

OFFICE OF HEALTH ECONOMICS

The Provision of General Medical Care in New Towns

Proceedings of a Symposium

held at

College of General Practitioners, London

19th & 20th April 1966



Edited by:

Dr John Fry & John McKenzie

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OHE

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THE NEW TOWNS OF BRITAIN



Introduction

MEETINGS can be of two types. In the first, a small group of experts are invited to describe some aspects of their work or their philosophy to the others present. Provided that the speakers are original, coherent and intelligible there is no problem in publishing a readable version of the proceedings. The second type of meeting depends on a free exchange of ideas between all the participants. Opening speakers are invited only to provide background facts, and to stimulate the group as a whole to creative thinking. It is virtually impossible to publish readable proceedings from such a meeting. Even a heavily edited verbatim report appears rambling and incoherent. A simple description of the discussion tends to lose the spirit of the meeting.

The OHE symposium on General Medical Care in New Towns, which we organised in April 1966 in co-operation with the College of General Practitioners, falls squarely in the second category. We have, therefore, not attempted to produce a comprehensive record of the proceedings. Indeed, in the conventional sense, this publication is not a report of the meeting at all. It aims only to record the conclusions—the areas of broad agreement, as well as the many questions to which no answers emerged—and more particularly to record, in the participants' own words, some of the highlights of the discussion. In many cases the choice of a passage or remark by one participant reflects a point made equally well by several others. In this sense, the following pages are intended primarily to stimulate the reader rather than to do justice to the many excellent contributions to the meeting. I am grateful to John Fry and John McKenzie for the way in which they have pieced together such a remarkably clear impression of the spirit of the meeting from the original manuscript.

To keep this report in a perspective it is necessary to state that the Working Paper for the Conference was Dr J. B. Dillane's survey on the general medical services in New Towns.* It is suggested that this be read together with this report.

This brings me to the purpose both of the meeting itself and of this report. Each is intended to distil and disseminate contemporary thought about the future of general medical care. The meeting focused on new towns because historically they should have provided an opportunity for experiment and evaluation. It should have been possible to develop blue prints from them; to provide a pattern for the future of medical care in the country as a whole. They have failed in this role. It was clear, also, that their failure to some extent reflects a lethargy amongst all those who might have taken responsibility for organising, reviewing and remodelling of medical care. Such remodelling is needed urgently to take account of the dramatic technical advances which have occurred since the inception of the National Health Service. The role of the general practitioner nowadays should bear little resemblance to his role in the 1930s, when he frequently had to tackle acute diseases with only the very few effective therapeutic weapons then available. Nor can the general practice based on the pattern established in the early part of this century take advantage of the new techniques of the computer age which are available to assist in the early diagnosis of the now prevalent chronic disorders.

The meeting itself recognised this failure to use the new towns to develop new patterns of medical care. But so far from causing despair, it stimulated a desire to find ways of ensuring that the failure was not repeated. As this report shows, what should be done was often far from clear. But there was a determination that the problems should be faced and solved, and that a new pattern of general medical care should emerge from experiments in future.

Nevertheless a word of caution is necessary. Those who attended the meeting had been invited, in the main, because they were known to have progressive and positive thoughts about the future of general practice. Is it possible that the lethargy which has pervaded the organisation of medical care in the past seventeen years still exists

* *Reports from General Practice No. IV, College of General Practitioners, 1966.*

elsewhere among those concerned with the health service? Are the health service administrators, and the medical and ancillary professions as a whole, really willing to support the kind of progressive reorganisation of medical care which seemed to gain such general support amongst the highly selective few who attended this meeting? It is to be hoped that all those who read this report will ask that question of themselves, and will be prepared to face boldly the need for drastic changes.

GEORGE TEELING-SMITH

The New Towns

'The most important thing about this Conference is that it has been held at all—but fifteen years too late.'

(F. SCHAFFER)

THE study of urban growth in Britain up to 1939 reveals a picture of expediency. Towns, industry and suburbia grew hodge-podge as results of economic pressures and incentives and blind intuition on the part of developers. The genesis of New Towns at the end of World War II and more recently has brought planning, at least theoretically, to a new level. Here were unique opportunities to start from scratch with often simply a nucleus of small villages or just agricultural land and to plan a cohesive community, integrated not only by buildings, but also by social amenities and by a community-spirit. In what other context would it be possible to talk of towns 'planned with a number of residential neighbourhoods, each with its own schools, shops and social facilities, and all within each reach of industrial areas essential to every new town. Parks and playing fields are sited conveniently for general use, and in the town centre are to be found the public buildings, offices and principal shops, with ample car parks close by.'

(*'THE NEW TOWNS'* HMSO 1965)

It must be admitted that this utopian blue-print for blissful New Town life has not always attained all that was desired of it for two reasons. The end product did not match the plan, first, because of costs and, second, because implementations of the plan produced new and unexpected social and human problems.

Nevertheless, as Mrs R. J. Youard, the first speaker, claimed

'New Towns are a creation of which this country can be extremely proud. Though not perfect they were something that no other country had attempted. Visitors from all the world come to see what we have done.'

Since their first conception views on the development of the New Towns have changed. At first the planners were somewhat naive in supposing that the British population would be stationary and it was simply a matter that if 60,000 Londoners could be rehoused in a New Town those left behind could spread themselves out. It is now very obvious that we have a growing and a mobile population, and one that is being increasingly attracted to the South-East of England. A major problem of planning concerned the people from the North and North West coming Southwards. It suggested the need for more New Towns in the North to provide better living conditions and in the South to cope with the bursting old houses of London.

Since the first set of New Towns, the Harlows, the Stevenages and the Crawleys, there has been a second generation of New Towns, such as Dawley, and a third generation in the planning stage, all of which are going to be much bigger and to grow much faster—twice as fast as now. Not only this but as Peter Cowan noted, new cities are now being planned of 300,000 to 500,000 people and providing services for such a population will raise further problems.

Under the Law the planning and building of a New Town is carried out for the Ministry of Housing by specially appointed New Town Development Corporation. Each Town has its own Corporation.

They have wide powers but they can exercise these only with the consent of the Minister, and the Minister in his turn is not free to support any experiment or activity without the concurrence of the Treasury.

Medical Care in New Towns

The Conference was concerned specially with general medical care in New Towns and its problems. In the discussion and debate it was easy to forget that in terms of costs and expenditure the provision of such medical services would account for no more than 0.5 per cent to 1 per cent of the total expenditure of a New Town Development Corporation. Bearing this in mind it became apparent that the priority of general medical premises was not very high and that it was often lost sight of altogether because there was no one strong spokesman ready and able to push its claims.

'Whilst it was hardly surprising that there had been so little Health Service planning in new and expanded towns, it nevertheless was disappointing when you realise that in the new towns every other form of social service was a model. The schools in New Towns are absolutely first class; the churches have developed well; community centres have been developed; playing spaces, industry and housing, public houses, shops and all other amenities that a town ought to have have been planned and developed as they should be—everything with the solitary exception of the Health Service.'

(LORD TAYLOR)

New opportunities—missed!

It was clear from the discussions that the lessons to be learnt from the present New Towns applied not only to future New Towns but also to re-developments in major cities. Even more important the New Towns could be regarded as experimental prototypes for the different patterns of medical care for the community as a whole.

'This is an opportunity worth gathering. New Towns are the one opportunity that we have for some joint co-operation. If we can't start it from virgin territory it is a pretty poor outlook.'

(DR C. BAINBRIDGE)

For the many reasons and excuses given there was in fact only Harlow where any realistic attempt at planning Medical Care had been made and even there no continuing evaluations have been made and no continuing experiments and research carried out.

Dr J. B. Dillane, who had undertaken the background work and prepared the working paper, had gone to the New Towns to try to find the growing points of the new forms of medical care there. However he found that not only were the general practitioners housed in the usual type of premises adapted from ordinary dwelling houses but their work and practice was being carried out in the same way as it was in the rest of the country.

The patterns of general medical care had been allowed to evolve without any leadership, direction or stimulus from forward-looking planners.

'Medicine has been left behind in planning for the remainder of the twentieth century. More direction in planning and co-ordination were needed because the freedom of being left alone may be the freedom, the privilege, of being left behind.'

(DR R. F. L. LOGAN)

Old Medicine

In spite of the brave hopes for a new medical world in the New Towns it became clear that medical care there was characterised by the same patterns as anywhere else, by a pronounced lack of experiment and little thought for advanced medical ideas.

'The only thing that's new about the New Towns is the buildings. We've got "old" doctors, with old ideas, established in a traditional pattern of general medical care.

'We've no "new" public either but merely ordinary men, women and children moved from one part of the same country to another taking along with them their deep-rooted beliefs, customs and expectations. From one new town to the next the same old out-of-date concepts are apparent. This is a major problem. This is the challenge requiring a re-education of the public and the medical profession to prepare for a new future of medical care.'

(DR J. FRY)

In a sea of brightness that comes from the new schools, shops and houses the medical services come out as poor companions.

'We have taken the New Towns and we have used them as a mirror to see how poorly our medical services stand out compared with the general efficiency of the New Towns themselves.'

(DR J. J. A. REID)

It seemed as though the problems of the provision of medical care in general had not been solved simply by placing them in the context of a new situation.

'These problems are by no means unique to the New Towns, but merely a reflection of our national problem. One could go further and suggest that the problems are, in fact, more simple or at least apparently and theoretically more capable of solution in the New Town as contrasted with the old-established situation.'

(PROFESSOR R. SCOTT)

Obstacles to Change

THE discussion analysed in as much detail as possible why it was that the new towns were not generating the most advanced ways of organising medical care in Britain nor even producing many new concepts. Initially, there seems often to be a problem of liaison between the medical profession and health service officials on the one hand and Town Managers on the other. This may be because the Town Manager, although anxious to liaise, was often appointed to an area which at that stage was little more than a mud flat or rough grassland. He had as yet no general practitioners in the area and no idea from where they would come eventually. He did not know the various peculiarities of the medical profession and its structure and was often reluctant to become involved in professional differences. He was uncertain of the correct stages of procedure, of whom to consult with first; since the National Health Service existed, the Manager usually decided to let the established agencies deal with the situation.

'The General Managers of all new towns are extremely conscious of the necessity to liaise. The problem is that we have several thousand acres of land and not a general practitioner in sight. The general practitioners are all round the countryside. No one will make the first move and for a long time you have to get along as well as you possibly can. We are conscious of the necessity to liaise and this is why we are here.'

(BRIGADIER R. S. DOYLE)

However, even when the new town is established alongside an existing small rural community with one or two general practitioners, the situation is often little better. Communication problems seem to emerge at two levels. Firstly, there seems to be inadequate communications between medical and lay bodies. This may occur because the early lay committees gave scant attention to health issues, or because they envisaged existing medical personnel as simply maintaining their current position vis-a-vis the existing rural community and having no new roles to play within the developing town. The doctors for their part are often suspicious of change and worried lest the developments might encroach unfavourably upon their existing practices. This often led to entrenchment and unwillingness to co-operate.

However, examples of this sort of active non-co-operation are not so extensive as is the apparent lack of communication between different individuals and authorities within the Health Service. Many of the new towns were defined as 'open areas', i.e., areas where any doctor might assume that his application for inclusion in the Executive Council's list would be accepted automatically. Thus with true entrepreneurial spirit a number of new doctors 'squatted' in the new towns. That is, they bought existing private houses within the area and set up in practice. Case histories from Dr Dillane's study have provided frequent examples of this: thus at Crawley,

'as the first residents were moving in, three doctors, in anticipation of the rapid increase in population, squatted within a period of three months. Existing groups of doctors in the old town felt forced to expand into the new housing area to prevent erosion of their practices, and so a bewildering series of branch surgeries was opened.'

(DR J. B. DILLANE. REPORTS FROM GENERAL PRACTICE IV. COLLEGE OF GENERAL PRACTITIONERS, 1966)

However, difficulties occurred not only because of events like this, but often because there seemed to be almost deliberate non-co-operation. The Executive Council on occasions appointed an outsider in spite of applications for branch surgeries from existing practices. Again once a new man was established they might not liaise with him when the growth of population reached a level at which another doctor was required. At Crawley,

'one doctor appointed by the Executive Council in 1958 moved into a typical area when there were only 200 residents. His list grew to 1900 in 18 months and at times

he was getting 250 new patients a week. Nonetheless, despite an Initial Practice Allowance of £65 per month his first years were difficult. Just at the time he was thinking of taking in a partner the Executive Council informed him that they intended to establish a second practice in "his" area. The doctor realised belatedly that he had had no guarantee protecting his interests when he came to Crawley. Happily, the matter was settled by the original doctor being allowed to choose his own partner.'

And at Stevenage,

'relations between the general practitioners and the Corporation did not get off to a good start and on several occasions the doctors found themselves at odds with the Corporation and the Executive Council at the same time. In 1948 the new houses were going up and although two existing practices in Stevenage wished to open branches in the new area an outside doctor was appointed by the Executive Council and supplied with a house by the Corporation. At one stage the Corporation provided premises for two branch surgeries within fifty yards of each other, although neither practice realised what was happening.'

However, this is no easy problem to solve. In a sense, as demonstrated by the analysis so far, laissez faire development is to some extent inevitable given that the general practitioner is to be allowed complete freedom. Freedom, that is, to apply to almost any area to set up in practice, to open branch surgeries and the like. Similarly, part of the Executive Council's difficulties may reflect the fact that inept control is inevitably worse than none at all. Also, the health service, and new town administrators have been aware of their limited scope for positive planning.

Planning—is it possible?

'Is it possible to plan medicine? My Executive Council carries out a perpetual tactical exercise without troops. It has no money and no powers of direction. It is no part of my task to make any sort of plea for anything approaching direction, or indeed, the superimposing of any will on people who still are individual contractors.' (F. HAYTER)

The lack of leadership was all too apparent as was the lack of any single person with the powers and the responsibilities of co-ordinating and planning all the medical services.

'The new town corporation general manager has a thousand and one problems to settle, but this one he cannot decide himself. Even after all these years of new town experience, and these two days of discussion he still will not be very clear where to go or what to plan for. I believe Mr Owen was right yesterday when he said that the Ministry of Health should give a co-ordinated lead in this situation and I was encouraged to hear Dr Shaw suggest that the Ministry could now give dynamic leadership. It is certainly needed. They have sat back over these years and not expressed a great deal of interest in the new towns.'

(F. SCHAFFER)

'It would be helpful for us (the Ministry of Health) to know what we should be doing.'

(DR R. M. SHAW)

In many ways one can draw a parallel with the problems of British railways. Just as the free enterprise development of railways in the nineteenth century produced rapid progress but led to duplication, inefficient use of capital, and an apparent plethora of patterns of communications, so freedom for doctors to elect where to practice and to choose the type of practice they wish to provide will lead equally to duplication and inefficient use of scarce manpower, to say nothing of less efficient medicine. However, the time came when some overall planning had to be applied to the railway system. Likewise it must be considered whether the system of general practice appropriate to the 1930s now needs rationalisation. What has to be decided is whether the advantages of freedom outweigh the resultant heavy cost, and indeed whether as a country this wastage can be afforded.

'We are living with a rationed commodity and this rationed commodity is medical manpower. For this reason alone we must plan and avoid wasteful deployment of our doctors, and particularly of the overlapping functions of doctors.'

(DR E. V. KUENSSBERG)

In most areas throughout the country medical care has evolved rather than been planned. Such matters as liaison with hospitals and group practice have varied con-

siderably from area to area and have been dependent upon individual attitudes and local opportunities and circumstances. More than anything else this has meant that 'planning' is a relatively unfamiliar word to the medical world. Thus many doctors find the concept of directed growth hard to accept, and perhaps even heretical. It hardly provides a good climate for an integrated planned approach in the new towns. However, perhaps such an analysis is to some extent unfair. Probably the greatest obstacle to planning has been the difficulty in formulating the right pattern for the future of medical care. The discussion illustrated only too well both the major areas of debate and the current variation in views concerning future trends. The issues raised included the allotment of hospital beds to general practitioners, the structure of medical training, the place of the general practitioners in modern medicine, the integration of different parts of the health service and attitudes to health centres.

'I know we British pride ourselves on improvisation but so far we have been trying to develop health services on virtually nothing; no bricks, no straw, practically no bodies.'

(DR C. BAINBRIDGE)

Planning for What?

The very bases for medical planning were shaky because the speed of medical progress and changing social views were such that any planning must be tentative and flexible and capable of meeting unforeseen situations. Thus the views of two teachers;

'Medical care as a whole and general practice in particular is in a state of flux and teachers must bear this in mind. In training our future doctors, therefore, we must stress the importance of flexibility and the capacity to adapt to changing medical and social needs. The future general practitioner will expect to have full access to diagnostic and therapeutic services, presently provided by the hospital, which he is now quite capable of using as a final year student. He will expect to work in close association with the Medical Officer of Health and the Industrial Medical Officer and be familiar with the concept of the population at risk and the techniques of screening. His training will have to include the disciplines of preventive medicine and epidemiology. He will require a substantial period of post-graduate training to fit him to become a member of a multi-discipline team. Finally the status as the independent contractor will have slightly less appeal for such a doctor who will be more ready than his predecessors to see the need for objective assessment and a review of his own performance and of the circumstances under which he works.'

(PROFESSOR R. SCOTT)

'How do you plan your health service or community health services when you are educating students who are out of date before they start? We heard this morning a little about old-fashioned and elderly general practitioners whose views were difficult to alter. I would suggest that undergraduates leaving the medical schools at the moment at the age of 23 are old-fashioned before their time. They are trained to think in terms of hospital treatment and very little is done at the present time to give them an insight into community care outside the hospital with reference to both local authority and general practitioner services.'

(DR J. A. D. ANDERSON)

Integration

Coming through the discussions was the repeated desire for an 'integration' of the many services. There was the wish to tidy up our old traditional ways resulting from the unplanned evolution of social and medical services. Take-over bids were thrown out by all three main groups but the loudest voices were those of the general practitioners.

'In our debate there has been some anxiety expressed as to who was taking over whom, as between the general practitioner and the hospital, the general practitioner and the Medical Officer of Health and the general practitioner and the Industrial Health Officer. There seemed, however, to be a majority view that habits and attitudes are changing for the better in the direction of collaboration and integration, and probably more so in the case of the younger recruits to the profession. Indeed it was suggested that unless these changes continued and were accelerated there might well be no more recruits to general practice.'

(PROFESSOR R. SCOTT)

'One of the things we have got to be quite clear about is the full integration of the Local Authority services into general practice and not vice versa. This means, to my mind, that the days of the infant welfare, maternity and child welfare clinic, either

separately or integrated, have gone, and it is long past the time that the general practitioners were given the full authority for infant and child welfare and maternity care. We have this in Crawley and have done it for years. The children are sent for by computer, so we don't have to send out to children due for immunisation, etc. They come to us by a card dispatched by the computer. This is the sort of thing you can get done. We have attached all our health visitors and district nurses and midwives to the doctors and the doctors have been told by the County Medical Officer of Health: These are your personnel; you organise it. Unfortunately, because we haven't been able to take over education, they still have some school services to undertake, so that every now and then we lose our health visitors for an afternoon. This is an extension of general medical services which is a lesson well worth learning elsewhere.'

(DR I. R. CLOUT)

'I would like to see much more integration of allied services, such as, for example, the National Assistance Board and the Ministry of Pensions.'

(MRS A. WILLIAMS)

*General Practitioners
and Hospitals*

It was most refreshing to hear from Dr R. Glyn Thomas, a hospital planner, of his belief:

'that from a hospital point of view and local authority point of view, our functions are really to act in support of the general practitioner service and not in competition with it. There are three things that a patient asks for: diagnosis, therapy and re-introduction into the social community that they know. I would think that the doctor should really be the person who is able to provide these three things for them.'

General practitioners were, in the majority, anxious to have access to hospital beds in which they might treat their own patients, but their desires did not appear to have met with much success.

'We as a body have got to insist that the general practitioner retains his place inside the hospitals, particularly for maternity service.'

(DR I. R. CLOUT)

'I am not happy about the suggestion of hospital beds. I want the general practitioner to look after people in their own homes, with the exception of maternity work.'

(DR J. SLUGLETT)

'On the question whether general practitioners should have hospital beds, on the whole of course they should encourage their patients to be treated in their own homes; it is much cheaper. But many patients are completely uncared for in their own homes and have to be moved into hospital. These people do not require to be looked after by consultants or specialists because they can be adequately looked after by general practitioners but they need the nursing of the hospital. Unfortunately, the Ministry of Health will have to alter its ideas in planning the number of beds in these areas. In our local hospital in Welwyn there are 10 beds for 20 doctors. I ask you!'

(DR K. C. HUTCHIN)

'We have a new hospital in Harlow now and we have 28 general practitioner maternity beds. We had a great fight to get those from the consultants; they were most unwilling to let us in. They have been going now for fifteen or sixteen months and we are all happy about it. We would like general beds but I can see no hope of this coming. Opposition is very, very strong against it.'

(DR C. M. TAYLOR)

Some Problems of Detail

The realities of planning were demonstrated by Dr Robert Smith and his team from Guy's Hospital, who have been preparing for general medical services in a new rehousing project for 60,000 persons at Woolwich.

The two main lessons that Dr Smith has learnt were—first, that it is essential for medical planning to start at the very commencement of any thinking and talking about any New Town, and to realise that this early stage is likely to be prolonged—so far the Guy's team has been planning for 3 years and it will be another 2 years before the first people would move in. Second, that planning costs money. The Guy's-Woolwich exercise, although admittedly it is somewhat unusual because it includes preparation for medical school involvement in addition to the provision of services, has cost nearly £50,000. Much of the basic research carried out by Dr Smith can be utilised by other New Towns and so the costs need not be so high, but allowances for planning must be budgeted for.

What Dr Smith was too modest to mention was that an essential reason for the success of his exercise has been due to the fact that he was there co-ordinating the work.

A summary of the needs for successful planning was well put by Mr F. Hayter: 'In a New Town situation three things make sense.

'First, that planning should be under the joint administrative control of the three National Health Service Authorities.

'Second, that the position of the Executive Council ought to be immeasurably strengthened by the doctors in the area. At the moment an Executive Council is advised by the local medical committee. This advice tends to be on matters of day to day administration. Future planning policy has not been a feature of this committee's work.

'Sometimes professional problems of a wholly local nature are taken to the Ministry, seeking, hopefully, some panacea, some master plan at National level.

'No New Town has ever been successfully staffed in conditions as they exist today; it will not be until there are more doctors. Under a National Health Service administration the joint planning, right at the outset, by all working in concert, ought to spring quite naturally and spontaneously without any other form of super-imposed planning body.

'Like all problems, planning depends upon one person taking enough initiative to get on with it.'

(F. HAYTER)

However, another point of view was put in a plea for structural reforms:

'One of the constant complaints of New Town administrators has been that no-one is in a position to provide an overall plan for health services, or even to provide authoritative advice. A number of speakers have reported, with some satisfaction, the success of their own attempts to bring the various interested parties together and to achieve some measure of co-ordination. Without in any way underestimating the value of these efforts, it is worth emphasising that they are only necessary because of fundamental weaknesses in the structure of our health services.

'The New Town situation, because it involves, so to speak, opening up fresh territory, underlines the absurdity of a fragmented health service which contains no provision for unified planning at regional or local level. Although we must necessarily continue to patch together the best working arrangements we can, it would be very unfortunate if we took it for granted that there would be no alternative. (Since any given administrative pattern rapidly generates a whole series of vested interests—and perhaps particularly in Britain—there are many temptations to come to terms with the existing system.) There is a strong case for structural reforms of the National Health Service, with the object of replacing tripartitism by an integrated system of preventive and curative, institutional and domiciliary services. Evidence in support of such a case can be adduced from a variety of sources, of which the experience of the New Towns is one.'

(F. M. MARTIN)

Health Centres

THE debate over the health centre provides a good example of the difficulties involved in developing and implementing new ideas. Problems have arisen over the type and size of the centre, its ownership, and even of the sharing of accommodation between the various branches of the health service.

Here was the idea of a health centre well thought out with plans and other details by the Dawson Committee in 1920.

An idea designed and intended to be an essential component of the National Health Service in 1948.

An idea that in 1966 is still unacceptable to a sizeable proportion of the medical profession.

'It is perhaps appropriate to mention shortly some of the reasons why the profession resist the unified building. Their one fear is that the individual doctor/patient relationship is lost. Well, this is a sort of jargon which is used continuously by people who do not know. They take examples from the worst hospital out-patient department and from the worst general practitioner, but that surely is not a fair complaint because there are an equal number of much better examples. Another point is that general practitioners are uncertain about the possibility of clinical direction. Again I think this is just simply an excuse which is being raised. A last ditch argument; there has been no evidence on this score. There is one complaint which is quite real, of which I have seen several examples, where the administering authority has no understanding of general practitioner needs. In one case, the doctors were not allowed to enter the health centre building after the cleaners had arrived which means that they could not get at their records after 6 p.m. This sort of thing requires just a little common sense.'

(DR E. V. KUENSSBERG)

In spite of these errors of sense and sensibility, the climate of opinion amongst general practitioners seems to be changing towards an interest in health centres as possible solutions to some of the problems of general practice organisation and practice.

Problems for Planners

A major problem for New Town planners has been that of providing finance for health centres. New Town Development Corporations have wide powers to build. They build houses, shops, offices, factories and there is nothing to stop them building health centres or group practices. The only difficulty until now has been that they must get a reasonable return. Now that the Review Body has recommended and the Ministry of Health accepted a wide scheme of reimbursing rents in general practice there appear to be no difficulties.

However, even so, it may be better to think in terms of combining the health centre with other social amenities.

'In Dr Dillane's paper which is so admirably clear and deals with all these points, there is a reference to it being perhaps easier to provide for doctors in a welfare building. I think we ought to be clear why this is a good suggestion. If you could think of it as a community building it is perhaps an easier term for us because welfare has other connotations. What we are saying from experience is that it is much easier to provide for a building where people are sharing entrance halls, central heating, passages, lavatories, cloakrooms—all the ancillary things—including car parks. If you can join with the local authority which is providing a branch library, youth clubs and other things—if the doctors can be fitted in it conveniently, without sacrificing what they particularly want—if they don't have to have the whole of the building themselves—they probably won't have to pay so much rent.'

(MRS R. J. YOUARD)

How Successful have Health Centres been in New Towns?

'If one were judging health centres pragmatically, in a political sense, one would judge them a failure. Concerning the people that have, in the past, been involved in the

planning, the general practitioners have uniformly been involved with their own affairs, their own practices, and getting on with the business of running their practice. They have not been interested in any planning at all.' (DR J. B. DILLANE)

In looking at the New Towns one may be quite justified in asking why there have been no more 'Harlows'. Why was the example of planned health centres as developed in Harlow over 10 years ago not repeated?

'I was rather disturbed to find how few other group centres there are except for the ones in Harlow. I was really astonished to think the other new towns haven't made very much progress this way, and that there are not many centres to show. I am talking in this instance of health centres, not just the group practice centre where a group of doctors come together to exercise their practice, but where maternity and welfare services are related and even dentists have their practice.' (MISS J. LEDEBOER)

The reasons are not far to see. At Harlow there was a single planner and co-ordinator, Dr Stephen Taylor (later Lord Taylor), who was paid and given certain responsibilities; there was considerable finance provided by the Nuffield Provincial Hospitals Trust to build and equip the health centres; and there was a general spirit of co-operation and enthusiasm in the New Town itself that was transmitted to the planning for general medical care.

Some other views

As further examples of the views of individuals on health centres we have on the one hand a Medical Officer of Health—

'Health centres; the word has been used very freely in the last two days, sometimes with emotional overtones. In fact, the phrase "health centre" has become to medicine rather as "comprehensive school" is to education, although this state of affairs seems to be cooling off. Health centres are essential if we are to attract young doctors to community medicine and there are many problems to be sorted out. I am sure we must experiment, but there are some things we must not do. One is to build health centres with separate wings for different branches of the health service.'

(DR J. J. A. REID)

—and on the other hand the views of two general practitioners working in New Towns but *not* from purpose-built premises.

'The move towards health centres today I feel is a thing to watch. Doctors are not any more in favour of health centres than they used to be. The only reason for the trend towards health centres is that doctors cannot afford to build or keep up their premises because of the capital expenditure involved. If there is an alteration in the financial arrangements I think the trend will be the other way again.'

(DR K. C. HUTCHIN)

'Frankly, I don't think it matters a scrap whether you practice in one type of premises or another. I would rather smell the mutton cooking from the doctor's supper than pine essence disinfectant. It is much more important for our patients to get to see the doctor conveniently and comfortably.'

(DR I. R. CLOUT)

Yet another view from a New Town manager, also without the practical experience of health centres in his own area:

'For myself, I am very much afraid of the health centre. I think there is a lot of very careless talk about health centres, and certainly our local politicians, talk with great fervour about this in terms of putting them in town centres.

'No bus company will run a bus service until the passengers are filling up their buses and the bus services are very sketchy in new towns and will remain so.'

(BRIGADIER R. S. DOYLE)

And a view from a consumer:

'I worry a little at the moment whether these premises for health centres may not be obsolete in 15 years' time. Again, I am a little worried that some of these centres seem to be planned for the efficient patient.'

(MISS NESTA ROBERTS)

In the West Riding the Medical Officer of Health, Dr R. W. Elliott, has pioneered the establishment of a number of health centres. They appear to have been a great success.

'Shared accommodation as far as we are concerned means that the general practitioner and the local health authority staff use the same rooms, at different times of course, so that the rooms are fully used throughout the day, and you don't have these empty palaces which have been mentioned so often. The place is put to full use and the staff of both sides get to know each other and work together. This surely is the plan for the future.

'We have various types of centre which can be used jointly by general practitioners and the local health authority; the Mini-clinic, the "E" type" and then special ones produced for special purposes. We are no longer producing the "palaces to the greater glorification of the local authority" which have been referred to, because these other smaller types of health centre fit the bill better and can be built far more quickly and cheaply and yet be efficient and good to work in.

'In the last ten years most local authorities have had quite an extensive programme of building clinics and we in the West Riding have found that many general practitioners wish to go into them, either as they are or after minor modification or extension. This is a fruitful source of ready-made joint user premises.' (DR R. W. ELLIOTT)

In looking to the future, Professor Richard Scott had the following views.

'A striking feature of the discussion was the general assumption that any Gallup poll today would reveal a marked swing towards the health centre.

'This might not be precisely the form of health centre envisaged in the original Act, and several different types of centre were described. First, the simplest and most numerous, catering for say 10,000 population would be more or less the traditional centre incorporating individual doctors, partnerships, or group practices, in common premises shared by the local authority. In the second category there would be in addition a wide range of diagnostic services with perhaps additional services provided by the local authority, the local social services and by the hospital. Thirdly, the main type of centre, would have all these services but more advanced diagnostic and treatment services, perhaps even beds for investigation and other treatment services such as cervical cytology, child guidance, orthopaedics, orthoptics and audiometry. Such a centre would be very near to, or preferably within the curtilage of a hospital.'

(PROFESSOR R. SCOTT)

*Some Current Problems
of Health Centre
Planning*

It is a fact that most modern medical buildings are out-of-date almost as soon as they are conceived and certainly by the time that they are opened for use. Hence the needs for flexibilities of thoughts, actions and buildings. This applies to health centres as well as to other medical buildings.

In the larger New Towns careful consideration must be given to the number of centres and their siting. Should there be one central health centre providing care for say 50,000 persons with, say, a series of peripheral clinics staffed by nurses or, should there be a number of smaller centres?

It is no use planning these centres in isolation from other facilities. For example, it is very necessary to keep the transport facilities in step with any medical building. Unless it is possible to ensure good transport facilities and access to a single central health centre it is no use even to consider such an exercise.

Ultimately:

'All you've really got to think about it: agree among yourselves and convince representatives of the Ministry of Health what you want them to support when the time comes.'

(MRS R. J. YOUARD)

Finance

ANOTHER obstacle to progress seems to be the financing of change. This is seen with regard to both the development of a medical centre and group practice. Clearly, the building of a medical centre is extremely costly, but some suggested that this could be used as a red herring to hold up development and that the costs themselves need not be excessive. With sufficient initiative, funds could often be found from a variety of sources, and the development need not be as expensive as was sometimes imagined, particularly if optimum use was made of the space provided by all branches of the health service.

'In a new town various solutions are, of course, possible, and often demonstrated as possible, because we have in Dr Dillane's Report various examples of how one can get over the various difficulties. This 'playing by ear', as I might call it is a valuable method of making progress, but it has a tremendous danger, and that is this: that you allow people to invest and maybe establish themselves in a slightly haphazard way which, when it comes to the complete plan, may prove a hindrance to progress rather than a help. Then, secondly, the provision of premises could be through various planning authorities, Development Corporations and so on. The local authority might offer space in premises constructed for their own welfare and health services to general practitioners, singly, or in groups. The local authority can finance, with the help of various Acts, the provision of health and welfare buildings, with less costs falling on their rates. Then, of course, you can come to Scotland, where we have the Central Government who can provide centres and general practice premises. Perhaps it is appropriate to say here that it was Sir Kenneth Cowan, the Medical Officer of Health who worked with you, Lord Taylor, in Harlow, who was the Chief Medical Officer in Scotland until recently, and is now succeeded by Professor Brotherston, of cottage industry fame. Voluntary agencies also provide help, as has been demonstrated so generously by the Nuffield Provincial Hospitals Trust. Then there is another exciting possibility, which as yet we have seen only ripples of, and that is the Regional Hospital Board which comes into the picture and finds that it has a local cottage hospital which it wants to shut, and yet it might be turned into some extremely useful centre.

'Where there is a will there are at least five official methods where planning could achieve the provision of premises from which the general practitioner could provide general medical care.'

(DR E. V. KUENSSBERG)

'In Runcorn the intention is that the central health unit is, in fact, to be financed by the Regional Hospital Board.'

(DR R. GLYN THOMAS)

'We have found that the easiest way of producing joint premises quickly for general practitioners and ourselves is to adapt existing clinics. I have clinics which have been adapted for practice by three general practitioners, at as low a cost as £1200 and with which the general practitioners concerned are delighted. I have other premises which have been adapted from a former drill hall which was used jointly in a village and surrounding areas for a training centre for mentally sub-normal children and for clinic purposes which has been adapted into an ideal health centre at a cost of no more than £5000 and there are five or six general practitioners practicing fully and solely there. You don't need extensive palatial places like the £100,000 health centre which we built at Cleckheaton and which accommodates seven general practitioners. You can make them in all sizes, at all costs, and you can get good conditions in any one of them.'

(DR R. W. ELLIOTT)

'The ghastly temple for the greater glory of the local authority which it calls a health centre must certainly not be allowed as a concept. The cost of health centres of the existing type varies from something like £15 per patient registered at that centre to

£1 per patient, so obviously there is something wrong here. I know of a health centre where the waiting area is divided by a curtain, one side for the local authority and the other for the general practitioner's patient. I know a health centre where the general practitioner does a sort of take-over bid for the Medical Officer of Health's work; what rubbish! Another image that must be destroyed is that the health centre is only a financial expedient for the benefit of the general practitioner. This negates completely the potential additional contribution to the overall community care that health centres themselves can make.'

(DR E. V. KUENSSBERG)

'We have no health centre, but we have set ourselves up in group practice, and four of us look after 9250 patients and we practice from a purpose-built centre which we designed ourselves and which contains two consulting rooms. We consult all day using the consulting space in rotation. We are even contemplating a fifth partner without increasing the space. The cost of this to us works out at ten shillings per patient, much lower than the figures mentioned.'

(DR J. S. K. STEVENSON)

But, in general, for a group practice the financial problems have been of more direct and personal significance. However they should be much relieved by the 1966 (Charter) arrangements for reimbursing general practitioners' expenses. It is clearly sensible for a number of partners to operate from a central building providing if possible a series of diagnostic services. However it has, in the past, been difficult for doctors to get finance at a cheap rate of interest for such schemes. Even when the Corporation or local authority was prepared to finance schemes this was done usually by leasing office space with its limited security of tenure rather than by lending money for the general practitioner to buy freehold property. Indeed, the problem exists in the same way for the individual doctor obtaining his dwelling or surgery from the local authority. Moreover there have been extraordinary variations in the length and terms of leases and in the size of rents. It is ironic that whilst new towns are given abundant scope to attract industry by the provision of subsidised buildings and the like, the doctors, providing an equally vital and scarce service to the community have often been denied such support.

'I think that the critical factor about planning will be premises. This brings in the important consideration of capital provision. The important point here is that we must have capital for building early; with regard to payment of rents later on I very much doubt whether this, in fact, is going to be a terrible problem for the doctors in the future. The Ministry of Health could provide capital under Section 43 of the National Health Service Act where under extraordinary circumstances the Minister can take such action as he sees necessary to ensure the provision of general medical services. But if the present shortages of general practitioners continues I am sure the new towns will provide extraordinary circumstances in which the Minister might find it necessary to use his powers. He might also find capital by altering the group practices loan scheme to provide capital for groups of doctors because what we need for the new towns is a practice loan before the group of doctors arrives.'

(DR J. B. DILLANE)

'There's one serious point which general practitioners will worry about. Whatever you do you must consider it—and that is security of tenure. The general practitioner must feel that he can continue with the patients with whom he is under contract or in contact. He does not like the possibility of being thrown out of his premises. Therefore this sensitive point must be taken into consideration when planning contracts for general practitioners. The loss of the capital outlay which a general practitioner may have from moving from his own house to a centre is one that will be always with us, but it is probably difficult to get round it.'

(DR E. V. KUENSSBERG)

'Coupled with a firm decision on what buildings are needed must come a review of the financial aspects. There are two problems here. First, policy can be frustrated all too easily by arguments about who pays for what—this is particularly so in the case of buildings for joint occupation.

'Second, capital expenditure priorities for medical services in new towns, including hospitals in particular, need to be more realistic. A separate allocation is required that takes better account of the speed of development, the growth of population and the rather special circumstances of these new communities. It has been done for roads; it can well be done here.'

(F. SCHAFFER)

The Need for Further Knowledge

IN considering the doctors premises and the tools and equipment that he requires, flexibility of thought in anticipating new trends is essential.

In past group practices and health centres in New Towns have been built without any special diagnostic and therapeutic equipment.

It was pointed out that for economic reasons it was impractical to expect small groups of doctors to be provided with radiological and pathological facilities on premises of this size. Regional hospital boards consider that only populations of 70,000 or more require consideration for a radiological unit.

From the meeting it was apparent that there were many different ways in which general medical premises could be financed and that all have been used successfully to put up buildings. However, many of these did not come within any overall scheme of planning for the New Town.

In the future two facts will alter the situation. First, there is going to be a period of relative shortage of medical manpower and the New Towns will have increasing difficulties in attracting general practitioners to come and work there. To attract them the New Towns will have to consider the provision of excellent purpose-built premises and other facilities for doctors, in order to induce them to come to their towns. Second, with the changed regulations, the general practitioners will now be able to reclaim the major part of their rent costs. This latter event will resolve problems that local health authorities have in building premises for general practitioners and receiving economic rents.

In planning for the future it is essential to accept that general practitioners must be provided with full modern radiological and pathological diagnostic facilities.

The ways in which such facilities are to be provided will depend on local details such as the population, the geographical situation, the existence of a hospital and the size of the practice groups. Thus in a New Town of over 70,000 without a nearby hospital it may be appropriate to plan for a diagnostic centre—either in a large health centre or separate.

In addition to diagnostic facilities plans for the future must take into account the newer methods and systems of record-keeping and data analysis and general organisation of the practices.

It was accepted generally that closer association between doctors, nurses, health visitors and midwives and others would lead towards the evolution of community health teams. Such teams would have special opportunities for increasing activities for prevention of disease and health education and would require equipment for these purposes.

The therapeutic tools in general practice have tended to be restricted to small pieces of equipment which take up little space but in planning for the future the closer reassociations between general practitioners and the hospitals must be anticipated. Should there be hospital beds and other hospital facilities for all doctors in New Towns?

Patients' Attitudes

Whilst speakers were willing to put forward their own subjective ideas on consumer requirements, it was agreed generally that another reason for indecision over planning was due to there being a basic lack of data on what the patient wants. Some of the questions as yet unanswered are as follows:—

Do people prefer surgeries in the centre of the town near to the shops and to work, or near to their homes?

Do they prefer an appointment system for surgery visits?

Do they prefer always to see the same doctor or are they happy to see anyone in the group?

On a matter of considerable personal importance there was discussion on the accessibility of the general practice premises to young mothers.

'The first point I would like advice about is: How far can a woman go with a pram, or how far is she prepared to go on a bus for treatment; and going on from that, what should be the range between centres or consulting rooms?' (A. M. GRIER)

'I think the pram-push distance can become a hindrance in our thinking, and I am quite clear in my own mind that, for instance, in our own practice we made one terrible bloomer some years ago. We spent a lot of money on a pram park. It was useless; we should have spent it on a car park. An increasing number of our patients now arrive by motor car with their babies in a carry-cot.' (DR E. V. KUENSSBERG)

Discussion also referred to the patients' wants in relation to the type of doctor in a modern society.

'Just as there is a new kind of medical service, so there is, I think, a new kind of patient. Pram-pushing and the smells of lunch do not dominate the thinking of this new kind of patient. His attitudes are more constructive. Among other things he—or she rather—is becoming increasingly conscious of the aid that could be provided by himself. I believe the educated consumer—the educated patient—could economise on medical care if he were properly informed—and not misled—about self-medication—and taken into confidence about modern medical practices and techniques. There would be an economy of money and effort. I am sure it would be valuable to explore this aspect of medical care which has been stimulated by the principles at work in the consumer movement.

'There is, of course, the Patients' Association which has not got a very friendly image for medical men; it has been largely concerned with grievances and particular complaints. But the Association is thinking now much more objectively and has been concerned about such things as screening and about medical education and organisation. The importance of the Patients' Association however is the finger which it points at the consumer of medical services, that is, at the patient. The patient is, or should be, the centre-piece in the vast area of medical care. After all, the medical service is for him, not for the doctor.' (MRS MARY ADAMS)

'I think I speak for many people when I say we do clearly want a personal doctor. We don't want a doctor who is on call seven days a week, we do want a doctor who is working in group partnership that gives him the relief and stimulation he deserves. We want him to work in premises and in circumstances which let him stretch his brains and preserve what skill his hand has got and avoid the obstruction and exhaustion that may harden his heart.

'I worry a little at the moment—possibly you do—whether the premises for health centres may be obsolete in 15 years' time. There are two guiding principles—we are certain to need more space than I think, and they should cost as little as is possible, compatible with efficiency. Again I am a little worried that some of these centres seem to me to be planned for the efficient patient who has two cars, and I cannot envisage any state of society when there will not be a number of persons who have one car or one person to drive it. As for pram-pushing, half a mile is a long way. Again I think there is a tendency—and I say this with all humility—for doctors to be rather fascinated by the gear. They want every kind of diagnostic aid. Obviously it is uneconomic to have four men practicing together using a whole lot of things which can be provided for fifteen men. Equally, obviously, technicians are scarce and getting scarcer. As for computer equipment, we now have computers like washing machines. On duplication, public health and industrial medicine how are you going to fit in school medical care and child health?' (MISS NESTA ROBERTS)

'There is some evidence, I think, that the new kind of patient is prepared to be served by a variety of specialist workers in the medical field—provided always, of course, that their efforts are co-ordinated and do not impose on him too many inconveniences.' (MRS MARY ADAMS)

'We have group practice; we don't have people join our list—they join the group, not any particular doctor's list. It is the group that looks after them, and we do not think that the patients suffers in any way by this. Each day we set aside three quarters of an hour when we all four doctors meet and discuss the patients' problems, and in this way we have continued vigilance over one another's thoughts and clinical actions.

By this I think the patient, in fact, gets a better service than if we were looking after our each individual sections of the community.' (DR J. S. K. STEVENSON)

'If you are planning any kind of medical service you ought to be certain of what the consumers think; at any rate some democratic attempt ought to be made to find out what people think. We want techniques to find out information. I collected a whole lot of examples such as, I think patients prefer this, that, or the other. This is not scientific evidence at all; it is one person's opinion. Let us find out what people think about your service. We want to know a lot more about people in general before we plan any co-ordinated health service.' (MRS A. WILLIAMS)

*Special Medical Problems
of New Town
Communities*

There remains one more cause of uncertainty. It is suggested that the medical problems which general practitioners have to face in new towns are different from those of the rest of the country. Certainly the age, class and job structure of the new town community may be atypical and the whole pattern of community life may be different. Thus the close proximity of the man in the street's home to his place of work may change his attitudes. At the same time the Industrial Health Service may be brought closer to general practice and inevitably must lead to a process of adaptation. Again the close physical ties of extended family, friends, even Church, may be broken as people move to a new town and may present psychological problems. In consequence the general practitioner may find himself used as a Father Confessor more often than previously. All this might go to explain the yet unproven claim that there seem to be a higher proportion of calls on the doctor in a new town than in other areas. Certainly it raises enough queries to justify a detailed sociological and medical evaluation. In addition, the need to carry out controlled evaluation of the medical care being provided has been almost entirely neglected.

'Eighty-one per cent of the tenants in our houses are under the age of 45. We are going to have a problem of old people in about 20 years' time.' (R. M. CLARKE)

'The work load of new town patients is about double that produced by old established communities. The reasons have been discussed many times. People cut off from granny and their old associations don't turn to the Church or the lawyers; they turn to us. I am convinced that the figure of 3000 patients per doctor in a new town is far more than a doctor can cope with effectively; the number would need to be very much less.' (DR K. C. HUTCHIN)

'I have found the same point as my colleague from Hatfield. Some new town practices still have a fair nucleus of old town patients, and they are quite different people, with consultation rates being much higher from new town people.' (DR C. M. TAYLOR)

'Dr Taylor did not explain why this happens. I can tell you the answer. First is the large number of children of young people who anyway have a high consultation rate. Second is lack of maternal advice to the mother. Third, there is a sort of feeling for perfection. People are very proud of their new homes and their new factories and they want everything perfect; they expect their children to be perfect too. If they have just a sniffle, they think they must take it early. They are quite rude and demanding.' (LORD TAYLOR)

'When looking at the provision of health centres and group practices in a growing and expanding town we should be able to apply the techniques of cost benefit analysis to see which alternative solution and pattern will be the right one for thirty or fifty years ahead.' (P. COWAN)

'It is terribly important that we should have medical records on which to base our future planning. We mustn't just go on recreating the previous kind of thing. We must find out what the doctors and nurses are doing; what kind of jobs the doctor is doing that somebody less highly trained could do better. Of course, when you start on this kind of game it opens up all sorts of things. We want a right conception of what health centre planning is; and it certainly is not just a building with a local authority clinic in one corner and general practitioners in the other.' (DR A. LAURIE)

Experiments: The Positive Side

It would be wrong, however, to paint too bleak a picture. Several important original experiments are to be found in New Towns, for example, in Harlow, Peterlee, Livingston, Woolwich and Runcorn.

In *Harlow*, the Nuffield Provincial Hospitals Trust made possible an important experiment in the provision of general practice from health centres. There are six centres strategically situated round the town. Each centre has a section for general practitioners and for the local authority with a common waiting room. A dentist is also usually housed in the same building. Leases are for 21 years and the doctors have absolute security of tenure for that time. The rents charged are also reasonable.

A planned experiment, this time within the Health Service is being undertaken at *Livingston* which was designated in 1962. Here the Scottish Home and Health Department has a complete plan for general practice from health centres. There will be five or six peripheral health centres in pedestrian precincts each serving a population of 12,000 with a Central Health Centre in the grounds of the District Hospital. The first general practitioner will be appointed by a committee representing the Home and Health Department, the Executive Council, the General Medical Services Committee and the Regional Hospital Board. Following this appointment the Executive Council will declare the area 'closed'.

It is hoped that the six doctors to be housed in each of the centres will have different fields of specialty and that each will continue to work for a portion of his time within the nearby hospital. Secretarial assistance and receptionists will be provided and the district nurse and health visitor will be attached to the practice.

'The building of a new town on virgin land with practically no population and therefore practically no regular medical services, appears to offer opportunities for some planned general practice together with the new district general hospital which will be somewhere in the region of 600 beds, I think. With this in the centre of the new town, there appear to be quite exciting possibilities for the co-ordination and integration of all the services.

'As far as the medical services are concerned the plan at present is that each district of 10,000 to 12,000 people will be served by health centres, staffed by perhaps five or perhaps six doctors in group or partnerships. The local authority facilities will be provided for these health centres, and at a later stage it may be that dentists will be in these health centres as well.

'When the district hospital is built it will be, as we see it at the moment, part of a central health service unit, because it is envisaged that a large centre with accommodation for general practitioners and local authority services will be built within the curtilage of the general hospital; that is, the central unit will be the focal point for all the health services in the new town. Since family doctors will be working next door to the hospital it will be physically easy to give them access to diagnostic aids. Indeed, since they are so close to the hospital, it will be of mutual benefit both to the hospital and general practice; and since local authority services will also be housed in the health centre could not the general practitioners do some of the local authority work as well if they so wish? We propose that the first general practitioners we appoint will have definite sessional appointments with the hospital; until the new hospital is built these appointments will be at Bangour. The appointments will be, in the first instance, in the medical assistant grade. The first practitioner on duty has a five-session appointment. The next post is intended for someone who is going to go into general practice in Livingston. He will spend six months to a year as a registrar. After he has finished this post he will go into Livingston as a "trainee" general practitioner and will eventually become a fully-fledged general practitioner with a part-time hospital appointment. We hope that all the appointees will have the opportunity to do local

authority work. It is anticipated, because of the close proximity of the three services and because many people will be working in two, if not three of the services, the demarcation will become suitably blurred and the demarcation disputes rather less than they might be otherwise, and we may in fact be able to understand each other better if we live together. There is always the possibility that some of the young men may eventually go altogether into the hospital service to a secure registrar post and so on. There is also the likelihood, when the central health services unit is built, that the young house physicians and surgeons in the hospital, living and working next door to this unit and seeing how general practice is run, and can be run, will be inclined to move into general practice.'

(DR A. K. MACRAE)

Perhaps the most ambitious of all is the present attempt by the Department of Medicine at Guy's Hospital to produce a comprehensive plan for the medical services to be provided in the new developments at *Woolwich and Erith*. The object was first to evaluate the medical needs of the community, and then plan to meet them.

'About two and a half years ago Robert Smith arrived to talk to me and we knew there was going to be a development in Woolwich. Here was an opportunity to see what you could do to integrate medical care for a phantom population.

'Two years ago we started looking at the symptoms suffered by the community living immediately round Guy's. They have provided us with a reasonable model of the sort of people who will go and live in Woolwich. What we wanted to find out was whether or not they had a lot of symptoms and what they did about them. I have to tell you that we have looked at about 3000 people, and we have asked them a very large number of questions in their own home. The results from a special sample of the whole group showed that about 12 per cent of the people in Bermondsey and Southwark are healthy; that a lot of them—30 odd per cent—have symptoms and take no action, but sometimes they should take action. Some people pass blood in their urine and do nothing about it, and some in their motions. Of the people who do anything about it, we were horrified to find that all our friends, the chemists, are really doing very much more medical care than the doctors. Twenty-two per cent went to see their general practitioners, but 66 per cent treated themselves with medicines from the chemist. We think, at the moment, our community around Guy's Hospital uses the medical services in a pretty haphazard way. They seem to try self-diagnosis and go to the chemist, and perhaps if that doesn't work they will go to the general practitioner.'

(PROFESSOR W. J. H. BUTTERFIELD)

'Good general practice today has demonstrated that general practitioners can provide a wide range of services and that standards need not fall if they are well supported by specialists in particular fields. It is this grouping of doctors together, linking with specialist groups, that we are aiming at in Woolwich and Erith; and on the other side we have linking committees dealing with the social welfare problems of the community. We are trying to make people understand what we are putting forward as a plan in a completely new area.

'We see in the main town centre a central unit which will house the records and the administration and will be the site for teaching and research. Around it there will be about four group practices, each with a group centre linked to the central unit. We see each area of the town looked after by a team of doctors—a group practice—and we see them working in the central area, but having in the peripheral part a local centre, where perhaps certain preventive health measures will be carried out. The group centre in the main part of the town and the local centre more peripherally situated will give the whole of this arrangement a flexibility. In ten years time when this scheme will be developed fully our views about what doctors should be doing will be much more developed than our ideas are today.

'As always, problems of communication have dominated the picture. Dr Elliott has, in fact, put his thumb on the crucial problem—personal rivalries between groups of doctors. Right from the very start, Professor Butterfield and I have been foot-slogging it throughout south-east London, talking, and we've been very, very encouraged indeed by the amount of general support we have had. We have formed a liaison committee consisting of the many people involved with direct statutory responsibilities and this liaison committee, now a fairly large group, meets regularly and a

smaller sub-committee also meets even more regularly. We are not a simple academic unit engaged alone in an exercise. The project has developed its own momentum and some of the burden is now being carried by the people on the ground who are responsible ultimately. The local authorities are playing a crucial part in this.'

(DR R. SMITH)

At *Runcorn*, following a great deal of preparatory planning and research at official level a plan has now been evolved. This consists of a number of health centres, but the interest here is the active participation and proposed financial involvement of the Liverpool Regional Hospital Board.

These experiments however must not be organised haphazardly but must be capable of assessment. It is already too late in Harlow because no built-in assessment and evaluation scheme was envisaged and we therefore are unable to arrive at anything more than subjective impressions of the success or failure of the project.

'In all our planning are we writing into the plans some form of controlled experiments by which we can judge whether or not the plans that we are producing are going to be better, worse, or just the same as anybody else's plans?' (DR J. A. D. ANDERSON)

Flexibility

IN the light of all these issues, it clearly emerged that flexibility of thought in planning at all levels was essential. Even though the philosophy upon which advanced medical care will be based during the next generation or so is not yet clear, there was confidence that within the next few years the heart-searching and evaluation will produce some clear-cut recommendations. It is important, therefore, that new town planning both in an administrative and a physical sense should be capable of being adapted at that stage to take account of these new theories.

There are also other reasons for flexibility. The best laid plans often go astray. The history of new towns to date has demonstrated only too clearly that the plans themselves are always changing. The size of the population to be absorbed may be doubled and the number of years allowed to achieve this potential may be cut by a third almost overnight. The medical services must be flexible enough to adapt to this. Again, the pattern of urban growth within the town may well change, suburbia may move out and the medical service must be able to follow. The necessary flexibility and progress in general can best be achieved perhaps through 'benevolent autocracy'.

'I don't suppose most of you have heard of Glenrothes. It is the northernmost new town and was designated in 1948. The target population is now 70,000 but originally it had a target population of 30,000. I think this is important because the original plan was based on 30,000 and immediately switched to 70,000, which meant a completely new look at the problem.'

(BRIGADIER R. S. DOYLE)

'I believe the only answer to put any sort of service in a new town is tremendous flexibility and flexibility at a very early stage.'

(MRS B. F. R. PATERSON)

'I thought we were looking forward, and it seems to me quite wrong to say, because the general practitioner couldn't do something in the past he mustn't do this in the future. The general practitioner could be considered for all sorts of jobs.'

(DR E. V. KUENSSBERG)

'Ideas are going to change. Therefore we want to keep the whole of the scheme as flexible as possible. When you talk to town planners and architects, however, they are not interested in flexibility. They are interested exactly in how much ground space you want and how much you are going to pay for it, and this sort of questioning reduces one's ideas about flexibility very considerably.'

(DR R. SMITH)

'We all know that the general pattern of medicine is changing all the time. What I want to stress is that the process of urbanisation also is changing all the time. Our population is growing and will have to be accommodated in some kind of new towns. We also know that the nature of our urban population is changing. It's becoming more affluent, more sophisticated, more demanding in many ways and more mobile. This is bound to affect the kinds of locations we choose for health centres. New cities are being planned now with populations of 300,000 to 500,000. We are beginning to see an acceptance of the idea that it's not always possible to limit the size of a new town or a new city. That a new town or city, in order to be flourishing, dynamic, exciting, vital place has in it plenty of growth and that growth will go on as the town lives on through its life. Now this growth in areas like these poses problems of distributing the medical services. Obviously you can locate your health centres or group practices stage by stage, but the town may grow away from them. What kind of investment should you make in the first series of structures you provide: and how long should you expect them to last? The population may move away. Of course this problem occurs in our existing cities as well. Also the kind of growth that's likely to occur in our urban areas will be somewhat different from the pattern of the past due

to the changes in the kind of urban population. We are getting more mobile: the two-car family will be upon us. This means we may well suburbanise. In spite of what planners like to think of as high density being acceptable to the vast majority of people, I think the process of suburbanisation is something that we will have to take account of. Once people become socially and physically mobile we can look forward to seeing much more spread cities. Again, the question of accessibility to various kinds of medical facility comes into question.'

(P. COWAN)

'There is a role which must be fulfilled by the Regional Hospital Board, a job which must be done by the Local Health Authorities, and a job which must be done by the general practitioner, and a job which can be done for industry—but what a difficult thing it is to fit it all together. One hopes that they'll be able to do it, and do it better than we have done in the first new towns. We have tried to show you the lessons we have learned, and you may think that we have been unduly undemocratic and rigid, but I think that there is a confusion of thought between democracy and executive action. Democracy is a marvellous way for deciding what should be done, but when it comes to getting the thing done, it's not quite so effective, and to use democracy as an executive machine is very often to stop things being done at all. All the success of the new town development corporations is due to the fact that they are not really democratic; they are executive machines. Now this means that all the other existing organisations, the existing public authorities, are themselves faced with people who are proceeding at a far faster pace than is usual.'

(LORD TAYLOR)

'I think we must remember that we are planning for the future, and the better the service the greater will be the demand. As time goes on people are beginning to come, not only because they are ill, but because they are unhappy, and this is where we have to bring to the surgery, organisations such as the marriage guidance people and social workers, and the rehabilitation officer. One of the problems in practice is looking after the whole person, and this again brings us back to the only thing you can plan for—for good health, positive health. Good health is the most precious gift that you can give to your child, and it is our duty to see that every child born has this asset of good health as a right. Our problem ought to be, how can we plan to promote this child's maintenance of that health. It should be our job to see that the environment of this child as it grows up is so arranged that its health shall be maintained at its highest, and having done this we would hope to rely less often on the remedial services of the hospital. The hospital is the sick service; the general practitioner and the health centre should be the positive, well service.'

(DR M. GARDINER)

Conclusions

THE Conference in many ways provided the first occasion for a really comprehensive examination of the issues associated with the problems of medical care in new towns and it was clear that many of these issues had wide application to health problems throughout the country. The detailed analysis which took place highlighted many of the problems involved and the sort of questions which still needed to be examined. To many questions the answers seemed reasonably clear: there was also general optimism that progress was being made towards integration of the Health Service. What was frustratingly missing was any clear way of moving through the administrative and professional jungles towards rational solutions.

'I think it is generally agreed that we ought to be looking at future patterns of medical care, that the time is ripe for experiment, that the new towns provide a unique opportunity for such experiment, and that any such experiments must be evaluated, the results made known to all concerned, not only in the future new towns, but to all concerned with medical care throughout the country whether they work in the hospital service or the local authority or general practitioner services. I think you agree that we cannot consider them in relation to general practitioner services in isolation; we must look at them together with the hospital services. Again, we must consider them in relation to the services of the local authorities, not only the domiciliary, midwifery and the nursing services, but also the welfare services and other social services. In a slightly different context I think the rehabilitation officer was mentioned and we must not forget the industrial health services. One of the things we have got to take into account in all this is that it is absolutely essential to make the best use of medical, and indeed other, manpower; we cannot afford to waste the skills of the medical and other professions. As far as the doctors are concerned this means that we must encourage working in groups, whether this means working in health centres or not. Whether or not you agree with health centres you must admit that there has been a renewed interest in them and this interest will surely increase, if and when the new charter comes into operation, if only for the fact that the provision for reimbursement of rents of premises will remove the present financial disincentive.' (DR R. M. SHAW)

'I believe in fact that we are entering a much more purposeful period in medicine, and as far as my own service is concerned, there have been rivalries, but my good friend "Dr Snoddy" has been laid to rest; his day is over and a new attitude from the Public Health Service is apparent. I think we paid too much attention as a profession to structural unification of the National Health Service, whereas functional unification is more important, and I believe this is possible. We don't have to wait for anything; I think we can achieve all the things we have been speaking about within our present legislative framework.' (DR J. J. A. REID)

However, many questions remained unanswered:

1. How can communications be improved between lay and medical groups and between the various parts of the Health Service?
2. How can true practical integration of all the branches of the Health Service be achieved?
3. How can the attitude of many general practitioners to the whole concept of planning be changed?
4. What will be the future role of the general practitioner within the Health Service?
5. What does the public want from the Health Service, what do they need, and what will they be prepared to accept?
6. How will it be possible to finance the development of efficient medical centres, group practices, or even the single general practitioner?
7. How can utopian ideas be translated into deeds under our present system of medical care?

The solution to these problems lies partly in detailed analysis of existing data which could well be supplied by the new towns already established. Indeed it is justifiable to question why such data has not been available regularly since the inception of the New Towns. It is also a matter of new research to fill in the existing gaps. The consensus of opinion at the Conference was that a central unit should be established to store existing data, encourage the collection of other available information and to generate and sustain further interest. If new research were to be undertaken some body such as this would also be required to act in a fund-raising capacity. Moreover, a unit of this sort would not only serve to collect information. It would also provide a centre to whom future New Town Managers and other interested parties might turn for guidance.

'I believe what we need—and this is coming out of the lack of any known place to go to for guidance into the broad terms of medical care and planning—is to establish a central group, if you like to call it that—certainly not a committee—of experts who might meet occasionally. Its functions would be essentially to collect and exchange information: a sort of clearing house. It might perhaps stimulate a study and evaluation of what is going on; but above all to act as an advisory and guidance group—not to tell you exactly what to do, but if you want to come to someone for advice, here would be the information. Now, we've heard about the need for planned experiment, and it is essential to have some realistic local liaison set-up, to which Dr Macrae referred this morning, which seems to have got off to a tremendous start at Livingston. I would like to suggest how these local liaison committees should be set up—this again might be a theme for the next meeting—whether the initial initiative ought to come from the new towns development group or from elsewhere.' (DR J. FRY)

'It would be wrong to imagine that the problems which have been raised are problems only for the twenty odd new towns dotted round the country. The queries concerning the future of medical care in new towns may be mirrored round the whole of Great Britain. The planning of urban society is a vital issue in all industrial centres, old and new. Thus, just as general studies would provide knowledge directly applicable to the development of medicine in new towns, so specific study of new towns would provide a viable contribution to the whole re-appraisal of medical care. The issue is, therefore, no longer whether we can afford to undertake research into medical care in new towns. Dr Forsythe spoke of the salvation of general practice. This immediately poses: salvation of what? It's the salvation of medical care in this country, and we cannot afford to ignore it.' (DR R. F. L. LOGAN)

Final Comments

1. The fact that in New Towns there has been no planning for medical care and that the same old-type general practice is being carried on merely reflects the general overall situation in the National Health Service. This is a serious indictment of the Service as a whole, but an even more serious indictment of the Health Service in New Towns where the opportunities should have been realised and seized 20 years ago. The very complex reasons for this situation have been analysed in the discussion, but general practitioners cannot escape their share of the responsibility.

2. Medical care is indivisible. The general practitioner is but a part of a system providing care for the individual, the family and the community. For many reasons Medical Care now has to be planned to provide maximum efficiency.

Now that we are faced with limited manpower for some time it is even more important that we increase the productivity of all medical personnel, doctors and nurses, by suitable planning and co-operation.

3. Planning has proved to require much time and money.

4. By virtue of the complexities and multiple involvement with various organisations there is need for a *co-ordinator* to take overall responsibility for the development of medical care services in a New Town. He should act through a local lay and professional *liaison group*.

5. Years of neglect in carrying our organised research studies of medical care services in New Towns has resulted in an almost total absence of experience and facts on the situation.

There is a need for a *central study group* that would have the support and facilities to carry out continuing studies on medical services in New Towns. This group would act also as a central intelligence unit, prepared and able to give advice when requested by New Town Managers.

6. Wherever and whenever possible the nearest Medical School and University should be involved in carrying out research and teaching in a New Town.

7. Whilst it is not possible to produce a blue-print which can deal with all details of medical care in a New Town it should be quite possible to agree on a set of guide-lines which would help the New Town Manager in procedure and actions.

8. Finally, the meeting ended without any definite ideas of how action may be taken on these suggestions.

It was agreed, however, that the Ministry of Housing in association with the Ministry of Health should be urged to take a lead in correcting the problems that have been defined and that publication of these proceedings was an urgent step to spread and deepen the discussion amongst the medical profession, the planners and the Administrators of Local and Central Government alike.