PRACTICE OBSERVED

Practice Research

Are the problems of primary care in inner cities fact or fiction?

JO WOOD

The belief that Britain's inner cities have some of the worst social and health problems combined with some of the poorest primary care predates the beginning of the National Health Service.[1] Recent reports on primary care in inner London have reinforced this belief. The Acheson report, for example, stated, "in those areas where need is greatest, the services are least able to cope with the resulting pressure and often appear to be in the greatest disarray."[2] Similarly, the Royal College of General Practitioners' (RCGP) report on inner London concluded, "generally speaking, the areas with the worst social problems have the least suitable primary care services available to them."[3] As hospital and social services are cut back this problem takes on a new urgency, and recommendations have been made to facilitate desired changes in the organisation of primary care in inner London.[4]

Opinion is divided about whether action along similar lines is needed in other cities. The RCGP's reported view is that London's problems are unique and that the capital should be treated as a special case. The General Medical Services Committee, on the other hand, maintains that the problems of London cannot be seen in isolation from those of other deprived areas.[5] Up to now, however, little information has been systematically collected about primary care specifically in inner cities outside London to support either view. This is the first of two articles that report on findings from a recent survey among general practitioners in Greater Manchester which shed some light on this issue. This article provides a profile of general practitioners who have surgery premises in the Manchester-Salford inner area and in adjacent areas of Greater Manchester, and it compares where possible the characteristics of general practitioners in the Manchester-Salford inner area with those of general practitioners in inner London. The second article will compare the organisation and staffing of general practices in the two inner cities.

Primary Care Research Unit, Department of General Practice, University of Manchester, Rusholme Health Centre, Walmer Street, Manchester M14 8NP

JO WOOD, BA, MSC, senior research fellow

Method

A survey was conducted among all 485 unrestricted principals with surgery premises in five central health authorities in Greater Manchester—Manchester North, Central, and South, Salford, and Trafford. There were 225 unrestricted principals with surgery premises in the Manchester-Salford inner city partnership area, delineated under the 1978 Inner Urban Areas Act, and 260 in the "outer" area—that is, the rest of the study area. The survey population excluded general practitioner assistants, vocational trainees, restricted principals, and unrestricted principals who provided services to people in the five health authorities but who had surgery premises elsewhere.

Personal interviews were conducted with 366 general practitioners, 75% of the survey population, by the field force of Research Surveys of Great Britain in mid 1981. The response rate was identical among general practitioners in the inner city partnership area and the "outer" area. A comparison of the respondents' profiles with family practitioner committee statistics showed that the doctors who were interviewed closely represented the survey population. The likelihood of doctors responding, however, decreased with increasing age. Thus information about doctors over 65 is slightly less reliable than other information.

Findings

DOCTORS AGED OVER 65

It is often said that inner city areas have an above average proportion of general practitioners aged 65 and over who practise single handed and have small lists of under 1500 patients. Table I gives the age and sex of general practitioners interviewed in the Manchester-Salford partnership area and the outer area. The inner area has a disproportionate share of general practitioners aged over 65 compared with both the outer area and England and Wales (6%). (All figures for England and Wales relate to 1 October 1980.) But the proportion of general practitioners aged 65+ in the Manchester-Salford inner area is half the proportion in inner London (18%). (All figures for inner London relate to the area covered by the four teaching authorities wholly within inner London in 1979.[6]) Furthermore, since the population of the Manchester-Salford area is about an eighth of the population of inner London the number of doctors concerned is much smaller: when the survey was conducted there were roughly 25 doctors aged 65+ in the Manchester-Salford inner area compared to about 200 in inner London in 1979.

None of the doctors aged 65+ whom we interviewed (15 in the inner area and nine in the outer area) fitted the stereotype of the elderly, single handed doctor with a patient list of under 1500. Although some of the doctors aged 65+ who did not take part in the survey may have fitted it, this finding emphasises the need to guard against the "ecological fallacy"—that is, interpreting correlations between general practitioners' characteristics as shown in the statistics of family practitioner committees at district level as if they existed at the individual level.

TABLE I—*Age and sex of general practitioners who practise in Greater Manchester**

Age (years)	Greater Manchester: Inner area (%) Men	Women	Total	Outer area (%) Men	Women	Total	Total (%) Men	Women	Total	1977 Inner London (%)	1977 England and Wales (%)
<35	7	18	9	16	27	18	11	24	14	10	18
35–44	30	32	30	29	34	32	30	40	31	18	28
45–54	32	36	33	32	27	31	32	30	32	30	30
55–64	22	9	20	17	2	14	15	4	12	23	20
65+	9	5	8	6	—	5	7	1	6	17	6
Total No of general practitioners	149	22	171	150	45	195	299	67	366	1131	22 100

*For definition, see text.

DOCTORS AGED UNDER 35

It is often said that there is a relative scarcity of young doctors in inner cities. The proportion of doctors aged under 35 in the Manchester-Salford inner area is similar to that in inner London (10%) and just under half the proportion in England and Wales (18%) (table I). The lack of a retirement policy and the lack of vacancies resulting from the rules and appointments procedures of the Medical Practices Committee are said to be the main reasons for the slow inflow of young general practitioners to inner London.[1] But without further investigation it should not be assumed that the same factors are necessarily responsible for the relative scarcity of young general practitioners in the Manchester-Salford inner area. For example, the dearth of doctors aged under 35 may be linked to the spatial concentration of doctors who qualified overseas, who, according to this survey and other research,[5] enter general practice late in their careers after completing some years in the hospital service in their country of origin and then in Britain.

Table I also shows that there are relatively few young women doctors in the Manchester-Salford inner area. Although the RCGP report does not comment on this point, it shows a similar scarcity of women doctors in inner London.[3] This imbalance may be some cause for concern, particularly in inner cities where ethnic minorities are concentrated and there may be cultural barriers to women consulting men doctors.

DOCTORS WITH SPECIFIC TRAINING

It is often alleged that there is a lack of doctors in inner cities who have been trained specifically for general practice. But this is not true of the Manchester-Salford inner area. When asked whether they had had one of four different types of training for general practice (recognised or self organised vocational training, trainee year, assistantship) a similar proportion of doctors in the inner and outer areas (37% and 42%, respectively) claimed that they had (table II). The Manchester-Salford inner area has recently gained a higher proportion of young trained doctors than the outer area. This is in contrast to the time before vocational training for general practice was compulsory and not only were there fewer doctors who had any specific training for general practice but fewer of them seem to have entered, and stayed, in practice in the inner area. A detailed look at the educational qualifications of young, trained doctors shows that most of those in the inner area first qualified overseas, whereas most of those in the outer area first qualified in Britain.

TABLE II—*Training and age of general practitioners*

	Age of general practitioners (years): Inner area (%) <40	40–54	55+	Outer area (%) <40	40–54	55+	Total (%) <40	40–54	55+
With training	74	27	18	65	41	25	69	34	21
Without training	26	73	82	35	59	75	31	66	79
Total No of general practitioners	39	83	49	67	92	36	106	175	85

DOCTORS WHO QUALIFIED OVERSEAS

It is often said that there is a concentration of overseas born or qualified doctors in inner city areas. In inner London 47% of doctors were not born in Britain, almost double the national average for 1980 (26%). Table III confirms that the picture is similar in the Manchester-Salford inner area, with the proportion of overseas qualified doctors—that is, doctors who did not qualify in the United Kingdom or Eire—being almost double the proportion in the outer area. A distribution map showing the scatter of doctors in the outer area also shows a concentration of those who qualified overseas in the declining areas of older housing around the periphery of the inner area; very few are found in the very affluent areas.

TABLE III—*Percentage of general practitioners who qualified in Britain and overseas*

	Inner area (%)	Outer area (%)	Total (%)
Britain	63	80	72
Overseas	37	20	28
Total No of general practitioners	171	195	366

Analysis of doctors' country of qualification by age shows no sign that the inner area is increasing its share of British qualified doctors. In the Manchester-Salford inner area one in two doctors under age 40 first qualified overseas compared to one in five in this age group in the outer area. Taking postgraduate medical qualifications, doctors who qualified overseas are better qualified throughout the area than British doctors who qualified in Britain. They are also more likely to have had some specific training for general practice, even after allowance is made for differences in the age structure of the two groups. But they are slightly less likely to have passed the membership examination of the Royal College of General Practitioners, which many consider to be the most appropriate postgraduate qualification for general practice (16% compared to 25%).

SINGLE HANDED DOCTORS

According to popular belief there is a concentration of isolated single handed doctors in inner city areas. An analysis of family practitioner committee statistics shows that there is a relatively high proportion of single handed doctors in both the inner and outer area (27% and 18%) compared with the national average (14%). The proportion of single handed doctors in the Manchester-Salford inner area is low, however, compared to the proportion in inner London (34%). Information doctors gave about the number of doctors in their practice—that is, the number with whom they worked—suggests, however, that family practitioner committee statistics overestimate the proportion of doctors who actually work single handed. According to doctors' own assessments of the number of principals in their practice (table IV), the proportion of single handed doctors interviewed (83% of doctors the family practitioner committee classified as single handed) dropped to 20%—about the same proportion as in the outer area (18%).

TABLE IV—*Percentage of general practitioners in practices of different sizes*

No of doctors in practice	Inner area (%)	Outer area (%)	Total (%)
One	20	18	19
Two	23	19	21
Three	29	26	28
Four	20	22	21
Five +	8	17	12
Total No of general practitioners	171	195	366

Information that doctors gave about the number of other doctors working from their premises also shows that family practitioner committee statistics may give a misleading impression of the proportion of physically isolated doctors. Only 10% of all doctors interviewed (48% of single handed doctors) work from premises they do not share with at least one other doctor. It is also noteworthy that 61% of single handed doctors in the Manchester-Salford partnership area work from health centres or purpose built premises and not, as often supposed, from premises that are not purpose built.

On average, single handed doctors are older than doctors in partnership. For example, in the inner area 6% of single handed doctors are under 40 compared to 29% who are in groups of three or more. In the outer area the respective figures are 17% and 37%. These figures suggest that single handed practice may be dying out and more quickly in the Manchester-Salford inner area than in adjacent areas. In inner London it has been suggested that forming group practices might be accelerated by "packaging" forthcoming vacancies in one and two doctor practices. To explore whether this was feasible in the Manchester-Salford inner area a map was produced showing the scatter of vacancies that might arise from retirements over the next five years. It was found, however, that because of the geographical scatter of the possible vacancies there was little scope for "packaging." This means that if group practice is to be encouraged in the short term other means of doing so will have to be found.

DOCTORS WITH SMALL LISTS

It is widely believed that there is a concentration of doctors with small lists—under 1500 patients—in inner city areas and that these doctors take private patients. The survey figures about list size show the average for the practice, based on doctors' estimates of the overall list size. As such they do not take into account "list inflation" or any tendency doctors may have to overestimate the number of patients on their lists. Thus they may underestimate the proportion of doctors with small lists of under 1500. It seems unlikely, however, that these factors will seriously distort relative differences in list size between doctors in the inner and outer areas.

Table V shows that there is no concentration of doctors with lists of under 1500 in the inner area. Although direct comparisons cannot strictly be drawn, the proportion is half the national average (8%) and a quarter of the proportion in inner London (17%). Twice as many doctors in the inner area as in the outer area have lists of between 1500 and 1999 and half as many have lists of between 2500 and 2999. On present criteria, therefore, the inner city is overdoctored rather than underdoctored—an unsurprising finding in view of the steep (25%) decline in the population of the inner area in the past 10 years. Perhaps by accident rather than design there is an element of positive discrimination in favour of the Manchester-Salford inner area as a whole on this crude measure.

Despite this, it will be noted that there is substantial spread of list sizes in both the inner and outer area. Although average list sizes are appreciably smaller in the inner than in the outer area, there is no positive association at the ecological level with private practice, the proportion of doctors claiming to have private patients being similar in both the inner and outer areas (21% and 24% respectively). In group practice private practice is most common among doctors with large lists—2000+—in the outer area.

TABLE V—*Percentage of general practitioners and estimated list size*

No of patients on list	Inner area (%)	Outer area (%)	Total (%)
<1500	5	4	5
1500–1999	31	17	24
2000–2499	36	34	35
2500–2999	16	31	24
3000+	11	13	12
Total No of general practitioners	171	195	366

DOCTORS' PREMISES

It is often said that there is a lack of purpose built premises in inner cities. Table VI shows, however, that contrary to popular belief a substantially higher proportion of doctors in the Manchester-Salford inner area than in the outer area are in health centres and purpose built premises (52% compared to 28%). This reflects Manchester-Salford's virtually completed slum clearance and redevelopment programme and Manchester Area Health Authority's health centre programme, which gave priority to the inner area. Rented premises are also much more common in the inner area, where just over one in three doctors rent their premises compared to one in 10 in the outer area. I do not know, however, whether this is related to the standard of practice premises and, if so, how.

TABLE VI—*Percentage of general practitioners with different types of premises*

Premises	Inner area (%)	Outer area (%)	Total (%)
Purpose built:			
Owned	16	13	14
Rented	12	2	7
Other:			
Owned	25	61	45
Rented	23	10	16
Health centre	24	13	18
Total No of general practitioners	171	195	366

Doctors in both the inner and outer area were generally very satisfied with their premises. Doctors in health centres were most satisfied and doctors in premises that were not purpose built least satisfied. Although this tells us nothing about the standard of practice premises, it suggests that there may be little spontaneous desire among doctors in present circumstances to improve their premises. Despite this, 39% of doctors in the inner area and 30% in the outer area agreed when questioned on this point that their premises were too small for all the staff who worked with them. According to doctors' own assessments, cramped premises are not a distinctive feature of the Manchester-Salford inner area.

Concern about the distance between doctors' homes and their surgeries has been linked with concern about practice premises and the use of deputising services. The survey findings confirm that inner city doctors are more likely to live five miles or more from their surgery premises (43% compared to 22%) and that the likelihood of doctors regularly using a deputising service at certain times is related to how far they live from their surgery. In the inner area doctors living five miles or more away were more likely to use a deputising service regularly before 11 pm on weekdays and sometime over the weekend. But the differences were not great. Moreover, there is no way of telling from the survey findings whether the two factors are causally related.

Discussion

The selected findings from the survey reported in this article show that the reality of general practice in the Manchester-Salford inner city area diverges from the popular image in several ways that are considered to be important. There is no concentration of isolated, elderly, single handed doctors with small lists of patients and no lack of purpose built premises in the Manchester-Salford inner area. But there is a definite concentration of doctors who qualified overseas and a below average proportion of young doctors. The reasons for this imbalance in the distribution of general practitioners and its effect on the pattern of primary care are far from clear, but they are being studied.

In the meantime the survey findings highlight two dangers. Firstly, there is the danger of generalising about inner city general practitioners on evidence that largely derives from family practitioner committee statistics at district level and anecdotal evidence relating to inner London. The analysis of doctors' characteristics in the Manchester-Salford inner area suggests that inner London may be unique in both the diversity and intensity of some of the medical manpower problems and so should be treated as a special case.

The dislocation of the primary care services expected in inner London over the next few years as a result of the death and retirement of general practitioners is unlikely to occur in the Manchester-Salford inner area and the need for measures to deal with this particular problem that much less. It seems unlikely that introducing compulsory retirement at 65 or excluding doctors aged 65 with small lists from calculations regarding the designation of particular areas, or both, will make much immediate difference to general medical services in the Manchester-Salford inner area.

This leads on to a second danger—that of concentrating on a marginal medical manpower problem. If the characteristics of the medical manpower in other inner city areas outside London are similar to those in the Manchester-Salford inner area then it seems more appropriate for politicians, administrators, and leaders of the profession to pay less attention in the future to the few isolated, elderly doctors with small lists and more attention to the ways in which most doctors in inner cities can be helped to care for some of the most deprived and unhealthy members of our society.

Conclusions

In Greater Manchester 366 general practitioners out of a survey population of 485 in five health districts were personally interviewed in 1981. A comparison of the characteristics of general practitioners with surgery premises in the inner city partnership area and of those in adjacent areas of Greater Manchester showed that although the popular image of inner city general practice contains elements of truth, it diverges from reality in several respects. The results of the study show that though inner London may be unique because of the diversity and intensity of its medical manpower problems less attention should perhaps be paid to a marginal group of elderly general practitioners and more attention to the ways in which most general practitioners in inner city areas can be helped to care for some of the most deprived and unhealthy members of our society.

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References

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A NEW REMEDY AGAINST CANCER—1835 The *Hippomanes Mancinella*, of the family of the Euphorbiaceæ, has been known since the conquest of America by its poisonous effects. It is the juice of this tree which the Indians employ to envenom their arrows; and it is extensively employed by the hordes which inhabit the Oronoko as an anticarcinomatous remedy. Numerous experiments have proved that arsenic is neutralised by the secretion of a cancerous ulcer, while it preserves its poisonous properties when placed in contact with any other sore. The same phenomenon is observed with respect to the mancinella; its poisonous properties are in like manner neutralised by the secretion of cancerous ulcers. The Indians who employ this substance in the treatment of cancer, surround the wound with a pasty material, and then apply to the centre of the sore a few drops of the juice of the mancinella; and eschar soon forms, and coming away in about forty-eight hours, leaves a clean wound, which rapidly heals. M. Germain, of Marseilles, has witnessed a great number of cures effected by the application of this remedy, which he recommends to the attention of physicians. (*Jour des Con Med Chir April.*) (*Lancet* 1834-5 ji:106.)

FACTORY LABOUR At Bradford: "Children of these years (thirteen) are obliged to be at the factory, winter and summer, by six in the morning, and to remain there till seven in the evening, with but one brief interval of thirty minutes, every day except Saturday, ceasing work on that day at some factories, at half past five, in others at six or seven pm. Not infrequently this labour is extended till eight or nine at night, fifteen hours, having but the same interval for meals, rest, or recreation; nay, such is the steady growth of this overworking system, that children have been confined in the factory from six in the morning till eight at night, fourteen hours, continuously, without any time being allowed for meals, rest or recreation; the meals to be taken while attending the machines; and this the practice of years." (John Malyn. "On Factory Labour." (Read before the Westminster Medical Society). *London Medical and Physical Journal* 1833; new series 14:109-20.)

Diary of Urban Marks: 1880-1949

I could not hope for any more assistance from my father. I had now to face the world. I returned to my lodgings and packed my belongings. I then hied myself to "Dicky Bird," the medical superintendent of the hospital to ask his advice. Dr Bird was always known to the students of St Mary's as Dicky. His duty was to guide the student through his career and I have no doubt that his advice was sought after qualification by many generations of students. He must have influenced hundreds of them. He filled the post for many years and on his death a few years ago many tributes of affection were paid to him in the "St Mary's Gazette," the local magazine issued monthly at the hospital. Dicky was good enough to offer me the post of casualty officer to St Mary's for the ensuing December. This post was unpaid but carried with it board and lodgings in the hospital. I accepted the post as a stop-gap while waiting for something to turn up. I returned to St Mary's on 1 December 1905, after spending the intervening month at home. The experience I gained in that month as casualty officer was invaluable. The post could be held only by a fully qualified man and he could not leave his duties unless he was relieved by another man who of course had to be qualified. There was a cheap weekend to Newcastle on Tyne and as I had not seen my fiancee, May Chapman, for some time I decided to go if possible. I obtained a substitute suitable to Dicky Bird and then pawned my microscope for £2-10-0. This was the first and only time in my life that I have had recourse to a pawnbroker. When I arrived in Newcastle I explained to May that I could not afford to take her to a theatre or buy chocolates. But that did not matter to her.