part of salaries of ancillary staff and all of rent and rates the Scottish Home and Health Department reviewed the rents charged to put them on an economic basis. Figures for the Centre for the year 1966–67 showed that the gross charge per suite including accommodation to be £1,015. Of this £513 was refundable as rent, rates and part of salaries for receptionists and secretaries, leaving a final demand of £502 per suite per annum. Allowing for differences of staffing, for the relatively costly method of heating the health centre, and for the changes in the basis of financing general practice (that is, the refund of rent, rates and part of the cost of ancillary staff), the health centre figures are still in line with that quoted by Dr McDougall.

Changes of staffing, and alteration in salary scale can be expected to be reflected now in the rentals asked for by the 'landlord'. The doctor usually has some say in the staffing of his own health centre but when many other services are provided it may be more difficult to control the number of secretaries and receptionists required, and hence the outlay by the individual doctor or practice, than in the case of a group practice outwith the health centre who are directly responsible for their staff and the hours they work.

Summary

Finance may be classed under the headings of Capital Cost and Running Expenses. Working from a health centre there is no capital cost for the practice premises of the doctor or group. Running expenses should not differ vastly whether one works in the health centre or in privately owned group practices. It is to be expected that economic charges will be made in most health centres for the use of ancillary staff services, heating and lighting and excepting so far as there may be peculiar differences in individual centres these should tally fairly well with privately owned premises. There may be slightly less control of the cost of providing receptionists and secretaries when these services are shared with other interests in a health centre.

Discussion

Dr A. Whitaker (*Guildford*) advised anyone building a centre to get some management consultants together first and do a study. In his practice it had cost £350 for two men to make a study for a fortnight, and the saving was in this case about £5,000. As for the bogey about finding capital to build etc., and the poor young doctor without any capital, they had spent £36,000 and they were making an annual repayment of £1,578, which was paying off the capital, part of the mortgage and the interest. The rent received from the NHS was £1,752 net. No capital at all had been found out of their own pockets.

Dr Williams (*Sydney*, *Australia*) sounded a note of warning about the efficiency expert. He was with a group practice of ten in Sydney. Two experts were consulted. One, after three weeks, said, "You need a new building". He was dismissed. The second one, after ten days, suffered from cerebral thrombosis and became a patient of the practice, after which the doctors sat down and worked it out for themselves.

During the discussion the question of the relative costs of small partnerships and group practices was raised. The difficulty of strict comparison of the respective financial statement was very great, as the facilities and services offered by the partners, and the needs of the patients in each area, varied.

Dr J. O. Fitzgerald believed that an appointments system should be such as to enable the patients to see the doctor rather than preventing the doctor from seeing the patient. Anyone having to wait more than 24 hours to see a doctor was being badly dealt with under any system of appointments. A statistician in their group had done a survey lasting about eight weeks, showing quite conclusively that the number of surgery attendances dipped from the beginning to the middle of the week, so that on Mondays and Fridays considerably more patients were seen than during the mid-week period. Then it was found that on the Thursday half the doctors

were on their half-day, and on the Wednesday a quarter of them were on their half-day, so that the graph actually coincided with the availability of the doctors. They were still trying to work out whether they were taking their half-days to suit the patients or whether the patients were trying to suit the doctors' arrangements.

By the efficient use of an appointments system the load could be spread evenly. They were seeing between 32 and 36 patients per day per doctor attending and this did not vary at all. It was just that the doctors and the patients had come to the same accommodation.

Dr Law (*Brent*) felt that the philosophy of group practice was of tremendous importance—how to remain a personal doctor while sharing the work. This had to be discussed among the partners and worked out very clearly. In some practices it was believed that the practice as a whole should look after the patients. "I believe", said Dr Law, "that one should be a personal doctor, and I think this philosophy can determine the nature of a practice. The next thing is to communicate this to the receptionist staff. I am meeting my receptionist staff to-morrow. We meet once or twice a year, when they tell us how we should run the place and we tell them again that they are not to make a barrier between us and the patient; that they should so ease the patients in their approach to us that they are ready to unburden themselves rather than come in and say, 'I am sorry to take up your time, doctor'."

In discussion it was emphasized that group practices are not necessarily partnerships, and the old legal agreement of partnerships was not necessary for group practices. A well drawn up business agreement was more in line with modern groups practice.

Administration in group practice

Dr V. W. M. Drury, M.B., Ch.B., F.R.C.G.P.

Definition. For the purpose of this study administration is defined as the planning, organization and execution of all those activities concerned with the day to day running of a group practice that do not need clinical skills.

Functions of group practice. In order to examine the requirements of administration we have divided the field of work of group practice into certain broad and possibly overlapping areas.

1. Preventive medicine.
   - (a) Screening.
   - (b) Immunization.
   - (c) Special clinics e.g. antenatal, well-baby, obesity etc.
   - (d) Health education.
2. Management of established conditions.
   - (a) Acute.
   - (b) Chronic.
3. Co-ordination of all supporting services for the patient.
4. Advisory rôle for the patient.
5. Certification.
6. Research and statistics.
7. The work of the doctor outside the practice.
8. Dispensing.

Administrative consideration

1. The prime function of administration is to provide the most favourable set of