THE COLLEGE OF GENERAL PRACTITIONERS

Report on

GENERAL PRACTICE IN THE NEW TOWNS OF BRITAIN

J. B. DILLANE, M.B., F.R.C.S.

CONTENTS

FOREWORD

The Practice Organization Committee received from Council of the College the remit . . . " to assemble the facts of general practice planning organization ".

In an attempt to assess what planning, if any, had been attempted in the unexplored situation of the new town, and to give us some sense of direction for the future, the committee commissioned Dr John Dillane to collect the facts by on-the-spot investigations.

The opinions and recommendations contained in this report are those of the author, and are not necessarily official College policy. It is Council's intention that these findings should contribute to the elucidation of the problems associated with the provision of general medical care in a new community and as such they are now published. These will help us even more to apply the lessons and experiences of the new towns to the wider aspects of planning for medical care in Britain.

If general practice is to develop, if we are to use the limited financial resources to the best effect, if the general practitioner is to have modern tools, a proper place from which to work and the support of the appropriate staff, we must be clear about the requirements. We must see to it that the opportunities of the new towns and new communities are grasped lest we perpetuate irretrievably in steel and concrete the mistakes of the past.

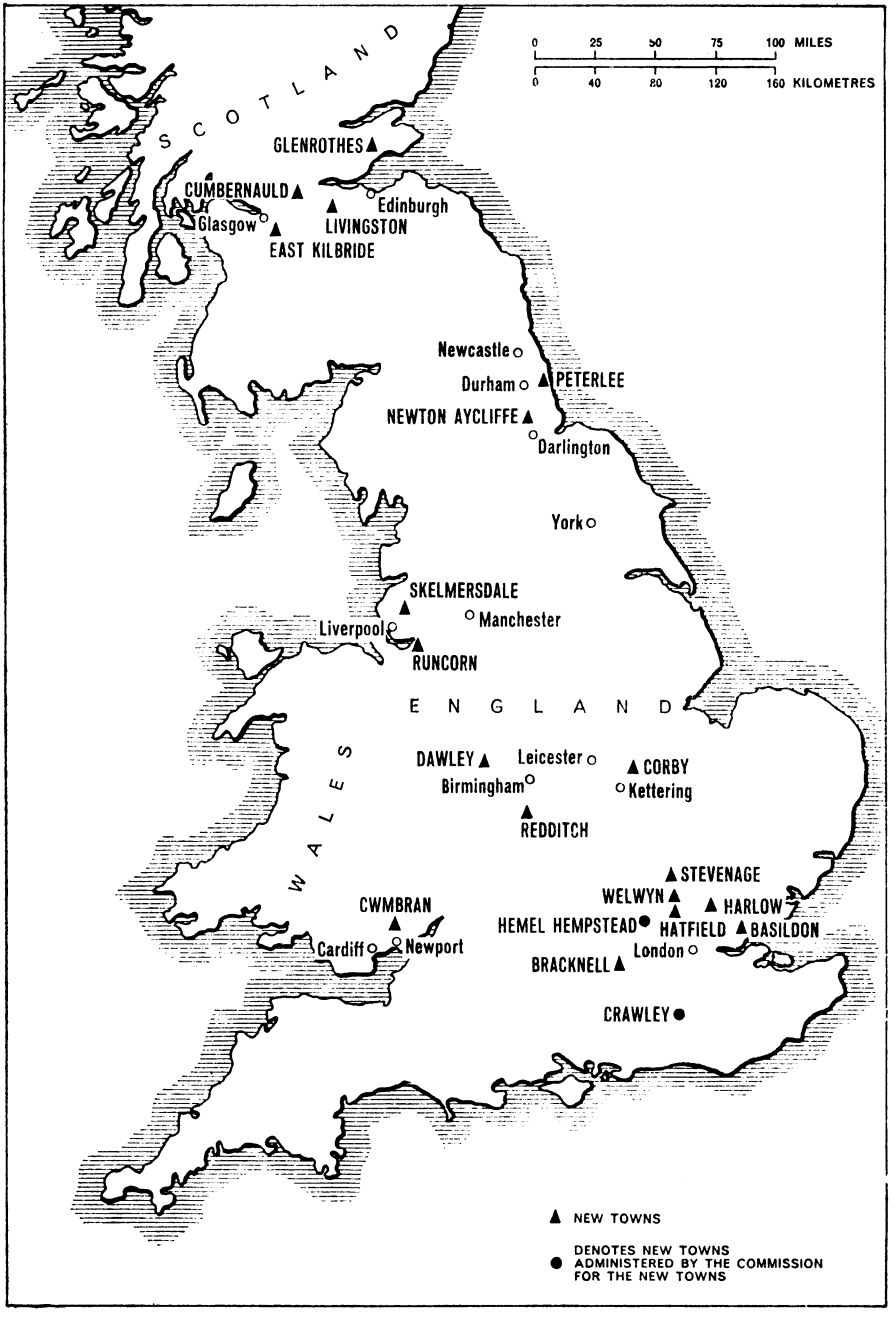
Council of the College gratefully acknowledges the debt owed to the imaginative support received from the Nuffield Provincial Hospital Trust, and in particular from its secretary, Mr Gordon McLachlan.

JOHN FRY
Chairman of Working Party

E. V. KUENSSBERG
Chairman, Practice Organization Committee

H. N. LEVITT, *O.B.E.*,
Chairman of Council.

THE NEW TOWNS OF BRITAIN



I

INTRODUCTION

THIS study was carried out for the Practice Organization Committee of the College of General Practitioners with a grant from the Nuffield Provincial Hospitals Trust. The report is intended primarily for the Practice Organization Committee but may be of interest to some lay people; accordingly, some aspects of the structure of health and welfare services, familiar to a medical audience, have been dealt with at some length.

Previous surveys had led to the conclusion that the premises in which doctors practice would have a very great influence on the way in which a family doctor service could evolve in the future. The recent South-east and North-west studies as well as the financial and industrial success of the established new towns have shown that more such developments can be expected in the future; for these general practice should be prepared, as they present both a problem and an opportunity.

As will be shown, the situation in the new towns is very mixed indeed with varying degrees of participation and interest on the part of the persons and organizations involved in bringing family doctor services to the inhabitants. This is not a desirable state of affairs to be allowed to continue into the future.

The report deals only with general practice in new towns. Other aspects of health and welfare, for example industrial health services and hospital facilities are not considered; nor is the situation in large developments (' Expanded Towns ') carried out by local authorities outside their own areas under the Town Development Act 1952 discussed. These developments could be the basis for a separate study.

We would emphasize that the report is written with the interests of general practice principally in mind in order to show up its problems. We do not wish to criticize those who have no responsibility for general practice or the welfare of general practitioners.

II

THE NEW TOWNS

The deliberate establishment of a sizeable centre of population where none previously existed and which is designed to provide the inhabitants with all their requirements is a peculiarly British achievement of the post-war years. The intention has been usually to relieve an area of over-crowding in a large city or to provide accommodation for workers and their families close to the industries in which they work. Private industrialists set up the first such centres at Bournville, Port Sunlight and New Earswick at about the end of the last century. Private companies founded Letchworth in 1903 and Welwyn Garden City in 1920 in order to place workers and industries close together in clean, airy, surroundings. These ' garden cities ' employed the reforming principles propounded by Ebenezer Howard in his book *A Peaceful Path to Real Reform*, published in 1898, but were also intended as financial investments. Although Letchworth and Welwyn were fairly successful by the late 1930's, they had not been copied when the second war commenced. In 1944 the *Greater London Plan* suggested that as part of the future development of the metropolis a series of satellite new towns should be built about 25 miles or more from overcrowded London.

Government response came towards the end of 1945 when a committee was set up under the chairmanship of Lord Reith " to consider the general questions of establishment, development, organization and administration that will arise in the promotion of new towns in furtherance of a policy of decentralization from congested urban areas; and in accordance therewith to suggest guiding principles on which such towns should be established and developed as self-contained and balanced communities for work and living."

In 1946 the Reith Committee issued three reports, which together contained a blueprint for the administrative and financial machinery needed for the creation of new towns, and recommendations concerning their size, their layout, and economic and social structure. The last of the three reports was divided into sections, each of which dealt with a separate subject, such as site selection, landscape treatment, building designs and constructional standards, industrial and trading facilities, public services, communications, housing, health and educational services and religious organizations. The recommendations in these reports were generally acceptable to the Government, and within a few months of publication the New Towns Act, 1946 was passed.

The New Towns Act, 1946, gave the Minister of Town and Country Planning

(now the Minister of Housing and Local Government) and the Secretary of State for Scotland, power, as the responsible Ministers, to designate any area of land in Great Britain as the site of a new town, and to appoint a development corporation to be charged with the layout and development of the town.

The Act dealt with the constitution and functions of the development corporations and the method by which the new towns were to be financed, as follows: each development corporation was to be appointed by the appropriate Minister and to consist of a chairman, a deputy chairman and not more than seven members; development corporations were to have general powers to acquire by agreement or by compulsory purchase any land or property necessary for their purposes, to carry out building and other operations, and to provide the services required for the development of the town; development corporations were to be allowed to contribute (with the approval of the Ministers and the concurrence of the Treasury) towards expenditure incurred by local authorities or statutory undertakings in performance of their duties in relation to the new towns; capital cost of development was to be advanced to the corporations by the Ministers out of money provided by Parliament and to be repaid by the corporations on terms approved by the Ministers with the concurrence of the Treasury; accountability was to be secured by means of annual reports and accounts submitted by the corporations to the responsible Ministers and thereafter laid before Parliament. The Act also provided that when the development corporations had substantially achieved their purpose of creating a balanced community, they should be wound up and their assets transferred to the local authorities. (*The New Towns of Britain*, H.M.S.O., 1964.)

Later, the New Towns Act, 1959 provided that new towns nearing the end of their development should be handed to a new body called the Commission for the New Towns which has administered Crawley and Hemel Hempstead since 1 April 1962 and which is taking over Hatfield and Welwyn Garden City on 1 April 1966. (The Act does not apply to Scotland.) The New Towns Acts 1946 and 1949 have now been superseded by a consolidating measure, the New Towns Act 1965.

The *site* of a new town will be determined by the function the town is to serve, and good water supplies, drainage and road communications are essential. Agricultural land of high quality is not built over, nor are mineral sources interfered with. Finally, much otherwise suitable land will be found to have been so heavily mined in the last century that engineering problems preclude its economic use. Often a mature town with its own social services and town or rural council will be included in the proposed new town area, in such cases there is continuing consultation between the Minister and his officers and the local authorities directly concerned.

Once the site is decided the intention to designate the area is advertised by the Ministry of Housing and Local Government, objections and comments by interested parties are invited, and normally a public enquiry is held before *designation* is formally effected. When this has taken place the *Development Corporation*

is appointed by the Minister and asked to prepare a *master plan* showing the broad outlines of its intentions for each section of the designated area. A less rigid document called an *interim plan* has come into use with the second wave of new towns designated since 1961/62. Once the Ministry is satisfied that the plan is economically sound and just to the interests of the local population and the general public, the development corporation prepare *detailed plans* for each area.

Where shops and services are to be found in an old town near the new corporation housing area, the domestic and welfare needs of the first residents are more easily provided, but through the new town concept many new communities have now been created where none previously existed and the technique for providing these needs has become highly developed. For example, the planners of Skelmersdale in Lancashire had prepared in advance detailed estimates of retail and service trade requirements, traffic flow in peak and off-peak hours on week days and at weekends, industrial floor area requirements, etc., before the first house was ready (this will be seen later to be relevant to the family doctor service).

The rents of houses provided by Development Corporations in England are subsidised by the Exchequer. At present the rate of subsidy is £28 per annum for 60 years for each dwelling provided, and where the dwellings are not provided by arrangement with a local authority to house the authority's overspill, a further grant amounting to £12 for each dwelling is paid by the Exchequer. Where the dwellings are provided to take a local authority's overspill the grant (£28 + £12) is paid to the Development Corporation by the Ministry who recover half the cost of the £12 from the local authority concerned. In Scotland the subsidy is £42 per annum plus £14 overspill allowance paid direct by the local authority to the New Town Corporation. Strictly, houses which are used for professional purposes lose the housing subsidy.

A corporation should regard general practitioners who occupy their buildings as they would any other commercial letting and require an ' economic ' rent. The obligation under the New Towns Act of 1946 is to satisfy the Government that the return is reasonable in all the circumstances; to do otherwise would expose them to Ministerial censure. As a corporation borrows money from the Treasury for repayment over 60 years, an economic rent for one year is interest and repayment of the capital element spread over 60 years, plus supervision, maintenance and profit. New Town Corporations lack a large housing stock with which newly constructed houses can be pooled. This becomes less marked as a

town grows. Local authorities' rents can be subsidized by rates but the £12 grant mentioned above is aimed at offsetting this to some extent. In a newer town, values rise with growth, particularly at a town centre, and for commercial development the corporation is obliged to charge the *market rent* which is the rent the market will bear. This tends to make the general level of new town rents high in comparison with some of those in old towns; the differential is especially marked in Scotland where rents have always been lower than in England.

The corporation also, naturally, controls the length and terms of *leases*. Although freeholds have been sold in some new towns, leasehold has been considered more desirable by the Ministry, both because a landlord has powers which can be used to preserve the character of a district and because possible long-term redevelopment of the area at a future time will be much easier if freeholds have have not to be reacquired.

Within the regulations imposed on it by the New Towns Act and the Minister, the corporation will always try to act in accordance with the common good; naturally, this may in particular cases overrule the interests of the individual.

The corporations have no direct responsibility to provide general medical services, but most, realizing that the interests of the public are involved, have tried to regulate the method by which family doctor services are provided.

III

HEALTH AND WELFARE IN THE NEW TOWNS

The Corporation

A new town corporation functions as a planning and development agency, and the wide powers conferred on them by the Acts are to ensure that the building of the new town is a success, and that the large capital outlay by the Treasury which they administer is protected. They have the power to contribute to the cost of expanding certain major facilities such as sewage disposal and water supply, or if appropriate, to provide such facilities themselves.

Social services, however, are provided through the rates, and as

the local authority and not the corporation collect the rates, health and welfare are normally the responsibility of the local authority. In the earlier years of a new town when the rate return is insufficient to pay for the required weofare facilities, the corporation are concerned that adequate provision should be made and in some cases may contribute directly or indirectly towards the initial provision of such services. Up till now general practice has not been considered eligible for such contributions.

The local authority

The local authority is the authority responsible for rate-borne services in a particular locality.

In the case of county borough the council is the local authority for the administration of all health and welfare services.

In administrative counties both the district councils (i.e. municipal boroughs, urban and rural district councils) and the county councils are local authorities for health and welfare services, there being a division of function between them. Thus the district council is responsible for environmental health services, e.g. water supplies, sewerage, disposal of refuse and sewage, control of infectious disease, and the important allied service of housing. The district council has also some limited welfare powers concurrently with the county council (e.g. provision of meals and recreations for aged people). The 'personal' health services, e.g. home nursing, domiciliary midwifery, health visiting, home helps, maternity and child welfare services, ambulance services, etc., together with all welfare services, are the responsibility of the county councils. County councils are not housing authorities.

Additionally, both county borough councils and county councils are education authorities under the Education Acts and as such have the responsibility for providing school medical services. District councils do not have these powers.

Under the Local Government Act of 1958, section 46, the council of any county district which is a borough or urban district having a population of 60,000 or more may make a delegation scheme, in which case the county council is required to delegate certain of its health and welfare functions to that council. This does not apply to a rural district council which, irrespective of its population, can only make such a delegation scheme with the specific consent of the Minister of Health.

The contribution of the local authority in the planning of new towns in the future is to be greater in some cases as a result of a decision taken by the Minister of Housing and Local Government

during 1965. Some new towns will be developed in conjunction with already existing large towns whose local authorities will be asked to work in partnership with the new towns development corporations. This must clearly influence plans for health and welfare in these schemes. Four such new towns are proposed for Northampton, Ipswich, Peterborough and Warrington.

The executive council

The executive council, which is responsible to the Ministry of Health for general medical services in its area, is a committee composed of professional (doctors, dentists, chemists) and lay representatives. It ordinarily covers an area of about the same size as a county or borough council and its executive officer is the clerk. In the provision of medical services to an area, he is a key figure because he is in continuing touch with both medical and lay opinion. In Northern Ireland one central Health Service Board carries out the functions of executive councils.

The medical practices committee

The Medical Practices Committee has the power, if it feels that an area has sufficient general practitioners to provide for the population, to declare the area ' closed '. This means that a doctor attempting to commence practice in the area would not be able to get on the executive ' list '. In a ' designated ' area, on the other hand (that is an area with the greatest shortage of doctors) a new doctor becomes eligible for the ' initial practice allowance ' (which at present is worth about £1,500 per annum) whilst he is building up his practice. In an ' open ' area, any doctor may assume that his application for inclusion in the council's ' list ' for such an area will be accepted automatically.

An important distinction to be remembered is that while the executive council must provide family doctor services, dental services are not ' guaranteed ', i.e. a patient must find his own dentist, and the executive council must find him a doctor.

The local medical committee

Every doctor, whether a member of the British Medical Association or not, is represented on the local medical committee. This is a statutory committee under the N.H.S. Act and its area corresponds to that of the executive council. Local medical committees have representatives on the executive council of the particular area.

The general practitioner

Each general practitioner enters into a contract with the local

executive council, but, although he must inform the executive of his surgery hours and undertake to be in attendance then, the administrative side of his practice is entirely his own affair. Thus, the number of people he employs as receptionists, secretaries, nurses, etc. can, and does, vary with his personal wishes. A general practitioner looks after an average of 2,362 people in England and Wales and in Scotland rather less. When the National Health Service began it was expected that general practitioners would gradually stop practising from their own homes and move into health centres. For various reasons this did not come about; in fact, doctors over most of the country developed a strong antipathy to health centres and, instead, group practice became more common.

In a group practice, several doctors, usually about four, collaborate to share the expense of providing premises, receptionists, cleaners, etc., and to enable each of them in turn to have some time off and to take holidays. Whilst it is usual for doctors in a group to be partners, that is, to share remuneration and expenses, this is not always the case. And even partners do not necessarily see each other's patients, except in an emergency. Since the inception of the National Health Service group practice has grown apace and today only 25 per cent of general practitioners are in single-handed practice as against 48 per cent in 1952. Although some groups of up to ten members exist, experience seems to show that inter-personal frictions are especially likely if the number exceeds five.

Recently, there has been a more ready acceptance of health centres among general practitioners, prompted, perhaps by the increasing cost of providing and maintaining a modern establishment from the doctors' own pockets. How this attitude will be influenced by the outcome of the present negotiations between the profession and the Minister of Health remains to be seen.

The new towns, so far, have always succeeded in attracting sufficient family doctors. Probably the egalitarian atmosphere, the opportunity to build a large practice quickly, the clean houses, the high birth rate (maternity is a rewarding facet of general practice) and the low proportion of old people are all inducements.

The Ministry of Health

The Ministry of Health in England and Wales, the Home and Health Department in Scotland, and the Northern Ireland Ministry of Health and Social Services are responsible for policy in health matters. The Ministry of Health has divisional and regional medical officers who liaise directly with local general practitioners whilst senior medical officers at the Ministry collaborate with the local health authorities and the regional hospital boards.

In view of the antipathy general practitioners have shown in

the past to working in local authorities' premises the Ministry of Health is at present noncommittal about health centres, but fosters the grouping of doctors in modern premises by providing interest-free 'group practice loans' repayable over 20 years, whereby money is loaned to general practitioners for building group surgeries.

The Scottish Home and Health Department, not the local authorities, has the responsibility for the establishment of health centres in Scotland. Centralized planning for health centres is therefore possible and the Department is now actively pursuing the establishment of health centres in Scottish new towns.

In Northern Ireland up to the present the responsibility for initiating health centres has lain with the Health Services Board. The board delegated its authority to the county health committee for the one centre which has been erected—in Co. Antrim. Under a new Bill it seems likely that the Northern Ireland Ministry of Health will become responsible for health centres (on the Scottish model) with the option of delegating to the Health Services Board, the hospitals authority or a county health committee in any suitable case.

Regional hospital boards

Regional hospital boards are responsible to the Ministry of Health for the efficient functioning of the hospitals in their areas, and they employ consultant doctors on contract. Hospitals have, since the beginning of the National Health Service, had the monopoly of laboratory and x-ray facilities. Thus, if general practitioners were to have diagnostic units in health centres these would probably have to be provided by the regional hospital board. Before the National Health Service, consultant outpatients' sessions in local health authority clinics were not uncommon, but since 1948 hospitals have tended to centralize the services of their consultants in hospital outpatients' departments.

Health centres

Under the National Health Service Act, 1946, section 21, the local authorities are the bodies responsible for the erection of health centres (except in Scotland). These were originally intended as buildings where the local health authority and general practitioners would work in collaboration, and it was hoped that in some cases the general practitioners would have laboratory and x-ray facilities to assist them in the diagnosis and treatment of their patients.

It is now obvious that many local authorities, while accepting the responsibility for providing maternity, school and child welfare clinics, have been unwilling to provide premises for general practitioners over whom they have no control.

General practitioners have in their turn, been unwilling to practise from premises controlled by a committee of lay people who, they feel, are not necessarily consistently well disposed to the medical profession.

A third deterrent to the realization of the health centre ideal is the great cost of such buildings—probably the idea is impracticable with less than six doctors serving about 15,000 people, and to house these with the equivalent local authority establishment would cost about £50,000 today. A county council, being responsible for a large area and many centres of population would be reluctant to undertake such a large outlay for one particular district (even if the Ministry of Health looked favourably upon the scheme).

The local health authority has important calls on its revenue besides health centres, such as the provision of accommodation for the aged, and centres for training the mentally subnormal. On such projects a local authority will have a long-term plan equivalent to the Ministry of Health's 10-year *Hospital Plan*, whereby a substantial annual outlay will be bespoken many years ahead. In the absence of very definite encouragement from the Ministry of Health they could not upset this plan by inserting or superimposing schemes for expensive health centres, particularly as loans to local health authorities for health and welfare schemes must have the sanction of the Ministry of Health, who are thus able to exert some influence on the total expenditure in a year and on the distribution of Treasury money through the various sub-divisions of this aspect of local government.

IV

GENERAL PRACTICE IN ESTABLISHED NEW TOWNS

The first new towns were designated in 1947 and 1948, shortly after the National Health Service had been set up. There was little history of co-operation amongst doctors, the executive councils were not really functioning, nor were the regional hospital boards. In consequence, corporations had to take such action as they could, in collaboration with local general practitioners, to ensure that some family doctoring service was available to incoming population.

In the section which follows no attempt is made to give an

exhaustive account of the history of general practice in each town; only relevant matters are touched on. Although the pitfalls which beset the planners are emphasized, it must be admitted that in every case the inhabitants are today receiving adequate medical care.

ENGLAND AND WALES

(1) **Crawley** (*Sussex*) lies 30 miles south of London on the London to Brighton Road. When the new town was designated in 1947, the population, distributed in hamlets around old Crawley, was under 10,000. At the end of 1964 the population was 61,400. The Crawley Development Corporation handed over responsibility to the New Towns Commission in April, 1962.

As usual, new neighbourhoods were built up in a centrifugal fashion from the original focus of population. The corporation's policy at the beginning was that each neighbourhood should have its own resident doctor. Building began in 1949 and in 1950, as the first residents were moving in three doctors, in anticipation of the rapid increase in population, squatted within a period of three months (it was an ' open ' area). This was possible because freehold premises, part of the old Crawley, could be purchased in close proximity to the new corporation housing. Existing groups of doctors in the old town felt forced to expand into the new housing areas to prevent erosion of their practices, and so a bewildering series of branch surgeries was opened (and in quite a few cases later closed).

The corporation architects had hoped to have a health centre in the new town, but a meeting of the general practitioners convened by the medical officer of health in 1950 was against the idea, and the proliferation of branch surgeries continued until about 1952 when the executive council took a hand and ' closed ' the area. Thereafter, the practices then in Crawley were not allowed to open branches in the newer neighbourhoods and a doctor was appointed by the executive council. The corporation, which at that time and subsequently received remarkably little informed advice from general practice, collaborated by renting him a centrally situated four-bedroomed corner house on to which a small surgery was added. Six such surgeries were built and doctors were offered the alternative of a 21-year lease or of buying the premises on a 99-year lease with, if necessary, the aid of mortgage facilities provided by the corporation. The surgeries originally provided by the corporation soon proved too small for more than one doctor and were, from the beginning, inadequate for serving the neighbourhood population of about 5,000. They were also incapable of being expanded without encroaching on the living accommodation.

This pattern of establishing doctors has not been without its difficult moments. One doctor appointed by the executive council in 1958 moved into a typical area when there were only 200 residents. His list grew to 1,800 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 realized belatedly that he had had no guarantees protecting his interests when he came to Crawley. Happily, the matter was settled by the original doctor being allowed to choose his own partner.

Crawley demonstrates how, with the earlier new towns the National Health Service was not at first functioning smoothly and the doctors of the old town intended simply to expand into fresh housing estates following the laws of supply and demand. It also shows how plans, in this case those of the old established practices, can be upset if there is any opportunity for doctors to squat in, or near, a new area. The corporation's original plan for a local doctor to live in each neighbourhood got off to a bad start because the architects were badly advised on the space requirements of general practice. The doctors of Crawley also showed the tendency, since shown in many new towns, to prefer to live away from their practice.

One further point—the influence of a hospital. There was a cottage hospital at Crawley which attracted family doctors of a high standard to the new town. This is ascribed to the obstetric unit where the general practitioner, unlike his fellows over most of the country, can attend his maternity patients in hospital. On the other hand, because the hospital provided first-aid facilities for Crawley industries it is felt that the development of an industrial health service has been forestalled. At Harlow the absence of such first-aid facilities persuaded industrialists to invest in a Trust, which provides industrial health services and incidentally gives an extra source of income to general practitioners.

(2) **Hemel Hempstead** (*Hertfordshire*) was already a township of 21,000 inhabitants when it was designated as a new town in 1947. The existing community had a long history; it had received Charters for markets and fairs from Henry VIII and had been a municipal borough since 1898. In April, 1962 the Commission for the New Towns took over from Hemel Hempstead Development Corporation. By the end of 1964 the population had risen to 66,000.

As with all early new towns, when a substantial population was already established, the four general practices of Hemel Hempstead old township guided the corporation on the way in which the new

housing estates were to be provided with general practitioners. Officers of the Development Corporation were in touch with Hertfordshire Executive Council from the outset and although Hemel Hempstead was regarded as an 'open' area, initial registrations were made, on the advice of the executive council, with practitioners already established in the town. This was because the clerk of the executive council said that there must be 3,000 people there before a new doctor could be introduced. Thus the first housing estates were served by branch surgeries of old Hemel practices.

In the first neighbourhoods to be established (say 1949–1951) building restrictions prevented the provision of purpose-built surgeries, incoming doctors leased or purchased corporation houses and, if necessary, surgery extensions were built by the corporation in return for additional rent. Normally the doctor would have been a nominee of one of the groups already in practice, but in 1952 a new group was founded by a doctor who discovered an existing freehold property inside a developing estate which provided a base for him to squat and to build up a practice. In time most of the residents of the new neighbourhood were his patients and provision of a further surgery for that neighbourhood by the development corporation was therefore unnecessary. The corporation later provided surgery accommodation for this practice in the neighbourhood centre. This surgery was provided in 1955 although the doctors had no say in its siting or its size.

More recent custom in planning a neighbourhood has been for the corporation to be advised by the executive council as to the number of doctors likely to be required and to set aside a pair of flats or maisonettes near the neighbourhood centre to be converted to the incoming doctor's requirements.

In the case of one practice, by 1961 the surgery was found to be too small and the difficulties experienced in trying to expand it highlight the necessity for some uninvolved but well-informed opinion to be available to both the corporation and the general practitioners. The doctors presented a plan for an extension drawn up by their own architect which was accepted by the corporation after 18 months of negotiation. The corporation then proposed an additional rent equal to $12\frac{1}{2}$ per cent of the gross cost (which included the architect's fees) plus a 15 per cent addition to cover the corporation's costs for 'general supervision', although the doctors' architect was to supervise building as part of his normal duties. Such an approach to the provision of premises for family doctors is perfectly proper, but can cause unnecessary bad feeling.

In Hemel Hempstead the formative period of both the National Health Service and the new towns is evident. The executive council

allowed doctors already established to guide development at the beginning but later the executive council became the corporation's main adviser. We see also how a doctor was able to start up a new group in freehold premises. In common with most new towns the consultant architects to the corporation had originally wished to incorporate a health centre in the plans for Hemel Hempstead, but this idea died an early death.

(3) **Basildon** (*Essex*) lies on land flanking the north bank of the Thames 30 miles to the east of London. The new town area which was designated in 1949 included 25,000 inhabitants. The present population exceeds 64,000 and the population target is 106,000 but this may be considerably increased.

In 1949 the enthusiasm for health centres was at its height and they were to be put in all new towns. Doctors coming to Basildon were told that they must agree eventually to practise from a health centre. By 1959 not only had the health centre not materialized, but the doctors were still practising from temporary surgeries, and often in their own homes—whereupon they began individually to make provision for, and to invest their capital in, their own premises, and now it seems impossible that they can ever be persuaded to practise from a centre.

The corporation has always been willing to be guided by the profession and to build the premises required by the doctors whether individuals or groups, but in spite of several meetings between the corporation, the general practitioners and the county and local authorities no policy has emerged.

(4) **Welwyn Garden City** (*Hertfordshire*) 22 miles north of London, was founded in 1920 by Ebenezer Howard the pioneer of town planning and when the new town was designated in 1948 the population was 18,500. It is now 40,000. In spite of its being so very well established, further expansion is proceeding and more doctors will be needed.

At the end of the war there were two groups of two doctors in general practice in Welwyn. A third practice was established when a doctor squatted in 1945 (his practice has now expanded to three partners). The New Town Corporation then became an influence on the development of general practice and, in a now well-established routine, accepts the recommendations of the executive council. In the past this has meant that a branch surgery for one of the Welwyn practices has to be built in each area. For this a corporation house has been modified and 15 such branch surgeries exist through Welwyn Garden City.

Several moves towards the centralization of general practice have occurred. In 1952 the county authorities suggested a health centre

as they were about to build a county clinic in Welwyn, but this initiative was turned down by the doctors who felt the rent would be high and were reluctant to leave their established places of practice. Again in 1964/65 the health centre idea was discussed and turned down.

Three years ago, two partnerships, one of five and one of four doctors, explored the idea of having a group practice building in the centre of Welwyn Garden City. It was hoped to attract a third partnership into the venture and to have private consulting rooms in the building which might be rented by specialists. The corporation were prepared in principle to provide a plot of land and even to put up the building. In spite of such co-operation the doctors were unable to proceed (even with an interest free group practice loan). This was because of the high site values at the centre of the new town. It was estimated that the capital cost would have been £50,000.

Welwyn illustrates the natural evolution of general practice in a new town and the impossibility of breaking the pattern of general practice once it has become established.

(5) **Hatfield** (*Hertfordshire*) was also one of the early new towns, being designated in 1948. It lies on the Great North Road south of Welwyn and its development corporation is identical with that of Welwyn. Together with the latter it is to be handed over to the New Towns Commission in April 1966. The original population of the area was 8,500 people and has now reached 23,350. The de Havilland division of Hawker Siddeley Aviation provides the main industrial employment for residents. There were originally 6 general practitioners; there are now 11.

The evolution of general practice has been similar to that in Welwyn. A site for a health centre was reserved in the plans for the town centre, but even in the early 1950's local councillors were complaining that residents would have too far to walk to such a centre.

The corporation provides a four-bedroom house for a doctor in a new area. He is asked for an economic rent, and in at least one case the corporation has insisted that the rent subsidy should be lost. On the other hand, the doctor is granted a 14 or 21-year lease with no break clauses.

The town centre, which has been delayed in its development, now seems very unlikely to get its health centre especially as one group of doctors has been allowed a site, close by the shops and near the central parking space, where they have erected a group surgery. The partnership originally had a house on land required for Hatfield

town centre and they were, of course, obliged to sell the property. For their present site, which is one eighth of an acre, the group have a 99-year lease.

(6) **Stevenage** (*Hertfordshire*) was the first of the new towns to be designated (in 1946) and is 31 miles north of London. Old Stevenage was a country town on the Great North Road, with a population of under 7,000. In 1965 the total population was 56,000 and the corporation expects to build to a population in excess of 60,000. Six neighbourhoods each of 10,000 to 12,000 population are planned and four of them are complete.

Relations between the general practitioners and the corporation did not get off to a good start in Stevenage and on several occasions 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 the 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. The original intense rivalry between doctors to be the first to open a branch in a new area has lessened. At one stage the corporation provided premises for two branch surgeries within 50 yards of each other. The executive council was aware of the position as was one of the doctors but the corporation, quite rightly, did not think it was their function to interfere.

Because Stevenage was an early new town, the problems of the establishment of general practice were all new. In addition the executive councils of the National Health Service were also feeling their way, and the superabundance of general practitioners made rivalry for practice openings rather sharp. These early troubles have had the good result that the corporation is now skilled in the mechanics of getting doctors' surgeries established.

There was a meeting convened by the county medical officer of health in 1955 at which he proposed a health centre for Stevenage, but the doctors felt themselves too committed to move into such a building completely. It was considered that to use the health centre as another branch surgery would not be economic. At present there seems to be no movement towards the centralization of general practice in Stevenage beyond the grouping which is occurring all over the country.

In Stevenage, the pattern of building a group up from two doctors by opening new surgeries and attracting additional patients is illustrated, together with the friction this can cause between adjacent practices.

There is an outpatients' clinic in the town centre provided and maintained by the hospital board.

Industrial health services have not developed in Stevenage. Industrial interests suggested that the regional hospital board should open a casualty department, but the regional hospital board indicated that this would only be possible if the general practitioners staffed the department. The general practitioners were too busy.

(7) **Newton Aycliffe** (*Co. Durham*) lies 12 miles south of Durham, and was designated in 1947. A Royal Ordnance factory was built at Aycliffe in 1940 and after the war was converted into an industrial estate. The idea of attracting population to this area was resisted by the county and the projected population was, therefore, limited by the Ministry to 10,000. In 1959 the county council, finding it hard to attract workers to other parts of the county, approached the Ministry and the projected population was raised to 20,000. In 1962 the then Lord Hailsham recommended that the Darlington/ Aycliffe area should be the focus for the development of the north east and the projected population of Aycliffe was thus, again, raised to 45,000. The present population is 16,000, and it is hoped to reach the planned population in ten years. A public enquiry was recently held into the draft designation order to increase the size of Newton Aycliffe.

Three group practices are strategically placed in the town at the moment. They were developed by the rural practices in existence before Newton Aycliffe was expanded. There is a small local authority clinic which will not be adequate for the expanded Newton Aycliffe. There is no local hospital. The corporation are prepared to lease a doctor a house, and in one case have made additions to it for surgery premises. They are also prepared to sell freeholds. (Under the New Towns Act, 1946 a corporation could not sell freeholds except to local authorities and churches. This was amended in 1954. More recently, as mentioned elsewhere, Ministerial policy has swung back to regard the selling of leases as more desirable.)

When the projected population of Newton Aycliffe was 10,000 the corporation explored the idea of a health centre and the general practitioners turned it down.

(8) **Cwmbran** (*Monmouthshire*), 18 miles north east of Cardiff, already had considerable industry located in the vicinity at the end of the war. Thousands of people used to travel to the valley every day and largely to solve this daily travel problem the new town was designated in 1949. At that time the population was 12,000 and in 1964 it had increased to 33,000. The ultimate goal is 55,000, which will make Cwmbran one of the largest towns in Wales.

The designated area included at least three hamlets, with the result, inevitable unless strong control is exercised, that general

practice has developed by means of branch surgeries within the new housing areas. The first developments occurred around the old housing, and as the in-coming doctors preferred to occupy old houses and to use them for the surgeries, the corporation could not do other than allow things to take their natural course; but they were in consultation with the executive council and the local authority, and made building plots or houses available to doctors when required. More recently, housing has begun to push into open fields, and the corporation have decided to erect a two-storey building for a group of four doctors (and a dental practice) to serve a population of 20,000. The corporation architects have been asked to design the building, but they have met the obious difficulty that the doctors who are to occupy it are not yet available for discussion on planning the surgery premises. General practice provides no body of experts with which such a corporation can confer.

At present the corporation are erecting this group practice building adjacent to a county health clinic in the centre of the new area and are prepared to rent, long lease or otherwise dispose of the building at a price just sufficient to cover the loan charges and the cost of keeping the buildings in repair, preferably to one firm of doctors. However, the population is not at present adequate for the executive council to consider establishing a new doctor and giving him the initial practice allowance. (Probably because it wishes to protect the interests of the two doctors already established when the population was 6,000, before this neighbourhood was scheduled for development). Meanwhile the development corporation has 2,000 houses out to contract and 60 are being completed each month, that is about 50 new residents are arriving every week.

(9) **Bracknell** (*Berkshire*) is 28 miles west of London and was designated in 1949 when the population was 5,000; by July 1964 there were 26,000 people. A second phase of development, on which building will shortly commence, will provide houses for 34,000 more people.

When the new town began developing about 1952 there were three doctors resident in Bracknell while some from Ascot (which is nearby) had patients in the area. The original policy was to accommodate a doctor in a new housing area by providing two adjacent corporation houses, one as a residence, the other as a surgery, with the expectation that the doctor would later build his own home and surgery. This plan worked for three or four years while the incoming doctors were partners of those already practising in Bracknell. Later the incoming doctors were single-handed and younger, were unable to afford to build their own home and surgery, and so had to remain in the temporary accommodation.

In addition, the new neighbourhoods were of such a size that the

doctor could have only about 4,000 patients on his list and thus was unable to afford a partner, or assistant, even though notified by the executive council that he had exceeded his maximum allowance of patients. These doctors have now seen the formation of groups as their salvation, and five recently approached the corporation for a site at the centre of Bracknell. The corporation felt this was a reversal of previous policy and asked the doctors to approach the executive council for its views on the closing of the neighbourhood surgeries in favour of a central group building. The executive council supported the idea. However, in July the local press began to report the proposed closure of the neighbourhood surgeries and some local councillors were vehemently against it. The local council were eventually satisfied that the benefits to the doctors of sharing accommodation would result in an improved service to the residents and, together with the county council, they supported the doctors in their approach to the corporation.

Concurrently the opinion of other doctors in Bracknell was undergoing a change. Whereas in January 1965 there was no support for a health centre, by September it had come to be considered desirable. This was in anticipation of the Doctors' Charter where a rent, even if high, might be re-paid to the doctor and the salaries of the health centre ancillary staff might also be re-paid.

Bracknell, therefore, highlights many of the difficulties faced by a corporation in planning for new town general practice. Neighbourhood surgeries are uneconomic both for groups and for single-handed doctors, yet if doctors want central group surgeries in a developed town it will be found that all the suitable sites are very expensive indeed. Some doctors want group surgeries, others are now beginning to want health centres.

It is planned that the extension area (34,000 population) should contain several health centres and there is a possibility that an industrial health service might be developed as at Harlow.

(10) **Corby** (*Northants*). The steel company of Stewarts and Lloyds Limited came to Corby in 1934 bringing many people from Scotland to the centre of the Northamptonshire iron ore field. The steel company built houses for its employees and later a council housing scheme was commenced. In 1950 when the new town was designated the population was 15,700 and in mid-1965 was estimated to be about 44,500. The corporation will go on building until the population reaches 55,000. New neighbourhoods are, therefore, proposed in the near future.

In 1950 there were seven general practitioners in Corby. The corporation felt that there should be a doctor resident in each neighbourhood and have been guided by the wishes of the incoming

doctor on the surgery accommodation, modifying a standard house to his requirements. (As an example, one doctor had one waiting room, two consulting rooms, an office and lavatory provided. The cost of the alterations to the house was £300 which was repaid to the corporation over three years.) The corporation have been anxious to stabilize family doctor services in each area and granted moderately long leases of 21 years initially or permitted the doctor to buy his house on a 99-year lease. Recently, however, doctors in common with most professional people, have preferred to live out of Corby and so tend to use only the surgery part of the accommodation. The corporation have always made a profit from doctors' premises.

The unique feature of medical practice in Corby is the Nuffield Diagnostic Centre, built in 1953 with funds provided by the Nuffield Trust. The centre is staffed by the Oxford Regional Hospital Board for whom it is an outpatients' department and the local general practitioners have the use of consulting rooms and access to the x-ray and pathology facilities in the centre. It has had the effect of drawing the Corby general practitioners together so that they not only know one another but have a rare unanimity of opinion.

The family doctors of Corby have full lists and as the area is not attractive the present shortage of general practitioners is going to be felt acutely in future housing developments. Ten years ago there were 84 applicants for a place in one of the partnerships within 24 hours of the appearance of the advertisement. This year one doctor has been trying to find a partner for nine months. The general practitioners already established in Corby feel little inclined to open branches in new areas as this would mean introducing new partners into their practices: A new partner would have to be paid at least £2,500 a year and even with an initial practice allowance and notional loading he would not earn this amount for at least the first few years. The senior partners would regard this as subsidising of the medical services of the new estate out of their own pockets.

In Corby the corporation have had a plan but have seen it modified as time went on. Relationships with the general practitioners have remained good. Among themselves the general practitioners have much more contact and co-operation because of the existence of the Corby Diagnostic Centre. Even the squatting of three doctors in 1957, 1958 and 1960 has not upset good relations and grouping has progressed. The shortage of doctors is seen as a serious and pressing problem in the proposed new housing areas of Corby. The established doctors, who have already full lists, do not ee this as their problem.

(11) **Peterlee** (*Co. Durham*), lies ten miles east of Durham city close to the sea, and at the time of designation in 1948 it was almost a virgin site. The population in 1964 was 17,000. The designated area of Peterlee is at the centre of a ring formed by mining ' settlements' or villages, of which the Easington Rural District is composed. The decision to build the new town was to prevent any marked extension of these unsatisfactory settlements and to provide a cultural, recreational and entertainments centre for the whole of the Easington Rural District. Having regard to its situation, it was felt that a comprehensive health centre was a practical proposition and this was completed by the local authority about 1960. Until the permanent building was ready, doctors had temporary accommodation in an old mansion which forms part of the community centre. A large proportion of the population of the new town originated from the surrounding mining settlements and a number of the families moving in have no need to change their doctor.

The 18 doctors who share the health centre accommodation, have their practices for the most part divided equally between the new and the old towns. They are accommodated in four suites, with a common waiting area. The rent is £300 per annum per suite, which includes the use of the waiting-room, the two-room suite, lavatory, furniture and rates, maintenance, cleaning, lighting and heating. The doctors provide their own reception and secretarial assistance and telephone. The economic rent is about £450 per annum. Under the agreement drawn up between the executive council representing the general practitioners and the local authority, provision is made for a review every five years of the rent paid by the executive council, if requested by either party. If any dispute is raised about the rent it can be referred to the arbitration of a person to be agreed in writing by the parties concerned.

It is felt that the accident of site and organization in the foundation of Peterlee, while making the health centre such an excellent solution for that place is rather unlikely to be repeated especially in the new towns of the future which are to be attached to large existing populations.

(12) **Harlow** (*Essex*) is 25 miles north of London. When it was designated in 1947 the population was less than 5,000, it is now over 66,000 and the ultimate population is planned to be 80,000.

The Nuffield Provincial Hospitals Trust has made possible a far-sighted experiment in the provision of general practice from health centres. (*Lancet*, 1958, **2**, 1055.) The Trust has provided capital for the erection of six health centres, each strategically placed to serve an area of Harlow. Because these health centres

are not provided by the local authority they do not come under the National Health Service Act, 1946 and advantage has been taken of this to provide dental suites as well as the general practice and local authority portions of the premises.

An industrial health centre has also been built with capital provided by the Nuffield Trust and the industrial health service is centred there.

Each of the health centres has a general practice section and a section for the local authority both on the ground level and linked by a common waiting-room. The number of general practitioners accommodated and the population served from the building varies between the centres so that it is not possible to give accurate costs.

1. Nuffield House	3½ doctors	1 practice	3 N.H.S. dentists	£24,000
2. Sydenham House	3¼ doctors	2 practices	L.H.A. dentist 18,000 patients	£24,000
3. Osler House	2 doctors	1 practice	No dentist 4,000 patients	£12,000
4. Keats House	3½–4½ doctors	2 practices	L.H.A. dentist 18,000 patients	£32,000
5. Addison House	4½ doctors	1 practice	N.H.S. and L.H.A. dentists 11,000 patients	£40,000
6. Lister House (1st phase)		1 practice	1 N.H.S. dentist (Eventually to serve 23,000 patients)	£55,000

These figures include site and costs, architects' and quantity surveyors' fees and, in most parts of the buildings, furnishing and equipment.

These figures, which were quoted by Lord Taylor in the *Lancet* of 15 November, 1958, of course include the local authority and dental portions of the health centres as well as the general practice parts. It was then estimated that for 10,000 patients the cost for general practitioners, clinics, National Health Service dentists and local authority dentists would be about £25,000 exclusive of furniture or £2 10s. 0d. per patient at risk: for general practitioner services alone the figure was about £1 0s. 0d. per patient at risk.

The Harlow general practitioners usually have a 21-year lease on their premises in the centres with no break clauses, the rent varies between £115 per consulting room without central heating and £230 with central heating. Tenancies are for furnished premises and are exclusive of rates; tenants are responsible for internal decorations and repairs, and provide their own ancillary staff and cleaners.

The terms of the leases have been very carefully defined to protect all parties including incoming assistant doctors. The experience

gained in drawing up these agreements and in the administration of the centres will be of very great value if ever this method of providing general medical services comes into common use.

Such a bold experiment as Harlow can be easily criticized and it may be significant that even though a decade has passed nobody has copied the Harlow health centres. This may be because they were a decade before their time, but more probably it is the difficulty of raising the considerable capital for such a scheme which has proved insuperable. Also it is sobering to remember that the Harlow experiment could possibly have been brought to ruin if one doctor had insisted on his right to practice where he pleased and had refused to move into a centre. This could, of course, happen in other places, but in Harlow all general practitioners who settled there were fully aware that there was no alternative for them but to work from the group practices and clinic centres since there is no private property available in the town where they could set up practice. This does not apply to old Harlow which is separated from the new town by the A11 road.

If Harlow general practice is going to serve as a model for new towns, not only will capital have to be found but a new type of medical administrator will be necessary to manage the centres—a task needing great tact and negotiating skill.

SCOTLAND

(13) **East Kilbride** (*Lanarkshire*) is separated from the southern outskirts of Glasgow by a green belt about two miles in width. The purpose of this new town is to relieve both housing and industrial congestion in Glasgow and the Clyde Valley. Designation occurred on 6 May 1947 and the population had increased from 2,400 to about 42,000 by late 1964.

The corporation reserved sites on the master plan for one central and several neighbourhood medical centres, but the Scottish Home and Health Department were not willing to acquire them because, they said, of the general practitioners' unhappy experience of the Stranraer and Sighthill health centres. The sites were then offered to the local (county) authority which was unable for financial reasons to exploit them. Before the new town there was one doctor. By 1953, when the first neighbourhood was complete, several doctors were established with bases in the old village and branch surgeries among the new houses. The corporation, in the hope of attracting professional tenants, made available office accommodation over the new shops of the neighbourhood centre. In the event, the doctors did rent some of this accommodation, and the corporation made such internal alterations as the doctors

wanted. The rent required for these offices is regarded by the doctors as high. There has been a recent rent increase, and as the leases are for only five years there is a possibility of such an increase every five years. The premises are incapable of expansion and as trucks unload at the back of the underlying shops noise is a problem.

There is a double impediment to the establishment of any sort of centralized medical services in East Kilbride. First, most suitable sites near the centre of each neighbourhood are already built upon, and those that remain have so appreciated in value that the doctors cannot afford the corporation's asking price. The second difficulty is the disunity amongst the general practitioners who have, after this time, established themselves in their own individual ways of general practice. The Scottish Home and Health Department have indicated that both the initiative and the plans for a health centre in East Kilbride must come from the family doctors themselves.

(14) **Glenrothes** (*Fife*) lies 30 miles from Edinburgh across the Firth of Forth and was intended to extend the industrial belt of Scotland towards the east, to help in meeting employment problems in the surrounding district, and to take the overspill population from Glasgow. When it was designated in 1948 the population in the area was 1,150. In 1964 it was 17,000. In the early stages, the new town was adequately served by the practices in the villages adjacent to Glenrothes. One of the original groups increased in number until they had a list of 12,000 patients and there were five partners. As the doctors felt it was unwise to have more than five in the group they at that stage advised the Fife Executive Council, through the local medical committee, to consider setting up a new practice in the town. This was done, and very soon the new single-handed practice became a partnership and with the active co-operation of the corporation in finding a site was able to build its own group practice centre. It is felt locally that this system has worked well and that the local medical committee is the body best qualified to advise on the timing of the introduction of new practices.

In Scotland the Scottish Home and Health Department (formerly the Department of Health) is responsible for the erection of health centres and it had planned to build one on an experimental basis at Glenrothes. But because of restriction on public spending about 1957 the plan was never carried out. Later, the medical officer of health for the County of Fife offered to build a local authority clinic large enough to include accommodation for general practitioners' surgeries. The general practitioners found that their suites of consulting rooms were to be upstairs and all the ground floor was to be devoted to public health accommodation. This they found unacceptable and in any case they did not relish the

prospect of being tenants of the local authority.

(15) **Cumbernauld** (*Dunbartonshire*), designated in 1955, lies between Glasgow and Edinburgh. The main purpose of the town is to assist in relieving congestion in the city of Glasgow. The original population was 3,500 people, the present population is 14,500, and the planned population is 70,000. In Cumbernauld new town plans for medical services were influenced by an upsurge in interest in health centres. The Scottish Home and Health Department purchased a site from the corporation in the first housing area and on it erected a medical services building which is administered by the county medical officer of health acting as agent for the Department.

The medical services building brings together the general practitioners, the local authority services and a dental practice who all share a single large waiting room. Before the building was completed the doctors were practising from corporation houses scattered through the new housing area and have proved reluctant to re-site their surgeries in the medical services building, especially as some would pay rent both for their home or branch surgery and for accommodation in the new building. However, the possibility that another doctor might commence practice in the part of the medical services building they failed to occupy proved a powerful inducement for them to move in. A doctor's rent in the medical services building is subsidised—each practice pays £275 per annum.

The whole of the old village of Cumbernauld lies within the designated area and is about to be redeveloped. Although one doctor practises in private premises there, the ability of the corporation to use compulsory purchase terms will prevent any more old premises being used by doctors who might ' poach ' from there into the new town. Cumbernauld is now a ' closed ' area, with the corporation working in association with the executive council and providing houses as temporary surgery accommodation in the newer areas not served by the medical services building only for those doctors nominated by the executive council.

At Cumbernauld, because of the peculiarities of the site, housing will be in compact units occupying the steep slopes on both sides of a hogsback, with the town centre at the highest point. As a result 50,000 people will be housed in 946 acres and all will be within 20 minutes walk of the town centre. A large health centre is to be built in the town centre and planning is now well advanced. Two additional small health centres will probably be provided in the residential areas at the ends of the ridge away from the town centre. The part the medical services building will play in this overall plan has yet to be decided.

The central health centre will provide consulting and diagnostic

facilities for the general practitioners whose patients reside in the central areas and diagnostic facilities for all the general practitioners practising in the new town. It is intended that patients from the outlying centres in need of diagnostic tests will be referred to it. A hospital outpatients' service will have to be built up as the population expands and for planning purposes it is proposed to set aside one general practitioner's consulting room in the first stage and four general consulting rooms in the completed central health centre. If and when a hospital is built, these services will be transferred to it. Such co-ordinated planning is possible as the authority of the Scottish Home and Health Department extends to the regional hospital board as well as to general medical and local health authority services.

COMMENTS

There has been a lack of standard practice in the provision of general medical services in these new towns and no co-ordinated approach to the problems is yet in evidence.

General practitioners have been reluctant to occupy local authority premises, preferring eventually to own their surgery buildings. Local authorities, moreover, have been unwilling to expend money on general practice, and to confound the problem even further the Ministry of Health has not actively encouraged local authorities to overcome their reluctance in providing the general practice portion of health centres.

The New Town Act gives authority to the corporation " generally to do anything necessary or expedient for the purpose of the new town or for purposes incidental thereto ". In this respect the corporation has a duty to build a new community in the social sense in addition to the erection of new buildings. This obligation is being realized more and more and full consideration is now being given in the pre-planning stage to welfare, social and community life.

Allowing an officer of a new town corporation to determine the nature of general practice, however, is not good policy and has not always been to the advantage of general practitioners. Most corporations deny that this could occur, but many general practitioners have experienced a great alteration in attitude, for good or ill, when the manager or chief estates officer has changed. On the

other hand, it must be said that corporations have often been conscious of the desirability of planning for general medical services but have received little assistance or support from general practitioners' organizations. Certainly the name of the British Medical Association was never mentioned in this regard. The executive council has in many cases not adopted an imaginative approach.

There has been an extraordinary variation in the length and terms of leases and level of rents which, of course, can be explained by variations in site and locality and in nature of the lease but it is felt that some standardization with regard to the position of general practitioners could be attempted. Some industries are given the benefit of low initial rents which later escalate to an economic level, the concession might be appropriate to doctors in growing neighbourhoods. New town rents are generally high and to compete with commercial interests for sites at town centres where market rents prevail is obviously something for general practice to avoid.

The general practitioner working in a village will have been serving farms and hamlets for some miles around. If the area is developed by a new town corporation it would seem unfortunate if the doctor was not consulted on his wishes regarding the development of that portion of his practice; in such cases corporation/executive council co-operation may seem rather remote to the individual.

Any form of planning must involve a certain amount of direction and it is difficult for the general practitioner to reconcile this with his status as an individual contractor.

V

PLANS FOR SECOND GENERATION NEW TOWNS

ENGLAND

So far as general medical services are concerned the outstanding development in the most recent new towns of England and Wales has taken place in Skelmersdale in Lancashire and Runcorn in Cheshire.

Skelmersdale (*Lancashire*), 13 miles north east of Liverpool, was designated in 1961 when the population was about 10,000. Housing has only just commenced and the planned population is 80,000.

It is intended that as each neighbourhood is commenced the Medical Practices Committee will 'open' the area, advertise, appoint the first doctor, and then 'close' the area. The doctor will be accommodated in temporary surgery premises, consisting of a corporation house internally converted and connected to the adjacent two houses which have been also altered to serve as a local authority clinic. The upper floors of these houses will be used by the health visitor, home help service, speech therapist, etc.

The first doctor will be invited to undertake local authority work and this, together with the initial practice allowance will supplement his income in the early days. He will be provided with a separate house to live in.

After about a year the original doctor will move into surgery premises in the local authority clinic, which will have been built, and notify the county authorities of the type of premises he will eventually require so that planning of them can commence. Subject to the approval of the executive council and the local medical committee he will have the main say in the appointment of the second doctor, who will come in as a partner and will practise from the house vacated by his senior. Eventually, six general practitioners will be accommodated in group premises serving 20,000 people within a radius of half a mile, with the local authority clinic alongside near the neighbourhood centre and the local schools. It is estimated that eventually five such sets of medical buildings will be required in Skelmersdale. The corporation houses originally used as local authority clinics and doctor's surgeries will eventually be re-converted for use as homes.

It is estimated that the economic rent for the group premises, assuming that they house six doctors and cost £13,000 to erect, would be £200 per doctor per annum. Another significant feature of the Skelmersdale scheme is that the doctors will be offered the opportunity of buying their premises over 20 years with the aid of a group practice loan. In fact, it will be to their financial advantage so to do.

The first doctor under this plan was appointed in May 1965 and has now indicated his ideas of accommodation in a group practice building, it has been agreed that he will only be charged a total of £95 per annum for the use of his present surgery premises. This is based on a rate of £15 per annum for one hour's use per day for a five-day week.

In the central area of the new town the hospital has come forward with a proposal to establish a polyclinic or multiple outpatient department. The county medical officer of health proposes to establish a group practice and clinic services building alongside it,

and the local dental committee has now indicated that they would like to consider joining in the scheme, since they regard it as an advantage to be close to the medical services.

Runcorn (*Cheshire*), 14 miles from Liverpool, on the opposite bank of the Mersey, is intended to relieve over-crowding in North Merseyside, particularly Liverpool. The development corporation was appointed in April, 1964 and the master plan is being prepared.

Present thinking is along the lines of the experience gained by the executive council and the local authority in dealing with a Manchester Corporation overspill estate at Hattersley, Cheshire, planned to house 15,000 people.

At Hattersley the county council used its powers under the Lands Act (not the National Health Service Act) to buy a site for both a clinic and a group practice side by side and the local health authority clinic is well under way. The group practice building will eventually accommodate a group of about five doctors and when it is completed, the group will have the option of buying it with the assistance of a group practice loan. In the meantime, rent of about £150 per annum will be paid by each doctor.

It is intended that Runcorn New Town will be dealt with in a similar way but, of course, on a larger scale involving the erection of about four such combined centres.

Should the county be unable to provide the first group practice premises when necessary, because of political or financial difficulties, the executive council will approach the corporation asking them to make their houses available for conversion on ' preferential terms ' in order that the doctors would not be asked for the full economic rent, at least for the first few years. It is hoped that the corporation might come to look on the provision of facilities for general medical services as a normal part of their capital outlay in planning a new town.

Dawley (*Salop*) lies between Wolverhampton and Shrewsbury and is 30 miles north west of Birmingham. The new town was designated in January, 1963 with the objective of accommodating some 55,000 people from Birmingham and the Black Country during the next 20 years. At present about 21,000 people live in the area.

The new town of Dawley is at a very early stage of development, but already in the old town, the corporation have bought a site and on it have built a group surgery for three local doctors. This was done in order to provide temporary premises for a group of doctors who had wished to build permanent premises in an area likely to be redeveloped. This action by the corporation required

a concession from the Ministry of Housing and Local Government and as the circumstances were exceptional it is unlikely to create a precedent.

The new town's first housing area is about to be started. This area will eventually accommodate about 8,000 people, comprising an existing group of dwellings housing 2,000 and a new section designed on Radburn principles to take about 6,000 newcomers. This housing unit will have a social centre, which will contain shopping facilities, a pub and a social building comprising a community centre with a library wing and a health clinic wing, at which will be based the county maternity service, the district nurses, midwives and other local county health services such as speech therapy. Next to this wing the corporation intends to build premises for a group practice which will be let to two existing medical practices at present located in the nearby settlement of Madeley. These are combining to form a group practice and will rent the premises from the corporation. It is hoped to enable them to buy the premises in due course.

Elsewhere in the new town, which the corporation expects to develop on the basis of residential units of 8,000 people, new group practices will be formed with the help of the executive council and the corporation expects to provide premises for these practices adjacent to the local authority clinics, initially letting and then selling them to the doctors if they so wish. It is recognized that a unit of 8,000 is too small for a group practice; it is thought therefore that each group practice will cover two such units, with branch surgeries in each centre.

There are several new towns in the planning stages, e.g. Washington, Co. Durham, 6 miles from Newcastle-upon-Tyne, and Redditch, Worcestershire, 14 miles from Birmingham, where the plans for the future of general practice have not yet been formulated.

SCOTLAND

Livingston lies in Midlothian and West Lothian 15 miles from Edinburgh. The area was designated in April, 1962 and it is intended to take families displaced by redevelopment in Glasgow. The corporation's aim is to build 1,000 houses a year from 1965.

Livingston will be the first new town in which the Home and Health Department has had a complete plan for general practice which it is intended will all take place 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 housing area will be

completed about 1971 and the first health centre by the end of 1967. The first general practitioner is about to be appointed by a committee representing the Home and Health Department, the executive council, the general medical services committee and the regional hospital board. He will have a temporary surgery supplied by the corporation pending the erection of the health centre. Following his appointment, the executive council will declare the area ' closed '.

The first general practitioner will have the initial practice allowance and duties at nearby Bangour Hospital to get him established. It is hoped that eventually he will work half in general practice and half in the projected Livingston District Hospital, probably at medical assistant grade.

The staff at the first health centre will gradually be built up on these principles and it is hoped to accumulate a group of about six doctors, all interested in different specialties, for each of the six centres in turn.

In a health centre the general practitioner will have secretarial assistance and receptionists; the district nurse and health visitor will be attached to his practice; he will have the use of x-ray plant for chest and simple bone and joint x-ray and laboratory facilities for haemoglobins and collection of blood samples and for simple urine tests. The local authority will provide physiotherapy clinics and social workers and supply welfare foods. The regional hospital board will contribute a consultant orthopaedic clinic to work in association with the school medical service in the centre.

It should be noted that the large hospital at Bangour, which is to be demolished and replaced by a new Livingston Hospital is an integral part of the initial plans for health centres in Livingston.

VI

CONCLUSIONS

New towns and the National Health Service grew up together but there is little evidence of any mutual advantage having resulted.

It is admitted that the residents of the earlier new towns have received adequate medical care. This has come about, despite the paucity of planning, because of the plentiful supply of doctors and

the various attractions of general practice in a new town.

Several influences are only now beginning to take effect and these will make some form of planning mandatory for the future if a satisfactory medical service is to be maintained and the Government is to fulfil its duty to supply family doctors for all the population. Far from providing a basis for future planning the premises for general practice in the earlier new towns will act as positive deterrents to any modernization.

The three main influences now emerging are the high cost of providing premises, which has been masked till now by the tendency of doctors to move into groups. This has probably contributed to the second main influence which is the strong rekindling of interest in health centres all over the country, even among well established general practitioners; there are now about 50 in various stages of development. If the present negotiations with the Minister of Health result in reimbursement of staff salaries and rentals this movement may become even stronger. This would lead to an ironic situation in the new towns as most have, at some stage, had a plan for a health centre which failed.

The third and probably most important influence is the increasing shortage of general practitioners. This last factor alone will make it necessary for corporations in the future to take steps actively to attract family doctors into each developing neighbourhood.

Finding the first doctor is not likely to be difficult, because the prospect of being the senior partner of a group in a matter of a few years will continue to be an attraction for the young ambitious graduate. However, the second and subsequent doctors will not have this incentive to go to a new town and if a plan for groups of three or four doctors is to be realistic these latter members will have to be offered strong inducements. Unfortunately, the only practice subsidy at present is the initial practice allowance which applies only to single-handed practices—this at a time when the emphasis is on the stimulation of group practices.

New town corporations are becoming progressively more aware of the part they need to play in the provision of welfare for a new population. Indeed until now such planning for general practice as has been seen has received its momentum entirely from the corporations who, however, have had no effective sounding board against which to test their opinions. Local medical committees and executive councils have, in general, not taken the opportunity to adopt a constructive and imaginative approach to the problems.

The future

Ideally, general practice should provide an *advisory panel* with

whom a corporation could discuss the provision of medical services long before any new doctors come to a new town. If such an initiative could come from the profession the present lack of co-ordination and precision in establishing family doctors might come to an end and the corporation could then approach the local interests to form a *liaison committee.* This might include representatives of the local medical committee, general practitioners already in the area, the regional hospital board and local hospital board of management, the local health authority, the executive council as well as the advisory panel and the development corporation. It is probable that ultimate executive power would be best left with the corporation and the executive council.

Finance will be an important factor in determining the future development of general practice within new towns. If, as seems most likely in view of the shortage of doctors and other factors mentioned above, some form of centralized general practice is decided by the liaison committee to be the most appropriate, a source of capital must be found which enables proper premises to be erected at an early stage of development in a neighbourhood. Provision of a modern well-planned medical building might well be the enticement needed to attract family doctors to future new towns.

Incidentally the increasing use of the motor car and improved road systems could lead to a revision of ideas on how far patients can be expected to travel to see their doctor. There is the possibility that medical centres would be better sited at the periphery of a town away from noise and bustle and with plenty of space for car parking.

The various sources of capital may be summarized as follows:

Section 2 Local Authority (Land) Act 1963

A local authority can apply under this section for Ministerial permission to erect suites for general practitioners.

Section 43 National Health Service Act 1946

Under this section the Ministry of Health would appear to have the power to take such steps as he thinks necessary to provide general medical services in exceptional circumstances. If the establishment of a new town was interpreted as providing such circumstances, capital could come from the Ministry of Health who could then erect practice centres, as is done by the Scottish Home and Health Department. This is unlikely to occur.

Group practice loans

It should be possible to extend this scheme so that group premises could be provided in the beginning of new housing estates in the expectation of, and with the intention of facilitating group practice

in that area. The obvious advantage to the general practitioners is that capital so provided is as an interest free loan repayable over 20 years, whereas capital administered through a corporation or local authority would always have to be re-paid to the Treasury over 60 years at an economic rate. The disadvantage is that it would perpetuate the present separation of general practitioners and local authority in separate buildings.

A ' Welfare ' building

The proposed finance corporation for general practice may provide the money required for medical buildings in new towns but there remains a possible source which has not yet been utilized—the Ministry of Housing and Local Government. For the Ministry of Housing and Local Government to sanction the supply of capital for a medical building it would be necessary for the doctors' premises to be included in a ' welfare ' building whose facilities would not be limited merely to medical welfare and could replace the present community centres. There would seem no reason why the medical and possibly the local authority portions of the amenity building should not go up in advance of its other components, provision being made in the plans for later additions. The doctors and the local authority clinic would be best in ground-floor accommodation, the welfare sections, dentists' and optometrists', welfare foods, a public hall, day nursery, library, youth centre and accommodation for the social development officer, could follow later either as additional wings or floors to the building.

The general practitioners could repay their portion of the capital outlay in the ' welfare ' building to the corporation through a 20-year group practice loan.

One of the important advantages of this scheme is that the ' welfare ' buildings would belong to neither the local authority nor the family doctors. Although there are recent signs of a rapprochement there is a long and sorry history of suspicion and lack of co-operation between the two, which has, in the main, been the fault of general practitioners. Under this one ' welfare ' roof as equal tenants there would be every opportunity for a happy co-operation. Also, of course, such a building would not be a health centre according to the National Health Service Act and this has practical advantages, as was mentioned in discussing the Harlow centres.

Compact health centres

If health centres are to succeed, the Ministry of Health will have to provide a ' psychological lift ' in their favour. Should the Government in the future begin to reimburse doctors for rents and staff salaries, increased agitation for health centres seems likely. The

Harlow experiment has shown that the administration of such centres is a highly complex and skilled operation—not the least of its many valuable lessons.

The health centre which has developed over the years of the National Health Service consists of two distinct parts—the compact general practice portion which is constantly in use and a local authority portion which is only sporadically used and in which space standards are more lavish; some of the most expensive accommodation, e.g. county dental suites, appear to have only occasional use. This pattern has arisen as a memorial to the inability of local authorities and general practice to work in harness and a more rational form needs to be evolved. For general practitioners to leave their section of a health centre and attend their own patients at maternity or immunization clinics in duplicate consulting suites in another part of the same building would seem to be absurd; and yet this is what is happening today. If rooms were provided for district nurses, health visitors and midwives in the general practice portion of a health centre the same functions could be carried out as efficiently as at present with enormous savings in building costs.

A '*compact health centre*' containing only general practice and maternity and child welfare services would serve the needs of a developing neighbourhood perfectly adequately and the other local authority welfare services such as dentists, physiotherapists and ophthalmologists could follow in their own accommodation later when the town is more mature.

An austere and graduated approach to clinic building would run counter to the traditions of local authority building, which has inclined in the past towards the palatial.

Finance from whatever source, will only be forthcoming for compact and efficient buildings and an entirely new approach to health centres including their financing is called for. As Harlow has shown, centres financed by some body other than the local authority can be much more flexible in their approach to the provision of medical care because they are not bound by the restrictions of Section 21 of the National Health Service Act.

The foregoing proposals are most appropriate for the new town to come. What practical steps can be taken in the immediate future for those new towns already involved in the provision of doctor services and those developments occurring under the Town Development Act?

With the difficulties inherent in the present situation, especially

in England and Wales an ideal solution is not possible. For the new towns just beginning some interim plan such as in Skelmersdale and Runcorn is the only possibility. By this means group practice and local authority medical services are brought into close association in separate but adjacent buildings, so that the stage is set for closer collaboration in the future. However, reimbursement by the Government of rents and the salaries of helpers as seems possible in the near future, would cause a dramatic change, doctors would probably become enthusiastic for health centres. Local authorities and corporations would also be able to build medical centres as the return on their capital would be guaranteed.

VII

RECOMMENDATIONS

(1) The Practice Organization Committee of the College of General Practitioners might consider:

   (*a*) Setting up an advisory panel to collect information about new town general practice and provide a body of experts capable of discussing architectural and administrative problems with development corporations.

   (*b*) Stimulate the formation of local *Liaison Committees.*

(2) The Practice Organization Committee of the College of General Practitioners might explore the possible sources of finances for medical buildings in new towns. The possible contribution of development corporations by providing surgeries as part of a *welfare building* might be borne particularly in mind.

(3) The Practice Organization Committee of the College of General Practitioners might consider initiating studies on the function, design and administration of health centres in order to evolve a more compact and economical unit.

Acknowledgements

I wish to express my thanks to the officers of the Ministry of Housing and Local Government and the Ministry of Health, the managers and officers of the new towns corporations and the Commission for the New Towns, the medical officers of health, clerks to the executive councils and general practitioners who have co-operated in the production of this report. Special thanks are due to Mr Howard Austen.