Child care in the new towns in the UK

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SUMMARY. New towns with large populations of children present ideal opportunities to study and implement extended primary care services for children. It appears that workload in most new towns is higher than in established communities. Often, the demanding nature of new town practice seems to have precluded innovations in primary care services for children. This report, which is general-practice orientated, can only indicate some aspects of child care in new towns which require further scrutiny. General practitioners are strongly divided in their views as to how they can act most effectively in child health, but there is no doubt that there is a chance in our new towns to nurture the idea of expanding the general practitioner's role in child care.

Introduction

IT is now over ten years since Dillane's report on general practice in the new towns of Britain (1966) and the Office of Health Economics Symposium (1967) on the provision of general medical care in new towns. The Office of Health Economics deplored the lack of innovations and apparent absence of an integrated approach to planning medical care in new towns.

New towns have peculiar problems, especially for child care, as they are new communities often containing a disproportionate number of young people and children. With the stimulus of the Scottish Home and Health Department report *Towards an Integrated Child Health Service* (1973) and the recent report of the Court Committee (1976), I decided to review child care provisions in new towns which are often cited as potential forerunners in innovative services for children.

Method

By 1976 there were 28 new towns in Britain, and development corporations, family practitioner committees (England and Wales), and primary care administrators (Scotland) provided background material on services provided. This information was scrutinized and it was decided to visit all new towns where specific attempts had been made to create new ideas, and to develop an integrated approach to community care. In addition, I visited a selection of other new towns as it was not possible to include all the new towns in the survey. The following new towns were included in the study:

England	*Scotland*
Harlow	Glenrothes
Milton Keynes	Cumbernauld
Runcorn	East Kilbride
Telford	Livingston
Skelmersdale	
Washington	

Results

General impressions

With the exception of Harlow in England and East Kilbride in Scotland, the most striking feature of the new towns visited was the age structure, where women in the childbearing age accounted for between 20 and 25 per cent of the population, and children under the age of 15 were between 35 and 40 per cent of the population.

Harlow and East Kilbride were older towns where there were many second generation families. It was not my remit to study the architecture and environs of the towns I visited, but I found towns like Harlow and East Kilbride attractive and pleasing, whereas some of the more recent towns had not yet developed an identity and were still rather dreary and without character. Many of the present generation may not see the end result of long-term development, and herein, perhaps, lies much of the frustration inherent in new towns.

Workload

General practitioners in the more recent new town developments often emphasized the problems of high consultation rates, the high incidence of emotional problems, marital problems, and also recurrent social

An edited version of the report of an Upjohn Travelling Fellowship.

problems, all of which had a direct and often indirect effect on child care. The frequently quoted figures of lower consultation rates in general practice (Royal College of General Practitioners, 1973; Marsh and Kaim-Caudle, 1976) may not reflect the trends in new towns. Workload studies from general practice should not be interpreted as the only measure of primary medical care services, as out-of-hours and weekend services are often omitted from general-practice statistics, and the use of deputizing services has become commoner in recent years. In new towns, patients uprooted from urban areas no longer have ready access to casualty departments, and deputizing services and the general practitioners are the main, if not the only, providers of primary medical care.

List sizes in new towns varied from 1,500 to 3,000 with the former practices being penalized financially for attempting to provide reasonable time for consulting, visiting, and meeting with nursing and social work colleagues to plan practice policies. Bigger practices were financially stable, but often seemed overwhelmed by the demands from patients at the expense of innovations.

There have been few reports published on workload in new town practices, but Bain (1974) has shown that new town residents in Livingston have an average surgery consultation rate of 3·0 per patient per year, but this does not include attendances at antenatal clinics, child welfare clinics, treatment room services and other health-centre services. The corrected figure for patient contact with all health-centre services in Livingston showed that patients were receiving items of services at a rate of 6·7 per patient per year. These figures have also been confirmed by Dingwall (1976) in Glenrothes. In Washington New Town, one doctor reported that the consultation rate in Washington was nearly twice that of settled conurbations in nearby Sunderland.

Bain and Philip (1975) in a study of consulting behaviour of patients during the first year in a new town showed that their consulting rates were significantly higher than those for established patients, and this was especially true of emotional illness in adults and respiratory and behaviour problems in children.

Child care

The arrangements for looking after children varied considerably in the towns that I visited, and there was limited evidence of general practitioners wishing to extend their responsibility into preventive care for the pre-school and the school child—despite the fact that they are constantly being asked to take a more positive role in providing child health services in the community. The Scottish Home and Health Department's report *Towards an Integrated Child Health Service* (1973) put forward practical proposals for integration of child care services, and the Court Committee (1976) has made similar proposals. There is no doubt that in new towns with large populations of children it should be possible to create an integrated approach to child health.

One of the centres where considerable information has been collected and described on primary care for children in new towns is Livingston, and the report by Stark and his colleagues (1975) demonstrated that children under 15 years of age accounted for 35 per cent of all items of services provided by general practitioners, and that approximately ten per cent of the children required frequent medical and social observation. By an integrated approach to planning, the Livingston scheme has been able to reduce the number of children's consultations which are followed by hospital and outpatient referral. Paediatric supervision in health centres has reduced the need for many patients to attend clinics which may be far away from their homes.

General practitioners in new towns were, on the whole, sceptical about the value of developmental screening clinics, and Reid (1974) when discussing integration of medical services, pointed to the problem where, with only a minority of general practitioners interested in assuming responsibility of the clinical staff of the former local authority, it was difficult to establish well organized developmental screening clinics.

In Livingston, East Kilbride, Runcorn, Milton Keynes and Harlow, general practitioners were participating in developmental screening clinics for children. In other areas, the routine surveillance of pre-school children was still organized by former local authority doctors and health visitors. Where general practitioners were closely involved with routine child care, immunization acceptance rates were high, suggesting that integration of preventive services leads to better patient education. The oft expressed doubts about the value of developmental screening need further interpretation, and it would seem reasonable to suggest that new towns provide satisfactory test beds for prospective studies of developmental screening.

Role of nurses

There were some divisions of opinion about delegation of immunization procedures to nurses, but the consensus view was that this was both realistic and practicable, provided mutual trust existed between doctors and nurses, and where the 'ground rules' ensured that doctors were available to give advice.

There was general agreement that the role of the nurse in the paediatric team was important, and if the nursing commitment were to extend into roles traditionally held by the family doctor, then the establishment of nursing staff needed to be greater than that measured by traditional experience in other areas. It has been shown that health visitors can perform a number of developmental examinations, but the routine workload of health visitors in new towns precluded this, apart from one or two notable exceptions. It will be necessary to make more concerted attempts to quantify the nurses' contributions to preventive paediatric care.

Handicapped children

The care of the handicapped child was difficult to assess

as this varied from region to region. In the majority of cases, children were being seen by many different specialists and in clinics which were often far from their homes. The continuing care of children with longstanding disorders was largely in the hands of hospital consultants, and the majority of general practitioners had little knowledge of the total incidence in their practices of such conditions as asthma, diabetes, and epilepsy. There were exceptions to this; for example, in Livingston, East Kilbride, Glenrothes, Thamesmead, and Milton Keynes, consultant paediatricians held regular clinics in health centres where general practitioners were free to attend and discuss problems. In Livingston and Milton Keynes there was evidence to support the view that the general practitioner can extend his traditional role into secondary care and public and preventive care.

Social work

There was frequent and considerable criticism of social work departments in new towns. It was often claimed that they suffered from frequent changes in staff and that the social workers were inaccessible and inexperienced. With a seemingly high incidence of marital problems and associated difficulties in mother–child relationships, general practitioners often expressed fears that early intervention in suspected deprivation and non-accidental injury was difficult to initiate. The sudden influx of large numbers of new residents often put intolerable pressures on social work departments, and one could sympathize with their difficulties. There were only a few health centres where there was direct attachment of social workers to group practices, but there was no doubt that this led to considerable improvements in communication.

Records

One encouraging feature of new town practices was the commitment to the development of new record systems. Over 80 per cent of the practices had A4 record folders and included child health records of screening and immunization. The existence of an integrated medical record provides an excellent starting-point for research, and there was no doubt that they provide considerable potential for studying child care.

Future study of child care in new towns will probably depend on increased involvement by academic departments of general practice and child health. Practitioners in Thamesmead and Runcorn had combined appointments where they were responsible both for primary care services and for teaching medical students. It might be an appropriate time for university departments of general practice and child health to develop links with new towns where the large child populations provide ample opportunity for both research and teaching.

The future

There is evidence (RCGP, 1973) that workload has been decreasing throughout general practice in recent years, and although the workload studies have included a wide range of practices, the experiences of general practitioners in new towns require closer scrutiny. Before criticizing doctors with large lists in new towns, one should not underestimate the difficulties of attracting doctors to these areas. Until there is a more realistic assessment of reasonable list sizes for general practitioners in new towns, it seems likely that any extension of general practitioners' provisions of services for children will be slow to develop.

The same problem arises in many of our urban areas where concern has been expressed about primary care services for children (Davis and Bamford, 1973). I am not an advocate of age-band specialization (McKeown, 1965), but I am prepared to accept that it may be a solution for some new town developments and large housing estates in our cities. The recent Court Committee Report (Committee on Child Health Services, 1976) has made alternative proposals and has suggested the creation of general-practitioner paediatricians. It is doubtful that there will be universal acceptance of this idea, but it would seem logical to have general-practitioner paediatricians in many of the new towns in the UK. McKeown's and Court's ideas have been criticized on the grounds of possible lack of continuity of care, but these criticisms founder when one discovers that many practices in new towns and in urban areas have a 20 to 30 per cent turnover of patients in a relatively short time.

The objectives of child care services in many new towns have often been well defined (Milton Keynes, 1969; Duncan, 1969), but little attempt has been made to quantify them. It seems appropriate to select common priority health problems in children, such as otitis media, asthma, handicapped children, child abuse, accidents and, in the first instance, to determine levels of incidence, prevalence, resource consumption, and long-term impairment. This would also provide a means of studying to what extent nurses, social workers and psychologists are involved in the care of these children. Having ascertained the extent of the problem, it would then be possible to decide objectively how care and organization could be improved, and the importance of preventive medicine in child health may be discovered. The same approach could be used in studying immunization and developmental screening.

Administrators were equally divided in their views on the financing of services in new towns, but it seems obvious that in areas with a rapidly growing population that do not have any existing health service facilities, certain priorities should be given to the needs of the incoming population. The counter argument is that such an investment is at the expense of health services needed elsewhere, but I would certainly consider that a very strong case could be made for entirely separate funding of support services in new towns, otherwise there is a danger that if services develop slowly, doctors will not be attracted to these areas.

The original suggestion, by Dillane (1966), that the Royal College of General Practitioners should take a more active interest in new town practice seems to have been bypassed. The opportunities to create integrated child health services in new towns should be both appreciated and encouraged by the College, health boards and health authorities.

References

Bain, D. J. G. (1974). *Health Bulletin,* **32,** 189-193.

Bain, D. J. G. & Philip, A. E. (1975). *Journal of the Royal College of General Practitioners,* **25,** 821-827.

Committee on Child Health Services (1976). *Fit for the Future.* Court Committee Report. Cmnd 6684. London: HMSO.

Davis, J. & Bamford, F. N. (1973). *British Medical Journal,* **1,** 801.

Dillane, J. B. (1966). *General Practice in the New Towns of Britain. Reports from General Practice No. 4.* London: *Journal of the Royal College of General Practitioners.*

Dingwall, D. (1976). Personal communication.

Duncan, A. H. (1969). *British Medical Journal,* **1,** 632-633.

McKeown, T. (1965). *Medicine in Modern Society.* London: Allen and Unwin.

Marsh, G. & Kaim-Caudle, P. (1976). *Team Care in General Practice.* London: Croom Helm.

Milton Keynes (1969). *British Medical Journal,* **1,** 628-632.

Office of Health Economics (1967). *The Provision of General Medical Care in New Towns 1966.* London: OHE.

Reid, J. J. A. (1974). *Health and Social Services Journal,* **84,** 1734.

Royal College of General Practitioners (1973). *Present State and Future Needs of General Practice. Reports from General Practice No. 16.* London: *Journal of the Royal College of General Practitioners.*

Scottish Home and Health Department (1973). *Towards an Integrated Child Health Service.* Edinburgh: HMSO.

Stark, G. D., Bassett, W. J., Bain, D. J. G. & Stewart, F. I. (1975). *British Medical Journal,* **4,** 387-390.

Acknowledgements

This study would not have been possible without the considerable help and hospitality received from the doctors in the new towns which I visited. I am also grateful to the health boards/authorities, and development corporations which provided additional information.

It was not possible to visit all new towns in the UK, but doctors in these areas were extremely helpful in forwarding information and comments.

I wish to express my gratitude to Upjohn Limited for supporting this study with the award of a travelling fellowship.

Transitory decrease in platelet monoamine-oxidase activity during migraine attacks

A highly significant decrease in platelet monoamine-oxidase activity has been observed in migrainous subjects during a migraine attack compared with activity outside an attack. The effect did not derive from drugs commonly used in migraine therapy.

Reference

Glover, V., Sandler, M., Grant, E., Clifford Rose, F., Orton, D., Wilkinson, M. & Stevens, D. (1977). *Lancet,* **i,** 391-393.