established principals who are looking for partners, and by regional postgraduate committees appointing trainers in general practice.

It is an open secret that some regional advisers and trainers look forward without enthusiasm to coping in future with the minority of entrants to general practice who show no interest in preparing themselves properly for their career. These after all are the people who have made mandatory training a necessity in the first place. Their arrival in training will make it all the more vital to ensure that standards of training, particularly in teaching practices, are high. Trainee doctors who do not want to learn or to make good use of their experience will need tighter supervision than the strongly motivated trainees now undergoing training by choice rather than compulsion. The work of the Joint Committee on Postgraduate Training, concerned as it is with setting standards for the quality of training programmes, will acquire a new significance.

The Vocational Training Bill should go a long way towards showing young doctors, the public at large, and our colleagues in other branches of medicine, that general practice is serious in its determination to improve its own standards. It will lay a more secure foundation of required experience from which to identify those doctors completing training who choose to show that they have achieved the standards of excellence the College seeks to promote in clinical practice.

REFFRENCE

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# NUMBER OF HEALTH CENTRES

THE revolution in the organisation of general practice which began in the 1950s and reached its full momentum in the 1960s had three main features: the acquisition of proper premises, staff, and equipment. In particular, this was the time when general practitioners began to move out of their homes into purpose-built premises whether privately or local authority owned.

Health centres, which had been an ideal of the Dawson Committee in 1920 had hardly been introduced at all in the 1940s, and only began to appear in the late 1960s. There were, for example, fewer than 100 health centres in Great Britain as late as 1968, whereas by 1974 this number had suddenly jumped to 600.

Health centres are, of course, by no means the only form of purpose-built premises, and are not even the commonest. Many general practitioners have themselves either built or converted private premises most successfully, often using loans from the General Practice Finance Corporation.

Nevertheless, the number of health centres and their geographical distribution are important, both nationally as an indication of the extent of the commitment by the National Health Service to primary medical care, and regionally as a yardstick by which different regions can be compared.

Lord Wells-Pestell (1976) recently provided in the House of Lords figures showing the number of general practitioners in each regional health authority in England and Wales who worked from health centres. Of the total 24,255 of practitioners in Great

Britain 3,537 (14·5 per cent) now work from health centres. This figure caused little surprise, as it was already widely known that about one in seven general practitioners was involved.

*Regional variations*

What, however, was much less well appreciated, was the analysis of health-centre building by regions, and here some significant variations have come to light.

The health authorities with the greatest number of general practitioners working from health centres proved to be the Northern Regional Authority (24·4 per cent) and the South-western Regional Authority (24 per cent), the latter owing much to the remarkable health-centre building programme developed in Devon by Lyons, the former County Medical Officer of Health, which involved more than half the practitioners of this big county. Wales and the Trent Regional Authority, each have over 20 per cent of doctors installed.

At the other end of the scale, however, health-centre provision by some regional authorities appears to be virtually negligible, for example, the South-east Thames (3·7 per cent of practitioners), North-west Thames (6·9 per cent) and the North-east Thames (7·9 per cent); they are in striking contrast and come bottom of this league. London appears to lag.

While it is possible that the regions with the fewest health centres could be the same as those where the practitioners have built many high-quality private premises, there is, however, no evidence that this is the case, and some evidence (Jefferys *et al.*, 1972) that a paucity of local authority owned purpose-built premises coincides with a paucity of privately owned purpose-built premises. Furthermore, Devon, the county with the highest number of health centres, also has a high number of purpose-built or converted premises.

It is therefore probable that a low proportion of general practitioners working from health centres is a rough and ready yardstick of deprivation of resources for general practice.

REFERENCES

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## SELF-EXAMINATION

The spread of group practice among family doctors which has been encouraged by the National Health Service through financial incentives and the building of health centres has furthered the delegation of many of the simpler tasks from the general practitioner to other members of the primary care team. Many nurses would now deal with minor casualty items, removal of stitches and so on. In this way the expensively-trained doctor is allowed to concentrate on those tasks appropriate to his training. There is no one who works in the National Health Service who can avoid the necessity to examine their practices and attitudes with a view to seeing if the overall cost effectiveness of the service can be improved.

REFERENCE

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