The role of practice manager—changes in attitudes promoted by the Royal College of General Practitioners

E. G. NELSON, LL.B., M.Sc.
Medical Care Research Unit
University of Newcastle upon Tyne

SUMMARY. Because of the roles traditionally required of them, and because of the insularity of ancillary staff in general medical practice, many senior ancillary staff may not have been giving their doctors the most effective support of which they are capable. This is changing as a result of the change-promoting activities of the North of England Faculty of the Royal College of General Practitioners.

A survey of ancillary staff and general practitioners in the North of England has shown that the Royal College of General Practitioners has assisted ancillary staff to a greater consensus of more progressive views about the emerging role of practice manager than is the case amongst general practitioners. The results also show that differences in the size of practices have determined whether or not a need for a practice manager is perceived.

The focus of interest created by this faculty of the Royal College of General Practitioners has resulted in the formation of special interest groups of senior ancillary staff in the North of England. These groups form a valuable resource for exploration and innovation to discover more effective means of organising and managing general medical practice.

Introduction

Reedy and Nelson (1974) have discussed the emergence in general practice of the position of practice manager. There will be many arguments that can be brought by those who are in the vanguard of that trend to support the view that more such appointments are inevitable, but the most prosaic, the pressure of work, seems to be enough by itself.

The desire for health, and therefore the potential demand for health care, is virtually limitless, though governed by patterns of disease and social behaviour it is liable to change (Wadsworth *et al.*, 1971). Since resources in general practice (the most important being doctors' time) are limited, the access of patients to the health care system has to be controlled. The concepts of preventive medicine and health education are bringing more work and new and different priorities.

These considerations require decisions to be taken by general practitioners about the policies they will adopt in their practices. For example, in a practice facing the crisis of a rapidly growing workload to be accommodated with limited resources, what is the strategic value of an appointment system? What are the essential qualities of general-practitioner services that an appointment system should be designed to preserve? What policies must be followed by the ancillary staff if those qualities are to be protected when the system is being used?

Paradoxically, one reason for the increase in work may be through employing more ancillary staff to cope with the routine clerical and administrative parts of an increased workload! A larger ancillary organisation means that work has to be allocated to more people, more people have to be given instructions and supervised, there are more opportunities for things to go wrong and more internal problems to be resolved. Then, the kinds of jobs and responsibilities associated with staff management become clearer.

It is therefore not surprising that a differentiation of functions is occurring (Drury and Kuenssberg, 1970), and that some practices come to rely heavily, if not entirely, upon the managing abilities of the senior member of their ancillary staff. And yet, it is probable that at present even the doctors in those practices are not receiving the most effective support which their senior ancillary staff are capable of giving them.

© *Journal of the Royal College of General Practitioners*, 1976, **26**, 282–291

The aims and objectives of the practice

As a general rule, arrangements in practices are not designed to assure that senior ancillary staff become fully conversant with the aims, objectives, interests or the values of their doctors, and may be designed to assure that they do not! They will, therefore, be hindered even when they are willing to assume responsibility and exercise their discretion in their doctors' interests.

Comparisons with other managers

Even when this problem is overcome, they will be restricted by the meagre arrangements that usually exist to enable them to acquire knowledge and experience of how medical practices can be managed most effectively.

For almost all other types of organisation general principles explaining their processes have been formulated, tested, and proven or disproven. Managers, through study and experience, have constructed concepts which enable them to subject organisations to intellectual appraisal and assessment. Innovations in one are publicised so that managers can consider the possibility of implementation in others. In these ways the learning experiences of management in one progressive organisation can be shared by management in many others and developments are accelerated. This has been made possible by increased facilities for educating management. The same is not yet possible in general medical practice when there are so few attempts to formulate and test general principles and when dialogue about such experience is so limited.

The waste of potential when ancillary staff are not fully informed on the interests of the practice is a problem which is largely an internal one of attitudes and human relations. Change must therefore be accomplished internally even though the idea might stem from some external source. Insularity, however, which prevents the diffusion of knowledge, experiences and ideas, can be overcome more easily with the help of an external agency.

Activities promoting changes

The North of England Faculty of the Royal College of General Practitioners

Activities promoting changes can be of two types: those aimed at bringing about changes so that organisations develop preconceived characteristics, or those designed to encourage organisations to adapt, in the way they think most suitable, to changes going on around them.

Aiding the diffusion of knowledge and breaking down traditional insularity comes into the latter category; for some time the North of England Faculty has been active in this way, and with some interesting results.

In 1972 a series of annual study days were designed to have a catalytic effect on the development of roles in general practice. Attendance was offered to all ancillary staff and also to local-authority-attached staff in the Northern Region; 120 people attended each of two meetings. Talks were given on the roles and work of those who participate in the provision of community health services. These were followed by general discussion.

Although in retrospect it is clear that the study day successfully achieved its purpose of generating interest and action, like all experiments, there were lessons to be learned from the organisation. At the time some senior representatives of practice ancillary staff felt that too many and varied occupations were represented, and that 120 people were too many for such a meeting, such large numbers not being conducive to discussion.

In 1973 the second study day was organised catering specifically for senior ancillary staff. Attendance was initially offered to a restricted number of doctors and their practice managers (or equivalents) accompanying each other from practices having four or more partners. The assumption was that only the larger practices were likely to have more differentiated management roles and would derive most benefit. It was over-subscribed, not by doctors, but by senior ancillary staff who could not persuade a doctor to accompany them. However, the original decision was reaffirmed and the numbers were restricted to about 40.

The programme was highly organised. There were five input sessions each followed by a period of small-group activity and then a plenary session. The subjects ranged over *The Practice Environment*, *The Internal Organisation*, *The Personnel Function*, *Information*, and culminated in a consideration of *The Role and Job of the Practice Manager*.

Again, lessons about such study days were learned. The arrangement of the day and the

expectations of the designers assumed a capability on the part of those attending to air and contrast ideas for the effective organisation and management of general medical practice. It soon became clear that although many participants were able to discuss practice organisation and management at length at a descriptive, anecdotal level, they did not possess a common conceptual framework within which their individual experiences could be easily related so as to promote analytical or constructive discussion. Many of the ancillary staff were inhibited even in participation in anecdotal conversation. Later it was said that this was the effect of the doctors' presence, a significant pointer to the nature of the working relationships existing between them!

In the long term it may be found that the most important discussion of the day dwelt on the fact that some of the ancillary staff, with long service, had never before met and talked with members of other practice organisations, and were amazed at the inexplicable differences which existed between practice organisations. At the end of the day nine senior ancillary staff decided to meet regularly at each other's surgery so that they might learn from each other and have some reference points when appraising their own organisation. It is to their credit that they now do this in their own time, at their own expense, and are willing to travel from coast to coast in the North of England.

Attendance at the 1974 study day was offered to any general practitioner or senior members of ancillary staff who cared to attend. Applications were received from more than 100 ancillary staff, many of whom were not of the senior grades to whom attendance was offered. Since it was still desirable that numbers on a single day be restricted, the organisers decided to hold two identical study days on consecutive months. On both occasions those who attended entered into lively discussion both in groups and in plenary sessions.

The special interest group of practice managers who wish to maintain regular contact with each other has now expanded to 25 people distributed throughout the North of England. They now feel ready to move on from the general discussion of organisation and management roles and want to examine particular facets of practice organisation and management in depth.

The programme for the study days organised in 1974 dwelt upon the expanding roles of some ancillary staff as practice managers; it was less organised and less specific in the subjects proposed for discussion. In the morning two members of the Royal College of General Practitioners gave papers covering the scope and possibilities for ancillary staff to expand their functions to include those of practice management. The afternoon was devoted to discussing some data provided by those attending that tended to shed some light on how far the concept of practice manager had progressed.

Afterwards ancillary staff asked their general practitioners to complete identical questionnaires. The data obtained from general practitioners and ancillary staff in large and small practices were compared with some interesting results.

These study days of the Faculty of the Royal College of General Practitioners can be seen as having initiated a series of events leading progressively along a defined path. The original purpose was to bring people together and stimulate general interest in the various roles in community medicine. That interest quickly became focused on the emergence of a role of differentiated practice manager. Much time has been devoted to examining it from various angles to be sure it really exists—the conclusion has now been reached that it does!

Since the last study days in 1974 some of the initiative can be seen to be passing from the Royal College of General Practitioners to the special interest group of ancillary staff. They have organised themselves as area representatives and are establishing local interest groups around the North of England to meet more often and discuss topics in more depth than has been possible at the annual study days. Their purpose now is to examine critically the contributions made by senior ancillary staff to practice organisations and to consider how they might contribute more effectively.

As individuals they are identifying strongly with their practices, and doctors could be surprised with the response if they would admit senior staff into the policy making processes and allow them more discretion in the implementation of their policies. As an institution they have no identity of their own, they turn to the Royal College of General Practitioners for help, advice, and recognition. So far the attitude of the North of England Faculty has been paternalistic and non-objective, but it is now possible that the progressive interest groups could be a

valuable resource in a search having as its object the discovery of more effective ways of organising and managing general medical practice. Among other things, it is possible that competent senior staff can contribute to the development of criteria and techniques for conducting practice audits, particularly non-clinical audits (Practice Organisation Committee, North of England Faculty, 1975).

There seem to be no precedents for handling the questions about with whom an organisation of practice managers could identify, or how it could be assured that general medical practice would derive maximum benefit from the enthusiasm and progessive attitudes of its members.

Contrasting opinions of doctors and ancillary staff

Even before the most recent developments resulting from the Royal College of General Practitioners' activities as catalyst, it seemed clear from our observations that senior ancillary staff were poised to accept a more important role in general practice. The question was, were their doctors ready to let them? It was decided to find out by contrasting their views on the subject. The 1974 study days were chosen as the most convenient place for collecting data.

Those attending were reasonably representative of the geography of the North of England and of population distributions. A gratifying number (28) travelled long distances to Durham from the Lake District, the West Coast areas, Northumberland and Yorkshire, but the majority (69) came from the more densely populated Tyneside-Durham-Teeside connurbations.

There was also a fairly even representation of large and small practices, and size is a factor which influences the emergence of a recognised practice manager. In the opinion of many doctors, it is when a partnership has grown to four doctors that the effects of size become most clear as, perhaps, hierarchies become recognisable among both doctors and ancillary staff. At the 1974 study days 54 of the ancillary staff were from practices of less than four partners and 43 from practices of four or more partners (table 1).

TABLE 1
REPRESENTATION BY PRACTICE SIZE OF THE ANCILLARY STAFF AND DOCTORS SURVEYED

Practice size	*Ancillary staff*	*Doctors*
Less than four partners	54	27
Four or more partners	43	24
TOTAL	97	51

The 97 staff who attended described their positions with 25 different job titles. Of the 97, 56 of them held senior positions (table 2). The variety of titles for what might be thought to be similar jobs is remarkable.

At the start of each study day those attending were asked to complete a questionnaire. A second identical questionnaire was administered at the end of the day. The plan was to contrast the results to discover whether views changed. Members of ancillary staff were asked to take a third identical questionnaire back to each practice that was represented and have it completed by a doctor. We used the replies received to contrast the views of the doctors and their ancillary staff.

Four general questions were selected:

(1) Who is responsible for routine non-medical jobs in the practice?

(2) Who is responsible for reviewing the procedures governing routine non-medical jobs and suggesting changes?

(3) What scope is there for a competent practice manager or equivalent to take the initiative and improve practice procedures?

(4) How much discretion could a competent practice manager be permitted?

Each question was repeated; in the case of questions one, two, and three, for six routine jobs, and in the case of question four, for six types of responsibility ancillary to medical work

TABLE 2
DISTRIBUTION BY JOB TITLE OF ANCILLARY STAFF SURVEYED

Title of position	*Representation*
Senior receptionist	24
Secretary/Receptionist	18
Practice manager	13
Receptionist	10
Secretary/Senior receptionist	5
Senior secretary	5
Nurse receptionist	2
Secretary	2
Medical secretary	2
Dispenser/Secretary	1
Dispenser/Nurse	1
Secretary/Receptionist/Nurse/ Dispenser	1
Medical receptionist	1
Clerk receptionist	1
Receptionist/Typist	1
Receptionist/Medical secretary	1
Senior Secretary/Receptionist	1
Head receptionist	1
Senior receptionist/Medical secretary	1
Secretary/Administrator	1
Secretary/Office manager	1
Practice administrator	1
Supervisor	1
Senior Receptionist/Practice manager	1
Secretary/Receptionist/Manager	1

TABLE 3
THE SPECIFIC JOBS AND RESPONSIBILITIES USED IN THE QUESTIONNAIRE TO CONTRAST VIEWS AND OPINIONS OF GENERAL PRACTITIONERS AND ANCILLARY STAFF IN LARGE AND SMALL PRACTICES

Routine non-medical work	*Responsibilities ancillary to medical work*
Handling patient records	Co-operating with health authorities, hospitals etc.
Keeping special records, e.g. age/sex index	Allocating work to other ancillary staff
Book-keeping and settling accounts	Appointing other ancillary staff
Ordering supplies, e.g. stationery and drugs	Handling personnel matters, e.g. arranging leave, days off; paying wages, etc.
Library services, e.g. indexing articles	Maintenance and repairs to buildings and equipment
Receiving patients, e.g. making appointments	Handling complaints

(table 3) In every case it was required that replies be placed on a scale, providing a distribution of views in response to each question.

It is to be expected that participation in discussion allows different points of view to be voiced, tested, and reconsidered with the possible result that some changes take place. This is what happened (table 4).

The first two of the general questions required replies to be based on perceptions of facts, about the organisation of each practice, i.e. who did the jobs listed, who reviewed the procedures for getting them done? Facts are immutable and ought not to change. But the study day did cause perceptions to change so that the size of the group concurring in their replies to the general questions one and two increased by six per cent and ten per cent respectively. In replying to questions three and four there was much more latitude for changes to take place since they were based more on opinion than on fact. Predictably, therefore, the changes in

TABLE 4

EFFECT OF STUDY DAY ON THE CONCURRENCE OF VIEWS AMONG ANCILLARY STAFF

Question	*Percentage of largest group of staff whose views concurred in respect of each general question*		
	At beginning of study day	*At end of study day*	*Per cent of change*
1 Who is responsible for doing the routine non-medical work in the practice?	*44*	*50*	*6*
2 Who is responsible for reviewing the procedures governing the routine work and suggesting changes?	*54*	*64*	*10*
4 What scope is there for a practice manager to take the initiative and improve practice procedures?	*47*	*61*	*14*
5 How much discretion could a competent practice manager be permitted?	*64*	*78*	*14*

them were greater, amounting in each case to an increase of 14 per cent in the size of the group concurring.

These changes occurred when, during the day, ancillary staff were given the opportunity to re-appraise their own practices in the light of what they had discovered about others, and to reconsider their opinions after having had the benefit of listening to others. Since the study days amount to a breaking down of the insularity of general practice so far as ancillary staff are concerned, it might be assumed that these changes are symptomatic of the general trend that will occur as more steps are taken in that direction. Consequently, it was decided to use these data obtained at the close of the study day to compare with those obtained from doctors.

The data obtained from the questionnaires is presented in tables 5, 6, 7 and 8 to show how the four general questions elicited different replies from doctors and ancillary staff in large and small practices. The main points are as follows:

(1) Consistently, there was a greater concurrence of views among ancillary staff than among doctors on matters concerning both the existing functions of senior staff and scope for further differentiation of the practice manager role.

TABLE 5

CONTRASTING THE VIEWS OF ANCILLARY STAFF AND DOCTORS ON THE QUESTION: WHO IS RESPONSIBLE FOR DOING THE ROUTINE NON-MEDICAL WORK IN THE PRACTICE?

Opinion groups contrasted	*Distribution of opinions in groups Per cent*			
	No-one in particular	*Doctors*	*Practice manager (or equivalent)*	*Other ancillary staff*
All ancillary staff	*5*	*9*	*50*	*36*
All doctors	*8*	*9*	*39*	*44*
Doctors by practice size:				
less than 4 partners	*9*	*12*	*41*	*38*
4 or more partners	*7*	*6*	*37*	*50*
Ancillary staff by practice size:				
less than 4 partners	*5*	*9*	*54*	*32*
4 or more partners	*6*	*8*	*45*	*41*

(2) There were differences in the perceptions of doctors and ancillary staff about the distribution of work. A significant general disagreement was registered concerning who reviews procedures (table 6). This must be the cause of some confusion in some practices.

(3) In reply to the fact-seeking questions (tables 5 and 6) the concurrence of views among both doctors and ancillary staff tends to be more marked in small practices than in large ones, suggesting that size equates with a tendency towards organisational variety.

(4) In reply to the opinion-based questions (tables 7 and 8), views of both doctors and ancillary staff in the larger practices give significantly more support to the expansion of the practice manager role, suggesting that the differences between large and small practices equate critically with the need or desirability of role differentiation.

TABLE 6

CONTRASTING THE VIEWS OF ANCILLARY STAFF AND DOCTORS ON THE QUESTION: WHO IS RESPONSIBLE FOR REVIEWING THE PROCEDURES GOVERNING ROUTINE WORK AND SUGGESTING CHANGES?

Opinion groups contrasted	*Distribution of opinions in groups Per cent*			
	No-one in particular	*Doctors*	*Practice manager (or equivalent)*	*Other ancillary staff*
All ancillary staff	5	14	64	16
All doctors	18	32	40	10
Doctors by practice size:				
less than 4 partners	19	30	37	14
4 or more partners	17	34	43	6
Ancillary staff by practice size:				
less than 4 partners	5	16	64	15
4 or more partners	5	12	64	19

TABLE 7

CONTRASTING THE VIEWS OF ANCILLARY STAFF AND DOCTORS ON THE QUESTION: WHAT SCOPE IS THERE FOR A COMPETENT PRACTICE MANAGER TO TAKE THE INITIATIVE TO IMPROVE PRACTICE PROCEDURES?

Opinion groups contrasted	*Distribution of opinions in groups Per cent*		
	Much or very much	*Some*	*little or very little*
All ancillary staff	61	21	18
All doctors	51	25	24
Doctors by practice size:			
less than 4 partners	49	19	32
4 or more partners	53	31	16
Ancillary staff by practice size:			
less than 4 partners	57	19	24
4 or more partners	65	23	12

Considerations for future change-promoting activities

The data we have obtained from 97 members of ancillary staff and 51 doctors confirm that doctors as well as ancillary staff in practices of all sizes give approval to role differentiation which would result in doctors disengaging (though not disavowing ultimate responsibility) from the practical management of non-clinical work. In this, however, they are more reserved than their ancillary staff. They are also much less agreed amongst themselves than ancillary staff are. Therefore, in matters of principle relevant to medical practice generally, it might

TABLE 8

CONTRASTING THE VIEWS OF ANCILLARY STAFF AND DOCTORS ON THE QUESTION: HOW MUCH DISCRETION COULD A COMPETENT PRACTICE MANAGER BE PERMITTED?

Opinion groups contrasted	*Distribution of opinions in groups Per cent*		
	Much or very much	*Some*	*Little or very little*
All ancillary staff	*78*	*13*	*9*
All doctors	*71*	*20*	*9*
Doctors by practice size:			
less than 4 partners	*64*	*23*	*13*
4 or more partners	*77*	*17*	*6*
Ancillary staff by practice size:			
less than 4 partners	*72*	*16*	*12*
4 or more partners	*84*	*10*	*6*

be expected that senior ancillary staff will tend to be the more progressive and that doctors will be the more cautious.

If ancillary staff are correct in their perceptions (table 6) that it is their senior members who are responsible for the important responsibiity of reviewing practice procedures and suggesting changes, then some doctors are unaware of events taking place around them. If, on the other hand, the replies of ancillary staff have been an expression of wishful thinking, then doctors are missing opportunities to delegate their non-clinical workloads.

If the first assumption is true then doctors cannot be considering the important question of whether or not it is necessary to institute any form of control on the way senior ancillary staff are discharging the additional responsibilities they have assumed. If the latter is true it may be that they have never considered the merits of delegation, nor the means by which more non-clinical responsibilities can be delegated.

In either event it seems that a case could be argued for an educational programme for general practitioners based on the basic principles of general management.

The possibility that size of practice organisation equates with a tendency towards variety has some bearing on the matter of axioms for " good " organisation and management. If in small practices the natural tendency is towards less variety then the chances are increased of establishing by observation and research the characteristics of a model practice.

Although there is no reason why many general principles and axioms might not be established for large practices, fewer of them could be relied upon to apply to any practice chosen at random, there may be choices to be made depending on the unique aspects of individual practices. In that event general practitioners may derive benefit from an educational programme designed to help them develop conceptual frameworks for appraising their own practices and selecting the most appropriate axioms and principles as a basis for organising and managing.

That size of practice should be a significant factor determining expressions of need or desirability about a role for a differentiated practice manager is probably the least surprising suggestion to emerge from our data. But since there is a current tendency for practices to merge and increase in size, then the need to ensure that role differentiation brings benefits and not problems increases too. However, sight must not be lost of the substantial proportion of doctors from small practices in our sample who felt that a competent practice manager could improve practice procedures, and that a competent practice manager could be permitted " much " discretion. Clearly we should guard against giving attention exclusively to the large practices.

The change-promoting activities engaged in by the North of England Faculty have now begun to have effect. They have served their purpose by breaking down the traditional insularity of ancillary staff in medical practice, and the more permanent arrangement of established interest groups located around the region and linked by a representatives' group is separate from the Royal College of General Practitioners, although still requiring its support. This,

effectively, has altered the circumstances that originally determined the most appropriate activity.

Senior ancillary staff are now eager to learn how they can organise and manage their practices more effectively. In the future the most appropriate activities for external agents to engage in will themselves undergo a change in emphasis: there will be a need for some general theories and models of practice organisation and management, when they are developed then doctors will require advice in applying them selectively, and, perhaps, assistance in effecting changes. Providing this advice and assistance are activities that will be found to be appropriate in the future, and the change-promoting agents will be those individuals and groups who are now beginning to concern themselves with the application of general theories and models. Application has been recognised as being in a state of flux (Royal College of General Practitioners, 1972) and will be settled only by doctors and their practice managers (or equivalent) who co-operate in developing and implementing new ideas.

If these conditions are correct the North of England Faculty has created an invaluable resource in its special interest group of senior ancillary staff, and considerable attention should be given to determining ways of assuring that maximum benefit is derived from it.

Conclusions

The broad outcome of the exercise in role development for senior ancillary staff is that both general practitioners and ancillary staff generally tend to favour a practice manager role for the senior member of ancillary staffs. Aspiring practice managers are keen to accept greater responsibility for contributing to the development of more effective and efficient practice organisations.

There is an urgent need, therefore, for the diffusion of knowledge gained from practical experiences of implementing and managing innovations in general practice. In the circumstances a high value would be placed on relevant case studies and reports of " action research " that highlighted responsibilities, tasks, problems and relations in realistic situations.

Since the open study day in 1972, which was based on the theme of roles in the primary medical care team, the joint working party subsequently set up to assist the development of the roles of senior ancillary staff has inspired the formation of a special interest group of those of them who have managerial responsibilities. This group complements perfectly the progressive attitude of the Royal College of General Practitioners.

With general practitioners of similar mind they can, if properly assisted and advised, play a large part in the search for more effective ways of organising and managing, particularly with regard to office methods, the distribution of work and responsibilities, and relations amongst practice personnel and others in the primary medical care team.

The position of the working party has altered significantly. Whereas it began as an organiser of study days, now, given certain additional resources and the co-operation of the general practitioners who employ the members of the special interest group of senior ancillary staff, it has the means to create opportunities to initiate, observe and report on the practical value of innovations in practice organisation and management.

The rapidity with which this new situation developed might be seen as some indication of its general acceptability and also as an indicator of the need for properly organised exploratory work in practices.

Recommendations

Experience has shown that this kind of " action research " should be directed and co-ordinated from within rather than by external agencies, although external advice and assistance would undoubtedly be required. The following suggestions should be considered:

(1) A working party should be set up permanently with the responsibility for initiating, observing and reporting on innovations in the organisation and management of general medical practice.

(2) The first task of the working party should be to consider the kind and scale of activities required in order to make a significant contribution to the development of more effective practice organisation.

(3) The second task should be to secure the co-operation of general practitioners and ancillary staff and the additional resources that would be necessary to support the scale of

activities decided upon. It would probably be necessary to apply for a research grant, for example from the Department of Health and Social Security or the Nuffield trusts (and probably in conjunction with a recognised academic institution).

(4) Thereafter the working party would be responsible for co-ordinating activities and obtaining reports for the benefit of all the members of its parent organisation.

REFERENCES

Drury, M. & Kuenssberg, E. V. (1970). *British Medical Journal*, **4**, 42–44.

Reedy, B. L. E. C. & Nelson, E. G. (1974). *Journal of the Royal College of General Practitioners*, **24**, 376–394.

Wadsworth, M. E. J., Butterfield, W. J. H., Blaney, R. (1971). '*Health and Sickness: The Choice of Treatment*.' Chapter 1. London: Tavistock.

The Practice Organisation Committee, North of England Faculty, Royal College of General Practitioners (1975). *The Journal of the North of England Faculty, Royal College of General Practitioners*, January, 1975.

Royal College of General Practitioners' Working Party (1972). *The Future General Practitioner—Learning and Teaching*. London: *British Medical Journal*.

NATIONAL HEALTH SERVICE EXPENDITURE

The latest annual figures of total National Health Service expenditure per head of population in each of the health regions of England were as follows:

Regional Health Authority	*Per capita revenue* £	*Expenditure capital* £
1. Northern	34,310	5,294
2. Yorkshire	34,123	4,962
3. Trent	30,271	6,518
4. East Anglia	32,167	5,776
5. North-west Thames	45,190	5,224
6. North-east Thames	43,616	4,849
7. South-east Thames	41,846	5,355
8. South-west Thames	44,117	5,529
9. Wessex	30,437	4,432
10. Oxford	33,316	8,309
11. South-western	35,745	5,333
12. West Midlands	32,153	4,524
13. Mersey	37,765	4,820
14. North-western	35,074	4,650

Note: These figures are based on the 1974–75 expenditure allocations and the mid-1974 population. Some of the differences between regions are due to variations in the age/sex structure, the incidence of teaching, etc.

REFERENCE

The Family Practitioner Services (1975). **2**, 230–231.