FAMILY DOCTORS IN ENGLAND WORKING IN GROUPS OF VARIOUS SIZES AND FROM PRIVATELY AND PUBLICLY OWNED SURGERY PREMISES - SOME COMPARISONS BASED ON A NATIONAL SURVEY IN 1969

by

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SUMMARY

Data from a postal survey addressed to about 2,000 family doctors in England in 1969 originally in order to investigate factors affecting their mobility (see Butler et al 1973) were examined to identify differences in professional characteristics between doctors practising singly and in partnerships of various sizes and between such doctors and those practising from health centres or other publicly owned premises. (The study involved a limited amount of additional field work to determine whether certain doctors worked from health centres or from local authority clinics; originally no distinction was made between these two categories)

The results, which were in broad agreement with those of two other studies, Cartright (1967) and Irvine and Jefferys (1971), suggested that doctors working in groups generally and in particular those using health centres as their main surgery premises were different in a number of respects from those working single handed or with one colleague - for example they were on call fewer nights per week, were more likely to have available a range of ancillary help and were more likely to have access to diagnostic facilities and to hospital beds. The implications of these apparent advantages for such doctors and their patients are considered.

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INTRODUCTION

Irvine and Jefferys (1971) when reporting on the British Medical Association Planning Unit Survey of General Practice in 1969, compared doctors in health centres with those practising elsewhere with respect to a number of personal and practice characteristics. The fieldwork for their postal survey, addressed to 776 family doctor principals in Great Britain took place in August 1969. In November 1969, a postal questionnaire was sent to 2,031 family doctor principals in England as part of a research project undertaken from the Centre for Research In the Social Sciences of the University of Kent at Canterbury (see Butler et al (1973)). This was primarily concerned with the study of factors affecting the mobility of general practitioners and in particular the designated areas incentive scheme. It did, however, include a number of questions on personal characteristics similar to those in the study of Irvine and Jeffreys. (In the sequel we will refer to the two studies respectively as the 'B.M.A.' survey and 'U.K.C.' survey.)

The debate about the pros and cons of health centres in a time of financial stringency is very much alive. Results relating to 1969 when only a few hundred doctors were practising from health centres must necessarily be a very uncertain guide to the way in which doctors working in health centres and in other circumstances differ today when some 4,000 doctors practice from such centres (D.H.S.S. (1977)a). But they do at least raise some questions about the possible consequences of organising and accommodating general practitioners in various ways. Additionally it is of some interest to compare the results of two independent surveys undertaken within a few months of one another (although they do relate to different populations). The details of such a comparison and also of a

discussion of a methodological issue relating to the wording of a key question are to be found in appendix IV

METHODS AND RESPONSE RATES

For the U.K.C. survey a stratified random sample from each standard region in England was selected (for full details see Butler et al (1973)). In particular the principals of each region were divided into two strata, those working in designated areas and those not working in such areas. A one-in-eight sample was drawn from those practising in designated areas and a sample of one-in-twelve from those practising in other types of area.[1] This resulted in a sample of 2,031 doctors[2] of which 1,721 replied. The respondents and non-respondents were compared with respect to several characteristics and it was concluded that those who had returned their completed questionnaires were a satisfactory cross-section of all general practitioners in the sample approached.

Those approached in the U.K.C. survey were asked whether or not they practised in a health centre or a local authority clinic,[3] and if so whether they were using the premises in question as a main or branch surgery. Also asked were a number of other questions (see appendix II for those to which reference is made in this report) among which was one concerning whether or not they were in receipt of a group practice allowance. Certain information was also obtained at the time when the original samples were drawn from the D.H.S.S. doctor index.

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[1] In two regions there was a slight variation from this scheme to take account of the very small numbers known to be practising in designated areas, but they scarcely affected the overall sampling fraction for England - and results for smaller areas will not be considered in this report.

[2] After removals due to death, retirement etc.

[3] Throughout this report the description "local authority clinic" and "other local authority premises" will be used interchangeably

The sampling scheme used in the B.M.A. survey is described by Irvine and Jefferys (1971). Briefly it was as follows:- in England and Wales the sample was drawn using a stratified sampling scheme so as to ensure the inclusion of sufficient numbers of doctors practising from health centres (as defined under Section 21 of the National Health Service Act of 1946), those receiving the group practice allowance other than those in health centres (GPA doctors) and those who were neither in health centres nor receiving group practice allowances (non GPA doctors). In Scotland the total population of general practitioners to be sampled was stratified by Executive Council Area and a sample of doctors was selected in such a way that the number of doctors drawn from each area was proportionate to the total number of doctors in that area. This procedure did not over-sample health centre[1] doctors; all types of general practitioners had an equal chance of being selected. In all 776 doctors were approached and 576 responded to the questionnaire; of these latter 428 practised in England

Thus here there is a difference between the B.M.A. and U.K.C. surveys. In the U.K.C. Survey a general sample of family doctors was asked for information about whether or not they practised from a health centre (or local authority clinic) and whether or not they were in receipt of a group practice allowance. The B.M.A. survey drew samples from several such categories, so provided the records from which they drew samples were not in error, there was no problem of definition or misleading answers

[1] as defined in the National Health Service (Scotland) Act (1947)

to be considered.

In the case of the U.K.C. survey 106 doctors were initially identified who stated that their main surgery was located in a health centre or local authority clinic and a further 56 who said that a branch surgery only of theirs was located in such premises. On reading the paper of Irvine and Jefferys (1971) and noting that our combination of health centres and local authority clinics into one class did not permit the comparison of our results with theirs, we wrote again in 1972 to the 162 doctors who in 1969 had reported themselves to be practising at health centres or local authority clinics (as either a main or branch surgery). On this occasion they were asked to complete a postcard indicating whether they had practised in 1969 from a Section 21 health centre as distinct from other local authority clinics and if so whether they had used the premises in question as a main or branch surgery (see Appendix III for a copy of the postcard and accompanying letter). By various means, additionally, in the case of those who in 1972 were deceased or otherwise uncontactable the desired information was obtained for all but four of the 162 doctors concerned.

The 1972 enquiry revealed that 18 of the 162 doctors who in 1969 had reported that they practised from a health centre or local authority clinic either as their main or branch surgery apparently practised at that time neither from a Section 21 health centre nor from a local authority clinic. Most of the 18 did in fact practise from premises that were manifestly 'health centre like' even if not strictly Section 21 health centres or local authority owned. For example some practised from premises provided by the Nuffield

Provincial Hospitals Trust and others from privately owned premises adjacent to or even attached to local authority clinics. In the case of the residue of the 18 no apparent reason of this kind could be found for their indicating in 1969 that they had practised from a health centre or other local authority premises. It may be that they regarded their privately owned premises as resembling health centres or simply that they had ticked the wrong box in the questionnaire (it is not known of course how many of those who in 1969 indicated that they did not practise at all from a health centre or local authority clinic made an error of the opposite kind - that is they did in fact work from such premises).

From the 1972 survey it emerged that in 1969, 72 doctors practised from Section 21 health centres as their main surgery and 29 from a local authority clinic as their main surgery. Seventeen reported that they had a branch surgery in a Section 21 health centre (their main surgery being neither in a Section 21 health centre nor in a local authority clinic[1]) and 22 said that they had a branch surgery in a local authority clinic (none of their other surgeries being in Section 21 health centres; nor was their main surgery in a local authority clinic). Table 0 shows how respondents answered in the 1969 and 1972 surveys.

As at the end of 1969 it is known (D.H.S.S. (1974)) that about 3½% of the family doctors practising in England were working from health centres as their main or branch surgeries. The corresponding

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[1] See the notes before the Tables in Appendix I for full details of the classifications used.

proportion of doctors among the respondents in the U.K.C. survey was just over 5%. Also a rather higher proportion of the doctors in the U.K.C. survey who practised from health centres used them as their main surgeries than was the case for England as a whole at that time (the proportion being 83% compared with 67%[1]) - though in fact as it turned out the proportion in 1969 was uncharacteristically low and the figure by 1973 for England resembled that found in the U.K.C. Survey). In the rest of this paper we shall refer to the original classification of the doctors according to whether or not they said in 1969 they practised from a health centre or local authority clinic as their main or branch surgeries as the '1969 classification' and the classification subsequently obtained distinguishing Section 21 health centres from other local authority premises as the '1972 classification.'

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[1] Irvine & Jeffrys (1971) found that 63% of their 'health centre' respondents had their main surgery at a health centre.

RESULTS FROM THE U.K.C. SURVEY

Note: It will be apparent from the tables within this report that comparisons are being made between classes of respondents which have some members in common - for example when comparing doctors practising from Section 21 health centres as main surgery with those in receipt of a group practice allowance the latter class will of course contain some who practised in health centres (unlike the BMA,survey see Irvine and Jefferys (1971)). Given that invariably in such comparisons a relatively small group of doctors is being compared with a much larger group to examine whether the former differ from the latter in respect of the proportion possessing some characteristic this does not present any difficulty of interpretation. This is because the number of doctors common to the two groups will be very small relative to the larger group and so will have little effect on the proportion in the larger group bearing a characteristic. In fact the effect of comparing groups of this kind will be generally to slightly understate any differences which may exist between them had the members of the smaller group belonging to the larger group been removed from the latter.

The grouping of general practititioners (tables 1, 2 and 2a[1])

Traditionally doctors who wished to work together in some sort of association would tend to form a partnership, much as any other group of professional persons or businessmen. This did not necessarily mean that

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[1] Tables are located in appendix I

they practised in close proximity to one another from the same premises. Three or more doctors (two or more in certain rural areas) however who did work together mainly from the same surgery premises[1] would each attract a Group Practice Allowance; to receive this allowance they need not necessarily be in a partnership. A health centre was from the earliest days of the idea seen as one means by which doctors not necessarily in partnership could practise from the same premises for at least part of their time (see for example Ministry of Health (1920)) The average number of doctors per health centre in England using a health centre as their main surgery has throughout the last decade been between 5 and 6 doctors (see for example DHSS(1974)and(1977)although this average concealed the fact that in rural areas there were a number of very small centres some housing only one doctor as well as some very large ones in urban areas accommodating the main surgeries of 20 or more general practitioners. In this first section then three characteristics of doctors concerned with their working in groups are considered, namely:-

1 whether or not they were in receipt of the Group Practice Allowance

2 the size of partnership (if any) of which the doctor was a member

3 whether or not the doctor practised from a health centre or local authority clinic as a main surgery or a branch surgery.

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[1] and satisfied certain other conditions e.g. as regards employment of ancillary staff (see Ministry of Health(1967))

Just over half of the respondents considered as a whole were in receipt of a Group Practice Allowance. Not unexpectedly very few (7%) of single handed doctors received the allowance compared with 28% of those practising in partnerships of two doctors and 85% or more of those practising in larger partnerships.

Using the 1972 classification, 83% of respondents practising from Section 21 health centres as their main surgery were in receipt of a Group Practice Allowance. The corresponding percentage for those practising from other local authority premises as their main surgery and from a Section 21 health centre as a branch surgery was 77% in each case; while only 62% of those who practised from other local authority premises received the allowance (that is not much greater than the proportion found among respondents as a whole).[1]

Fifteen percent of those practising from a Section 21 health centre as their main surgery and 3% of those in receipt of a Group Practice Allowance were not in partnership (these figures respectively are the same as those reported in the BMA survey).

The average sizes of"partnership" of those practising from health centres or local authority clinics as a main or branch surgery respectively,and of those in receipt and not in receipt respectively of the Group Practice Allowance are given in table 2. Interestingly the average size of partnership of those practising from Section 21

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[1] The use of the 1969 classification to divide doctors into those practising and not practising respectively from health centres or local authority clinics gave a similar percentage receiving the Group Practice Allowance among those using health centres or local authority clinics as main surgeries as was found using the 1972 classification; but compared with the 1972 classification gave an exagerated impression of the difference between the doctors who use such premises as main surgery and those who used these premises as a branch surgery i.e. the 1969 classification inevitably concealed the difference between health centres and other local authority premises revealed by the 1972 classification.

health centres as their main surgery was slightly smaller than that of those practising in any other way from local authority premises, although it was among the former that the highest proportion reported that they were in receipt of a Group Practice Allowance. In fact it appears that at least half of the doctors practising single handed or in partnerships of 2 from health centres as their main surgery were in receipt of a Group Practice Allowance compared with an "expected" percentage of about 20% had the same proportion of such doctors been in receipt of this allowance as in the group of all respondents practising single handed or in a partnership of 2.[1] A slightly smaller proportion of doctors practising in partnerships of two or single handed from other local authority premises as their main surgery appeared to be in receipt of a Group Practice Allowance compared with an "expected" proportion of 23% if they had resembled in this respect the respondents as a whole practising single handed or in partnerships of two. By contrast those practising single handed or in partnerships of two who had only a branch surgery either in a health centre or other local authority premises were scarcely more likely than the respondents as a whole (practising alone or in partnerships of 2) to receive a Group Practice Allowance.

So it does seem that practising from a health centre as a main surgery did permit a number of doctors who were single handed or in partnerships of two to work as part of a larger group of practitioners as indicated by their receiving the Group Practice Allowance. Even so, about 40% of such doctors in the survey who practised from a health centre as their main surgery did not receive the Group Practice Allowance presumably because they were working from small centres in rural areas. (This is assuming that eligible doctors in larger health centres were in fact receiving the Group Practice Allowance).

Footnotes on pg. 11a

[1] i.e. 20% is the weighted average of the percentages of single handed doctors and doctors in partnerships of two respectively in receipt of the Group Practice Allowance where the percentages are those for all respondents of this kind and the weights are the relative frequencies of single handed doctors and those in partnerships of two among the respondents who practised from health centres as their main surgery.

Some comparisons between single handed doctors, doctors in partnerships of various sizes, doctors practising from health centres and doctors practising from local authority clinics

In this section results are briefly presented taking account of the following findings:[1]

a) In most cases where comparison is possible the results obtained in the UKC and BMA surveys were in broad agreement in respect of differences between doctors practising in the various circumstances considered in this report. The absolute magnitude of the percentage of doctors in a given category occasionally differed somewhat in the two surveys but this was probably a consequence of differences of phrasing and construction of questions used and also because different populations of doctors were sampled. (For further details see Appendix IV)

b) Since the great majority of those in partnerships of three or more were in receipt of Group Practice Allowance it seemed reasonable to take partnership size as an indicator of the number in the group (practising from the same premises) of which the respondent is a member (especially in view of comments under (c) below). Accordingly in this section we shall not in general refer to differences between doctors receiving or not receiving respectivly the Group Practice Allowance. (See however Appendix IV)

c) In the case of many of the characteristics considered there

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[1] Appendix IV includes a detailed comparison between the BMA and UKC survey results, a comparison of doctors in receipt of a Group Practice Allowance with doctors not receiving this allowance and an examination of the differences in the conclusions to be drawn when using the 1969 and 1972 classifications respectively of doctors practising from/not practising from health centres and local authority clinics.

was a continuing increase (or decrease) in the proportion of respondents possessing a characteristic as one proceeded from single handed doctors through doctors in partnerships of increasing size. Moreover, single handed doctors and doctors in partnerships of 5 or more (the largest partnership size identified) often constituted the opposite extremes as far as the proportion possessing a characteristic was concerned between which all other categories of respondents (i.e. not just when classified by partnership size) considered in this report were located. For this reason the approach adopted below is to examine differences between respondents belonging to partnerships of various size and between those practising single handed; then to examine how doctors practising from Section 21 health centres as main or branch surgery and those practising from other local authority premises compared with doctors practising in partnerships of various kinds.

Age (tables 3 and 3a)

Single handed doctors were on average about 5 years older (average age 51 years) than those in partnerships of 3 or more (average age 46 years). The average age of doctors who were members of partnerships of two principals was midway between these two figures. Doctors working from Section 21 health centres as their main surgery were of about the same average age as those practising generally in partnerships of three or more. However those practising from health centres as a branch surgery or from other types of local authority premises were in general slightly older.

The number of (NHS) patients registered with a doctor[1] (tables 4 and 4a)

This varied very little with partnership size around the average

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[1] In the case of those in partnership this was the average number of patients per doctor in the partnership.

for respondents as a whole of 2550 patients (slightly greater than that for doctors as a whole at this time in England)[1]. Doctors practising from Section 21 health centres or other local authority premises as main or branch surgery had on average a list size about 5% greater than this figure (in the case of those practising from Section 21 health centres as their main surgery this was not due to the fact that a disproportionate number of such doctors among the respondents were located in designated areas though this would be a possible"explanation"for the size of lists of those practising from local authority clinics as main or branch surgery or from health centres as a branch surgery, see table 0).

The distance between the doctor's home and main consulting room (table 5)

Nearly half of the single handed doctors, a quarter of those in partnerships of two and one-in-ten of those in partnerships of three or more had their main consulting rooms in their own home - although the percentage of doctors living more than two miles from their main surgery did not vary greatly with partnership size (between 22% and 30%). Doctors practising from Section 21 health centres as their main or branch surgery and those practising from other local authority premises as their main surgery were more likely to live more than 2 miles from their main consulting room than doctors in general including those in partnerships of 3 or more doctors.

Number of nights on call per week on average (tables 6 and 6a)

Single handed doctors were on call for an average of almost 5 nights per week. The larger the partnership of which the respondent was a member the fewer the number of nights he was on call on average; so that for those who belonged to a partnership of 5 or more doctors the average number of nights on call per week was little more than 2. Doctors practising from a Section 21 health centre as their main or branch surgery fared about as well in this respect as those in partnerships

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1 See DHSS (1971)

of three doctors generally, whilst those in other local authority premises seemed to be on call for slightly more nights per week.

Type of ancillary help available (tables 7 and 7a)

Four percent of the respondents were without any ancillary help at all and predictably almost all of these were single handed or working in partnerships of two. Generally the larger the partnership of which the respondent was a member the more likely he was to have a variety of ancillary helpers available. Thus of those in partnerships of 5 or more 39% had the assistance of a secretary/receptionist, a nurse and at least one other category of helper, compared with 10% of the single handed doctors. Doctors practising from Section 21 health centres as their main surgeries did even better, 48% of them having such a variety of help available; and in fact both those who had their main surgery in health centres and those who only had a branch surgery in a health centre were considerably more likely to have a social worker attached to the practice than any other category of doctor (except perhaps those working from other local authority premises as their main surgery).

Items of equipment used in the consulting room (tables 8,8a and 9)

Doctors were asked to indicate which of the list of nine items of equipment (see Appendix II) they used in their consulting rooms. In terms of the total number of such items (admittedly a very crude index of range of equipment in use) although generally the larger the partnership to which a respondent belonged the greater the number of items used by him in his consulting room, the difference was not great ranging from four items on average for single handed doctors to five for those in partnerships of 5 or more.

However the sort of equipment used by doctors did vary with size of partnership. Single handed doctors were much less likely to use in their consulting room an ECG machine, a Wright Peak Flow Meter, ESR tubes and proctoscope than those working in partnerships of four or more doctors. Doctors whose main surgery was in a Section 21 health centre were more likely even than those in the largest of partnerships generally to use an ECG machine or an HB meter and as likely as those in such partnerships to have the use of a Wright PeakFlow meter; and doctors using health centres as their branch surgery were almost as well provided in these respects. Doctors working in other types of local authority premises seemed to use fewer of the items of equipment in question than those in health centres.

The question on which these analyses are based is arguably unsatisfactory from the point of view of assessing the extent to which GPs used various kinds of equipment if only because it referred to the use of the euqipment in the consulting room. Thus for example the fact that doctors working from a health centre as their main surgery were less likely than any other category of doctor considered to use an equipped emergency bag or sterile gloves may well be due to the fact that certain items of equipment are to be found in a health centre(or similar purpose built group practice premises) but not actually in the consulting room. Indeed such equipment may not even have been owned by the respondent or his partners.

Direct access to diagnostic facilities (tables 10 and 11)

In the UKC survey doctors were asked to indicate whether or not they had direct access (that is not through casualty or consultant) to each of the following facilities: Full size chest X-rays, bone and joint X-rays, bacteriological examination of urine, and glucose tolerance tests.

Once again the familiar pattern recurred of doctors practising in partnerships of 3 or more principals being more likely to have access to each of the four facilities than those practising single-handed or in a partnership of two doctors. Doctors using Section 21 health centres as a main or branch surgery seemed to fare in this respect about as well as those in partnerships of three or more. Those working from other local authority premises as main or branch surgery however were relatively unlikely to have access to all four facilities. This was substantially due to the fact that relatively few of such doctors had access to glucose tolerance test facilities (though those using local authority clinics as main surgeries were generally badly off). This test was also available to relatively few single-handed doctors compared with those in partnerships of three or more.

Direct access to hospital beds (table 12)

Just over half the respondents had access to hospital beds of some kind and as usual single handed doctors were generally worse off in this respect than those in partnerships of 3 or more. Sixty one percent of single handed doctors did not have access to any kind of beds compared with 50% of those in partnerships of two and 40% of those in partnerships of 3 or more. Single handed doctors were less likely than those in partnerships of three or more to have access to obstetric beds and/or to 'other' beds. Those practising from health centres as a main or branch surgery tended to be about as likely to have access to beds as those in partnerships of three or more doctors but those practising from other local authority premises seemed relatively poorly off.

Appointments held outside general practice (table 13)

Twenty six percent of the respondents held hospital appointments and 48% held other medical (non hospital) appointments (there is some overlap between these two groups as some doctors held both kinds of appointments, see table 13) 34% of those in partnerships of 4 or more held hospital appointments compared with just over 20% of those practising in partnerships of three or less (this percentage did not otherwise vary much, with partnership size). There was relatively little variation in partnership size at all in the percentage of respondents holding non-hospital appointments. Doctors practising from health centres as a main or branch surgery and those practising from other local authority premises as their main surgery were about as likely as those in partnerships of four or more generally to hold hospital appointments but the proportion of those practising from health centres as their main surgery who held non-hospital appointments was the lowest of any of the groups considered in this report and indeed in general doctors practising from local authority owned premises did seem to be a little less likely to hold appointments outside general practice than respondents as a whole, and in particular those in larger partnerships. On the other hand those practising from such premises as a branch surgery did seem more likely to hold non-hospital appointments than any other group considered in this report.

Respondents' assessment of their opportunities for attending post-graduate or refresher courses (see table 14)

Overall 78% of the respondents rated their opportunities as good or very good. The larger the partnership of which a doctor was a member the more likely he was to rate his opportunities as good or very good in this respect. Thus for example 64% of single-handed doctors felt this way

about their opportunities compared with 87% of those practising from partnerships of four or more doctors. Those practising from health centres or other local authority premises resembled those working in these larger partnerships in their assessment of their opportunities for attendance of courses.

Respondents' assessment of communications from hospital when patients have been discharged (table 15)

Overall 61% of the respondents rated such communications as good or very good (virtually all the remainder falling in the poor or very poor category). Generally single handed doctors and those in partnerships of two appeared more satisfied with these communications than those in partnerships of three or more. Doctors using health centres or other local authority premises as their main surgeries tended to be less satisifed with these communications than any other category of doctor considered in this report; by contrast the group of respondents using such premises only as branch surgeries contained a relatively high proportion of doctors who were content with communications from hospitals about discharged patients.

DISCUSSION

It is clear that single handed doctors, and to a lesser extent those in partnerships of two, differed in a number of respects from those working in larger partnerships of the kind which generally attract the Group Practice Allowance; also that those working from Section 21 health centres as their main surgery tended to resemble doctors working from the larger partnerships. The differences reported between doctors practising single handed and in partnerships of various sizes are broadly in line with those found by Cartwright (1967)[1] based on a survey conducted in 1964, and it has already been noted that where the UKC survey and the BMA survey (Irvine and Jefferys (1971)) dealt with the same topics they were generally in agreement as regards comparison between doctors working from health centres, in group practice and not in group practice respectively. So although the numbers of doctors in the UKC survey working from health centres were small it seems reasonable to accept that the differences reported exist in a qualitative sense (that is thinking in terms of the direction of the differences rather than their precise magnitude) the question is why do they exist and does it matter?

It seems likely that there are several different explanations for the various differences observed.

First, it seems reasonable to suppose that the mere fact of belonging to a group of doctors practising from the same premises is sufficient explanation for the fact that doctors in health centres[2] and larger partnerships:

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[1] Though she did not find that those in partnerships of four or more doctors were more likely than single handed doctors to have access to hospital beds.

[2] Except where otherwise stated the discussion will be concerned with doctors working from health centres as their main surgeries

(a) Tended to be on call for far fewer nights than those practising single handed or in a partnership of two[1] (because it is simply easier to arrange a rota system if one is already a member of a group of colleagues).

(b) Tended to live farther away from their main consulting rooms than those working single handed or with a single colleague (primarily because only among the latter group did any number live at their main surgery premises - since in the case of a group practice, it is unlikely that more than one principal (or two[2]) will live on the premises.

Secondly, belonging to a group of doctors practising from the same surgery premises can lead to economies of scale in a fairly obvious way when employing staff or purchasing instruments and it is also simpler to attach nursing and other staff to one relatively large practice than to share these between several smaller units. So this fact alone is the probable explanation of the finding that doctors in health centres and the larger partnerships tend to be assisted by a wider range of staff than those practising single handed or with one colleague (being in a health centre of course almost inevitably means that a variety of NHS staff whether attached or not will be working in the same building). The simple 'size of group' factor may partly explain why those in health centres and larger groups generally appear to use a wider variety of equipment in the consulting room (especially in the case of more costly equipment) than those practising single handed or with one colleague; but there may be other explanations too. For example the fact that single handed doctors and those in

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1 and **not** working as part of a larger group of doctors or in a health centre. This qualification should be understood throughout this discussion when single handed doctors and those in partnerships of two are being contrasted with doctors in group practice and/or health centres. See also the note on page 8.

2 e.g. in the case of a married couple where both are principals of the practice.

partnerships of two are older[1] than those in larger partnerships and/or in health centres, or (and this may be associated with age and experience) doctors practising in relative professional isolation may be of comparatively independent disposition feeling less need to rely on a range of equipment.

Again the greater age on average of the single handed and those in partnerships of two may in turn mean that they have had longer to become aquainted with hospital colleagues in the locality (see Butler et al(1973)). This may be the reason why these doctors were more satisfied with communications from hospital when a patient is discharged than those practising from health centres or as members of a larger partnership generally - or perhaps it may be that the former expected less in terms of communications from hospital colleagues than those who worked everyday in larger groups of fellow GPs. Yet again it may be that the relative isolation of general practitioners working single handed or with 1 colleague means that they have of necessity to take more trouble to develop closer relationships with hospital doctors since they do not have GP colleagues so readily available to turn to for a second opinion.

But what was the explanation of the finding that doctors in health centres and larger partnerships generally were more likely to have direct access to diagnostic facilities and to hospital beds? It is easy to understand why it is simpler to arrange for a collection scheme for pathology specimens from a group of doctors than from a series of doctors practising in separate premises but this type of explanation could hardly suffice to explain the result that doctors in health centres and other groups apparently more often enjoyed direct access to X-ray facilities as well. One possible explanation is that a group of doctors whether in publicly or privately owned premises may form a more effective and more organised 'power block' in negotiations than a series of doctors

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Footnotes on page 22a

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[1] Cartwright (1967) reported that in her survey the older a doctor (strictly the longer he had been qualified) the more likely he was to practise single handed, the less likely to have direct access to hospital beds and the less likely to have access to diagnostic facilities. However the relationship with age was not so simple in the case of likelihood of having a hospital appointment or in respect of the average 'score' for procedures undertaken by the doctor. It is important to note that she (and we) found that differences between single handed doctors and those in partnerships of various sizes persisted when age was taken into account.

practising in separate units. Possibly those practising single handed or in a partnership of 2 from relatively simple premises may see a sharper distinction between services they render to patients and those provided by hospital colleagues and be more ready to refer patients to consultants who would then take responsibility for any diagnostic procedures. (See Cartwright (1967)).

Again it may be a question of location. Health centres and privately owned group practice premises tend usually to be situated in some centre of population albeit often of the scale of a small town. The centre of population may also contain a hospital of some kind and if not the health centre or group practice premises may assume the role of a kind of outpost of the hospital - perhaps (see Dowie 1975) providing a base where outpatient sessions are held, or at least enjoying a special relationship with the nearest hospital because it is at once relatively isolated from hospital facilities and also the nearest thing to a hospital in its immediate locality (see, for example, the Nuffield Centre at Witney, Hicks (1976)).

These kinds of considerations may also explain why health centre doctors and those working in large partnerships generally were more likely to hold a hospital appointment (also perhaps it is easier for colleagues in their group to provide cover when the doctor in question is at the hospital). Or it may be that a group of doctors have between them a better network of communications with other colleagues and so are in a better position to know of vacancies and to be able to recommend a suitable colleague. The fact that it is easier to obtain cover from colleagues in a group is also a possible explanation for the finding that those in health centres or group practice generally assess their opportunities for postgraduate or refresher courses more favourably than single handed doctors or those in partnerships of two.

For whatever reason doctors working from Section 21 health centres as their main surgery at the time of the survey, in common with those practising generally in larger partnerships displayed a number of characteristics which while they do not necessarily lead to the provision of better care at least seem to offer the doctors involved the opportunity to call more easily on a wider range of support of one kind or another.[1] The range of ancillary help available (in respect of which health centre doctors were particularly well placed), the range of equipment in use in consulting rooms, direct access to diagnostic aids and hospital beds are fairly obvious examples of this kind; and so arguably in a less direct way are opportunities for postgraduate and refresher courses and the holding of hospital appointments.

The fact that doctors working from health centres as their main surgery and those in large partnerships generally were on call relatively few nights a week is another indication of support which a doctor in a group may hope to obtain from his colleagues. From the patients' point of view of course this means he was less likely to be attended by his own doctor than would be the case if he were registered with doctors practising in the traditional way, (though it is questionable as to whether it is beneficial to the patient in the long run for his doctor to be on call for a high proportion of the nights of the week). The fact that doctors in health centres and

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[1] Moreover Cartwright (1967) reported that the larger a partnership of which a respondent was a member the more likely he was to enjoy general practice

those in larger partnerships generally usually live away from their surgery premises (and doctors' private residences are not always listed in telephone directories) may also tend to lead to a feeling of greater isolation for the patient from his own doctor than would be the case in a small practice.

What then from the matters considered in this report, is there to commend the health centre as distinct from practising in a group in privately owned premises? Being in a group working from shared privately owned or rented premises does not require that all the doctors involved should be in partnership (see for example the group practice premises in Wallsend, Northumberland (Dawes and Bevan(1976)) and Herne Bay, Kent (Barton (1975))but it inevitably does imply some kind of legal and financial agreement between those who share the premises in this way. Such an arrangement between all the doctors involved is not necessary in health centres. So the health centre does offer an opportunity for a doctor to be a member of a group of general practitioners without the necessity that he be associated with any or all of them via a legal or financial agreement. In fact the average partnership size of doctors practising from health centres as their main surgery was not much greater than the average for all respondents in this study although the great majority of these health centre doctors were in fact in receipt of a group practice allowance compared with only about half of the respondents as a whole. Also because in a typical health centre a variety of NHS staff will be based there this facilitates access on the part of the doctor to such staff and vice versa even if there is no formal attachment scheme in operation - and it is clear from this study that doctors in health centres had access to a wider variety of staff than even those in the largest partnerships; and they were particularly well placed

in respect of social workers relative to colleagues practising from privately owned premises. Since in addition those in health centres as main surgeries were as likely as those in larger partnerships to regard their opportunities for attending post graduate or refresher courses being good or very good and to hold hospital appointments, it is worth noting that the average list size of the doctors in health centres was larger than the average for the respondents as a whole and in particular for those in receipt of group practice allowances and those working in larger partnerships generally.

So far this discussion has been confined to doctors practising from health centres as their main surgery - but for whatever reason the small number of respondents in the survey practising from health centres as a branch surgery seemed to share to some degree many of the apparent benefits of those based at health centres. [The reasons for this are not clear; they were members of larger partnerships than those using health centres as their main surgery but were less likely to be in receipt of a group practice allowance; they also had relatively large list sizes (larger than those using health centres as their main surgery, and indeed, see Table 0, were much more likely to be located in Designated Areas)]

At the time of the original survey in 1969 it had been assumed that there was no need to make a distinction between doctors practising in health centres and those working from other local authority premises - the rationale for this being that the crucial distinction was thought to be between those practising in publicly owned premises as distinct from privately owned premises and among the former between those using such premises as main surgeries and branch surgeries (only) respectively. The results based on the 1972 classification of doctors according to whether they practiced from section 21 health centres or from other local authority premises when compared with those based on the 1969 classification, strongly

suggest however that this assumption was incorrect.[1] Generally those working from other local authority premises as their main surgery seemed to differ in a number of respects from those practising from Section 21 health centres or those working in larger partnerships. Compared with those whose main surgery was in a health centre, respondents who had their main surgery in other local authority premises were older, their average partnership size was slightly larger but they were less likely to be in receipt of a group practice allowance, they had a larger list size (they were much more likely to be located in designated areas), they lived closer to their main surgeries, were on call for more nights per week, tended to be less well off in terms of ancillary help available and to use fewer items of equipment in the consulting rooms; in particular they were much less likely to use an ECG (though not less lightly to use an HB meter); and to be less likely to have direct access to diagnostic facilities or hospital beds. They were however as likely to hold appointments outside general practices e.g. hospital and non hospital, and more likely to feel that opportunities for attendance at post graduate courses were good or better and slightly more likely to feel that communications from hospitals when patients were being discharged were poor.

There was also a small group of doctors who used local authority clinics as a branch surgery (only)[2]. These appeared to be a very heterogenous group and the results relating to characteristics considered in this survey seemed to form a much less consistent pattern than those for the other categories of doctor practising from publicly owned premises. Arguably in this category in particular the nature of the main surgery premises (which would be privately owned) was a much more important determinant than the fact of practising for the odd session at some local authority clinic.

Given then that there did appear to be a difference between doctors

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[1] In this and the next three paragraphs results from Appendix 4 are summarised and discussed.

[2] And did not practice at all from health centres, or from local authority clinics as a main surgery.

practising from local authority clinics as their main surgery and those practising from health centres, it is not surprising that the original 1969 classification produced some misleading results. For example using the 1969 classification it appeared that doctors in publicly owned premises were older generally than doctors in privately owned premises whereas this was entirely a feature of those practising in local authority premises other than health centres; it also gave the impression that doctors in publicly owned premises were less likely to use some items of equipment than those in the larger partnerships; generally again a characteristic of those practising from local authority clinics as main or branch surgery.

A further consequence of using the 1969 classification was that it appeared that doctors working in publicly owned surgery premises tended to be concentrated in designated areas. This was certainly true of local authority clinics but not of Section 21 health centres.

So far some differences between professional characteristics of general practitioners who work alone or with one partner and those who practice in groups and/or from health centres have been noted. These differences may or may not be a consequence of the doctors being organised in these various ways. However it has been argued that practising in groups and/or from health centres does make it easier to achieve some ends although there may be other ways equally acceptable and effective of attaining them. To take a simple example; working in a group of doctors makes it easier to arrange an off-duty rota to reduce the number of nights an individual is on call; but so does joining a deputising service.

So should general practitioners be encouraged to work in groups and/or health centres? One reason for doing this would simply be in order to improve their conditions of work (that is without any objective relating

to services to be provided directly in mind).

It has already been noted that Cartwright (1967) found that family doctors in larger partnerships were more likely to enjoy general practice than those in smaller partnerships or practising single handed. Moreover the marked increase over the last decade

(i) in the proportion of family doctors in England practising in partnerships of three or more[1] and

(ii) in the proportion of family doctors in England working from health centres[2], are just two indications that many doctors see the advantage of working in some kind of association with medical and/or other health service colleagues.

Equally however not all doctors in any age group take this view and some of those who find themselves in groups and/or health centres do feel that in moving to a larger organisation they have foregone some of the advantages enjoyed when practising single handed or with one partner. (See e.g. Dawes and Bevan, 1976). So it seems likely that this division of opinion among family doctors as to the most suitable environment in which to practice will continue to exist. This leads to a second question: is group practice or health centre practice to be recommended on the grounds that it will lead to a better service for patients? Arguably when resources are scarce this would be a more compelling reason for recommending investment in these developments at the expense of spending money on other parts of the health service than if they were put forward merely with a view to improving working conditions - particularly since the general practitioner has a greater say than most people in determining his conditions of work.

The role of the family doctor has several facets including those of:

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[1] 67% of those providing unrestricted general medical services in 1976 compared with 38% in 1966 (DHSS, 1977 b)

[2] from less than 2% in 1966 to nearly 20% in 1976 (DHSS,1977 a)

1. The medical expert (knowledge and skill in diagnosis and treatment),
2. The gateway to specialised services (requiring medical expertise and also knowledge and critical appraisal of services available, and depending to some extent on skill in professional and inter-professional relationships),
3. The personal and confidential counsellor (with whom the patient may discuss most intimate and alarming matters of health).

It may be that one form of organisation of general practitioners will be helpful to them in the exercise of one of these functions and another would be more suitable to the exercise of another, for example being based in a health centre might be more helpful than working in relative isolation as far as being a 'gateway to specialised services' is concerned; but the converse could well be the case in respect of a general practitioner's function as a 'personal and confidential counsellor'.

The situation might be resolved if it were possible to attach some weights to the three facets identified above. However it appears that patients vary in the importance they attach to any one of these. For example Cartwright (1967) reports that patients of doctors working single handed were inclined to favour this type of arrangement on the ground for example of continuity of care by the same individual; while those whose doctor was one of a partnership favoured this arrangement for such reasons as the opportunity to get a second opinion either on the part of the patient or the doctor. Again, while some patients welcome the nurse working with the general practitioner others do not, particularly if they fear that this is encroaching upon their relationship with the doctor (see Cunningham et al., 1972, Bevan et al., 1976). In fact it is probable that the same person will at one time lay greater emphasis on one aspect of the general practitioner's role towards his patient and at other times other aspects will be more

important. Moreover there appears to be no evidence,

(a) that there are necessary hazards or benefits to patients' health if their doctors practice in one of the permitted organisational arrangements rather than another,

(b) or that there are necessary cost differences between various ways of practising.

All this suggests that given the present state of knowledge it would be unwise to be dogmatic about the best ways of organising primary care and general practice in particular. It does also raise the question of how far large health centres which effectively concentrate all the primary care services of a sizeable community in one building should be encouraged in so far as they reduce the variety of "G.P. outlets" available to patients - though such centres may sometimes be unavoidable.

However a further and more important point arises from this discussion. The way in which general practitioners are organised and accommodated (i.e. whether they practice alone, with a single colleague, in a group and/or in a health centre) is essentially a matter of working environment - physical, professional and social. The work of a number of writers on organisation and in particular that of Herzburg[1] warns that securing a satisfactory environment in this way while it may well lead to the absence of discontent on the part of the workforce in question should not be expected to motivate them to greater achievement. Such motivation, it is argued, is more likely to come from stimuli or changes which directly relate to the responsibility and goals of the worker.

Perhaps because of a reluctance to intrude upon the 'clinical freedom' of doctors and other health service professionals it seems that the provision

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[1] These ideas are well summarised in Pugh et al. (1971)

of additional resources for the development of primary health care has been chiefly concerned with improving the working environment (as broadly defined in this discussion) for this sector of the National Health Service with only very non-specific guidance and discussion about what it is that these additional resources are supposed to achieve in terms of their effect on services.

This is a pity because arguably the involvement of the recipients in a dialogue and perhaps a contractual arrangement centering on the development of services may be to provide the crucial motivating stimulus which is currently missing. And it is when additional resources are on offer to a section of those providing health services that it is probably least difficult to link their provision with some contract with the recipients as to what shall be done (or at least attempted) in terms of services provided.[1]

The remarks in the latter part of this discussion lead to the following recommendatio

As an alternative to the current approach of providing health centres where certain criteria, such as need for G.P. and other primary care accommodation, are satisfied, it is proposed that the following approach be adopted in selected cases on an experimental basis.

Instead of submitting a proposal which conforms to the current health centre pattern, those involved at the local level, family doctors, community nurses, etc., serving a locality, in conjunction with the District/Area, should be invited to put forward a scheme for improving services. Essential to such a scheme would be an agreed set of specific objectives as to the improvements in services that the scheme would seek to achieve and an agreed set of criteria for appraising the extent to which these agreed objectives were being attained if the scheme were to be implemented. The scheme might or might not involve a building and organisation approximating

Footnote on page 32a

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[1] On a much larger scale compare the requirement imposed on doctors and institutions in the United States of America, if they are to provide services to patients under one of the government financed schemes of care recently introduced, that they agree to participate in some form of quality review McLachlan (1977).

to a health centre of the conventional kind. In order to secure resources the applicants would need to satisfy those providing these:

(a) as to the suitability of the objectives

(b) as to the likelihood that the scheme would achieve them.

The idea would be to encourage flexibility of approach (which would hopefully be an attraction to those planning and providing services at the local level[1]) and to concentrate on objectives for improving services and schemes for achieving these. This would involve extra work for those at the local level and indeed for those scrutinising applications but might be worthwhile if it encouraged innovation and offered the opportunity of coping with local problems in a way particularly adapted to local needs and assets.

There are many details to be worked out and difficulties to be overcome before the approach recommended here becomes feasible. However, it seems well worthwhile exploring the possibilities further and setting up a pilot scheme.

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[1] Since if such a scheme were seen as an alternative to a conventional average sized health centre quite substantial resources might be available.

REFERENCES

Barton, D.G. (1975) Private communication.

Bevan, J.M., Cunningham, D., Floyd C.B. (1976) Doctors on the Move: an assessment of an experimental surgery scheme in general practice. Canterbury: University of Kent, Health Services Research Unit, Report No.29.

Cartwright,A. (1967) Patients and their doctors - A study of general practice. London: Routledge and Kegan Paul.

Cunningham, D.J., Bevan, J.M. and Floyd C.B. (1972) Community Medicine.128,534-538

Dawes, K.S. and Bevan, J.M. (1976) The Wallsend Medical Centre - A study of the workload and of the attitudes of patients and staff. Canterbury: Health Services Research Unit, Report No. 20

Department of Health and Social Security (1974). Annual Report for 1973 London: H.M.S.O. (Cmnd 5700)

Department of Health and Social Security (1977)a. Annual Report for 1976 London: H.M.S.O. (Cmnd 6931)

Department of Health and Social Security (1971) Digest of Health Statistics for England and Wales (with summary tables for Great Britain) 1970. London: H.M.S.O.

Department of Health and Social Security (1977)b Health and Personal Social Services Statistics for England (with summary tables for Great Britain) 1977. London: H.M.S.O.

Dowie, R. (1975). The Purpose and Siting of Consultant Outpatient Sessions (HSRU Report No. 17) Canterbury: Health Services Research Unit, University of Kent.

Hicks, D. (1976). Primary Health Care - a review. London: H.M.S.O.

Irvine, D. and Jefferys, M. (1971) BMA Planning Unit Survey of General Practitioners 1969. British Medical Journal, 4, 535-543

McLachlan G. (ed.) (1976) A question of quality? Roads to assurance in medical care. London, Oxford University Press (for the Nuffield Provinical Hospitals Trust).

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

Ministry of Health (1967) E.C.N. 634 (ECL 82/67) National Health Service: General Medical Services: Statement of Fees and Allowances. London: Ministry of Health.

Pugh, D.S., Hickson, D.J., and Hinings, C.R. (1971) Writers on Organizations (2nd edition)Harmondsworth, Penguin Books Limited.

APPENDIX I

THE TABLES

NOTES ON THE TABLES

1. Details of the categories of General Practitioners

Neither main nor branch surgeries located in Health Centre or other Local Authority premises: these were the respondents to the original survey in 1969 who answered the Questionnaire to this effect (i.e. does not include the very small number of respondents to the 1972 re-survey who reported that they fell into this category).

Main Surgery in the Health Centre or other Local Authority premises - 1969 classification: these were respondents who indicated that their main surgery was located at a Health Centre or other Local Authority premises (and in some cases also their branch surgeries).

Branch Surgery in Health Centre or other Local Authority premises - 1969 classification: these were respondents who indicated that they had a branch surgery (but not their main surgery) located at a Health Centre or other Local Authority premises.

Main Surgery in a Health Centre - 1972 classification: these were the respondents whose main surgery was located at a Section 21[1] Health Centre (and includes those who had other surgeries at either a Health Centre or other Local Authority premises).

Branch Surgery in Health Centre - 1972 classification: these were respondents who had a branch surgery which was located at a Section 21 Health Centre and whose main surgery was located neither at a Health Centre nor at other Local Authority premises.

Main Surgery at other Local Authority premises - 1972 classification: these were respondents whose main surgery was located at Local Authority premises other than a Section 21 Health Centre and includes those who also had a branch surgery located at either a Section 21 Health Centre or other Local Authority premises).

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[1] Section 21 of the National Health Service Act (1946)

Branch Surgery in other Local Authority premises: these were respondents who had a branch surgery which was located in Local Authority premises other than a Section 21 Health Centre (and whose main surgery was located neither in a Health Centre nor in other Local Authority premises). This category does not include any who additionally had a branch surgery located in a Section 21 Health Centre.

2. Calculating the percentages

The design of the original survey was such that a one-in-eight sample of principles practising in designated areas was approached whereas the sampling fraction was one-in-twelve for those in other types of areas (see page 2). Accordingly the percentages quoted in the tables were obtained by weighting the results for non-designated areas by a factor of 1.5 before combining them with those from designated areas. The totals in the last column of the tables are actual unweighted totals of respondents in the various categories.

3. Note that percentages will not always sum across as a row to 100% due to rounding effects.

4. Some of the percentages are based on very small numbers of respondents - hence the need for caution in interpreting differences between groups.

TABLE O

DISTRIBUTION OF THOSE RESPONDENTS WHO IN 1969 STATED THAT THEY PRACTISED FROM HEALTH CENTRES OR OTHER LOCAL AUTHORITY PREMISES BY THEIR ANSWERS IN THE 1972 SURVEY

(WHICH ALSO RELATED TO PLACE OF PRACTICE IN 1969)

		1969 classification			
		Main surgery in health centre or other local authority premises		Branch surgery in health centre or other local authority premises	
		DOCTORS PRACTISING IN		DOCTORS PRACTISING IN	
		DES.AREAS	NON DES. AREAS	DES.AREAS	NON DES. AREAS
Main surgery in health centre	1972 classification	24	42	2	4
Branch surgery in health centre		1	0	11	5
Main surgery in other local authority premises		16	9	2	2
Branch surgery in other local authority premises		0	1	13	8
Premises not in health centre or other local authority premises at all		3	8	3	4
No response		2	0	2	0
TOTAL		46	60	33	23

Note: entries in this table are unweighted numbers of respondents. (see notes before Table O)

TABLE 1

DISTRIBUTION ACCORDING TO WHETHER OR NOT GENERAL PRACTITIONERS WERE IN RECEIPT OF GROUP PRACTICE ALLOWANCE FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

		WHETHER OR NOT IN RECEIPT OF GROUP PRACTICE ALLOWANCE			
DESCRIPTION OF CATEGORIES OF GENERAL PRACTITIONERS [1]		In receipt %	Not in Receipt %	Not Stated %	TOTAL 100%
Neither main nor branch in surgeries located in Health Centre or other local authority premises		53	46	1	1523
Main Surgery in Health Centre or other local authority premises	1969 classification	81	19	0	106
Branch Surgery in Health Centre or other local authority premises	1969 classification	70	30	0	56
Main Surgery in H.C.	1972 classification	83	17	0	72
Branch Surgery in H.C.	1972 classification	77	23	0	17
Main Surgery in L.A. prem.	1972 classification	77	23	0	29
Branch Surgery in L.A. prem.	1972 classification	62	38	0	22
Single Handed Doctors		7	92	1	337
Member of Partnership of 2 doctors		28	72	1	465
" " " " " 3 doctors		85	14	1	440
" " " " " 4 doctors		88	12	0	256
" " " " " 5 or more doctors		93	6	1	223
All respondents		55	44	1	1721

[1] See notes before table 0

TABLE 2

DISTRIBUTION ACCORDING TO SIZE OF PARTNERSHIP (IF ANY)

TO WHICH GENERAL PRACTITIONERS BELONGED FOR THE

INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF CATEGORY[1] OF GENERAL PRACTITIONER		PARTNERSHIP SIZE (DOCTORS)					
		Single Handed %	2 %	3 %	4 %	5 or more %	TOTAL 100%
Neither main nor branch surgeries located in H.C. or L.A. premises		20	28	25	15	12	1523
Main Surgery in H.C. or other L.A. premises	1969 classification	15	25	27	16	16	106
Branch Surgery in H.C. or other L.A. premises	1969 classification	7	15	30	22	26	56
Main Surgery in H.C.	1972 classification	15	25	21	22	17	72
Branch Surgery in H.C.	1972 classification	13	5	44	18	21	17
Main Surgery in other L.A. premises	1972 classification	10	32	23	12	23	29
Branch Surgery in other L.A. premises	1972 classification	11	23	30	17	19	22
In receipt of Group Practice Allowance		3	14	38	24	22	955
Not in receipt of Group Practice Allowance		42	44	8	4	2	755
All respondents		20	27	25	15	13	1721

[1] See notes before table 0

TABLE 2A

AVERAGE SIZE OF PARTNERSHIP FOR VARIOUS CATEGORIES OF DOCTOR

Neither main nor branch surgeries located in H.C. or L.A. premises	2.8
Main Surgery in H.C. or other L.A. premises (1969 classification)	3.0
Branch Surgery in H.C. or other L.A. premises (1969 classification)	3.6
Main Surgery in H.C. (1972 classification)	3.1
Branch Surgery in H.C. (1972 classification)	3.4
Main Surgery in other L.A. premises (1972 classification)	3.2
Branch Surgery in other L.A. premises (1972 classification)	3.2
Those in receipt of Group Practice Allowance	3.7
Those not in receipt of Group Practice Allowance	1.8
All respondents	2.8

(Note: Partnerships of 5 or more doctors are taken to contain an average of 5.5 doctors - which was the average size of such partnerships in 1969 in England (DHSS, 1971))

TABLE 3

DISTRIBUTION BY AGE OF GENERAL PRACTITIONERS FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		AGE IN YEARS				
		under 35 %	35-44 %	45-54 %	55 and over %	Total 100 %
Neither main nor branch surgeries located in H.C. or L.A. premises		9	33	33	26	1523
Main Surgery in H.C./L.A. premises	1969 classification	12	32	27	30	106
Branch Surgery in H.C./L.A.premises	1969 classification	9	31	31	29	56
Main Surgery in H.C.	1972 classification.	13	35	26	26	72
Branch Surgery in H.C.	1972 classification.	5	41	21	33	17
Main Surgery in L.A. prem.	1972 classification.	14	26	26	33	29
Branch Surgery in L.A. prem.	1972 classification.	-	19	38	43	22
Those in receipt of Group Practice Allowance		12	36	30	21	955
Those not in receipt of Group Practice Allowance		4	28	35	33	755
Single Handed Doctors		2	21	35	42	337
Member of partnership 2 doctors		7	34	33	27	465
" " " " " 3 doctors		10	38	32	21	440
" " " " " 4 doctors		14	37	27	22	256
" " " " " 5+ doctors		15	32	32	22	223
ALL DOCTORS		9	32	32	27	1721

[1] See notes before table 0

TABLE 3A

AVERAGE AGE (YEARS) OF DOCTORS FOR VARIOUS CATEGORIES OF DOCTOR

Neither main nor branch surgeries located in H.C. or L.A. premises	47.6
Main Surgery in H.C. or other L.A. premises (1969 classification)	51.1
Branch Surgery in H.C. or other L.A. premises (1969 classification)	47.7
Main Surgery in H.C. (1972 classification)	46.2
Branch Surgery in H.C. (1972 classification)	47.9
Main Surgery in other L.A. premises (1972 classification)	47.1
Branch Surgery in other L.A. premises (1972 classification)	52.1
Those in receipt of Group Practice Allowance	45.2
Those not in receipt of Group Practice Allowance	49.4
Single Handed Doctors	51.4
Member of Partnership of 2 doctors	48.1
" " " " " 3 doctors	46.4
" " " " " 4 doctors	45.4
" " " " " 5 or more doctors	46.2
All respondents	47.2

Note: Those under 35 years of age were taken to be on average 30 years of age, those over 55 years of age were taken to be on average 60 years of age; the average age of those in other age groups was taken to be the mid point of the age range of the group. (See table 3)

TABLE 4

DISTRIBUTION BY NUMBER OF PATIENTS ON LIST OF GENERAL PRACTITIONERS

FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		LIST SIZE[2] under 1600 %	1600-2199 %	2200-2599 %	2600-3199 %	3200 & over %	TOTAL 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		9	21	24	29	16	1523
Main Surgery in H.C./L.A. premises	1969 classification	1	20	21	38	20	106
Branch surgery in H.C./L.A. premises	1969 classification	3	10	20	51	16	56
Main Surgery in H.C.	1972 classification	1	22	22	38	17	72
Branch Surgery in H.C.	1972 classification	-	8	33	33	26	17
Main Surgery in L.A. prem.	1972 classification	-	15	17	44	24	29
Branch Surgery in L.A. prem.	1972 classification	4	15	9	59	13	22
Those in receipt of Group Practice Allowance		5	21	27	33	15	955
Those not in receipt of Group Practice Allowance		13	20	20	28	19	755
Single Handed Doctors		16	14	17	25	27	337
Member of partnership 2 doctors		11	26	21	27	16	465
" " " " " 3 doctors		5	21	25	36	13	440
" " " " " 4 doctors		4	19	33	31	13	256
" " " " " 5+ doctors		5	20	28	35	12	223
ALL DOCTORS		9	20	24	31	17	1721

1 See notes before table 0

2 This was average list size of partnership for those in partnership (i.e. of NHS patients)

TABLE 4a

AVERAGE LIST SIZE (TO NEAREST 10 PATIENTS) OF RESPONDENTS IN VARIOUS CATEGORIES OF DOCTOR

Neither main nor branch surgeries located in H.C. or L.A. premises	2480
Main Surgery in H.C. or other L.A. premises (1969 classification)	2660
Branch Surgery in H.C. or other L.A. premises (1969 classification)	2720
Main Surgery in H.C. (1972 classification)	2620
Branch Surgery in H.C. (1972 classification)	2760
Main Surgery in other L.A. premises (1972 classification)	2760
Branch Surgery in other L.A. premises (1972 classification)	2700
Those in receipt of Group Practice Allowance	2570
Those not in receipt of Group Practice Allowance	2490
Single Handed Doctors	2530
Member of Partnership of 2 doctors	2470
" " " " " 3 doctors	2550
" " " " " 4 doctors	2540
" " " " " 5 or more doctors	2540
All respondents	2550

Note: The average list size of those with lists under 1600 was taken to be 1500, the average list size of those with lists over 3200 was taken to be 3300; the average list size of other groups was taken to be the mid point of the range of list size in the groups. (See Table 4)

TABLE 5

DISTRIBUTION ACCORDING TO DISTANCE OF MAIN CONSULTING ROOM FROM HOME FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		DISTANCE OF MAIN CONSULTING ROOM FROM HOME						
		Consulting Room at Home %	Less than two Miles[2] %	2 - 5 Miles %	6 - 10 Miles %	More than ten Miles %	Not Stated %	TOTAL 100 %
Neither main nor branch Surgeries located in H.C. or L.A. premises		25	49	23	3	-	1	1523
Main Surgery in H.C./L.A. premises	1969 classification	2	60	33	2	2	2	106
Branch Surgery in H.C./L.A. premises	1969 classification	15	59	22	4	-	1	56
Main Surgery in H.C.	1972 classification		64	32	-	2	3	72
Branch Surgery in H.C.	1972 classification	-	59	36	5	-	-	17
Main Surgery in L.A. prem.	1972 classification	10	54	36	-	-	-	29
Branch Surgery in L.A. prem	1972 classification	17	70	6	4	-	4	22
Those in receipt of Group Practice Allowance		9	60	27	2	-	1	955
Those not in receipt of Group Practice Allowance		40	36	19	3	-	1	755
Single Handed Doctors		49	27	19	3	-	1	337
Member of partnership	2 doctors	27	47	22	3	1	1	465
" " " " "	3 doctors	13	56	27	3	-	1	440
" " " " "	4 doctors	9	58	28	2	-	2	256
" " " " "	5+ doctors	9	68	21	1	-	1	223
ALL DOCTORS		23	50	23	3	-	1	1721

[1] See notes before table 0

[2] Excluding those whose main consulting room was at their home

TABLE 6

DISTRIBUTION BY THE NUMBER OF NIGHTS THE GENERAL PRACTITIONER IS ON CALL ON AVERAGE PER WEEK FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		NUMBER OF NIGHTS ON CALL PER WEEK					
		Every Night %	5 or 6 Nights %	3 or 4 Nights %	2 or Fewer Nights %	Not Stated %	Total 100 %
Neither main nor branch surgeries located in H.C. or L.A. premises		11	13	33	42	1	1523
Main surgery in H.C/L.A. premises	1969 classification	4	9	34	52	2	106
Branch Surgery in H.C./L.A. premises	1969 classification	5	4	24	67	-	56
Main Surgery in H.C.	1972 classification	3	8	33	55	1	72
Branch Surgery in H.C.	1972 classification	8	-	31	61	-	17
Main Surgery in L.A. prem.	1972 classification	9	18	27	36	9	29
Branch Surgery in L.A. prem.	1972 classification	6	9	32	53	-	22
Those in receipt of Group Practice Allowance		1	7	32	58	2	955
Those not in receipt of Group Practice Allowance		21	19	33	25	2	755
Single Handed Doctors		38	21	17	22	1	337
Member of Partnership 2 doctors		7	14	49	28	2	465
" " " " " 3 doctors		1	6	43	46	2	440
" " " " " 4 doctors		1	10	20	68	1	256
" " " " " 5+ doctors		2	9	15	72	2	223
ALL DOCTORS		10	13	32	43	2	1721

[1] See notes before table 0

TABLE 6A

AVERAGE NUMBER OF NIGHTS ON CALL PER WEEK FOR VARIOUS CATEGORIES OF DOCTOR

Neither main nor branch surgeries located in H.C. or L.A. premises	3.3
Main Surgery in H.C. or other L.A. premises (1969 classification)	2.8
Branch Surgery in H.C. or other L.A. premises (1969 classification)	2.4
Main Surgery in H.C. (1972 classification)	2.7
Branch Surgery in H.C. (1972 classification)	2.6
Main Surgery in other L.A. premises (1972 classification)	3.4
Branch Surgery in other L.A. premises (1972 classification)	2.8
Those in receipt of Group Practice Allowance	2.5
Those not in receipt of Group Practice Allowance	4.1
Single Handed Doctors	4.8
Member of Partnership of 2 doctors	3.5
" " " " " 3 doctors	2.6
" " " " " 4 doctors	2.4
" " " " " 5 or more doctors	2.3
All respondents	3.2

TABLE 7

DISTRIBUTION ACCORDING TO TYPE OF ANCILLARY HELP AVAILABLE TO THE GENERAL PRACTITIONER FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		TYPE OF ANCILLARY HELP AVAILABLE[2]						
		None %	Sec/rec only %	Nurse only or Sec/rec + Nurse %	Other only or other + one of Sec/rec or Nurse %	Sec/rec + Nurse + other %	Not Stated %	Total 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		5	24	40	8	22	1	1523
Main Surgery in H.C./L.A. premises	1969 classification	-	10	45	2	43	-	106
Branch Surgery in H.C./L.A. premises	1969 classification	-	24	41	12	23	-	56
Main Surgery in H.C.	1972 classification	-	6	46	-	48	-	72
Branch Surgery in H.C.	1972 classification	-	31	23	18	28	-	17
Main Surgery in L.A. prem.	1972 classification	-	16	51	3	30	-	29
Branch Surgery in L.A. prem.	1972 classification	-	26	38	13	23	-	22
Those in receipt of Group Practice Allowance		-	17	44	6	32	-	955
Those not in receipt of Group Practice Allowance		9	31	35	11	12	1	755
Single Handed Doctors		13	31	30	14	10	2	337
Member of partnership	2 doctors	5	28	39	8	19	1	465
" " " " "	3 doctors	1	26	43	7	24	-	440
" " " " "	4 doctors	-	16	43	6	35	-	256
" " " " "	5+ doctors	1	8	47	4	39	1	223
ALL DOCTORS		4	24	40	8	23	1	1721

1 See notes before table 0

2 Sec/rec = Secretary/Receptionist
Nurse = District Nurse, Health Visitor or other SRN/SEN
Other = Social Worker(or ancillary help other than secretary/receptionist or nurse)

TABLE 7A

PERCENTAGE OF GENERAL PRACTITIONERS WHO HAD A SOCIAL WORKER IN OR ATTACHED (EITHER PART TIME OR WHOLE TIME) TO THE PRACTICE FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		PERCENTAGE WITH SOCIAL WORKER IN OR ATTACHED TO PRACTICE	TOTAL 100%
Neither main nor branch surgeries located in H.C. or L.A. premises		6	1523
Main surgery in H.C./L.A. premises	1969 classification	21	106
Branch surgery in H.C./L.A. premises	1969 classification	7	56
Main surgery in H.C.	1972 classification	22	72
Branch surgery in H.C.	1972 classification	23	17
Main surgery in L.A. prem.	1972 classification	16	29
Branch surgery in L.A. prem.	1972 classification	6	22
Those in receipt of Group Practice Allowance		9	955
Those not in receipt of Group Practice Allowance		4	755
Single Handed Doctors		4	337
Member of partnership	2 doctors	7	465
" " " "	3 doctors	7	440
" " " "	4 doctors	7	256
" " " "	5+ doctors	12	223
ALL DOCTORS		7%	1721

1 See notes before table 0

TABLE 8

DISTRIBUTION BY NUMBER OF ITEMS OF EQUIPMENT (OF THOSE LISTED IN QUESTIONNAIRE - SEE APPENDIX II) USED BY GENERAL PRACTITIONER IN CONSULTING ROOM FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		NUMBER OF ITEMS OF EQUIPMENT USED								
		0 or 1 %	2 %	3 %	4 %	5 %	6 %	7 or more %	Not Stated %	TOTAL 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		5	9	20	28	17	12	8	1	1523
Main Surgery in H.C./L.A. premises	1969 classification	6	13	17	26	18	9	12	1	106
Branch Surgery in H.C./L.A. premises	1969 classification	3	13	18	21	24	16	6	-	56
Main Surgery in H.C.	1972 classification	3	16	16	23	19	8	15	-	72
Branch Surgery in H.C.	1972 classification	5	8	28	13	10	31	5	-	17
Main Surgery in L.A. prem.	1972 classification	10	10	15	30	20	12	3	-	29
Branch Surgery in L.A. prem.	1972 classification	-	11	19	24	30	11	4	-	22
Those in receipt of Group Practice Allowance		3	10	18	26	16	14	12	1	955
Those not in receipt of Group Practice Allowance		7	10	22	28	19	10	4	1	755
Single Handed Doctors		9	10	20	28	17	12	3	2	337
Member of partnership	2 doctors	4	11	20	27	19	12	6	1	465
" " " " "	3 doctors	5	10	21	30	15	10	7	1	440
" " " " "	4 doctors	3	8	20	24	20	14	11	-	256
" " " " "	5+ doctors	3	6	17	26	14	16	18	1	223
ALL DOCTORS		5	9	20	27	17	12	8	1	1721

[1] See notes before table 0

TABLE 8A

THE AVERAGE NUMBER OF ITEMS OF EQUIPMENT USED IN THE CONSULTING ROOM BY VARIOUS CATEGORIES OF DOCTOR (FOR A LIST OF ITEMS SEE APPENDIX II)

Neither main nor branch surgeries located in H.C. or L.A. premises	4.2
Main Surgery in H.C. or other L.A. premises (1969 classification)	4.3
Branch Surgery in H.C. or other L.A. premises (1969 classification)	4.3
Main Surgery in H.C. (1972 classification)	4.4
Branch Surgery in H.C. (1972 classification)	4.3
Main Surgery in other L.A. premises (1972 classification)	3.9
Branch Surgery in other L.A. premises (1972 classification)	4.2
Those in receipt of Group Practice Allowance	4.4
Those not in receipt of Group Practice Allowance	3.9
Single Handed Doctors	3.9
Member of Partnership of 2 doctors	4.1
" " " " " 3 doctors	4.0
" " " " " 4 doctors	4.5
" " " " " 5 or more doctors	4.8
All respondents	4.2

TABLE 9

PERCENTAGES OF GENERAL PRACTITIONERS USING VARIOUS KINDS OF EQUIPMENT IN THEIR CONSULTING ROOMS FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		PERCENTAGE WITH EQUIPMENT IN CONSULTING ROOM									
		Height Scale %	E.S.R. Tubes %	Micro-scope %	H.B. Meter %	Sterile Gloves %	Proctoscope %	E.C.G. Machine %	Wright Peak Flow Meter %	Equipped Emergency Bag %	TOTAL 100%
Neither main nor branch surgeries located in H.C. or L.A. premises		90	22	26	25	76	76	16	7	73	1523
Main Surgery in H.C./L.A. Prem.	1969 classification	90	20	22	32	72	71	32	13	60	106
Branch Surgery in H.C./L.A. prem.	1969 classification	87	14	20	27	83	76	21	12	79	56
Main Surgery in H.C.	1972 classification	92	23	26	34	69	78	39	13	62	72
Branch Surgery in H.C.	1972 classification	87	16	21	31	67	72	38	13	82	17
Main Surgery in L.A. prem.	1972 classification	86	17	13	33	80	68	19	10	61	29
Branch Surgery in L.A. Prem.	1972 classification	96	11	25	23	96	74	13	15	70	22
Those in receipt of Group Practice Allowance		92	25	29	28	75	80	25	9	70	955
Those not in receipt of Group Practice Allowance		86	18	22	22	77	72	8	6	76	755
Single Handed Doctors		85	17	25	23	78	66	7	5	74	337
Member of partnership	2 doctors	87	21	22	24	78	76	12	6	77	465
" " " " "	3 doctors	88	22	25	25	71	77	17	7	70	440
" " " " "	4 doctors	96	23	27	28	77	84	27	10	69	256
" " " " "	5+ doctors	96	30	36	31	78	81	34	13	66	223
ALL DOCTORS		89	22	26	26	76	76	17	8	72	1721

[1] See notes before table 0

TABLE 10

DISTRIBUTION BY NUMBER OF DIAGNOSTIC FACILITIES (FROM AMONG THOSE LISTED IN QUESTIONNAIRE - SEE APPENDIX II) TO WHICH THE GENERAL PRACTITIONER HAD DIRECT ACCESS FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		NUMBER OF DIAGNOSTIC FACILITIES AVAILABLE						
		0 %	1 %	2 %	3 %	4 %	Not Stated %	Total 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		3	4	8	16	68	1	1523
Main Surgery in H.C./L.A. premises	1969 classification	3	4	5	21	66	1	106
Branch Surgery in H.C./L.A. premises	1969 classification	4	1	6	30	58	-	56
Main Surgery in H.C.	1972 classification	1	3	4	22	70	-	72
Branch Surgery in H.C.	1972 classification	5	-	15	8	72	-	17
Main Surgery in L.A. prem.	1972 classification	9	9	10	26	46	-	29
Branch Surgery in L.A. prem.	1972 classification	4	-	4	30	62	-	22
Those in receipt of Group Practice Allowance		2	3	5	16	73	1	955
Those not in receipt of Group Practice Allowance		6	4	10	18	60	2	755
Single Handed Doctors		9	4	13	18	55	2	337
Member of Partnership 2 doctors		3	5	8	19	63	2	465
" " " " " 3 doctors		3	2	5	15	73	1	440
" " " " " 4 doctors		-	3	6	12	77	-	256
" " " " " 5+ doctors		1	3	6	17	72	-	223
ALL DOCTORS		4	4	7	17	67	1	1721

[1] See notes before table 0

TABLE 11

PERCENTAGE OF GENERAL PRACTITIONERS WITH DIRECT ACCESS TO VARIOUS DIAGNOSTIC FACILITIES FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		PERCENTAGE WITH DIRECT ACCESS TO: Full Size Chest X-Rays	Bone and Joint X-Rays	Bacterio-logical Examination of Urine	Glucose Tolerance Tests	TOTAL (100%)
Neither main nor branch Surgeries located in H.C. or L.A. premises		86	82	94	76	1523
Main Surgery in H.C./L.A. premises	1969 classification	86	85	94	76	106
Branch Surgery in H.C./L.A. premises	1969 classification	93	76	96	72	56
Main Surgery in H.C.	1972 classification	91	87	97	81	72
Branch Surgery in H.C.	1972 classification	90	79	95	77	17
Main Surgery in L.A. prem.	1972 classification	70	67	88	68	29
Branch Surgery in L.A. prem.	1972 classification	96	89	96	66	22
Those in receipt of Group Practice Allowance		89	86	96	81	955
Those not in receipt of Group Practice Allowance		83	76	91	70	755
Single Handed Doctors		79	71	88	64	337
Member of Partnership	2 doctors	84	80	94	72	465
" " " "	3 doctors	89	86	95	81	440
" " " "	4 doctors	91	88	98	83	256
" " " "	5+ doctors	91	85	98	82	223
ALL DOCTORS		86	81	94	76	1721

[1] See notes before table 0

TABLE 12

DISTRIBUTION ACCORDING TO TYPE OF HOSPITAL BEDS TO WHICH GENERAL PRACTITIONERS HAD DIRECT ACCESS (AND RETAINED FULL RESPONSIBILITY FOR TREATMENT OF PATIENTS) FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		DIRECT ACCESS TO BEDS					
		None %	Obstetric beds only %	Other beds only %	Obstetric and other beds %	No answer %	TOTAL (100%)
Neither main nor branch Surgeries located in H.C. or L.A. premises		47	30	9	13	1	1523
Main Surgery in H.C./L.A. premises	1969 classification	40	29	11	18	1	106
Branch Surgery in H.C./L.A. premises	1969 classification	58	25	4	13	-	56
Main Surgery in H.C.	1972 classification	41	26	15	17	1	72
Branch Surgery in H.C.	1972 classification	41	46	-	13	-	17
Main Surgery in L.A. prem.	1972 classification	54	26	3	17	-	29
Branch Surgery in L.A. prem.	1972 classification	55	30	9	6	-	22
Those in receipt of Group Practice Allowance		40	33	10	16	1	955
Those not in receipt of Group Practice Allowance		55	25	8	10	2	755
Single Handed Doctors		61	21	8	8	2	337
Member of partnership 2 doctors		50	30	7	12	2	465
" " " " " 3 doctors		40	35	11	13	2	440
" " " " " 4 doctors		35	31	9	23	2	256
" " " " "5+ doctors		44	30	9	16	1	223
ALL DOCTORS		47	29	9	13	2	1721

[1] See notes before table 0

TABLE 13

DISTRIBUTION ACCORDING TO TYPE OF APPOINTMENTS HELD BY GENERAL PRACTITIONERS (OUTSIDE GENERAL PRACTICE) FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		APPOINTMENTS HELD - (OUTSIDE GENERAL PRACTICE)				
		Hospital only %	Non-Hospital only %	Hospital and Non-Hospital %	None %	Total 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		13	36	12	38	1523
Main Surgery in H.C./L.A. premises	1969 classification	19	24	18	40	106
Branch Surgery in H.C./L.A. premises	1969 classification	9	37	13	41	56
Main Surgery in H.C.	1972 classification	19	21	14	46	72
Branch Surgery in H.C.	1972 classification	10	49	21	21	17
Main Surgery in L.A. prem.	1972 classification	12	20	25	43	29
Branch Surgery in L.A. prem.	1972 classification	4	40	15	41	22
Those in receipt of Group Practice Allowance		15	35	14	36	955
Those not in receipt of Group Practice Allowance		11	36	11	42	755
Single Handed Doctors		11	35	10	44	337
Member of Partnership 2 doctors		11	34	13	42	465
" " " " " 3 doctors		13	39	10	38	440
" " " " " 4 doctors		15	31	18	35	256
" " " " " 5+ doctors		21	35	14	29	223
ALL DOCTORS		13	35	13	39	1721

[1] See notes before table 0

TABLE 14

DISTRIBUTION ACCORDING TO GENERAL PRACTITIONERS' ASSESSMENTS OF THEIR OPPORTUNITIES FOR TAKING POST GRADUATE OR REFRESHER COURSES; FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		OPPORTUNITIES FOR ATTENDANCE AT COURSES					
		Very Good %	Good %	Poor %	Very Poor %	Not Stated %	TOTAL 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		31	46	15	5	3	1523
Main Surgery in H.C./L.A. premises	1969 classification	34	49	13	1	4	106
Branch Surgery in H.C./L.A. premises	1969 classification	47	35	16	1	-	56
Main Surgery in H.C.	1972 classification	37	44	14	2	3	72
Branch Surgery in H.C.	1972 classification	67	23	10	-	-	17
Main Surgery in L.A. prem.	1972 classification	30	57	10	3	-	29
Branch Surgery in L.A. prem.	1972 classification	36	51	13	-	-	22
Those in receipt of Group Practice Allowance		34	50	11	2	2	955
Those not in receipt of Group Practice Allowance		30	41	20	7	3	755
Single Handed Doctors		29	35	21	10	5	337
Member of Partnership	2 doctors	27	46	18	6	3	465
" " " " "	3 doctors	31	50	14	2	3	440
" " " " "	4 doctors	36	52	9	2	-	256
" " " " "	5+ doctors	42	45	9	2	1	223
ALL DOCTORS		32	46	15	5	3	1721

[1] See notes before table 0

TABLE 15

DISTRIBUTION ACCORDING TO GENERAL PRACTITIONERS' ASSESSMENTS OF COMMUNICATIONS FROM HOSPITAL WHEN PATIENTS HAVE BEEN DISCHARGED, FOR THE INDICATED CATEGORIES OF DOCTORS WHO RESPONDED

DESCRIPTION OF GROUP[1]		COMMUNICATIONS FROM HOSPITALS					
		Very Good %	Good %	Poor %	Very Poor %	No Answer %	TOTAL 100%
Neither main nor branch Surgeries located in H.C. or L.A. premises		7	54	30	5	4	1523
Main Surgery in H.C./L.A. premises	1969 classification	4	47	41	5	4	106
Branch Surgery in H.C./L.A. premises	1969 classification	8	63	26	4	-	56
Main Surgery in H.C.	1972 classification	2	46	42	6	4	72
Branch Surgery in H.C.	1972 classification	0	82	13	5	0	17
Main Surgery in L.A. prem.	1972 classification	) 9	41	48	3	0	29
Branch Surgery in L.A. prem.	1972 classification	)15	49	30	6	0	22
Those in receipt of Group Practice Allowance		5	52	33	6	5	955
Those not in receipt of Group Practice Allowance		10	56	26	5	4	755
Single Handed Doctors		12	55	23	5	6	337
Member of partnership 2 doctors		7	56	28	5	4	465
" " " " " 3 doctors		6	52	31	6	4	440
" " " " " 4 doctors		4	55	34	4	3	256
" " " " " 5+ doctors		7	50	37	3	3	223
ALL DOCTORS		7	54	30	5	4	1721

[1] See notes before table 0

APPENDIX II

Questions, to which reference is made, in this report, from the "Designated Areas Study" questionnaire administered in 1969. (The full questionnaire is printed in J.R. Butler et al (1973), Appendix B.)

1. What other medical appointments do you currently hold outside the provision of general medical services?

Appointment	Type of Appointment
1	
2	
3	
4	

2. Do you receive a group practice allowance? (Please tick)

No ☐

Yes ☐

3. What ancillary help, either full-time or part-time, do you have in or attached to the practice? (Please tick all that apply)

No ancillary help ☐

Secretary/receptionist ☐

District Nurse ☐

Health Visitor ☐

Other SRN/SEN ☐

Social Worker ☐

Other ancillary help ☐

4. Are your main or branch consulting rooms in a Local Authority Clinic or a Health Centre? (Please tick)

	No	Yes
Main consulting rooms	☐	☐
Branch consulting rooms	☐	☐

5. How many nights of the week are you on call, on the average, for cases other than obstetrics? (Please tick)

Every night	☐
5 or 6 nights	☐
3 or 4 nights	☐
2 or fewer nights	☐

6. Do you have direct access to any NHS beds where you retain full responsibility for the treatment of your patients whilst in hospital? (Please tick all that apply)

No beds at all	☐
Obstetric	☐
Medical	☐
Surgical	☐
Geriatric	☐
Other	☐

7. To which of the following facilities do you have direct access (i.e. not through a consultant or casualty)? (Please tick all that apply)

Full size chest X-rays	☐
Bone and joint X-rays	☐
Bacteriological examination of urine	☐
Glucose tolerance tests	☐
None of these	☐

8. In general, how would you describe: (Please tick)

	Very Good	Good	Poor	Very Poor
Arrangements for getting your elderly patients into hospital?	☐	☐	☐	☐
Communications from hospital when patients have been discharged?	☐	☐	☐	☐
Your opportunities for taking post-graduate or refresher courses?	☐	☐	☐	☐

9. Do you use the following equipment in your consulting room? (Please tick all that apply)

Height Scale	☐
ESR tubes	☐
Microscope	☐
HB Meter	☐
Sterile Gloves	☐
Proctoscope	☐
ECG machine	☐
Wright Peak Flow Meter	☐
Equipped Emergency Bay	☐

10. How far do you live from your main consulting room? (Please tick)

Main consulting room as part of residence	☐
Less than 2 miles	☐
2 - 5 miles	☐
6 - 10 miles	☐
More than 10 miles	☐

APPENDIX III

The short questionnaire sent in 1972 to respondents to the original 1969 questionnaire who then said that either their main and/or branch consulting rooms were in a Local Authority Clinic or a Health Centre.

THE QUESTIONNAIRE (IN THE FORM OF A POSTCARD)

Code No. _____

Were your main or branch consulting rooms in a Local Authority Clinic or a Health Centre in December, 1969? (please tick boxes as appropriate)

HEALTH CENTRE (as defined in section 21, N.H.S. Act 1946)

Main Consulting Rooms	Branch Consulting Rooms
☐	☐

LOCAL AUTHORITY CLINIC

Main Consulting Rooms	Branch Consulting Rooms
☐	☐

Thank you

APPENDIX IV

Further commentary on tables 3 to 15 - Doctors in receipt of the group practice allowance compared with those not in receipt of this allowance - results from the U.K.C. Survey compared with those from the B.M.A. Survey - a comparison between the results obtained using the 1969 classification and the 1972 classification of doctors according to whether they practised from Health Centres and/or local authority Clinics.

Age (Tables 3 and 3a)

Doctors in receipt of the group practice allowance were considerably younger than those not receiving this allowance; in fact the average age of the former was lower than that of any other category of doctors considered in this report.

The finding that doctors practising from Section 21 Health Centres as their main surgery were younger than those not so doing is in agreement with the conclusion drawn from the B.M.A. Survey on this matter as is the finding that doctors receiving the group practice allowance were generally younger than those not receiving this allowance.

Note that using the 1969 classification of doctors according to whether or not they practised from Health Centres or other Local Authority Clinics would have led to the impression that doctors practising from such premises were somewhat older than doctors in general whereas in fact those practising from Section 21 Health Centres (according to the 1972 classification) were younger than doctors in general and it was doctors working from other Local Authority premises that tended to be of above average age.

The number of patients registered with doctors (note in the case of doctors in partnership, this is the average number of patients per doctor registered with the practice) (Tables 4 and 4a).

Doctors in receipt of the group practice allowance had slightly larger lists than those not in receipt of this allowance.

It appeared that the respondents to the B.M.A. Survey included a higher proportion with very small lists (1500 or less patients per doctor) than respondents in the U.K.C. Survey. (Even when respondents from Wales and Scotland are excluded)

The 1969 classification of doctors according to whether or not they used Health Centres or Local Authority Clinics as their main or branch surgeries gave a similar impression to that obtained using the 1972 classification namely that such doctors tended to have larger than average list sizes, though it is known in the case of those working from Section 21 Health Centres that this was not because they tended to be predominently in designated areas.

The distance between a doctor's home and his main Consulting Room (Table 5)

23% of the doctors in the U.K.C. survey practised from their own homes as their main surgery and a further 50% lived within two miles of their main surgery. In the case of those receiving group practice allowance, 9% had their main surgery in their home and a further 60% lived within two miles of their main surgery. 40% of those not in receipt of group practice allowances had their main consulting room at their home and in addition 36% lived within two miles of their main surgery.

In the B.M.A. Survey respondents were asked whether their main surgery was located at their own or a partner's home. 31% of the respondents as a whole reported that their main surgery was in their own or a partner's home compared with 20% of the GPA doctors and 40% of the non GPA doctors.

Findings based on the 1969 classification of doctors according to whether or not they worked from Health Centres or other Local Authority premises would, like those based on the 1972 classification have suggested that such doctors tended to live further away in general from their main surgery than doctors practising in other kinds of premises. However using the 1969 classification, it appeared that there was a difference between those using Local Authority (Health Centre or Clinic) premises as branch surgeries and those using such premises as main surgeries whereas the 1972 classification suggested that there was some difference between the relatively small number of doctors practising from local authority premises as their branch surgeries who in general lived very close to their main surgeries

and those practising from Health Centres as main or branch surgeries and from other local authority premises as main surgeries who in each case appeared to live on average relatively far from their main surgeries.

The number of nights on call per week on average (Tables 6 and 6a)

Doctors in receipt of the group practice allowance were on call for relatively few nights per week on average and in fact fared slightly better in this respect than doctors practising from Section 21 Health Centres as their main surgery.

The use of the 1969 classification of doctors according to whether or not they practised from Health Centres or other Local Authority premises suggested that those using such premises as branch surgeries were on call for rather fewer nights per week than those using such premises as their main surgery. Using the 1972 classification however indicated that this difference was almost entirely accounted for by those using Local Authority Clinics as main and branch surgeries respectively and indeed there was relatively little difference between those using Section 21 Health Centres as main and branch surgeries as far as the number of nights on call per week was concerned. In fact the use of the 1972 classification did also indicate that doctors in Health Centres fared rather better than those in Local Authority Clinics.

Type of ancillary help available (Table 7 and 7a)

Predictably none of the respondents who were in receipt of a group practice allowance were without some kind of ancillary help compared with 9% of those not in receipt of the group practice allowance. 32% of the former compared with 12% of the latter had the assistance of a secretary/receptionist, nurse and other staff. 9% of doctors receiving group practice allowances had a Social Worker in or attached to their practice compared to 4% of those not in receipt of that allowance.

97% of the respondents in the B.M.A. Survey had some ancillary help compared with 96% in the U.K.C. Survey. Generally it is not possible to compare further details of the kind of ancillary help available to respondents in the two Surveys. However the B.M.A. Survey agreed with the U.K.C. Survey in suggesting that doctors practising from Health Centres were more likely to have staff of various kinds employed or attached to their practices than doctors generally in receipt of group practice allowance and both these categories of doctors were much more likely to have such assistance than those not in receipt of the group practice allowance. In particular, the B.M.A. Survey as in the case of the U.K.C. Survey suggested that Health Centre Doctors were much more likely than any other category to have the assistance of a Social Worker.

Using the 1969 classification of doctors according to whether they practised from Health Centres or Local Authority Clinics would have brought out the greater likelihood of doctors practising from such premises as their main surgeries having staff other than secretary/receptionists (and in particular Social Workers) However it would have failed to make the distinction between Health Centres and other Local Authority premises which was apparent when the 1972 classification was used.

Items of equipment used in the Consulting Room. (Tables 8, 8a and 9)

(See the note in the main text about the limitations of the question on which these results are based). Doctors in receipt of group practice allowances used on average about the same number of items of equipment in their Consulting Rooms as those practising from Section 21 Health Centres as their main surgery but not quite as many as those in partnerships of four or more. Those not in receipt of group practice allowances tended to resemble single handed doctors generally and used fewer tools on average than those in partnership. With individual items of equipment it appeared that those in receipt of group practice allowances were more likely to use all the listed items of equipment

in their Consulting Rooms than those not in receipt of such an allowance except sterile gloves and equipped emergency bags. However those in receipt of a group practice allowance generally were slightly less likely to use the listed items than respondents working from the largest partnerships considered.

The B.M.A. Survey also considered equipment available to General Practitioners and found that "Doctors in Health Centres more commonly reported having haemoglobinometers, electrocardiographs and peak flow meters on their premises than those in G.P.A. (Group Practice Allowance) and especially non G.P.A. practices but were no more likely to have other types of equipment listed" (a different list from that used in the U.K.C. Survey). This conclusion was supported generally speaking by the U.K.C. Survey. More particularly on the matter of the comparability of the B.M.A. and U.K.C. Survey results, the table below indicates some items of equipment giving the proportions respectively of B.M.A. and U.K.C. respondents as a whole having access/using (in their consulting rooms) these items. In the case of the B.M.A. Survey it was a question of having these items on the premises, in the case of the U.K.C. Survey using the items in the consulting room.

Equipment	B.M.A. Survey	U.K.C. Survey
Proctoscope	70%	76%
Electrocardiograph	10%	17%
Microscope	34%	26%
Haemoglobinometer	35%	26%
ESR tubes	'uncommon'	22%

The use of the 1969 classification for doctors according to whether or not they practised from Health Centres or Local Authority Clinics would have inevitable obscured the fact that doctors in Health Centres were more likely to use certain items of equipment than those practising from other Local Authority premises.

Direct access to diagnostic facilities (Tables 10 and 11)

Respondents in receipt of the group practice allowance were more likely to have direct access to each of the four facilities listed than those not in receipt of such an allowance but generally did not do quite so well in this respect as those in the larger partnerships (four or more doctors).

The use of the 1969 classification of doctors according to whether or not they practised from Health Centres or other Local Authority premises, gave the impression that those practising from such premises either as main or branch surgery, tended to be rather less well off in terms of access to diagnostic facilities than respondents as a whole, whereas this was entirely a characteristic of doctors practising from Local Authority Clinics. The use of the 1969 classification also gave the impression that those practising from Health Centres or Local Authority Clinics as main surgeries were less well off than those practising from such practices as branch surgeries, whereas the 1972 classification makes it clear that this was entirely due to the very low proportions of respondents who used Local Authority Clinics as their main surgery who had access to diagnostic facilities.

The B.M.A. Survey also examined access of doctors to diagnostic facilities and produced results very similar to those in the U.K.C. Survey. Thus 88% of doctors in the B.M.A. Survey compared with 86% in the U.K.C. Survey had access to Chest X-ray, 83% of those in the B.M.A. Survey compared with 81% of those in the U.K.C. Survey had access to bone and joint X-rays. The B.M.A. Survey also found rural doctors were more likely to have access to radiological, haematological, and bacteriological facilities than their urban colleagues,a finding that is compatible with the conclusion of the U.K.C. Survey (see Butler et al(1973))that doctors in designated areas fared less well in such respects than those in non-designated areas.

Direct access to hospital beds (Table 12)

Doctors in receipt of the group practice allowance were more likely to have access to obstetric beds and to other beds than those not in receipt of this allowance. Generally the former resembled doctors working in partnerships of three or more doctors.

Once again using the 1969 classification according to whether they practised from Health Centres or Local Authority premises failed to bring out the considerable differences existing between those in Health Centres and those in other types of Local Authority premises and made a distinction between those practising from such premises as main surgery and those practising from them as branch surgeries which was not borne out at all when the 1972 classification was used.

Appointments held outside General Practice (Table 13)

Respondents in receipt of group practice allowances were more likely to hold hospital appointments than those not in receipt of the allowance but there was relatively little differences between these two categories of doctor as regard proportions holding non-hospital appointments.

33% of the respondents to the B.M.A. Survey had hospital appointments compared with 26% in the case of the U.K.C. Respondents. Fourth fifths of the respondents to the B.M.A. Survey had non hospital appointments compared with 48% of those who replied to the U.K.C. questionnaire. This very wide difference between the results from the two surveys appears to be at least in part due to the nature of the questions used.

In the B.M.A. Survey the matter of appointments outside general practice was the subject of a more detailed set of questions than was the case in the U.K.C. Survey where respondents were simply asked to list up to four current appointments outside general practice (see appendix II)

The use of the 1969 classification of respondents according to whether or not they practised from Health Centres or other Local Authority premises obscured to some extent the fact that doctors working from Health Centres as their main surgery were relatively unlikely to have any such appointments.

Respondents' assessment of their opportunities for attending post-graduate or refresher courses. (Table 14)

Respondents in receipt of group practice allowance were generally more likely to rate opportunities as good or very good than those not in receipt of such an allowance and in this respect generally resembled those practising in partnerships of three or more doctors.

The use of the 1969 classification of doctors according to whether or not they practised from Health Centres or other Local Authority Premises would have led to much the same conclusion as was obtained using the 1972 classification, namely that those practising from Health Centres or other Local Authority Premises resembled those working in the larger partnerships generally in their assessment of their opportunities for attendance at courses.

Respondents' assessment of communications from hospital when patients have been discharged (Table 15)

Respondents in receipt of group practice allowances were less likely to rate these communications as good or very good than those not in receipt of such an allowance.

In the case of those working from Health Centres or other Local Authority Premises, the crucial distinction, as far as their assessment of communications from hospitals was concerned, was whether or not they practised from such premises as main or branch surgery rather than whether the premises were Health Centres or Local Authority Clinics. Hence the results obtained using the 1969 classification were much the same as those obtained from the 1972 classifiction.