of hours work. Increasingly organisation of general practice - especially with the advent of appointment systems and larger groups - is being recognised as important.

iv. Integration of curative and preventive services

Integration of services has been the dominant argument in proposing centres, and it has often been hoped that liaison with hospital staff, as well as between general practice and local authority staff, would be

facilitated in health centres. Dawson (1920)[8] and the British Medical Association (1942)[6] stressed this.

Taylor (1952)[9] writing on the early development of health centres in Harlow New Town, considered that the "definitive feature" which distinguished health centres from good group practice premises was the "close working relation" with local authority staff in their preventive work. Whereas good group practice premises could provide the rota systems, ancillary help and opportunity to work with other general practitioners as colleagues, they did not, as a health centre could, enable the general practitioner to work closely with the local authority staff. In 'Good General Practice' (1954)[10] Taylor stressed this again, together with the view that where ever possible clinics should be adjacent to group practices if a centre were not feasible.

In the Ministry of Health Circular 7/67[11] it is stated that "The Minister regards the main purpose of a health centre as facilitating integration of the family doctor and the hospital and local authority services". The Future Structure of the National Health Service (1970)[12] states that the aim of health centres "is to co-ordinate local preventive and curative services so as to provide integrated health care to community". The Todd Report (1968)[7] sees the health centres as "the most obvious and natural setting" for general practice in the future, particularly as only the health centre could link with the district hospital, unlike group practice premises.

One implication of these recommendations is that centres should be large and centralized as this justifies and enables the attachment schemes, the rota systems and the outlay of capital on building and equipment.

SIZE OF HEALTH CENTRES

In talking of 'size' in the context of health centres at least three factors must be taken into account :

i. Physical size of building, the number and dimension of rooms
ii. Local authority and (where applicable) outpatient population served from the centre
iii. General practice population served from the centre

These factors are related - a centre must be built large enough to cater for the population it is planned to serve. The total population served by a centre depends on both the list sizes of the general practitioners practising there, and the local authority services provided. The maternity and infant welfare sessions at the centre may serve a whole town, but only half that town's general practitioners may be in the centre, so the local health authority catchment area may be quite different to that of the general practitioners. If the local authority provides specialised services at the centre, such as child guidance or social workers for the handicapped, then the catchment area for these services will be larger still. And, of course, any introduction of outpatient sessions may increase the catchment area of the centre.

The building must correspondingly be of a size to cater for the rooms for the various activities and the waiting and reception areas needed. Where general practitioners are concerned, the main factor is the number of consulting suites needed, usually about one per general practitioner, as especially with appointment systems, large or small list sizes do not make much difference.

The John Scott Centre (1952) is perhaps an extreme example of services being 'out of balance' with only six general practitioners but a wide range of local authority services including physiotherapy, child guidance and classes for the handicapped, serving a much larger population than the general practitioners in the centre. Now the emphasis is on bringing all the general practitioners in an area into a centre if possible. This does not always materialise - in Farnham (1968), for instance, seven general practitioners are in the centre and four outside, the general practitioners in the centre covering about 16-17,000 of the town's 25,000 population.

The problems of having centres catering for large populations are both external (the transport of patients to the centre and the visiting distances for general practitioners and nursing staff) and internal (the direction of patients and the social and work relationships between staff). A large centre building can be treated either as a whole (e.g. Mansfield 1968) or as a number of units, as is proposed for the central health centre at Thamesmead (Smith et al 1966).[13] The latter proposal, although it does not affect distances to the centre for patients and medical staff, would affect the social and professional relationships of staff and the direction of patients. The John Scott Health Centre (1952), for instance, although a large building, is not necessarily difficult for the patient to deal with as entrances are separate and clearly marked for general practitioner and other services and the patient has only to operate within a section of the building. With centres such as that planned for Middlesborough, with 21 general practitioners and nearly 62,000 registered patients, the problems caused by size become critical.

The physical size of the centre, and the related matters of siting and catchment areas is one of the most important aspects of health centre planning, for the size of the centre is a fairly rigid factor and cannot easily be altered. Extensions and additions to centres are feasible where land is made available and the centre planned in such a way to allow for this, whether extensions are horizontal - onto more land - or vertical - adding another storey. Flexibility is of prime importance, as emphasized by Moss[14] and Ottewill[15] who criticised a number of centres and group practice premises on these grounds. One problem centres have in particular is the importance of combining flexibility with sound proofing.

The factors affecting size needed may vary over the years considerably :

i. Total population size may alter - increasing or decreasing. This factor will be of relatively little importance in urban centres, with a stable population, and there is a case therefore for building the most elaborate centres in these positions. Rural populations, and housing estates, present more potential variation in demand.

ii. Type of population may alter - Young families on new housing estates create a demand for space for ante natal and infant welfare sessions, the elderly need chiropody services.

iii. Numbers and types of personnel working from the centre may alter - Changes may take place in the types of staff who are considered essential in centres, as other workers than those traditionally included (community nursing staff and general practitioners) may be given accommodation or hold sessions there. In one area visited for instance it was thought desirable, if possible, to have child care officers and probation officers (for counselling) working in centres.

iv. Ways of working may alter, changing room requirements - Elliott[16] stresses the need for "the provision of more individual consulting rooms rather than the large 'halls' and rooms of the past, for such activities as chiropody, health visitor consultation work, screening techniques and so on. The falling off in attendance at ante natal and school clinics, and the consequent consultation appointments for school health and general practitioner ante natal and child welfare clinics has had a similar effect". The increased use of appointment systems, and perhaps the increased expectations of privacy by patients, together with a trend towards general practitioners doing more local authority clinic work, affect provision of rooms.

v. Distribution of centres may alter - Views on distribution may change, for instance, if transport is provided for patients to come to centres, less widespread building of centres is possible.

vi. The maximum or minimum 'desirable' size may alter - A 'desirable' size for centres, in terms of catchment areas (both for local authority, general practitioner and, where applicable, outpatient services) is not agreed upon. It is evident, however, that centres catering for increasingly larger populations are acceptable, at the same time as the building of moderate sized centres, say for four to six general practitioners, continues. Thus, there is a range in size from one doctor centres in rural Devon to the 21 doctor centre proposed for Middlesborough.

vii. Transport systems may alter - Centres for large populations and, therefore, built at a greater distance from the homes of many people than the older pattern of scattered doctors' surgeries and local authority clinics, may be more possible with changes in private and public transport systems. On the one hand, private car ownership is increasing, but will probably not provide for all patients needs. A system of special buses for centres is another possibility. The larger the population, and the wider the catchment area, for which the centre is built, the more important considerations of transport systems become.

DESIGN OF HEALTH CENTRES

Certain aspects of health centre design are worth discussion, not so much from an architectural point of view, but because they involve general principles about how health centres should function and be organised. Some aspects of design are more relevant to this than others, and these can be listed as :

i. Reception and waiting areas
ii. Shared accommodation
iii. Common rooms
iv. Number of floors

i. Reception and waiting areas

The Ministry of Health Draft Design Guide (1968)[17] recommends one reception and waiting area for local authority and general medical services, as being less expensive, easier to supervise, and more flexible if for instance more general practitioners join the centre.

Early centres tended to have separate waiting rooms for each practice, (Jack Cohen 1956, John Scott 1952, Nechells Green 1960) or sub waiting areas (Hythe 1965). Recent policy has been to provide the combined waiting and reception area, and apart from the practical reasons given for this (as above) would seem to be symbolic of 'integration' of local authority and general medical services. Problems arise however from this type of design. It can be confusing for the patient. This is not so in smaller centres (for example those with up to six general practitioners) but may worsen when centres are larger than this.

Where centres are built on two floors and general practitioners are on both floors (Mansfield 1968, and plans for Dover) reception obviously has to be divided. Sub waiting areas also arise even where not planned, as for instance at Rugeley (1967) where chairs have been placed in the corridors off which the consulting rooms open.

The problems of large common waiting areas are that for the patient they become confusing, impersonal and less private, and for the reception staff, difficult to manage. Especially with the elderly in mind it is particularly important to make reception - and the progress to the doctor's surgery - as easy as possible. Where centres are large (say 10 or more doctors using the centre as a main surgery) sub division of

waiting is probably essential, and desirable with seven or more doctors practising mainly from the centre.

In the second survey of patient opinion in Wallsend, which is at present (1971) being undertaken, a number of replies already received have included complaints about impersonality in the Wallsend Medical Centre (1968), and the feeling of being treated like a number. This is a centre comprising the main surgeries of six doctors and a branch surgery for three others, with one main reception and waiting area, and so is comparable to health centres catering for six or more doctors.

ii. Shared accommodation

Accommodation - consulting and examination rooms in particular - is shared by general practitioners and local authority staff in some centres, (notably those of the Yorkshire West Riding and Devon County Councils). This kind of sharing is to be distinguished from sharing of consulting rooms between doctors in the same practice.

One of the strongest arguments in favour of shared accommodation is reduction in cost. Another argument in favour put forward in the Draft Design Guide (1968)[17] is that sharing "encourages a close working relationship". However, if consulting rooms are shared, it usually means that sessions for local authority staff and general practitioners have to be held at separate times, and the personnel involved may in fact not see each other much, since one or other will be out visiting.

An increasing problem is that of arranging sessions not to overlap, as doctors are tending to hold surgeries earlier in the evenings so as to finish the day earlier than traditionally. This trend is marked in Wallsend (1968) despite the fact that at least one section of patients say they would like later surgeries.

iii. Staff common rooms

According to the Draft Design Guide (1968)[17] "a single common room for all members of the staff - both lay and professional - can play a very important part in promoting cooperation and good relations between the various users of the Centre". By the nature of the work in community health services, personnel will often be away from the centre. Doctors, district nurses, health visitors and midwives go out on visits. Other staff, such as chiropodists, speech therapists or where applicable,

hospital consultants, may only visit the centre for at most a few sessions per week. If staff do not meet each other informally, for instance at coffee time, they may in fact never see each other face to face, simply referring patients to other staff without meeting them.

Apart from wanting to promote informal relationships - presumably the idea behind the statement in the Design Guide - a common room provided for all in itself implies some degree of equality between those using it. When more than one common room is provided, the implication is that some personnel are too 'senior' to use the common room. In a sense, therefore, a common room for all is symbolic - of the integration of staff and mutual respect which it is wished to foster.

In some centres two common rooms have been provided. Tamworth (1968) has one room for reception and secretarial staff, and another for doctors and nursing staff. Rugeley (1967) has a small room for doctors only. These arrangements reflect the wishes of personnel. Where only one room is provided, it may only be used by one section of staff, and not all of them.

It is often the general practitioners who wish to preserve a room apart, for discussion of practice matters and cases, and Gibson (1970)[18] recently advocated this arrangement. Who uses the common room is of course influenced by the design of the building. The common room - as has frequently been stressed - must be equally accessible to all preferably near the 'clinic facilities' as the Draft Design Guide says (1968).[17] One solution to the problem of one or two common rooms is a divisible room, as at the Wallesend Medical Centre.(1968).

iv. Number of floors

Most health centres are traditionally one storey buildings, there being a belief that buildings for general medical practice should be at ground floor level. There have been two storey centres since the earliest purpose built centres e.g. John Scott (1952), Jack Cohen (1956) and the house adaptions such as Greenhill/Bradway (1958), the first and temporary John Ryle centre (1952) and Haygarth, Harlow (1952). More recent centres on two floors include Witney (1966) with seven general practitioners, Holmfirth (1969) with 7 general practitioners, as well as large centres such as Mansfield (1968) with 13 doctors and the centres planned at Dover for 12 general practitioners, and at Worcester for 17 general practitioners.

Wherever possible, general practitioner consulting rooms have been kept on the ground floor, and frequently the dental unit - which usually has a separate waiting area - is on the upper floor.

As far as patients are concerned, general practitioner services on an upper floor are probably acceptable. When lifts are provided, patients rarely use them. Is this because those who need them the most tend to be the elderly, who may not feel able to cope with 'machinery', or is it because patients do not feel they need to use the lifts?

The effect of having two or more floors is probably most felt by staff, as it is liable to divide personnel in the centre, particularly if not all staff use any common room which is provided. With two floors, it is easy for staff to come and go from the building without ever seeing staff on another floor.

On the other hand, division of this kind can be put to good use. Patients waiting to see doctors do not necessarily mix well with mothers and babies going to infant welfare clinics. It is probably better if children going to visit a child guidance clinic are separated from other centre patients.

SERVICES PROVIDED BY HEALTH CENTRES

i. Executive Council Services

Nearly all statutory health centres provide general medical services. There are four exceptions, comprising a diagnostic centre, and three pre-1948 centres in London (Curwen and Brookes 1969).[19] The average number of doctors per centre is five to seven, and 4.4 per centre use their centre as a main surgery. Thus 77 per cent of general practitioners in centres are using the centre as a main surgery, but this proportion should increase if as is planned, 83 per cent of practitioners in centres being built, and 89 per cent of practitioners in centres approved, will use their centre as main surgery premises (figures taken from 1969 Annual Report of the Department of Health and Social Security). The Department discourages the use of centres as branch surgeries by general practitioners. Some of the large, early centres in particular were used in this way (e.g. Alderman Jack Cohen, Sunderland 1956, Peterlee 1960, William Budd 1952) and this did not help the effort to integrate staff and services.

Few centres provide general dental services. Curwen and Brookes (1969)[19] state that 11 centres, of which five were in operation in 1948, provide this service. Harlow, with its centres financed by the Nuffield Trust is a notable exception to this, as in these both general medical services and general dental services are provided. Apart from the conditions of salaried service for general medical dentists in centres, which applied until 1966, and which could have acted as a bar to dentists entering centres, accommodation for dentists will not necessarily be sanctioned. In one county visited, it was decided that there was an ample supply of dentists suitably housed and therefore their inclusion in a health centre would not be justified. The prohibition on private dental patients in health centres is also a deterring factor. Pharmacists are very rare in centres. The Alderman Jack Cohen centre (1956), Sunderland, is the only post 1948 centre known to the writer providing this service.

ii. Local Health Authority Services

Maternity, child welfare and immunisation and vaccination sessions are almost invariably provided in centres. Occasionally the ante natal sessions will be held in a nearby hospital instead as for instance at Holmfirth (1969), where they are held in the general practitioner hospital.

Whether or not attached, health visitors are usually given office space in centres, and often district nurses and midwives also. In any case the centre if not providing office space, is a base for community nursing staff.

The service provided by a well equipped and staffed treatment room is a feature of health centres, and perhaps one of the most important contributions a health centre can make to medical care. The smallest centres, housing two or three doctors, such as the E-type found in the West Riding of Yorkshire or the Devon centres, tend to be without this accommodation. A treatment room can become in effect a minor casualty department, enabling first consultation with a nurse but with a general practitioner usually on hand if necessary. Dixon (1969)[20] describing the work in the treatment room at St. George's Health Centre, Bristol (1964), states that 15 per cent of those treated came on their own initiative, without referral. At Witney (1966), a Nuffield Trust Centre in Oxfordshire, a survey lasting two months in 1968 and including a study of the nurse's work in the treatment room there, showed that 37 per cent of those attending came direct to the nurse. As well as providing a service for patients a treatment room is of course useful for doctors, in order to off load minor procedures.

Apart from these basic services, which are common to most centres, a wide variety of other services can be found in centres. Dental clinics and rooms for school medical clinics are fairly common. Information (published or gathered informally) from 49 centres shows that 73 per cent had a local authority dental suite. A child guidance clinic may be based in the centre and rooms given to social workers and mental welfare officers. Other sessions are held, commonly by visiting staff, not based in the centre, in particular chiropodists and speech therapists,ophthalmologists, and occasionally probation officers and child care officers.

Being purpose built, centres provide accommodation for various clinic sessions to be developed, such as 'minor ailment' clinics for children, B.C.G. innoculation sessions, geriatric preventive clinics, family planning (commonly held by the Family Planning Association in centres) and cervical cytology. In this way, centres can be fully exploited and utilized, with evening sessions, as well as the traditional afternoon maternity and child welfare clinics.

HEALTH CENTRE STAFFING AND THE CONCEPT OF THE COMMUNITY HEALTH TEAM

Any discussions of the staffing of health centres must involve some discussion of the concept of the community health team.

The idea of a team implies both that the members of it collaborate and cooperate with each other, and that they are concerned with the care of the same group of patients. Reasons generally given for having a team are :

1. The work for staff is more interesting and therefore creates more job satisfaction
2. Duplication of work can be avoided
3. The patient will not receive conflicting advice
4. More help can be given to the patient, as more than one type of worker can easily be called in
5. Delegation of work is possible. The doctor may delegate to the nurse or health visitor.

On the other hand there are arguments against having a team which may apply especially to larger teams :

1. The patient may have difficulty in dealing with larger numbers of people
2. Internal communications within the team may be difficult
3. Conflicts may arise within the team as to the best action to take, which are not easily resolved without a clear cut hierarchy
4. Confidentiality may be diluted, especially if the patient's case is discussed widely, or if his records are widely accessible.

Current opinion is increasingly growing in favour of at least a limited team in community health services, and for this discussion one is interested in how far building health centres affects the team. The main areas for debate, to be taken in turn are :

i. Types of personnel in the team - who is in it?
ii. Ratios of personnel in the team
iii. Leadership
iv. The geographical distribution of the members of the team - should all members work from the same premises?

i. Types of personnel in the team

When attachments are made of community nursing staff to general practitioners, this arrangement is usually referred to as one which forms a community health team, and the forming of attachments is encouraged by the Department of Health and Social Security. A team therefore can be said to consist of at least one doctor with community nursing staff attached, the precise numbers and types of nursing staff involved being variable.

Anderson et al (1970),[21] in a follow up study on attachment of community nurses to general practices, have found that the number of nurses working in these schemes has more than doubled in two years. It is estimated that 29 per cent of health visitors and 25 per cent of home nurses are now attached.

Such a team can be formed with or without health centre premises. In some areas, e.g. Yorkshire West Riding, Oxford and Hampshire attachments and health centre development have gone hand in hand - indeed the Medical Officer of Health of Hampshire will not build health centres unless doctors participate in attachment schemes (personal communication from P.L. Lloyd).* Obviously when early health centres were built there were no attachment schemes as schemes started in 1956 and did not increase steadily until 1960 onwards (Ambler 1968).[22] Attachment schemes can be developed successfully without health centres - for instance where good group practice premises exist. On the other hand, can health centres bring about integration of general practitioner and local authority work, without attachments? In Hampshire it would be said that integration without attachments was not feasible, whereas in other areas which are developing health centres, such as Birmingham, it would be claimed that integration and cooperation could come about without attachments.

Gibson (1970)[18] has suggested that community nursing staff should be attached to centres, rather than to particular general practitioners in a centre. This raises the whole question of the basis, in terms of patients, of the team. It has been accepted that, as staff are attached to the general practitioner, the doctor's list forms the basis of the team's work, rather than the geographical area. The general practitioner, retaining his position as a kind of 'entrepreneur', is exceptional, among community health workers, in not being based upon a district. Problems can arise when the attached staff have to cross the administrative boundaries of the local authority. McGregor (1969)[23] has described a

---

* Chief Administrative Officer, Health Department

total attachment scheme in Southampton which has this difficulty.

Several writers take the membership of the team further, to include some kind of social worker. Experiments have been made in attaching medical social workers, described by Forman(1968)[24] and recently by Evans (1969).[25] One practice at Andover holds case conferences which include either a 'psycho-social' worker or a health visitor with further training, as happens at Darbishire House and Hulme House (1962) (a group practice centre). Including social workers in the team, however, if this is considered desirable, may be made impossible by the reorganising of local authority social and welfare workers into teams in Social Service Departments. Moreover general practitioners may not be in favour of these arrangements. In a recent interview survey of general practitioners in a London Borough, described by Harwin et al (1970) it was shown that few doctors either have regular contact with social workers, or wish to have such contact. Any contacts were usually initiated by the social workers, and less than half of the doctors interviewed were favourably inclined to the idea of teamwork with social workers.

Section 21 of the 1946 National Health Service Act enabled a wide range of personnel to be employed in health centres, such as pharmacists, opticians and general medical dentists, although under conditions i.e. salaried service to the Executive Council which were not conductive to entering, until the Act of 1968 allowed payment by item of service.

Incidence of pharmacists in centres is rare (Curwen and Brookes 1969)[19] and similarly for general medical dentists, yet there is a case, on medical grounds, for these personnel to be included.

Howells (1970)[26] see some disadvantages in pharmacists being in health centres, in that patients might be disinclined to see the pharmacist for advice, and would have to travel to the centre for prescriptions made out at home, but it would mean that the general practitioner could discuss drugs, their dosage and availability and in general it would be easy for the patient to obtain his prescription.

Do we want these types of personnel to be in the team? Or if not do we want them to associate more closely with the basic 'community health team'? (i.e. general practitioner and community nursing staff).

So far only health centres have provided premises and welfare on any scale from which a wide variety of health personnel can work, and it is

because of this that the concept of the team is particularly relevant when discussing health centres. Centres are expensive, and usually permanent buildings - who works in them determines size of building and types and numbers of rooms - so decisions on type of staff liable to work in the centre are particularly important.

ii. Ratios of workers in the team

Available staff determine ratios as much as any other factor and this varies according to district. Laurie (1969)[27] has outlined ratios of staff for centres serving populations of 10,000, 20,000 and 30,000, all on the basis of doctors being grouped in fives (enabling some specialisation by them), with increasingly more supporting services as the size increases. Each group of five doctors would have five nurses and a social worker. Impressions from talking to general practitioners are that they feel that up to five general practitioners is the number which can successfully work as a group. The Todd report[7], citing 12 general practitioners as a group size reflects a trend in the literature to proposing increasingly larger group sizes as desirable, but presumably such groups would have to be divided in order to function well. As, during the years since the National Health Service was formed, single handed practitioners have declined in number, so partnerships and larger groups have increased, but there are still few of the sizes envisaged by the Todd Report.[7]

On the other hand, as certain personnel, such as social workers, are so few relatively in number, if one is to be a member of the team, the number of general practitioners and nurses in that team will be proportionately larger. Alternatively, a social worker could be associated with a number of smaller teams, each comprising say four general practitioners, two health visitors, two district nurses and two midwives. Similar patterns could apply to such people as pharmacists, dentists and ophthalmic opticians.

iii. Leadership

Writers on the subject of the community health team, and attachment schemes, generally refer to the general practitioner as 'team leader'. The general practitioner is the most highly trained of the medical staff in the community, and traditionally has had a directing role. Some challenge to this role comes from health visitors, whose role is not purely medical but social as well, and more opposition is likely if social workers work in the team as well. As Anderson (1969)[28] recognises, this problem arises when

the 'team' grows larger than just the general practitioner, the employed or attached nurse and the secretary.

Related to this is the problem of first contact for the patient. Traditionally the patient has come first to the general practitioner for help on matters both medical and often social, and has when necessary been referred to other personnel. In some practices however practice nurses may be the patients first contact, (see for example Weston Smith and O'Donovan 1970)[47] although the option of seeing the general practitioner first is still available. Where the general practitioner has an appointment system, the patient may be also in a sense 'filtered' by the receptionist, who decides on the basis of the patient's description of his condition, how soon he may see his doctor. The system of contact is therefore already becoming more complex for the patient.

If social workers are to be included in the team, the doctor as sole or main agent of first contact would be unacceptable. Instead cross-referrals and case conferences would be necessary, the patient choosing whom he first wished to see. This would therefore involve 'multiple access' for the patient, for which guidance would be needed. Health centres provide a physical basis for multiple access, as the patient need only go to one place, and can be conveniently referred to other personnel in the same building. As one health centre administrator said, a patient coming to the centre could feel that someone there would help them, even if not the first person they came to. At the same time it must not be forgotten that all this may be confusing for the patient, especially the elderly, as it means dealing with a larger number of personnel.

iv. Geographical distribution of members of the team

Health centres can provide common premises for doctors and nursing staff, as also of course do purpose-built group practice premises, but the latter cannot so easily cater for a wider range of staff. In a recent survey Law (1970)[29] found that "premises were generally too small" among the practices with attached staff, for the services now provided. Of course once the potential inadequacy of purpose built group practice premises is realised, plans in future can be made with this in mind.

The basic team, of doctor and community health staff, can then be accommodated in health centres or other purpose built premises, and current opinion sees common premises as essential, for the basic team. What might be called the 'extended' team, including at least a social worker, cannot

usually be accommodated in group practice premises. Two questions arise from this, firstly, do we want the team to be extended, (larger teams may not function so effectively), and if we do, is it necessary that all members should be based at the same premises? Decisions on these questions are needed, before a large building programme is embarked upon. If the idea of 'itinerant' workers is accepted,that is, workers not based at one centre, but travelling to a number of centres to hold sessions which is what frequently occurs now for instance with chiropodists and speech therapists, provision must be made for them in the building.

The Draft Design Guide (1968)[17] states that a health centre "should be primarily associated in the public mind with family doctoring and preventive services. The tendency to extend the concept of the health centre so that it becomes an all embracing point of reference for a whole variety of very loosely connected services in an area should be avoided". Obviously the line has to be drawn somewhere, the problem is precisely where - if the above statement is taken as definitive, it would seem to exclude workers at present in local authority welfare departments.

DIAGNOSTIC FACILITIES IN CENTRES

i. X-ray Units

It has not been a policy in England to equip health centres with x-ray units. Hythe Health Centre in Hampshire (1965),is the only example of a section 21 health centre with this equipment known to the writer - it is situated in the adjacent general practitioner hospital, with which it is connected by a passage way. Non section 21 health centres having x-ray units are the Nuffield Health Centre in Witney (1966), which provides a full range of outpatient sessions for the Oxford Regional Hospital Board, and Darbishire House (1954), the general practice teaching unit for the University of Manchester has non contrast x-ray facilities. Apart from these the diagnostic centre at Peckham (1961) also has an x-ray unit. It could also be argued, that where a centre is adjacent to, or near to a general practitioner hospital with an x-ray unit, as for instance occurs at Ilkley (1968) and Holmfirth, West Riding (1969) and Tamworth (1968) Staffs, then the centre virtually has an x-ray unit, since the general practitioners have complete access and control, and the patients are on familiar ground. The Dawson Report (1920)[8] envisaged x-ray units being housed in centres, and where general practitioners have had this service as for instance at Darbishire House (described by Ashworth 1955,[30] 1963,[31] 1966[32]) they consider it important and justified. The high cost of buying and renewing the necessary equipment, and the shortage of radiographers at present mean that direct access to x-ray units in hospitals will be the solution for most general practitioners. Direct access is officially encouraged but not compulsory, and degree of access can vary between hospitals, and within a hospital can vary in type of investigation made available. Lennon (1969),[33] reviewing papers about the use general practitioners make of x-ray departments, concludes that "The weight of published evidence indicates that patients referred by general practitioners have a higher abnormality rate than those referred by outpatient consultants."

ii. Pathology and other diagnostic facilities

Pathology services in centres are limited. In some centres (e.g. John Scott (1952), Nechell's Green (1960) and Witney (1966) small laboratories were incorporated, but in the first two of these, the laboratories are not normally used as such. Apart from having haemoglobinometers, E.C.G. machines, and occasionally a centrifuge and microscope, centres are not equipped for any elaborate procedures.

Equipment already in centres is not always fully utilised, for instance at Hythe (1965) and Mansfield (1968) doctors have said that the haemoglobinometers were not much used. This situation is partly a result of shortages of staff, as technicians are difficult to find (at John Scott (1952) a technician can no longer be found to man the laboratory) and partly a result of techniques in processing, which require large batches of material for analysis automatically. Signy (1967)[34] has discussed the increasing need to centralise pathology services making provision for any elaborate techniques in centres unlikely, as this would be costly and an inefficient use of manpower and equipment. Instead emphasis needs to be laid upon giving direct access to pathology tests, and to making collection of specimens efficient. Collection involves two stages, obtaining the specimen from the patient, and transporting specimens to the hospital laboratory. Collection from the patient can be done in health centres at regular sessions, specimens being taken either by health centre staff or possibly by visiting technicians. At Hythe (1965) a pathologist makes a weekly visit to collect specimens from patients, and similarly at Tamworth (1968) a hospital nurse visits three times a week to collect blood specimens from patients. Collection of specimens and their transport to the hospital can be organised on a regular basis from centres. Frequently informal arrangements exist for this, a hospital or local authority van making a call at a regular time. Centres, because they tend to bring a larger number of doctors together, as well as the local health authority clinic attenders, make collection organisation more practicable.

OUTPATIENT SESSIONS IN HEALTH CENTRES

Outpatient sessions in health centres in England are rare. Witney (1966), a Nuffield financed centre, and Hythe (1965) hold a full range of sessions. A few centres hold one or two sessions, for instance William Budd (1952) (ante natal), Mansfield (1968) and Arnold(ophthalmology), Faringdon (1948)(ante natal and gynaecology), Tamworth (1968) and St. Heliers Road, Birmingham (1967)* (both holding psychiatric sessions - the last is a section 22 clinic functioning like a health centre). Where the centre is near to a general practitioner hospital, outpatient sessions may be held in that hospital, for instance at Holmfirth (1969) (geriatrics and gynaecology), but otherwise this service has not been developed, and has not been a part of health centre policy in England as it has in Scotland.

The provision of outpatient sessions has been advocated by Draper (1967)[35] in community care units catering for populations of 50,000 and similarly by Mackenzie (1967).[36] Carstairs and Skrimshire (1968)[37] find that data available for planning what outpatient sessions could be held in centres, is unreliable, and conclude that only by studying a system of outpatient services in action at a centre can reliable data be obtained. Changes may occur in the use of outpatient services when they are held in centres, which cannot be foreseen. For instance, if sessions held in centres have the effect of 'educating' the general practitioner (as well as the consultant) referrals may decrease. Wade and Elmes (1969)[38] doing a two month survey of all outpatients referred to them at the hospital concluded that 85 per cent of the patients could have been dealt with in a health centre. (The authors themselves see patients in the Finaghy (1965) health centre in Northern Ireland, as well as at the hospital.) The effects therefore of introducing a full range of outpatient sessions to health centres on a widespread scale, which has not been done so far, cannot be known.

Arguments for having such sessions in centres may be summed up as follows :

a. The general practitioner would be 'educated'; apart from this presumably being a desirable aim in itself, together with the closer liaison and easier communication with consultant staff which could also result, it is arguable also that workload would decrease. This might come about if the general practitioner was able to diagnose and treat more cases by himself, and if he was able to refer more accurately to the relevant consultant. On the other hand of course, with increased availability of

---

* Opened as clinic 1931 - family doctors entered 1967

consultant services, demand might well increase.

b. The patient would see the consultant in a familiar and therefore more reassuring atmosphere.

c. The patient would have less distance to travel. Health service plant has tended increasingly to centralise, but at least visits to outpatient sessions held in a centre would mean less distance for the patient, than visits to sessions based on district general hospitals, given that the former would serve populations of up to 50,000 and the latter at least 100,000, if not up to 300,000 if the recommendations of the Central Health Services Committee report on district hospitals is accepted (1969).[39]

Certain problems could arise if outpatient sessions were held in centres.

a. The diagnostic equipment of the centre would not be adequate for the consultants needs in investigating the patient. This would clearly apply if as seems most likely centres in general will not have x-ray or elaborate pathological services. However, Forsyth and Logan (1968)[3] in their survey of outpatient departments state that a large number of patients did not in fact have x-ray or pathological investigations. This was particularly marked in certain specialities, where the proportion of once only attenders not having these kinds of investigations was high, such as psychiatry (98 per cent), dermatology (90 per cent) and E.N.T. (see Table 3). It would seem to be more feasible to hold sessions in these specialities at health centres.

b. One outpatient session per week requires a population, depending on speciality, of at least 17,000. Mackenzie (1967)[36] gives figures required to hold one session per week in various specialities (see Table 4). Which specialities are held, or how regularly, will relate to the population otherwise served by the centre. It might not seem worthwhile holding sessions at a small centre at long intervals. Many centres, by this definition, would not be eligible for sessions, but the central large centres being built and planned at the moment would seem to be suitable..

THE RELATIONSHIP BETWEEN HEALTH CENTRES AND HOSPITALS

The roles of the modern hospital have been summarised in 'Present State and Future Needs of General Practice' (2nd edition 1970)[40] as the provision of the following :

a. Diagnostic Centres - for local general practitioners, providing easy, free and direct access to the laboratories and radiological departments.

b. Outpatient Departments - where specialist advice and care is given to ambulatory patients who are seen by appointment - following referral from general practitioners.

c. Inpatient Departments - where patients are admitted for diagnostic and therapeutic care.

d. Domiciliary Consultations - by specialists, intended to provide not only specialist advice to patients confined to their homes but also planned to encourage meetings between specialists and general practitioners for educational purposes.

e. Local Medical Centres - for post-graduate and specialist training.

It has been, for some time, generally accepted that hospitals should be the only institutions providing inpatient care. (Dawson(1970)[8] had originally envisaged that health centres could provide this type of care). Thus hospitals provide specialised treatment for non ambulatory patients, supporting diagnostic facilities, radiology and pathology, servicing the hospital itself, and the physical base for specialised medical staff.

Community health service plant (health centres etc), for ambulatory patients, or those who can be nursed at home, are normally staffed, and built separately from hospitals although generally depend for radiology, pathology and cardiology etc upon the relevant hospital department.

Possible relationships between hospital and community health service staff and plant are :

i. All medical care, staff and plant, being incorporated into the hospital service. This idea is probably unacceptable, for reasons of travel for the patient alone, apart from the problem of whom the patient would first contact in such an arrangement. The British Medical Association Planning Unit Report No. 4 on Primary Medical Care suggests (1970)[41] that

experiments could be made in this method, although it is a break with traditional practice, and may not be desirable. "Personal doctoring and continuity of care are likely to be jeopardised".

ii. All health services, both personnel and plant, being based upon the site of the district general hospital. By this is meant that all primary care would be provided in buildings on the hospital site, including the first consultation by the patient with the doctor or other medical worker. The difficulties of transport for patients,although this arrangement would be feasible in dense urban areas, mean that this system could not adopted extensively.

A number of health centres have been built adjacent to general practitioner hospitals e.g. Ilkley (1968), Hythe (1968) and Tamworth (1968). Such an arrangement normally means that the doctors in the centre not only are involved in care of inpatients but have access to x-ray and pathology, and other services such as physiotherapy.

However, general practitioner hospitals are declining rather than increasing in number, and although this arrangement seems highly satisfactory for the general practitioners in these centres near hospitals, such centres, if present policy over closing general practitioner hospitals continues, will remain in the minority. One county authority visited had deliberately sited its health centres next to such hospitals, so that the latter could not easily be closed down. General practitioner hospitals provide considerable stimulus and scope for the general practitioner, and are probably pleasanter (because nearer to home, and less overwhelming) for the patient, but problems of the adequacy of diagnostic and other equipment, and standards of treatment, do arise.

iii. Limited duplication in all health centres, of services traditionally provided at hospitals.

Such services could be :

a. Diagnostic e.g. x-ray equipment
b. Outpatient sessions (see also page 21) - outpatient sessions might involve providing special diagnostic equipment as well, otherwise the 'duplication' is of personnel only, i.e. the hospital specialist.
c. Beds for day surgery - such provision is planned at Runcorn, and has been advocated by Draper and Israel (1968).[42] This

could involve duplication of both equipment and personnel if, for instance, specialists attended, supervised or undertook such procedures.

iv. Some health centres duplicating certain hospital services, as in (iii) above, and others not - a satellite system in other words.

This would, in a sense, create three tiers in the medical care system, and there are indications that this kind of system is evolving. Thamesmead central health centre may have x-ray facilities (Smith 1966)[13] and Witney (1966) providing x-rays and a full range of outpatients sessions could be said to fall into this system. Some future plans for new towns indicate this. Sichel (1970)[43] writes that, for instance, at Washington, County Durham a health centre in the town centre is planned to provide outpatient sessions, radiology and a physiotherapy unit.

v. Overlap of personnel, although not of services, between health centres and hospitals. In the current situation, hospitals and community health services are staffed by different personnel. The causes of this are partly administrative (the tripartite system involves different employing bodies) and partly a result of specialisation. If the former barrier were removed (cf The Green Papers 1968,[44] 1970[12]) the latter would still remain.

Specialisation, and separation of, personnel, can be argued for in several ways. Apart from being administratively convenient and forming the basis of a career structure (e.g. staff nurse to ward sister, registrar to consultant) it can be argued that specialisation maintains quality of care, since a specialist in a subject e.g. obstetrics will be better than someone only partly working in that field. On the other hand, specialisation may hinder the individual from understanding problems in other areas, and one effect in partciular - that of excluding the general practitioner from work in hospitals - has often been criticised.

Conversely, hospital staff do not normally work in community health, the exception perhaps being the hospital specialist in child guidance clinics. Specialists holding outpatient sessions in centres, where this occurs, are still providing a'hospital service'. It has been suggested that physiotherapists, occupational therapists and medical social workers, traditionally based in hospitals, should be seconded as part of the community health team (Macdougall 1970)[45] and in a recent experiment (Hockey and Buttimore 1970)[46] a district nurse was attached to a district hospital to provide aftercare for patients discharged early. Such arrangements mean

that staff could work in both hospital and community health spheres.

Where general practitioners have hospital beds, another kind of 'overlap' of personnel exists, but this is not dependent on having health centres.

Provision of physiotherapy is feasible in some centres particularly in the central larger ones. A large room, if used also for relaxation classes and health education, can be justified for physiotherapy. Health centres with this service include John Scott (1952) and Witney (1966).

vi. Health centres as general practice teaching units. Where such units exist (Darbishire House, Manchester 1954 and Edinburgh 1959) they are linked to medical schools. Section 21 health centres (which the above two are not) could, however, offer facilities for teaching both in general practice and in other medical and social fields. Health centres have the advantage for this purpose, of providing more room than most general practice premises and of giving the opportunity of meeting a wider variety of professional staff.

ACHIEVEMENTS OF HEALTH CENTRES

As described earlier there have been several aims in building health centres - here one must consider how far these aims have been fulfilled.

i. Provision of purpose built premises for community health services

It is probably generally agreed that centres provide good premises for community health services, particularly when taking into account the scale of building which is possible, and the fact that building will be modern. Group practices can of course house themselves equally in modern buildings, or modernise older buildings, but not normally on a scale which allows other community health services to be provided for.

ii. Professional contact, and less isolation for the general practitioner

With the growth of partnerships and the decline in single handed practice, the problem of isolation of general practitioners is declining anyway, irrespective of health centre development, especially as grouping has been encouraged financially. Health centres do provide premises for single handed doctors as well as those in groups, and in this sense can contribute to reducing professional isolation in a way not otherwise available.

iii. Better organisation

Emphasis has increasingly been placed on the importance of organisation of general practice, appointment systems, ancillary help, and record keeping. To some extent, the increase in group practice itself is bound to bring about the need for better organisation, and just as group practice has been encouraged financially, so has the acquisition of ancillary staff through direct reimbursement. Health centres probably do not make much difference either way to the quality of organisation of general practice itself, but, particularly in the case of large centres, more elaborate telephone and secretarial equipment can be efficiently used and financed.

iv. Integration of curative and preventive services

Integration of work, and cooperation of staff in the various aspects of community health services, has been long put forward as the chief aim of building health centres. There are three general ways in which this integration could be measured :

a. Extent of administrative integration
b. Extent of work load being undertaken jointly rather than separately
c. Extent of informal relationships.

a. Extent of administrative integration

In the strictest sense this form of integration would imply one authority administering community health services, and no such situation at present exists, although it would come about to some extent if the proposals for area health authorities, outlined in the Green Paper on 'The Future Structure of the National Health Service',[12] were to be implemented.

Two features of the proposals in this Green Paper modify complete integration. In the first place, the local authority, as opposed to the area health authority, "will be responsible for services where the primary skill is social care or support". Thus social workers, child care officers etc will be employed by a separate body from those employed by the area health authority, making any integration of organisations between the two kinds of personnel (with social or medical skills) more difficult.

Secondly, it is proposed that, in order to retain "the present status of family practitioners as independent contractors", doctors, dentists, etc will enter into contract with a statutory committee to be established by each area health authority. Thus intentionally "the family practitioners .... will not be under the direct control of the area health authority. But there will in practice be substantial integration in the organisation and planning of the services". While provision is made for a special type of contract between doctors, dentists, etc, and whatever type of health authority is established, it is hard to see how integration can be implemented.

b. Extent of workload being undertaken jointly rather than separately

There are at least two possible measures of integration in work load, the extent of attachment schemes, and the extent to which general practitioners undertake work more commonly done by local authority doctors.

The most recent survey on the progress of attachment schemes by Anderson et al[21] shows that attachments of health visitors have risen to 29 per cent and of home nurses to 25 per cent. However, as pointed out elsewhere, these schemes can operate successfully independently of health centres.

On the other hand, health centres can facilitate general practitioners undertaking the work of local authority doctors by holding school medical and similar clinics, notably as done at Hythe Health Centre (1965) in Hampshire and at Harlow (1950s) where the general practitioners carry out school medical, as well as ante natal and immunisation clinics. However, this is exceptional at the moment.

c. Extent of informal relationships

Informal relationships are not easily measured as any assessment is subjective, relying on the individual giving his opinion. Articles describing particular centres in operation tend to paint a glowing picture of relationships between doctors and local authority staff, but the impression given in these writings is often not borne out by visits to centres.

One measure of informal relationships is found in the use of the staff common room. In most centres visited only the local authority staff tended to use the common room, and not the doctors, who instead take coffee or tea elsewhere, in the office of their secretary, or in their consulting rooms. It is not that staff are on bad terms, but they tend to remain apart - in general it seems to be doctors who separate themselves from the rest.

On this basis, it would seem that centres have not fulfilled all their expectations, in particular where 'integration' is concerned, of local curative and preventive services. As far as integration with the hospital service goes, it is very limited. Being in a health centre is not likely to make any difference to relations with hospitals as compared to working in more traditional arrangements, since as has been shown, so few centres in England hold outpatient sessions or are otherwise linked with hospitals.

Centres are however becoming increasingly acceptable to general practitioners, and the interest shown by local authorities, encouraged by the Department of Health and Social Security (stated in Circular 7/67) in building centres, is in itself a measure of success. Centres can give a physical base for experiment and change of patterns in community health service arrangements.

THE FUTURE OF HEALTH CENTRES

At present the rate of health centre building is increasing but the situation is not static and several factors could substantially affect the amount and type of health centre provision.

The legal framework has had in the past considerable effect upon health centres, in particular those built under Section 21 of the 1946 National Health Service Act. Under this section, the local authorities were enabled to build health centres, and local authorites have therefore in general been the owners of centres letting out accommodation in centres to non local authority staff. This situation has been at times a cause of considerable friction, and has accounted for much of the reluctance of many general practitioners to enter health centres. Also as centres are built by local authorities, this has a considerable effect on their distribution geographically. Some local authorities have been more ready, or more able financially, than others to support health centre building, and this has resulted in an uneven distribution. The attitudes of general practitioners and their relations with local health authorities have, of course, also been a factor, but if general practitioners have wanted to practise in centres, and the local health authority was unwilling to provide them, as for some time happened for instance in Kent, centre building will be delayed.

Staffing of centres has been affected by the legal framework. Until 1966, general medical dentists could only enter centres under salaried service, in the Executive Council. Since then they have been able to opt for payment by item of service. Pharmacists could only enter centres if employed by the local authority, until the 1968 Health Service and Public Health Act prohibited this and allowed pharmacists to enter as contractors, permitting also some private practice. Until reimbursement for rent, rates, services and ancillary staff for health centre doctors was introduced (as laid down in circular E.C.L. 30/67), general practitioners could be considerably financially burdened if they entered centres.

This brings into discussion a more recent development, namely the Social Service Act 1970, which has implications for the whole question of staffing and the role of health centres. Hitherto centres have been one of the rare places where social work staff could be enabled to work in the same building, although not necessarily alongside the medical staff. The establishing of Social Service Departments, which will absorb some services already provided by the local health authorities is intended to integrate

personal social services, but at the same time hardens the administrative barrier between social and medical services provided by local authorities. Whereas on the one hand interest is increasing in involvement of social workers in general medical practice, with the recognition of the role of social factors in medical care, on the other hand such involvement is being made more difficult as presumably attachments of social workers and their inclusion in some kind of 'community health team' would be hindered.

Further changes are likely to be made to the whole structure of the National Health Service. Reorganisation is under debate, and it is not clear what form the new structure might take, but it can be fairly safely assumed that any such change can have considerable effect on health centre provision, and distribution. The Green Paper published in 1968 'The administrative structure of medical and related services in England and Wales'[44] proposed that there should be set up "a new area authority for health service". Such an authority would be responsible for a wide range of services at present divided administratively between Regional Hospital Boards, 'teaching hospitals', the local health authority and the Executive Councils, and the aim of this new administrative framework would be to improve coordination, planning, and the balance between hospital and community care.

Health centres would be the responsibility of the new area authority (paragraphs 25 and 27) and the first Green Paper[44] specifically envisages that a Child Health Service could be provided by doctors working in centres, as recommended by the Sheldon Committee on Child Welfare Centres in 1967.

In the second Green Paper, 'The future structure of the National Health Service', (1970)[12] the emphasis is again on bringing together the 'out of hospital' services, both in health centres and group practices, alongside which social service units might be sited.

If health centres became the responsibility of area health boards, and were therefore not under local authority management, provision of centres could be considerably affected. Geographically the distribution of centres could change, and the attitudes of doctors who at present do not wish to be in local authority premises, might alter. At the same time the community nursing staff would be under the same authority as the general practitioners, and conflicting loyalties could be removed, with the emphasis being made instead upon teamwork and cooperation. The effect of reorganisation in the community health services is probably as much an effect upon attitudes as upon administration.

Health centres may also be affected by changes in policy, which could take place equally within the existing health services structure or without it. As centres are at present provided by local authorities, any reform of local authority boundaries could also change geographical distribution.

Increasing centralisation of certain resources on grounds of efficiency and high standards has been a feature of policy in the National Health Service. This is marked in the hospital sector, where in England there is now a policy of closing down cottage hospitals, reducing the numbers of casualty/accident centres, increasing the size of population for district general hospitals, making hospital services therefore more distant for more people. Incorporated within the hospitals are diagnostic facilities, and the expense of equipment, and the shortage of staff to man it, has combined to justify centralising these facilities too.

In 'Building for health' OHE (1970)[2] it is argued that instead of steadily increasing the "concentration of physical capital expenditure on hospital building" (in effect district hospital building) more should be invested in community based services. This proposed change of the balance of investment would involve providing "adequate facilities at an intermediate level, as represented by the health centre or similar unit". Any increased expenditure on community health facilities, and corresponding decrease of expenditure on the hospital sector, would be justified economically by the work which could then be kept from the hospitals and undertaken in the community, apart from being probably more convenient and pleasanter for patients. Thus it is argued that outpatient sessions could be held in centres, minor operations could be done in health centres provided general practitioners improve their organisation of work and have adequate help, and more patients discharged earlier from hospitals if domiciliary care was improved.

The 'community care units' suggested by Draper and Israel (1968)[35] are one alternative to the present balance between resources in the hospital and community health sectors. The kind of unit proposed is not unlike that put forward by Dawson [8] fifty years ago for 'primary health centres' which as well as providing child welfare and similar services, would have radiography and laboratory facilities, and inpatients. 'Community care units', it is proposed, would serve a population of 25,000-50,000 with 10-12 general practitioners in small teams. Radiological facilities would be available, and outpatient sessions held in the unit, where day surgery

could also be undertaken. The adoption of any such system would amount to a reversal of current policy. Most centres at present built or planned not only cater for smaller populations but do not have the facilities needed. As discussed earlier, the general opinion is that x-ray and pathology services need to be centralised for efficiency, resources being scarce. What is not known is the pay off which could result from reversing the policy of centralising these services. Moreover a development in the techniques of radiography and pathology, could enable these facilities to be much more widely distributed.

Health centres have developed in an ad hoc manner. There is still no generally applied policy on staffing or distribution of centres and the administrative framework of the National Health Service is itself under debate. Until it is clear in what way the National Health Service will develop, and what policies will be adopted in the whole sphere of health services it is difficult to see in what way centres will evolve. Centres are still in an experimental stage, and until more is known about the effects of having various kinds of centres, with one or two or many doctors, with limited or extensive facilities, linked closely with hospitals or not, general policies cannot be made on centre development.

REFERENCES

1 Ryan, M. (1968) Health Centre Policy in England and Wales. British Journal of Sociology, 19, 34-46.

2 O.H.E. (1970) Building for Health. London : Office of Health Economics.

3 Forsyth, G. and Logan, R.F.L. (1968) Gateway or dividing line. London : Oxford University Press for Nuffield Provincial Hospitals Trust.

4 Wofinden, R.C. (1967) Health centres and the general medical practitioner. British Medical Journal, 2, 565-567.

5 Lees, W. and Carr, T.E.A. (1960) Survey of Health Centres and Group Practices. Ministry of Health, London.

6 British Medical Association (1942) Medical Planning Commission : Draft Interim Report. British Medical Journal, 1, supplement, 743-753.

7 G.B. Royal Commission on Medical Education (1968) Report. (Todd Report) London : H.M.S.O., Cmnd. 3569.

8 G.B. Ministry of Health. Consultative Council on Medical and Allied Services (1920) Interim Report on the Future Provision of Medical and Allied Services. (Dawson Report) London : H.M.S.O. Cmd. 693.

9 Taylor, S. (1952) Haygarth House, Harlow : building a health centre. Lancet, 1, 253-257.

10 Taylor, S. (1954) Good General Practice. London : Oxford University Press for Nuffield Provincial Hospitals Trust.

11 Ministry of Health Circular 7/67, 21st April 1967. Health Centres

12 G.B. Department of Health and Social Security (1970) The Future Structure of the National Health Service. London : H.M.S.O.

13 Smith, R., Curwen, M.P., Chamberlain, J. and Butterfield, W.J.H. (1966) The Woolwich and Erith Project : Planning a Community Health Service, Lancet, 1, 650-654.

14 Moss, R. (1966) Design of health centres. Medical World Newsletter, 1, No.21, 10-12.

15 Ottewill, D. (1966) Environmental studies in local authority health and welfare centres research project : preliminary studies. The Author.

16 Elliott, R.W. and Douglas, W.M. (1965) Development of a health centre and afterthoughts. Medical Officer, 113, 73-79.

17 Draft Health Centre Design Guide (1968). Ministry of Health.

18 Gibson, R. (1970) Organisation and management of health centres. British Medical Journal, 2, 353-356.

19 Curwen, M. and Brookes, B. (1969) Health Centres : facts and figures. Lancet, 2, 945-948.

20 Dixon, P.N. (1969) Work of a nurse in a health centre treatment room. British Medical Journal, 4, 292-294.

21 Anderson, J.A.D., Draper, P.A., Kincaid, I.T. and Ambler, M.C. (1970) Attachment of community nurses to general practices - a follow-up study. British Medical Journal, 4, 103-105.

22 Ambler, M., Anderson, J.A.D., Black, M., Draper, P., Lewis, J., Moss, W. and Murrell, T.G.C. (1968) The attachment of local health authority staff to general practices : a study in three county boroughs with special reference to health visiting. Medical Officer, 119, 295-299.

23 McGregor, A. (1969) Total attachment of community nurses to general practice. British Medical Journal, 3, 291-293.

24 Forman, J.A.S. and Fairbarn, E.M. (1968) Social Casework in General Practice. London : Oxford University Press for Nuffield Provincial Hospitals Trust.

25 Evans, J.W., Lovel, T.W.I. and Eaton, K.K. (1969) Social workers and general practice. British Medical Journal, 1, 44-46.

26 Howells, A. (1970) Pharmacy inside and outside health centres. Royal Society of Health Journal, 90, 14-15, 42.

27 Laurie, A. (1969) Health Centre Development. Health Bulletin, 27, 46-51.

28 Anderson, J.A.D. (1969) The health team in the community. Lancet, 2, 679-681.

29 Law, R. (1970) Communication and co-operation within the primary health team. Journal of the Royal College of General Practitioners, 20, 6-12.

30 Ashworth, H.W., Davie, H.M., Goldie, H. and Lenten, J. (1955) Darbishire House Health Centre : The First Year's Work. Medical World, 83, 226-234.

31 Ashworth, H.W., Davie, H.M., Goldie, H. Lenten, J. and Gunn, A.D.G. (1963) Darbishire House Health Centre, Medical World, 99, 466-475.

32 Ashworth, H.W., Davie, H.M., Goldie, H. and Lenten, J. (1966) Trends in the Pattern of General Practice. Medical World, 104, No.9, 4-19.

33 Lennon, E.A. (1969) How general practitioners use x-ray departments. Health Trends, 1, 17-18.

34 Signy, A.G. (1967) Pathology and the G.P. Medical World, 105, No.5, 7,8,11-13.

35 Draper, P. (1967) Community care units and inpatient units as alternatives to the district general hospital. Lancet, 2, 1406-1409.

36 Mackenzie, A.S. (1967) The economics of staffing health centres. Medical World, 105, No.4, 25,27-31.

37 Carstairs, V. and Skrimshire, A. (1968) The provision of outpatient care at health centres : a review of data available for planning. Health Bulletin, 26, 12-22.

38 Wade, O.L. and Elmes, P.C. (1969) An analysis of outpatient referrals. Update, 1, 721-724.

39 G.B. Central Health Services Council (1969)The Functions of the District General Hospital (Bonham-Carter Report). London : H.M.S.O.

40 Present state and future needs of general practice : reports from general practice. College of General Practitioners, 1970.

41 British Medical Association (1970) Planning Unit Report No. 4 - Primary Medical Care. London : British Medical Association.

42 Draper, P. and Israel, S. (1968) Community care units : staffing and economic aspects. Journal of the Royal College of Physicians of London, 2, 251-257.

43 Sichel, G.R.M. (1970) Planning of Health Services in New Towns, Part III. Some schemes described. Health Trends, 2, 31-33.

44 G.B. Ministry of Health - Green Paper (1968) National Health Service : The Administrative Structure of the Medical and Related Services in England and Wales. London : H.M.S.O.

45 Macdougall, I.A. (1970) Some views on developing the community health team. Health Trends, 2, 70-71.

46 Buttimore, A. and Hockey, C. (1970) Cooperation in Patient Care. London : Queen's Institute of District Nursing.

47 Weston Smith, J. and O'Donovan, J.B. (1970) British Medical Journal, 4, 673-677.

48 G.B. Central Health Services Council, Standing Medical Advisory Committee (1967) Child Welfare Centres : a report of a sub-committee. (Sheldon Report) London : H.M.S.O.

TABLE 1

Percentage of total of practitioners providing general medical services

Analysis by size of partnerships for selected years

Size of partnerships	1952	1960	1969
Single handed principals	43.4	29.7	21.7
Partnerships of 2 doctors	33.3	34.8	25.6
Partnerships of 3 doctors	15.0	20.7	26.1
Partnerships of 4 doctors	5.6	9.4	15.3
Partnerships of 5 doctors	1.8	3.2	6.7
Partnerships of 6 or more	0.9	2.2	4.6
All principals*	100 (17,204)	100 (19,833)	100 (20,133)

Source : Annual Reports of the Department of Health and Social Security

*The figure in brackets is the total number of principals on which percentages in the corresponding row are based.

TABLE 2

Preference for size of partnership of first and final year medical students who propose to opt for general practice (1966)

Type of partnership	First year students		Final year students	
	No.	%	No.	%
Single handed	30	8	12	3
Small partnership	268	70	173	41
Large group or health centre	84	21	236	56
All types	421	100	382	100

Source : G.B. Royal Commission on Medical Education (1968) (Todd Report)[7]

TABLE 3

Outpatients without investigations by number of consultations and specialty (excluding later admissions as inpatients) (percentage)

Specialty	Number of consultations	Nil radiological	Nil pathological	Neither X-ray nor pathology
Psychiatry	1	99	98	98
	2	96	98	94
	3+	92	90	87
Ophthalmology	1	98	98	96
	2	98	98	97
	3+	91	91	87
Dermatology	1	98	92	90
	2	96	86	84
	3+	99	79	77
E.N.T.	1	90	97	88
	2	76	93	72
	3+	65	88	58
General surgery	1	87	91	83
	2	52	73	43
	3+	50	62	39
Gynaecology	1	97	70	69
	2	91	49	46
	3+	90	53	46
Orthopaedics	1	56	97	55
	2	52	95	51
	3+	44	87	42
Paediatrics	1	68	72	53
	2	67	60	41
	3+	53	41	30
Medicine	1	48	69	38
	2	34.5	50.5	21.5
	3+	29.5	38.5	15.5
Chest	1	17.5	85	15
	2	13	52	8
	3+	12	33	3

Source : Gateway or dividing line (1968) Forsyth and Logan[3]

TABLE 4

Population required to support one outpatient session per week (England)

General medicine	17,000
Mental illness	17,900
General surgery	20,300
Orthopaedics and traumatic	21,000
Chest diseases	21,400
Ophthalmology	27,000
Obstetrics	29,800
E.N.T.	37,200
Gynaecology	46,000
Dermatology	53,900
Paediatrics	66,000

Source : The economics of staffing health centres (1967) Mackenzie [36]

APPENDIX

Proforma used to obtain detailed descriptions of health centres and the activities undertaken therein

HEALTH CENTRES

HEALTH CENTRES

NAME OF CENTRE	
DATE	
ADDRESS	
TELEPHONE NO(S)	
YEAR AND MONTH OF OPENING	
SPONSORING AUTHORITY	
COST	
LOCAL AUTHORITY AREA	
M.O.H.	
SIZE OF POPULATION SERVED BY LOCAL AUTHORITY	
SIZE OF POPULATION SERVED BY L.A. PERSONNEL IN CENTRE	
TYPE OF AREA - URBAN/RURAL/INDUSTRIAL/RESIDENTIAL	

HEALTH CENTRES

ROOMS

NAME OF CENTRE		DATE	

TYPE OF ROOM		NO OF - WHERE APPLICABLE	AREA IN SQ FT	PERCENTAGE OF TOTAL AREA	ROOM NO(S)	USE IF OTHER THAN SPECIFIED	G.P./L.A./R.H.B. AREA
consulting							
examination							
treatment							
laboratory (other than dental)							
X-ray							
clinics							
offices							
reception							
waiting areas	total area						
	no. of seats						
dental surgery							

HEALTH CENTRES

ROOMS cont'd

NAME OF CENTRE		DATE	

TYPE OF ROOM	NO OF - WHERE APPLICABLE	AREA IN SQ FT	PERCENTAGE OF TOTAL AREA	ROOM NO(S)	USE IF OTHER THAN SPECIFIED	G.P./L.A./R.H.B. AREA
dental laboratory and dark room						
recovery room						
common rooms						
health education						
playrooms						
kitchen						
stores						
toilets and sluices - staff						
toilets and sluices - patients						
passages and halls						
pram shelter						

HEALTH CENTRES

ROOMS cont'd

NAME OF CENTRE		DATE	

TYPE OF ROOM		NO OF - WHERE APPLICABLE	AREA IN SQ FT	PERCENTAGE OF TOTAL AREA	ROOM NO(S)	USE IF OTHER THAN SPECIFIED	G.P./L.A./R.H.B. AREA
car parking area	staff						
	patients						
car spaces	staff						
	patients						
cycle parking area							
other							

HEALTH CENTRES

EQUIPMENT IN CENTRE

NAME OF CENTRE		DATE	

TYPE		WHETHER IN CENTRE YES/NO	NO. OF	OWNED BY	IF L.A., RENT FOR YES/NO (HOW CHARGED)	USED BY	COMMENTS
X-ray							
E.C.G.							
Audiometer							
Sterilizer	wet						
	dry						
Tipping couch							
Microscope							
Centrifuge							
Haemoglobinometer							
Other							

HEALTH CENTRES

RECORDS

NAME OF CENTRE		DATE	

TYPE OF RECORD		WHETHER KEPT YES/NO	LENGTH OF TIME KEPT	COMMENTS
Surgeries	length			
	attendances			
	no. of casuals			
	no. of latecomers			
	no. of non-attenders			
	booking rates			
	average consultation rates			
Visits	initial			
	repeat			
Surgery/visit ratio				
Morbidity				

HEALTH CENTRES

RECORDS.cont'd

NAME OF CENTRE		DATE	

TYPE OF RECORD		WHETHER KEPT YES/NO	LENGTH OF TIME KEPT	COMMENTS
Treatments	nos of			
	types of			
Investigations				
Diagnoses				
Age/sex register				
Referrals	X-ray			
	path			
	outpatient			
	inpatient			
Researches				
Other				

HEALTH CENTRES

PERSONNEL

NAME OF CENTRE		DATE	

PERSONNEL	NO. OF	NO. FULL TIME	NO. PART TIME	NO. BASED AT CENTRE	NO. VISITING CENTRE	EMPLOYED BY (WHERE APPLIES)	COMMENTS
G.P.'s - main surgery in H.C.							
G.P.'s - branch surgery in H.C.							
Dentists							
Pharmacists							
Chiropodists							
Dentists (local authority)							
Dietitians							
District nurses							
Doctors (local authority)							
Educational psychologists							
Health visitors							

HEALTH CENTRES

PERSONNEL cont'd

NAME OF CENTRE		DATE	

PERSONNEL	NO. OF	NO. FULL TIME	NO. PART TIME	NO. BASED AT CENTRE	NO. VISITING CENTRE	EMPLOYED BY (WHERE APPLIES)	COMMENTS
home helps							
medical social workers							
mental welfare officers							
midwives							
occupational therapists							
orthoptists							
physiotherapists							
psychiatric social workers							
radiographers							
remedial gymnasts							
social workers							

HEALTH CENTRES

PERSONNEL cont'd

NAME OF CENTRE		DATE	

PERSONNEL	NO. OF	NO. FULL TIME	NO. PART TIME	NO. BASED AT CENTRE	NO. VISITING CENTRE	EMPLOYED BY (WHERE APPLIES)	COMMENTS
speech therapists							
administrator(s)							
secretaries							
receptionists							
typists							
caretaker(s)							
ancillary technical							
M.O.H.							
nursing officers							
public health inspectors							
registrars							

HEALTH CENTRES

CLINICS

NAME OF CENTRE		DATE	

TYPE OF CLINIC	WHETHER HELD YES/NO	WHEN STARTED	APPOINTMENT SYSTEM STATE WHETHER NONE, PARTIAL OR WHOLE	TIMES HELD	HELD BY (NAME AND TITLE)
nte natal					
udiology					
ervical cytology					
hild guidance					
hest					
hiropody					
ental					
amily planning					
ealth education					
mmunisation and vaccination					

HEALTH CENTRES

CLINICS cont'd

NAME OF CENTRE		DATE	

TYPE OF CLINIC	WHETHER HELD YES/NO	WHEN STARTED	APPOINTMENT SYSTEM STATE WHETHER NONE, PARTIAL OR WHOLE	TIMES HELD	HELD BY (NAME AND TITLE)
infant welfare					
mental welfare					
nurseries/play groups					
parent craft					
preventive					
school medical					
other					

HEALTH CENTRES

DIRECT ACCESS DIAGNOSTIC FACILITIES

NAME OF CENTRE		DATE	

TYPE		AVAILABLE YES/NO	WHERE AVAILABLE	WHETHER USED IN LAST 3 MONTHS YES/NO	ARRANGEMENTS FOR TRANSPORT OF SPECIMEN AND REPORTS
Radiology	chest				
	orthopaedic				
	I.V.P.				
	barium meals				
	barium enemas				
	cholecystograms				
	other				
E.C.G.					
Physiotherapy					

HEALTH CENTRES

DIRECT ACCESS DIAGNOSTIC FACILITIES cont'd

NAME OF CENTRE		DATE	

TYPE		AVAILABLE YES/NO	WHERE AVAILABLE	WHETHER USED IN LAST 3 MONTHS YES/NO	ARRANGEMENTS FOR TRANSPORT OF SPECIMENS AND REPORTS
Pathology	haemotology				
	biochemistry				
	bacteriology				
	cervical cytology				
	histology				
	other				

HEALTH CENTRES

HOSPITAL OUTPATIENT SESSIONS

NAME OF CENTRE		DATE	

TYPE OF DEPT	WHETHER PATIENTS REFERRED TO BY G.P. IN LAST 6 MONTHS YES/NO	WHETHER REFERRED TO SESSION IN CENTRE	TIMES OF SESSIONS IN CENTRE	WHERE HELD IN CENTRE	WHERE PATIENTS HAVE BEEN REFERRED TO OUTSIDE CENTRE (NAMES OF HOSPITALS)
chest disease					
dermatology					
general medicine					
general surgery					
geriatrics					
gynaecology					
obstetrics					
opthalmology					
orthopaedics					
ortorhirolaryngology					

HEALTH CENTRES

HOSPITAL OUTPATIENT SESSIONS cont'd

AME OF CENTRE		DATE	

TYPE OF DEPT	WHETHER PATIENTS REFERRED TO BY G.P. IN LAST 6 MONTHS YES/NO	WHETHER REFERRED TO SESSION IN CENTRE	TIMES OF SESSIONS IN CENTRE	WHERE HELD IN CENTRE	WHERE PATIENTS HAVE BEEN REFERRED TO OUTSIDE CENTRE (NAMES OF HOSPITALS)
iediatrics					
iysiotherapy					
sychiatry					
nereal disease					

HEALTH CENTRES

HOSPITAL INPATIENT FACILITIES

NAME OF CENTRE	DATE

TYPE OF HOSPITAL	NAMES OF HOSPITALS AVAILABLE	APPROXIMATE DISTANCE FROM CENTRE
teaching		
general		
psychiatric		
geriatric		
orthopaedic		
maternity		
G.P.		
ambulance stations		