RESEARCH REPORT

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COMMUNITY PHYSICIANS AND COMMUNITY MEDICINE

A SURVEY REPORT

Sarah Harvey and Ken Judge

KING'S FUND INSTITUTE

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FOREWORD

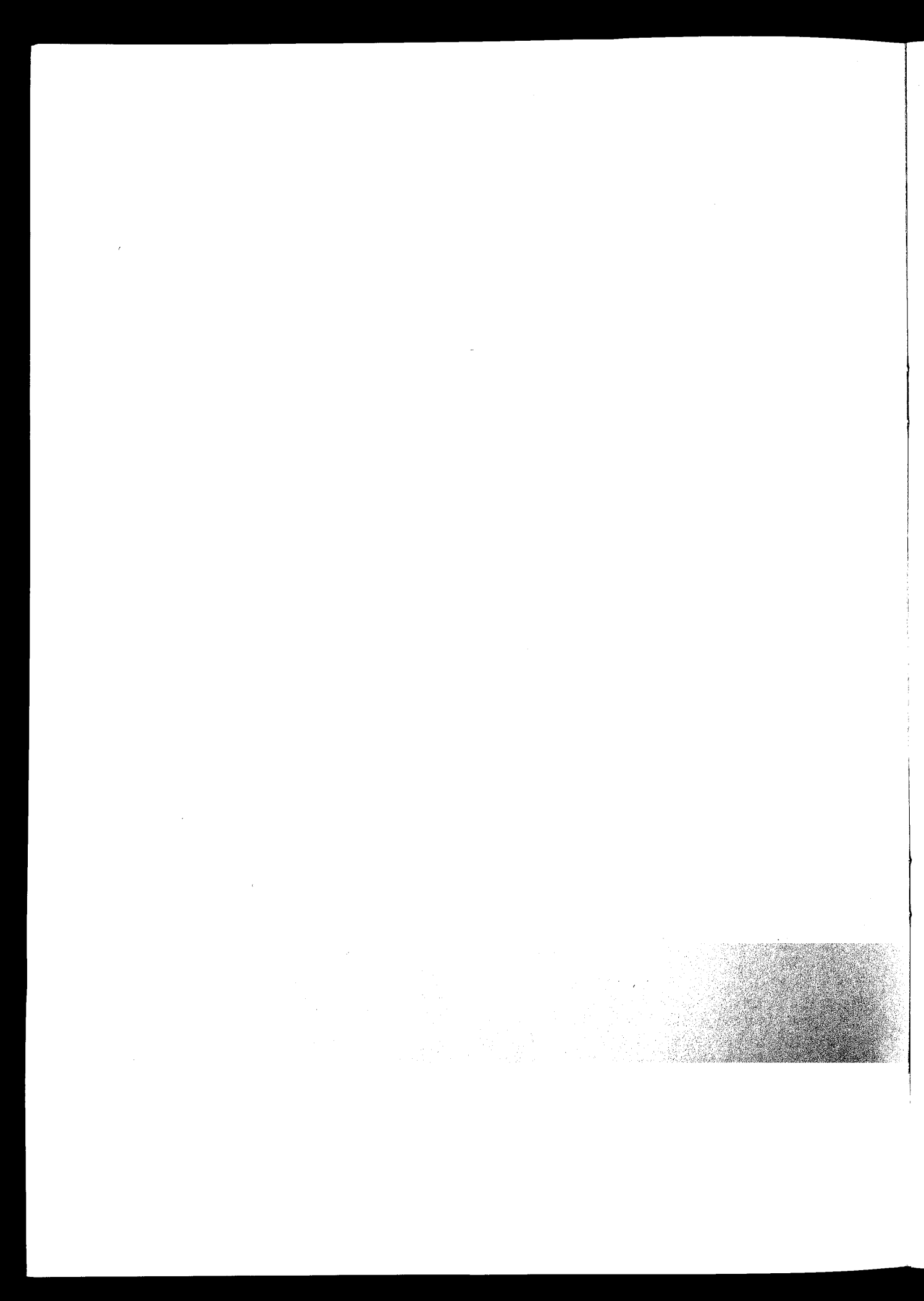
This report is based on a survey of community physicians undertaken by the King's Fund Institute at the invitation of the Acheson Committee of Inquiry which is considering the future development of the public health function. The survey was intended to explore certain aspects of the experiences of community physicians employed in English health authorities which it was thought might help the Acheson Committee in its deliberations. It is important to emphasise, however, that sole responsibility for the selection, interpretation and presentation of findings contained in this report rests with the Institute.

PREFACE

In January 1986, when the Secretary of State for Social Services announced the establishment of a Committee of Inquiry into the future development of the public health function and community medicine, which I was asked to chair, he indicated that it would be a broad and fundamental examination of the role of public health doctors. Clearly, such a task has required detailed investigation of how the specialty of community medicine functions within today's Health Service. We have received much evidence, both written and oral, but we felt that an independent, authorative survey of how the specialty perceives itself was required. We looked to the King's Fund Institute to carry out that survey. In the short time it has been in existence the Institute has rapidly built up a deserved reputation for thorough and independent research and analysis of health policy issues.

Ken Judge and Dr Sarah Harvey were asked to produce their report as quickly as possible, so that it could be of maximum benefit to Members of the Inquiry as they considered their recommendations. In view of the tight timetable which was imposed upon them, the result is a remarkably comprehensive overview of the specialty as it is today. Their survey has proved invaluable to the work of the Inquiry. We are still formulating our own conclusions and recommendations and the survey has made a major contribution in informing our discussions.

Sir Donald Acheson
KBE DM DCs FRCP FFCM FFOM
Chief Medical Officer, DHSS



SUMMARY

★ Public health issues are at the forefront of contemporary debate about health policy. A government inquiry under the chairmanship of the Chief Medical Officer, Sir Donald Acheson, is currently considering the future development of the specialty of community medicine and its role in the field of public health.

★ In July 1986, the King's Fund Institute undertook a survey of community physicians in English health authorities on behalf of the Acheson Committee. The purpose of the survey was to collect information on the personal characteristics, types of jobs, education and experience of community physicians and to investigate the priorities and normative beliefs which they attach to the various tasks which their jobs entail. Approximately 86 per cent of community physicians contracted to English health authorities responded to the survey.

★ It is useful to make the distinction between academic community physicians who are principally engaged in teaching and research and who usually have honorary contracts with health authorities, and those community physicians who are employed by and work in health authorities. This report is concerned solely with the latter group of community physicians.

★ The speciality of community medicine was formed in 1972. A distinction can be made between those who worked in public health before the formation of the specialty (58 per cent of community physicians fall into this category) and those who have trained in community medicine since 1972. Thirty per cent of community physicians have received no further training since the specialty was founded and seventeen per cent of community physicians are over the age of 60.

★ Community physicians have a range of different jobs and some have more than one job; 23 per cent of community physicians have two jobs and 4 per cent have three jobs. The majority of community physicians, however, have relatively straightforward work arrangements: 55 per cent have one full-time job as a specialist in comunity medicine (SCM) or district medical officer (DMO).

★ There has been much debate about the accountability of community physicians following the introduction of general management into the National Health Service (NHS). Forty-nine per cent of community medicine posts are accountable to general managers, but there is still considerable uncertainty amongst individual community physicians about their specific managerial and professional accountability.

★ Twenty-one per cent of community physicians have no specific experience of communicable disease control in a clinical, laboratory or epidemiological context. One-quarter of community physicians give this task low priority in their current jobs, but two-thirds of community physicians believe it to be an important responsibility for the specialty as a whole.

★ Seventy-five per cent of community physicians currently play some role in the planning and management of child health services, but there is a widespread feeling that this function is inappropriate to the specialty of community medicine.

★ Community physicians give the highest priority in their current work to advising the health authority about medical matters and to the planning and evaluation of services for priority client groups.

★ Although there is a degree of consensus about the central tasks which community physicians should be involved in, there is considerable diversity of opinion about the priority which should be given to other areas of interest.

The main conclusions of the report are that:

1. The status and identity of community medicine have suffered from reorganisations in the health service and from confusion about what the key responsibilities of the specialty are. Diversity in the types of tasks and responsibilities performed by community physicians suggests that there may be a case for the specialty to opt for more formal specialisation either in the initial training or in subsequent courses. Attention should also be given to the form of organisation which would best facilitate the effective performance of the functions of community medicine.

2. The Faculty of Community Medicine have stressed the community physician's role in health promotion and disease prevention and as an advocate for healthy public policies. The priorities and beliefs of individual community physicians, however, indicate that planning and advisory functions are given greater emphasis than health promotion.

3. Public health issues require a multi-disciplinary approach and community physicians are just one of several sources of professional expertise. There have been a number of problems in the relationships between community physicians, health and local authorities and with other professions such as environmental health officers and general practitioners. These suggest that a clearer remit for community medicine may be called for, or that the training which community physicians receive should better prepare them for the organisational environment in which they are expected to operate.

4. Community physicians have an important role to play in the identification and provision of information on the nature and determinants of ill-health in the population. The collection, analysis and presentation of this information requires resources. The effective performance of some of the responsibilities of community medicine may be constrained by the financial and staffing resources which are currently available.

SUMMARY

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[illegible] physicians have no [illegible]

★ Community physicians [illegible]

INTRODUCTION 1

Public health issues are at the forefront of contemporary debate about health policy. Since the inception of the NHS the scope of public health has been defined in broader terms and new challenges have been identified. This has raised questions about professional responsibility and expertise in the field. Medical officers of health (MOsH) were traditionally associated with public health concerns until 1974, when MOH posts were abolished. Many of the former MOsH, however, were reappointed as community physicians in the newly formed specialty of community medicine. Community medicine assimilated some of the responsibilities of the MOsH, but also took on a range of other functions which have become increasingly varied. This diversity and various reorganisations of the NHS has left many community physicians feeling confused and uncertain about their role and responsibilities. Partly in response to an outbreak of salmonella poisoning at Stanley Royd hospital the government established, in January 1986, a committee of inquiry into public health and community medicine under the chairmanship of the Chief Medical Officer, Sir Donald Acheson. Its terms of reference are:

To consider the future development of the public health function including the control of communicable diseases and the specialty of community medicine following the introduction of general management into the Hospital and Community Health Services, and recognising a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible (DHSS, 1986).

Community physicians undertake a range of different tasks in the course of their work and the Acheson Committee has compiled a working list of areas of responsibility which they consider to be the domain of Community Medicine. Since we will refer to these tasks throughout the report, they are worth spelling out in full. Community physicians, as a group, are thought to be involved in the following tasks:

- ★ determining the health needs of whole populations;
- ★ contributing to the planning of appropriate health services and evaluating the outcome of such services;
- ★ providing health authorities with medical advice as and when necessary;
- ★ control of communicable disease;
- ★ providing medical advice and support to local authorities in connection with their environmental health, social services and housing functions;
- ★ health surveillance of pre-school and school age children, advice and support to local authorities in connection with their statutory duties;
- ★ prevention, health promotion and health education;
- ★ provision, co-ordination and evaluation of programmes which require the co-ordination of the work of both hospital and community based doctors (eg immunisation programmes).

The King's Fund Institute was invited by the Acheson Committee to conduct a survey of community physicians in English health authorities. The purpose of the survey was to collect information on the personal characteristics, types of jobs, education, training and clinical experience of community physicians, and to investigate the priorities and normative beliefs which they attach to the various tasks and responsibilities which their jobs involve. Additional background information was requested from health authorities on the number of occupied and vacant posts for community physicians, trainees in community medicine and clinical medical officers. The health authorities were also asked to supply information about managerial and organisational arrangements concerning community physicians employed by the authority. The primary purpose of this report is to present the results obtained from the survey. Throughout the report we use the term community physician to refer to all staff who are medically qualified in community medicine, excluding trainees and those with only honorary appointments. The term specialist in community medicine (SCM) is used to refer to the consultant level career grade.

The remainder of the report is divided into six parts. In part 2 we give an outline of the history of the specialty of community medicine and consider some of the persistent problems which it has faced. In the third part we describe the methodology of the survey and this is followed by a presentation of the results. Patterns of employment and models of organisation in community medicine are described in part 4, whilst part 5 presents a profile of the general characteristics, qualifications and lines of accountability of community physicians. The sixth part of the report is devoted to an analysis of the priorities and beliefs which individual community physicians attach to the tasks which their job entails. Finally, in part 7 we draw some conclusions about the present and future state of community medicine.

THE CHANGING FACE OF COMMUNITY MEDICINE

2

2.1 The Emerging Specialty

Public health physicians were employed as Medical Officers of Health in district councils from 1872 and in county councils from 1888; the posts and training being statutorily defined. Under the MOsH, the work of the public health department grew, particularly after 1929 when the local authorities added the administration of the old poor law hospitals to their responsibilities in preventive health and domiciliary care. The National Health Service Act 1946 removed the responsibility for hospital management from MOsH leaving domiciliary midwifery, health visiting, vaccination and immunisation and environmental hygiene as their principal health functions (Lewis, 1986). The status of the MOH inevitably suffered as the size of the department was reduced.

The responsibilities of the MOH were again diminished following the recommendations of the Seebohm Committee, which identified that public health tasks were not being effectively performed under the existing local authority structure (Seebohm, 1968). The committee did not, however, recommend that health and welfare departments be joined under the control of the MOH. The unified social services departments which came into being in 1971, effectively gave social workers their independence and reduced the size and functions of the departments of public health. Public health doctors were subsequently given a role within the reorganised health service.

The Royal Commission on Medical Education introduced the term community medicine in 1968, defining it as:

> *the specialty practised by epidemiologists and administrators of health services*
> (Cmnd 3569, 1968, para 133, p. 66).

In 1972, the Faculty of Community Medicine was founded by the UK Royal Colleges of Physicians. The specialty of community medicine was created from an unstable alliance of three disciplines - public health, medical administration and academic social medicine - and the amalgamation of these disparate elements has contributed to the somewhat confused identity of the specialty.

Between 1948 and 1974 the NHS had a tripartite structure consisting of hospital boards, local authority health departments and executive councils which administered the family practitioner services. This structure was replaced in 1974 by regional, area and district health authorities. The aim of the restructuring was to get a better balance between hospital and community services and acute and chronic conditions. The Royal Commission on Medical Education (Cmnd 3569) had earlier identified the need for service co-ordinators and it was intended that community physicians, with their boundary spanning remit, would play a crucial role in facilitating integration in the reorganised health service.

The creation of the specialty of community medicine and the reorganisation of the NHS resulted in a redefinition of the scope and responsibilities of public health doctors. The position of the Medical Officer of Health was abolished in 1974, many of the legal and administrative powers of the post passing to the Chief Environmental Health Officers (Acton and Chambers, 1986). These changes had both positive and negative consequences for community medicine. On the one hand, community physicians were given a defined position on the health authority's management team and had the opportunity to advise their clinical colleagues and non-medical administrators on public health issues. In theory, they also had the power to initiate policies themselves and veto certain policy options. On the other hand, the community physician's relationship with the local authority was weakened and became mainly advisory. The Association of Metropolitan Authorities (AMA, 1986) have commented that community physicians often find themselves compromised in their advisory capacity to local authorities, particularly if they are expected to act as a negotiator for health authority policies.

The abolition of the area health authorities in 1982 did not pose a fundamental challenge to the status of community medicine, but the changes did precipitate some upheaval in managerial relationships and staffing within the specialty (Lewis, 1986). Indeed, in multi-district areas the re-organisation may have been advantageous in that it presented the opportunity for districts to strengthen relationships with their local authorities. The same cannot be said of the changes following the most recent development in the organisation of the NHS. Following the recommendations of the Griffiths report (Griffiths, 1983) the complex consensus management teams were replaced by general managers at all levels from the region to units. The practical implications of these arrangements for the specialty of community medicine were not considered in advance.

The introduction of the new managerial structure has raised questions about the managerial role of the community physician and there is concern that a diminution in this function could have an adverse effect on the specialty's status. There are two issues underlying this concern. The first is that health authorities are no longer obliged to employ medical officers in a managerial capacity; some health authorities have dropped medical officers from their management teams or even disposed of the post of DMO. The second issue is that of the accountability of community physicians. The DHSS circular on the implementation of the Griffiths proposals (DHSS, 1984) made the distinction between managerial and professional accountability. In general terms, the new arrangements mean that both DMOs and SCMs are professionally accountable to the health authority for the quality of their medical advice, but are

accountable to general managers for the performance of their managerial functions. District health authorities have interpreted the management recommendations of the Griffiths report in different ways; indeed variety and adaptation to local requirements have been encouraged at the ministerial level. This means that it is difficult to gain an overall view of the impact which the introduction of general management has had on community medicine and comparisons are made more complicated by the variety of titles given to the posts held by community physicians. The Faculty of Community Medicine, however, have noted that a situation in which a SCM is managerially accountable to a Unit General Manager (UGM) may result in the UGM being involved in the procedures by which community physicians are appointed: this in turn implies that the UGM would have the power to dispense with a community physician post (Faculty of Community Medicine, 1985).

The various structural and managerial changes in local government and in the NHS have meant that public health and community medicine has had a chequered history. Within the NHS there remains considerable uncertainty as to the role and status of the community physician. Organisational restructurings have contributed to this uncertainty, but it is also due to the failure of community medicine to focus its activities and consolidate its identity. The breadth of skills and interests encompassed within community medicine may be viewed as a strength or a weakness and we discuss some of the issues about which tasks should be the domain of community medicine in more detail below. In principle, the very nature of community medicine is potentially challenging to current health authority practice and the structure of medical thought, but some have argued that community physicians have lacked the professional status, resources and political influence to be an effective force (Tudor-Hart, 1986).

2.2 Issues in community medicine

There have been several attempts to spell out the roles and responsibilities of community physicians and the shifting emphases and interpretations have led to confusion about the function of community medicine. The Hunter Working Party on Medical Administrators (DHSS,1972a), for example, stressed a management role for community physicians involving co-ordination of services and analysis of the health needs of populations. Similarly, the report on management arrangements for the reorganised NHS recognised the community physician's place in health authority management teams (DHSS, 1972c). By contrast, the White Paper on Reorganisation of the NHS (Cmnd 5055, 1972b) presented a more pragmatic picture of community physicians involved in epidemiology and the fostering of preventive medicine, as well as playing a central part in the planning and management of the unified service.

There is some evidence to suggest that community physicians would prefer closer links with clinical practice. Acheson's survey of trainees in community medicine revealed that the majority thought the opportunity to engage in part-time clinical practice would be beneficial to the specialty, in that it could further the attainment of its objectives and facilitate relationships with other specialties (Acheson, 1979). A survey of SCMs in the South East Thames region also revealed favourable attitudes towards part-time clinical practice (Heller and Pearce, 1980). Acheson suggested that these attitudes were related to an underlying anxiety in community medicine that SCMs would be solely associated with work which could be more appropriately carried out by administrators, sociologists or environmental health officers. The responses also reflect a recognition of the association between clinical practice and high occupational status which is pervasive in the health service and at the root of some of the problems affecting community medicine.

Information on the types of tasks which community physicians perform is limited. Donaldson and Hall (Donaldson and Hall, 1979; Hall, 1982) conducted a comprehensive analysis in 1977 of the time which community physicians allocated to different tasks based on detailed time diaries. On average community physicians spent 60 per cent of their time on administrative tasks. Planning activities accounted for 14 per cent of ascribable task time, whilst clinical work accounted for just 1 per cent of community physicians' work time. The introduction of general management into the health service may have implications for the administrative component of community physicians' workloads, but the extent of this is not yet clear.

We noted earlier that the Griffiths managerial arrangements have been perceived as posing a threat to the position of community physicians in the managerial structure of the NHS. It is not only the managerial function of community physicians which has been challenged in recent years. The role of community physicians in public health issues has been the subject of much debate. McCarthy (1985), for example, argues that the traditional role of the Medical Officer for Environmental Health is an anachronism and that medical advice on this subject could be adequately performed by a local consultant with specialist back-up where necessary. Moreover, managerial arrangements in local government have facilitated an expansion of the roles, skills and influence of environmental health officers; a development which community physicians have been slow to acknowledge. As the debate on public health issues has widened, so it has become increasingly clear that the community physician is only one of several sources of expertise (King's Fund Institute, 1987; AMA, 1986).

The community physician's expertise has also been challenged in the field of child health services. SCMs, general practitioners (GPs) and clinical medical officers (CMOs) are responsible for different aspects of these services, although to some extent their responsibilities overlap. The Court report (Court, 1976) recommended that child health, and in particular paediatric assessment, should be the responsibility of GPs and consultant community paediatricians. Clinical medical officers, however, continue

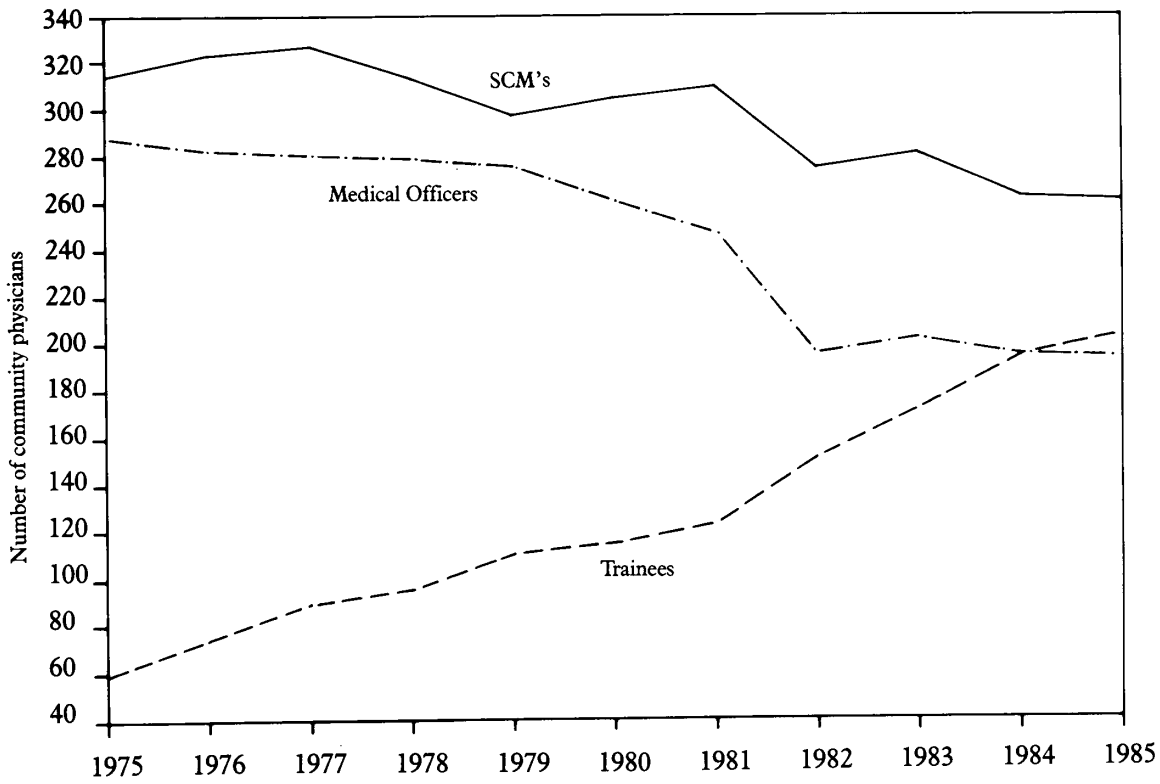
to practice in the field of child health and community physicians have retained some responsibility for the planning and management of child health services. Donaldson and Hall's survey (Donaldson and Hall,1979) revealed that 94 per cent of community physicians had some responsibility for child health and 54 per cent worked solely in that field. Although there has been some reduction in the number of community physicians participating in child health care, the appropriateness of this role for community medicine has been persistently challenged. The Society of Community Medicine (1986) point out that although community physicians could play a role in the co-ordination of child health services, not all community physicians are adequately trained in this field. Experience in the child health services was an integral part of the training for a MOH, but this has not been a requisite for doctors training in community medicine since 1974.

2.3 Historical Trends

Recruitment of trainees to the specialty has been erratic since its inception. This was noted by the Social Services Committee (1981) as being due to the poor image of community medicine following the reorganisation of the NHS in 1974. The committee associated this with the financial disadvantages of a career in community medicine compared with other specialties; there is little opportunity for private practice, overtime working, or gaining merit awards. Staffing problems in community medicine have also been exacerbated by organisational and managerial restructuring of the health service. With the reorganisation of the NHS in 1974, posts for community physicians were established at regional, area and district levels. In contrast to the recruitment of trainees, there was no shortage of applicants for these posts. The abolition of the area health authorities in 1982 brought considerable changes in staffing arrangements in that district community physicians and area medical officers competed for posts as district medical officers and specialists in community medicine. Twenty per cent of the total number of community physicians took the opportunity to retire (Lewis, 1986). Figure 1 illustrates the trends in employment of community physicians from 1975 to 1985; the figures are derived from the DHSS annual returns of community medicine staff. The three curves illustrate trends in the number of SCMs, medical officers (consisting of regional, area and district medical officers and district community physicians prior to 1982) and trainees in community medicine (senior registrar and registrar grades) employed on a full-time basis, in English health authorities, between 1975 and 1985.

FIGURE 1

TRENDS IN THE EMPLOYMENT OF FULL-TIME COMMUNITY PHYSICIANS 1975-1985



In the case of SCMs the general trend has been one of decline, though with some notable fluctuations. From 1975 to 1977, there was an increase in the number of SCMs, corresponding to a period of adjustment to the new specialty and the reorganised health service. Another increase in SCM numbers took place between 1979 and 1981, but the abolition of the area tier in 1982 reversed this trend. The downward trend has continued, although the curve does show a levelling off in the rate of decline. Against this trend, there has been a consistent increase in the number of SCMs working on a part-time basis. There has also been an overall decline in the employment of medical officers since 1975, the curve showing similar periodic fluctuations to that for SCMs. In direct contrast is the trend in the number of trainees which shows a consistent increase throughout the period. On a regional basis, the increase in trainees was particularly marked in the West Midlands, South Western and Northern regions. The higher level of trainee recruitment is beginning to make an impact on the number of vacant posts in community medicine. The returns for 1983 (DHSS, 1984) indicate a total of 188 vacant posts for SCMs. By 1985 the number of SCM vacancies had fallen to 36 (DHSS, 1986).

As yet it is probably too soon to identify the impact of the Griffiths arrangements on employment trends in community medicine. District Medical Officer (DMO) posts are the most likely to be affected and these have shown no significant decline to date. Estimates based on the survey responses (see Table 1), however, imply that there are only 150 DMOs and this differs quite significantly from the 180 recorded in the 1985 DHSS returns (DHSS, 1986).

2.4 Conclusions

In this section we have traced the changing fortunes of public health medicine, from its origins in local government, through the foundation of the specialty of community medicine, to the various administrative restructurings of the NHS. These historical developments provide the context for an understanding of contemporary problems in community medicine, most of which are not in fact new.

The role and functions of community physicians have been challenged in a number of areas. The results of the survey, discussed below, suggest that part of the problem lies in the heterogeneity of the specialty; community physicians having quite different training, skills and experiences of the practice of community medicine depending in part upon the date at which they entered the profession. There may be substantial differences between those who trained before 1974 and those whose education in community medicine was completed after that date. If there is continuing confusion as to the identity and role of the specialty, any measures adopted to remedy the situation should take into account variations within the specialty. These internal differences may prove less significant as the former MOsH reach retirement age.

SURVEY METHODOLOGY AND RESPONSE

3

3.1 A Survey of Community Physicians

In July 1986 the King's Fund Institute conducted a survey of community physicians employed in English health authorities. The aim of the exercise was to collect information about the work-related tasks performed by community physicians, and the relative importance of those activities and to relate such data to additional information about personal characteristics, education and training and previous clinical experience.

In May 1986, a letter from the Chief Medical Officer was sent to the Chairmen of English health authorities explaining the purpose of the survey and the role of the Institute and requesting assistance. Health authorities were requested: (a) to complete a questionnaire about the employment of community physicians and (b) to distribute a separate questionnaire to individual community physicians. The timetable for the survey was very tight; crucially, this did not allow time for the piloting of the survey but consultation was as wide as possible. One important change which we made at this stage was to extend and clarify the range of tasks undertaken by community physicians. Starting from the list of eight tasks identified by the Acheson Committee and listed on p.1, we included a revised set of eleven which are listed in Appendix IV.

3.2 Response to the survey

We received completed questionnaires from 92 per cent of English health authorities; all of the regions responded together with 176 of the 191 districts. We also obtained a very good response from individual community physicians, but estimating the response rate is slightly more complex than for the health authority questionnaire.

In order to calculate the response rate of individual community physicians we need to know the total number of community physicians employed in English health authorities on the date of the survey. One of the purposes of the health authority questionnaire was to provide such an estimate. The results are shown in Table 1. Assuming that non-respondent authorities are similar in their employment of community physicians to those that did return completed questionnaires, we estimate that 560 qualified community physicians were contracted in July 1986. This figure can be compared with the DHSS returns for September 1985 and 1986 which are summarised in Appendix I. The difference between our estimate and the DHSS returns is largely accounted for by our inclusion of locums and more joint appointments, which are treated differently in the official statistics.

Of the 525 questionnaires received from community physicians there were 493 usable "cases", representing 482 individuals when allowance is made for those with joint appointments who returned more than one questionnaire. These figures, which are summarised in Appendix II, suggest a response rate of 86 per cent when compared with the estimated population derived from Table 1. In the subsequent analysis we have limited respondents to one questionnaire and excluded those with honorary appointments only, giving us 444 individual cases. For the most part, those with honorary appointments are academic community physicians and their work programmes are significantly different to those community physicians who are spend a substantial proportion of their time on health authority work.

In the rest of the report we present some of the results from the survey. For the most part the discussion relates to the responses of individual community physicians. The questionnaires completed by regional and district health authorities, however, provided some interesting information on the pattern of organisation and employment in community medicine in England which is summarised in the next section.

TABLE 1

COMMUNITY PHYSICIANS CONTRACTED TO ENGLISH HEALTH AUTHORITIES*

July 1986

Grade	Regions			Survey Districts[1]			All Districts[2]			Total[2]			
	F/T	P/T	Hon	F/T	P/T	Hon	F/T	P/T	Hon	F/T	P/T	Hon	Total
RMO	13	-	-	-	-	-	-	-	-	13	-	-	13
DMO	-	-	-	138	5	2	150	6	2	150	6	2	158
SCM	46	6	21	186	39	20	202	42	22	248	48	43	339
Other	3	3	-	27	8	3	29	9	3	32	12	6	50
TOTAL	62	9	21	351	52	25	381	57	27	443	66	51	560

1. Data response: N = 176
2. Estimate

* Including locums and multiple appointments: F/T - full-time; P/T - part-time; Hon - honorary.

EMPLOYMENT PATTERNS 4

4.1 Regional and District Data.

The health authority questionnaire requested data about all community medicine staff in post on 15 July 1986. Tables 2 and 3 show the number of community medicine staff by employing authority, together with some simple descriptive statistics. The main points can be summarised as follows.

★ The majority of community physicians work on a full-time basis.

★ The average DHA employs 1 SCM and the average RHA employs 3.3 SCMs.

★ Roughly 80 per cent of the DHAs responding to the survey employed a DMO.

TABLE 2

COMMUNITY PHYSICIANS EMPLOYED IN DISTRICT HEALTH AUTHORITIES, 1986*

POSITION	SUM	MEAN	MINIMUM	MAXIMUM
COMMUNITY PHYSICIANS				
District Medical Officer				
- full-time	138	0.78	0	1
- part-time	5	0.03	0	1
Specialist in Community Medicine				
- full-time	186	1.06	0	5
- part-time	39	0.22	0	4
Other Community Physician				
- full-time	27	0.15	0	3
- part-time	8	0.05	0	1
TRAINEES				
Senior Registrar Grade				
- full-time	4	0.02	0	1
- part-time	3	0.02	0	2
Registrar Grade				
- full-time	7	0.04	0	2
- part-time	0	0	0	0
Senior House Officer				
- full-time	16	0.09	0	4
TOTAL	433			

*N = 176

TABLE 3

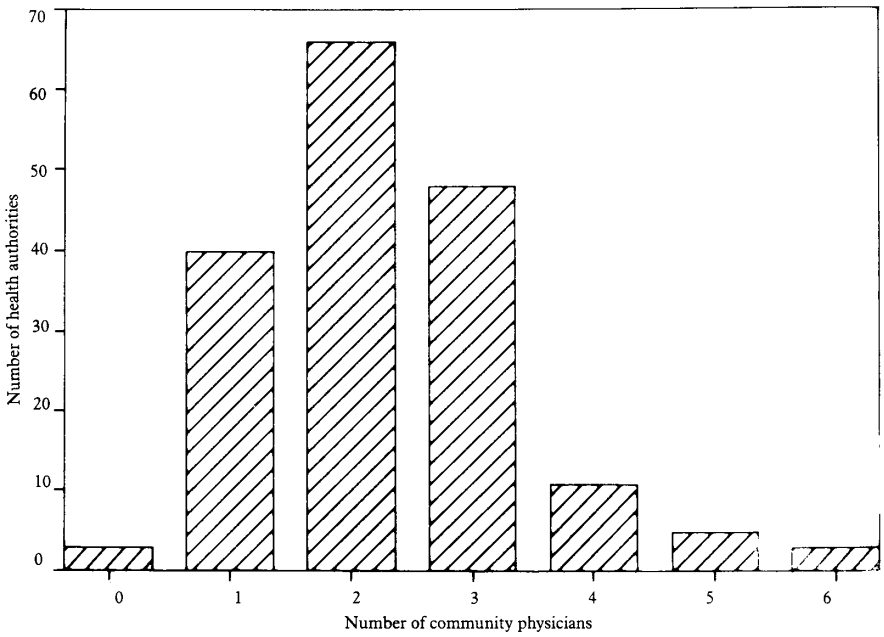
COMMUNITY PHYSICIANS EMPLOYED IN REGIONAL HEALTH AUTHORITIES, 1986*

POSITION	SUM	MEAN	MINIMUM	MAXIMUM
COMMUNITY PHYSICIANS				
Regional Medical Officer				
- full-time	13	0.93	0	1
- part-time	0	0	0	0
Specialist in Community Medicine				
- full-time	46	3.29	0	5
- part-time	6	0.43	0	2
Other Community Physician				
- full-time	3	0.21	0	2
- part-time	3	0.21	0	2
TRAINEES				
Senior Registrar Grade				
- full-time	90	6.43	0	16
- part-time	3	0.21	0	1
Registrar Grade				
- full-time	90	6.43	0	21
- part-time	3	0.21	0	1
Senior House Officer				
- full-time	2	0.14	0	1
TOTAL	259			

* N = 14

FIGURE 2

COMMUNITY PHYSICIANS EMPLOYED IN DISTRICT HEALTH AUTHORITIES IN ENGLAND



SCMs are employed by regional and district health authorities. Tables 2 and 3 show that although the majority of SCMs work in DHAs, the average number of SCMs employed in a RHA is roughly three times the number employed in the average district. This is to be expected, bearing in mind the relative size of the population in the employing authority. SCMs employed at the regional level may have different responsibilities to SCMs employed by district health authorities and we return to this point in a later section.

The pattern of employment of district based community physicians is shown in Figure 2. The main point to note here is that three districts responding to the survey employed no community physicians at all. Figure 3 shows the districts' employment of full-time SCMs. Fifty-one DHAs employed no full-time SCM. The modal classes in Figures 2 and 3 indicate that the most common pattern of community physician employment in district health authorities is for there to be two community physicians: a DMO and a SCM.

FIGURE 3

SPECIALISTS IN COMMUNITY MEDICINE (FULL-TIME) EMPLOYED IN ENGLISH HEALTH AUTHORITIES

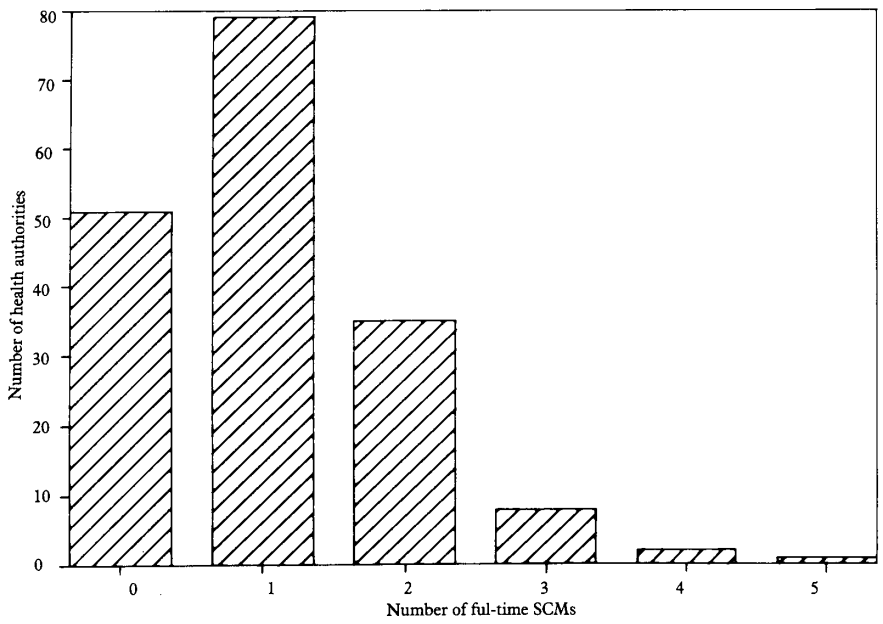


FIGURE 4

COMMUNITY MEDICINE TRAINEES IN REGIONAL HEALTH AUTHORITIES, 1985

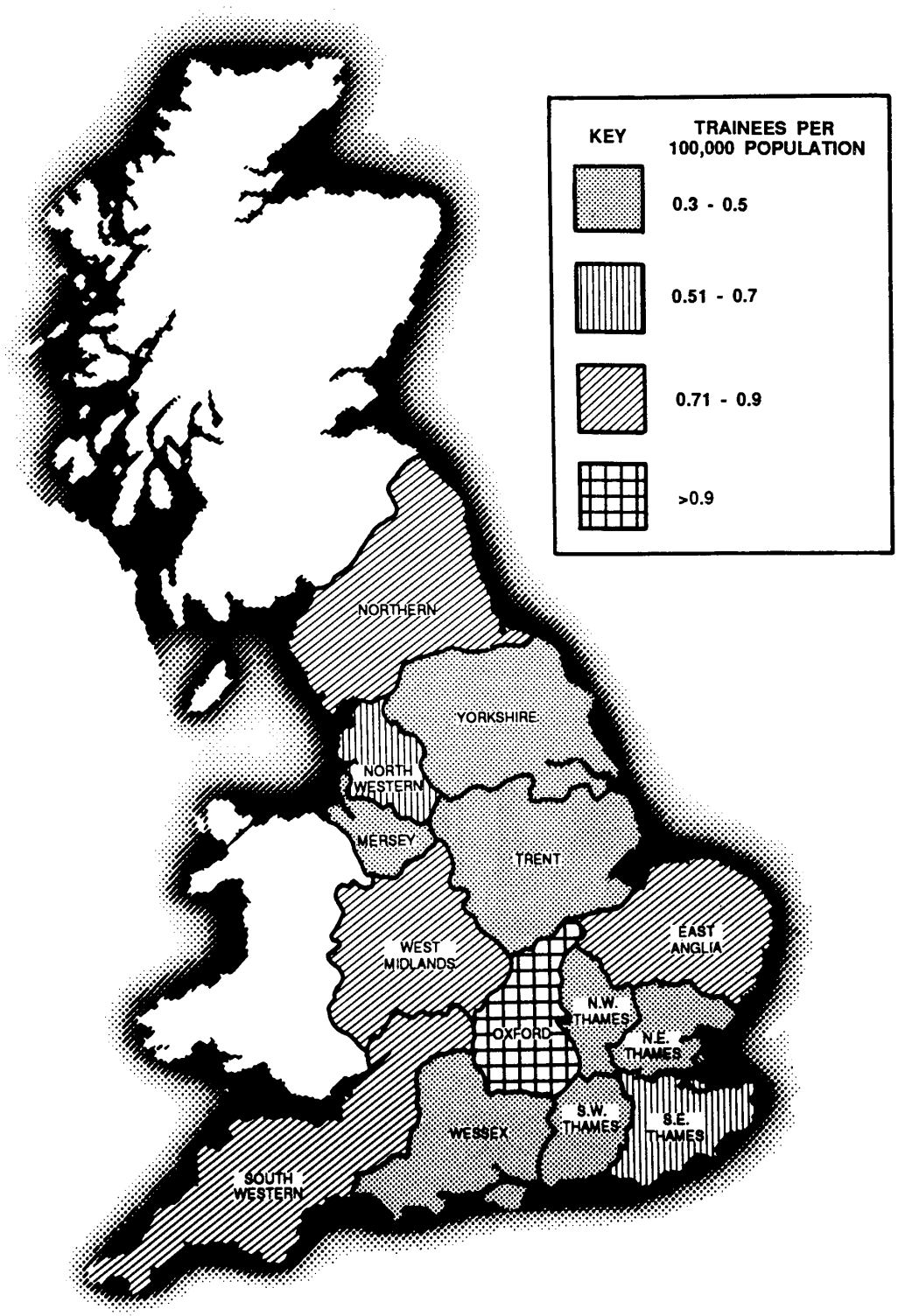


TABLE 4

TRAINEES IN COMMUNITY MEDICINE*

Position	RHA		DHA		TOTAL
	Full-Time	Part-Time	Full-Time	Part-Time	
Senior Registrar	90	3	4	3	100
Registrar	90	3	7	1	101
Senior House Officer	2	0	15	-	17
Other Trainee	1	-	1	-	2
Total	183	6	27	4	220

*Responding authorities: N = 190

The normal training grades in community medicine are at registrar and senior registrar level and the numbers of trainees at each of these grades are roughly comparable. The majority of trainees in community medicine (83 per cent) are employed by the regional health authorities on full-time contracts (see Table 4). Some trainees are employed by DHAs but these are more likely to be at the senior house officer grade than in the higher trainee grades.

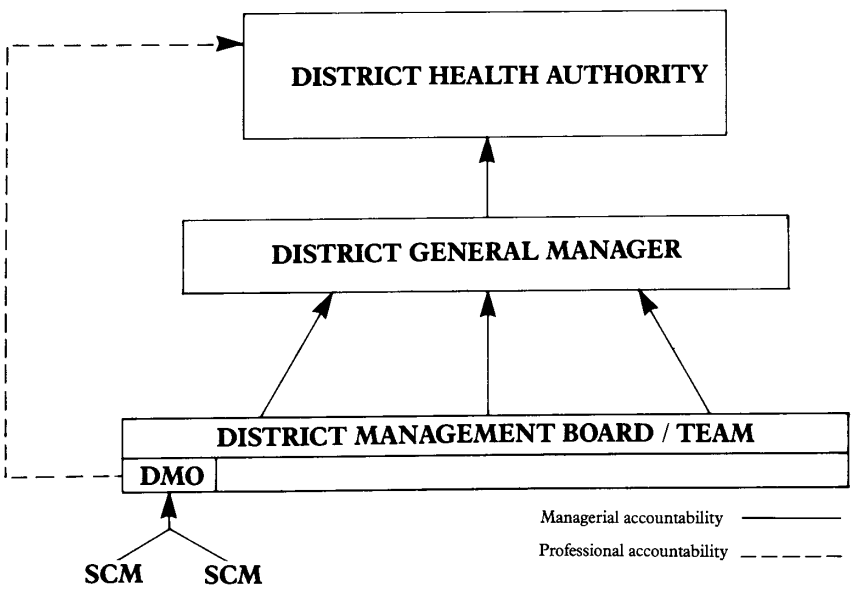
The number of community medicine trainees employed shows a distinct regional variation which is shown in Figure 4. In the case of some regions, there is a discrepancy between the number of trainees recorded in the survey and the number recorded in the DHSS returns. For this reason Figure 4 is based on the DHSS data for 1985. Some of the variation between regions might be explained by the relative sizes of their populations, so the number of trainees has been standardised per 100,000 resident population. The map shows that Oxford RHA has the largest number of trainees in relation to the size of the population. A further point to note is that three of the Thames regions are below average in the number of trainee community physicians they employ. This contrasts with the pattern of training in clinical specialties and is due to the fact that training in community medicine is not concentrated in teaching hospitals. Variations between health authorities are significant in that the employment of a trainee will affect the types of tasks in which the fully qualified community physicians become involved.

4.2 Models of organisation.

The health authorities were also asked to supply details of the organisational and managerial arrangements for community medicine. Unfortunately, the response rate was poor. Only 8 of the 14 RHAs and 57 of the 176 responding DHAs (32 per cent) provided information on their organisational structures and there was considerable variation in the quality and detail of the districts' responses. Moreover, the pace of change in general management is such that the structural arrangements may have changed since July 1986. Bearing these limitations in mind, we can identify some fairly common models of organisation and management relating to community medicine. The most common structural arrangement is shown in Figure 5.

FIGURE 5

A MODEL OF THE ORGANISATION OF COMMUNITY MEDICINE



In this example, the DMO, as a member of the District Management Board/Team, is managerially accountable to the district general manager, but is responsible to the health authority for his/her professional practice. SCMs are managerially accountable to the DMO. Newcastle, Huddersfield, East Birmingham and Southampton Health Authorities are examples of this model of organisation, although the composition of their management boards differs.

A variation of this arrangement occurs where there is a functional division in SCMs' responsibilities and hence in their managerial accountability. In Sheffield Health Authority, for instance, there is a SCM (environmental health) who is managerially accountable to the UGM (community) and a SCM (information and health promotion) who is accountable to the DMO. Where a community physician has more than one job, there may be more than one line of accountability. In Kidderminster Health Authority, for example, the district medical officer is identified as having two other jobs, as Director of Community Medicine and as Medical Officer for Environmental Health (MOEH). As DMO he is managerially accountable to the district general manager; as Director of Community Medicine he is responsible for the SCMs and is accountable to the Health Authority; and as the MOEH he is managerially accountable to the district council.

Some authorities provided details on the composition of their district management teams/boards. The structure of district management teams is not prescribed and a number of different arrangements have been adopted. In addition, job titles and divisions of responsibility make comparisons difficult. It is not possible to give a comprehensive account of the managerial arrangements affecting community medicine on the basis of the information provided, but some illustrative examples of management team structures can be given. One arrangement, which seems to be fairly typical, is exemplified by Barking, Havering and Brentwood Health Authority where the District Management Board consists of the 3 UGMs, consultant and GP representatives (both elected), various managers with functional responsibilities for planning, finance, personnel and estates, the district nursing advisor and the DMO. In West Lancashire HA, there is a similar structure but whilst the District Nursing Advisor and the DMO attend the meetings of the management group, they are not members of it. Under this arrangement the GP and consultant representatives are identified as the key medical advisers to the health authority. In other authorities where the units are organised on a geographical basis managers with specific service responsibilities are members of the management team. For instance, Lewisham and North Southwark HA's team includes the Director of Community Health Services and the Director of Mental Illness Services, as well as the UGMs. A quite different structure has been adopted by Southampton HA where two management boards have been set up. The executive board consists of all the UGMs, whilst the corporate board consists of Assistant General Managers with functional responsibilities.

PROFILE OF COMMUNITY PHYSICIANS 5

5.1 Introduction

In this part of the report we present some descriptive information derived from the questionnaires completed by individual community physicians. The discussion is divided into five sections. In 5.2 and 5.3 we discuss some general characteristics of community physicians, including details such as age, sex, and previous medical experience. Section 5.4 consists of an analysis of the various qualifications held by community physicians and section 5.5 outlines the different types of jobs which community physicians have. This is followed by a discussion of accountability arrangements in community medicine in section 5.6.

The survey respondents listed 75 different job titles and some individuals hold more than one post. It is important to make the distinction between grades of appointment and job titles. Most jobs in community medicine are RMO, DMO or SCM grade posts, but in some authorities, the names of these posts have been changed. Community physicians also hold a variety of jobs which are less directly related to their specialty. These jobs tend to be held in conjunction with jobs in community medicine but Table 12 shows that 6 community physicians who responded to the survey have a single job as a general manager. In this section we are concerned with all jobs which the respondents listed, not only those which are typically associated with the specialty of community medicine. For these reasons we have classified the jobs which community physicians have into 8 categories which are listed below.

General Management
Medical Management
Specialists in Community Medicine
Miscellaneous Medical
Policy Planning and Information
Quality Assurance
Academic
Miscellaneous

Further details on the types of jobs included under each of these categories and their frequency of occurence are given in Appendix III.

5.2 General characteristics.

Tables 5 to 7 show frequencies of the personal characteristics, public health responsibilities and experience in community medicine of community physicians by employment status (full or part-time). The figures are expressed as a percentage of the 444 respondents. The key points to note are as follows.

★ Approximately one-third of community physicians are female.

★ Seventeen per cent of practising community physicians are over 60.

★ Thirty-nine per cent of community physicians currently have roles as medical officers in environmental health and 47 per cent are designated proper officers.

★ Fifty-eight per cent of community physicians worked in public health before 1974.

★ Almost 60 per cent of community physicians have previous experience as clinical medical officers.

The age structure of the specialty is particularly interesting bearing in mind the differences between community physicians who entered the specialty at its inception and those who have trained subsequently. Although 17 per cent of community physicians responding to the survey were over 60, only 5 per cent reported having plans for retirement.

The salmonella outbreak at Stanley Royd hospital, and the emergence of new forms of communicable disease such as legionella and AIDS have contributed to a renewed concern about professional skills and responsibility for communicable disease control. Not all of the proper officer functions concerning the enforcement of statutes which relate to communicable disease control require medical expertise, and some may be more appropriately located within the duties of environmental health officers (Institution of Environmental Health Officers, 1987). Seventy-one per cent of community physicians reported to be designated proper officers or deputies. Community physicians were asked if they had a minimum of three months experience in communicable disease control in a clinical, laboratory or epidemiological setting. A cause for some concern is the proportion of community physicians with no experience in any of these contexts; further analysis revealed that 21 per cent of community physicians lack specific experience in the control of communicable diseases. We will return to this point in our discussion of the priorities which community physicians attach to different tasks.

Diversity in the number and types of jobs, contracts and qualifications held by community physicians makes analysis of these characteristics quite complex. The majority of community physicians (55 per cent), however, work full-time, have just one job, and are DMOs or SCMs. Focusing on these relatively straightforward cases provides a means of identifying some general patterns which are otherwise difficult to discern. Table 8 shows the frequency of characteristics of the subset of community physicians who have one full-time job as a DMO or SCM. Specialists in community medicine are divided into those employed by a RHA and those employed by a DHA since there may be distinct differences in their characteristics and experiences. The main points can be summarised as follows.

★ DMOs are typically male & between 50 - 60 years old.

★ The senior jobs in community medicine are predominantly held by men.

★ DMOs and district based SCMs are more likely to have worked in public health before 1974 and to have worked as clinical medical officers than regional SCMs.

★ DMOs are more likely to have had experience of communicable disease control than SCMs.

TABLE 5 PERSONAL CHARACTERISTICS OF COMMUNITY PHYSICIANS*

Characteristic	Employment Status	
	Full-time[1]	Part-time/Joint[2]
	%	%
Gender		
- Female	28.5	2.9
- Male	60.7	7.9
Age		
< 40	12.3	2.5
41 - 45	9.9	1.1
46 - 50	12.3	0.7
51 - 55	15.5	0.4
56 - 60	25.4	2.5
61 - 65	12.3	2.2
65 >	1.3	1.3
Retirement Plans		
- Yes	3.8	1.3
- No	85.3	9.2
- Not known	0.2	0.2

*N = 444

1. Full-time employment with one or more health authorities
2. Part-time employment with one or more health authorities and/or joint employment in teaching or research institution

TABLE 6 COMMUNITY PHYSICIANS WITH DESIGNATED PUBLIC HEALTH RESPONSIBILITIES*

Characteristic	Employment Status	
	Full-time[1]	Part-time/Joint[2]
	%	%
Designated Proper Officer		
- DPO	42.9	4.7
- Deputy	22.7	1.3
- Neither	23.1	4.5
- Not known	0.5	0.2
Medical Officer for Environmental Health		
- MOEH	35.7	3.8
- Deputy	18.2	1.3
- Neither	33.2	5.4
- Not known	2.1	0.2

*N = 444

1. Full-time employment with one or more health authorities
2. Part-time employment with one or more health authorities and/or joint employment in teaching or research institution.

TABLE 7 COMMUNITY PHYSICIANS' PREVIOUS MEDICAL EXPERIENCE*

Characteristic	Employment Status	
	Full-time[1]	Part-time/Joint[2]
	%	%
Public Health Prior to 1974		
- Yes	52.6	5.4
- No	36.6	5.4
Clinical Medical Officer Experience		
- Yes	53.3	6.3
- No	35.9	4.5
Military Medical Experience		
- Yes	20.4	2.2
- No	68.8	8.5
Medical Experience Overseas		
- Yes	31.7	3.1
- No	57.6	7.6
Communicable Disease Control: Clinical Setting		
- Yes	46.7	4.9
- No	37.7	4.9
- Not known	4.9	0.9
Communicable Disease Control: Epidemiology		
- Yes	60.0	8.1
- No	26.1	2.1
- Not known	3.0	0.7

*N = 444

1. Full-time employment with one or more health authorities
2. Part-time employment with one or more health authorities and/or joint employment in teaching or research institution

TABLE 8

COMMUNITY PHYSICIANS WITH ONE FULL-TIME JOB: GENERAL CHARACTERISTICS*

	DMO's n=71	SCM's (District) n=142	SCM's(Region) n=32	Other Community Physician n=38
	%	%	%	%
PERSONAL CHARACTERISTICS				
Gender				
- Female	22.5	41.5	37.5	23.7
- Male	77.5	58.5	62.5	76.3
Age				
<40	9.9	14.1	15.6	15.8
41-45	11.3	8.4	15.6	10.5
46-50	5.6	16.9	9.4	21.0
51-55	21.1	15.5	-	13.2
56-60	31.0	28.9	37.5	31.6
61-65	19.7	14.1	21.9	5.3
>65	1.4	2.1	-	2.6
EXPERIENCE IN COMMUNITY MEDICINE				
Public Health Prior to 1974				
- Yes	64.8	62.7	34.4	55.3
- No	35.2	37.3	65.6	44.7
Clinical Medical Officer Experience				
- Yes	60.6	65.5	28.1	60.5
- No	39.4	34.5	71.9	39.5
MFCM				
- Yes	87.3	88.7	96.9	89.5
- No	12.7	11.3	3.1	10.5
FFCM				
- Yes	56.3	16.2	34.4	42.1
- No	43.7	83.8	65.6	57.9
Communicable Disease Control: Epidemiology				
- Yes	74.7	64.8	43.8	18.4
- No	25.3	35.2	56.2	81.6
Communicable Disease Control: Clinical Setting				
- Yes	67.6	54.2	21.9	44.7
- No	32.4	45.8	78.1	55.3

*N = 283

A higher proportion of senior community medicine posts are occupied by men than by women, but it it is important to note that the gender differential is less marked than in other medical specialties. Only 12.5 per cent of hospital based consultant posts in 1985, for example, were occupied by women (DHSS, 1986), as compared with over twenty per cent of the full-time consultant posts in community medicine.

5.3 Qualifications and Training

Community physicians responding to the survey had 66 different academic and professional qualifications. For simplicity we have focused on the three most common postgraduate qualifications in community medicine: Member of the Faculty of Community Medicine (MFCM), Fellow of the Faculty of Community Medicine (FFCM), and the Diploma in Public Health (DPH). Table 9 shows the combinations of these qualifications, the most common being the MFCM on its own which is held by 31 per cent of community physicians. There are two apparent anomalies to note. The first is that 19 individuals who are employed as community physicians (4.3 per cent) have none of these key qualifications in community medicine. More detailed investigation shows that this group consists of community physicians with formal qualifications in general medicine, some with an MSc in community medicine, and a couple with specialist qualifications in obstetrics and gynaecology. The second anomaly is that three doctors claim to have the FFCM without a MFCM or DPH. The most likely explanation is that the respondents simply stated the highest qualification and thought it unnecessary to mention that they held a MFCM or DPH in addition to the FFCM.

We noted earlier that there may be a difference in skills and experience between those who had entered community medicine prior to 1974 and those who entered the specialty after that date. Doctors who have previously practised as medical officers of health, however, may have undergone some further training since 1974 and this needs to be taken into account if we are to assess the significance of differences between types of community physicians. The most common qualification held by MOsH was the Diploma in Public Health (DPH). This was replaced by other training courses (M.Sc and Consortia) with the founding of the specialty of community medicine, but a few community physicians

TABLE 9 **KEY QUALIFICATIONS IN COMMUNITY MEDICINE***

Category	MFCM	FFCM	DPH	N	%
1	X	X	X	19[1]	4.3
2	X	✓	X	3	0.7
3	X	X	✓	10	2.2
4	✓	X	X	139	31.3
5	✓	✓	X	51	11.5
6	✓	✓	✓	102	23.0
7	X	✓	✓	10	2.2
8	✓	X	✓	110	24.8
Total	390	164	227	444	100

*N = 444
1. See text for explanation

TABLE 10
TRAINING IN COMMUNITY MEDICINE UNDERTAKEN SINCE 1974*

COURSE/QUALIFICATION	NUMBER	%
DPH	37	8.3
MSc	59	13.3
Consortia	82	18.5
Other courses	177	39.9
No further training	140	31.5
TOTAL	495[1]	

*N = 444
1. Community physicians may have attended more than one course.

TABLE 11
JOB CATEGORIES AND PERMUTATIONS*

Category	Jobs		
	by person	by job	by permutation (pair wise)
General Managers	36	38	40
Medical Managers	177	183	186
Specialists in Community Medicine	252	255	262
Miscellaneous Medical	43	46	51
Information & Planning	28	28	33
Quality Assurance	11	11	14
Academic	35	39	44
Miscellaneous	4	5	8
	586	605	638

* N = 444 : 321 with one job, 104 with two jobs and 19 with three jobs.

TABLE 12 **PERMUTATIONS OF JOBS IN COMMUNITY MEDICINE***

Category	ONE JOB	MULTIPLE JOBS: PAIRWISE PERMUTATIONS								TOTAL
		General Managers	Medical Managers	SCMs	Misc Medical	Info & Planning	Quality Assurance	Academic	Misc	
General Managers	6	●	22	7	2	-	-	3	-	40
Medical Managers	96	22	●	13	17	20	7	13	1	186
SCMs	200	7	13	●	16	4	1	18	3	262
Miscellaneous Medical	9	2	17	16	●	-	2	3	2	51
Information & Planning	4	-	20	4	-	●	-	4	1	33
Quality Assurance	3	-	7	1	2	-	●	1	-	14
Academic	2	3	13	17	3	4	1	●	1	44
Miscellaneous	-	-	1	3	2	1	-	1	●	8
TOTAL	320	34	93	61	42	29	11	42	8	638

*N = 444

gained the qualification of DPH after 1974. Community physicians were asked about formal training in community medicine which they had undertaken since 1974. The training may have led to a formal qualification such as an MSc or may have consisted of participation in various courses. The numbers of community physicians participating in these different forms of training are shown in Table 10. The column total is greater than the number of respondents (444) since some community physicians took part in more than one form of training. The key points to note are as follows:

★ Over 30 per cent of community physicians have received no further training in their specialty since 1974.

★ Only 37 community physicians were awarded the DPH after 1974.

★ Forty per cent of community physicians have taken part in general training courses since 1974 and 21 per cent have attended courses resulting in a recognised qualification.

5.4 Job Types and Permutations

Community physicians hold a variety of jobs and some have more than one. To simplify the analysis of jobs and the different permutations of multiple jobs we have used the 8 categories of job types listed earlier. Table 11 shows that of the 444 individual respondents, 321 have one job, 104 have two jobs and 19 community physicians have three jobs, giving a total of 586 jobs. Some respondents, however, have more than one job in a particular category. There are in fact 605 distinct jobs and these are summarised in the third column of the table. A further level of complexity is created by the permutations of these jobs, which are summarised in the fourth column. Table 12 shows the permutations of multiple jobs in more detail. The main points to note are as follows:

★ The most common post is that of a SCM, with just one job.

★ Community physicians hold 38 jobs in general management.

★ Academic jobs tend to be held in conjunction with jobs involving specialist practice or management.

★ Half of those employed as medical managers have other jobs.

The introduction of general management into the NHS has been a cause for some concern in the specialty of community medicine, not least for the uncertainty which has surrounded the future of their managerial functions. Table 12 shows that community physicians hold 38 jobs in general management; of these, over half the jobs were held in combination with a medical management role. Academic posts in community medicine are predominantly held in conjunction with other jobs, the most common being jobs as SCMs and in Medical Management. This is an important point bearing in mind the origin of community medicine in the alliance of academic social medicine, public health and medical administration, and suggests that some unification of the specialty's functions is afforded by individuals having multiple jobs.

5.5 Accountability

The interpretation of the management recommendations of the Griffiths report (DHSS, 1983) has resulted in a variety of accountability arrangements for community physicians. In some health authorities this means that community physicians may be managerially and professionally accountable to different individuals. Table 13 shows community physicians' interpretations of their accountability by job type. For simplicity we have concentrated on two grades of community physician; the DMO and the SCM. Of the 586 jobs held by the survey respondents, 49 per cent were managerially accountable to a general manager; DMOs are more likely to be accountable to a general manager than is a SCM. There was, however, considerable uncertainty amongst individual community physicians about their accountability. This was particularly marked in the respondents' perceptions of professional accountability, 28.3 per cent claiming that they did not know who they were accountable to or that they were accountable to no-one. This is consistent with the commitment to clinical independence which is typical of the medical profession as a whole. The fact that 14.5 per cent of community physicians were uncertain of their managerial accountability indicates that there is still some confusion amongst individuals concerning the implications of managerial restructuring for their specific job(s). Indeed, some of the DHAs responding to the request for information on organisational arrangements for community medicine pointed out that the arrangements had yet to be agreed or were awaiting approval from the RHA.

TABLE 13
MANAGERIAL AND PROFESSIONAL ACCOUNTABILITY OF COMMUNITY PHYSICIANS*

JOB TYPE	MANAGERIAL ACCOUNTABILITY			PROFESSIONAL ACCOUNTABILITY			
	General Managers	Medical Managers	Other	Health Authority	Medical Managers	Other	
	%	%	%	%	%	%	N
District Medical Officers	78.0	-	22.0	62.9	3.8	33.3	132
Specialists in Community Medicine	35.7	41.3	23.0	30.2	39.7	30.1	252
Other	46.5	7.4	46.1	25.2	6.5	68.3	202
Total							586

*N = 444

PRIORITIES AND BELIEFS 6

6.1 Introduction

A principle objective of the survey was to identify the current work priorities of individual community physicians and their beliefs about the relative importance of different tasks for the specialty as a whole. In the introduction to this report we listed 8 tasks defined by the Committee of Inquiry as the domain of community medicine. Some tasks which community physicians may be involved in are not made explicit in the list; the supervision of trainees in community medicine is one example. The general term health service planning is also unhelpful; some community physicians may be involved in planning for specific client groups or in different aspects of planning. For these reasons eleven areas of responsibility were used in the survey. These are listed in Appendix IV together with a description of the tasks included under each heading.

Community physicians were asked to rank the priority which they gave to each of the 11 tasks in their current work practice, on a scale from nought to 4. They were also asked to rank their personal beliefs about each task according to how appropriate it was for the specialty of community medicine, the scale ranging from 1 (inappropriate) to 4 (very important). Some community physicians provided details of additional responsibilities in which they were personally involved and these are listed in Table 14. Some of these tasks were specific to an individual (eg examiner for medical schools and housing advisor to the private sector), but three tasks - occupational health, research and inspection of private nursing homes - were listed by over 4 per cent of the survey respondents. Community physicians were also asked to explain any differences between their existing priorities and normative beliefs.

This part of the report is divided into three sections: in 6.2 we present some simple descriptive statistics of patterns of variation in community physicians' priorities and beliefs; in 6.3 we examine individual accounts of the mismatch between priorities and beliefs and in 6.4 we discuss the results of a multivariate analysis of potential causal factors which may explain variations in priorities and beliefs.

6.2 Patterns of Variation in Priorities and Beliefs

Table 15 presents some basic descriptive statistics of the priority which community physicians attach to certain tasks. The main points to note are as follows.

- ★ Medical advice to health authorities is given the highest priority overall, followed by planning and service evaluation for priority client groups.
- ★ Community physicians attach a high priority to most of the tasks mentioned. On average the lowest priority is given to medical staffing and child health.
- ★ Twenty-six per cent of community physicians currently have no responsibility for child health, but 23 per cent said this responsibility took a high priority.
- ★ Twenty-six per cent of the respondents give the control of communicable disease and environmental health no or low priority in their current jobs.

TABLE 14

ADDITIONAL TASKS AND RESPONSIBILITIES IN COMMUNITY MEDICINE

15-25 cases	Occupational Health Research Inspection of private nursing homes
2-15 cases	Home defence/war planning eg. "prevention of nuclear war"! Medical policy development Family planning and cervical cytology Liaison with voluntary bodies Drug abuse Quality assurance Capital planning Media guidance Computer development Cremation forms
One case	Custodian of child abuse register cases Data protection Medical referee Port Medical Officer Performance indicators Housing Liaison (private sector) Placement of psychiatric patients Honest broker Visiting lecturer Medical Ethics/Philosophy General Practice Estate Management Medical audit Examiner for medical schools

TABLE 15

CURRENT WORK PRIORITIES OF COMMUNITY PHYSICIANS*

TASK/RESPONSIBILITY	PRIORITIES* None 0	1	2	3	High 4		MEAN	MODE	Coefficient of variation x100
	%	%	%	%	%	N			
Control of communicable disease and other environmental health	10.1	16.4	18.8	16.0	38.7	426	2.6	4	54.5
Medical staffing	25.0	17.3	20.1	23.2	14.4	423	1.8	0	75.9
Medical advice to health authorities	5.6	6.8	11.7	19.4	56.5	428	3.1	4	38.2
Medical advice to other statutory authorities	12.2	10.8	20.5	21.4	35.1	425	2.6	4	53.8
Child health	26.0	18.7	16.5	15.8	22.9	423	1.9	0	79.4
Health service planning and evaluation - acute services	16.8	11.6	17.5	19.3	34.8	422	2.4	4	60.7
Health service planning and evaluation - priority groups	9.6	6.1	17.4	19.8	47.1	425	2.9	4	45.8
Joint planning	12.6	12.1	19.9	25.6	29.7	421	2.5	4	54.8
Health information and monitoring	7.5	12.2	22.3	22.8	34.3	425	2.6	4	48.1
Health promotion /health education	9.8	11.4	20.5	22.5	35.8	430	2.6	4	50.5
Education and Training	11.7	16.9	24.0	25.0	22.4	420	2.3	3	56.8

* Respondents were asked to indicate "the current priority you attach to each one" of the tasks/responsibilities listed in the table.

TABLE 16

NORMATIVE BELIEFS ABOUT TASKS IN COMMUNITY MEDICINE*

TASK/RESPONSIBILITY	BELIEFS* Inappropriate 1	2	3	Very Important 4		MEAN	MODE	Coefficient of variation x100
	%	%	%	%	N			
Control of communicable disease and other environmental health	6.4	5.9	20.3	67.4	423	3.5	4	24.9
Medical staffing	18.2	30.9	28.8	22.1	411	2.5	2	40.4
Medical advice to health authorities	3.3	2.8	13.6	80.3	426	3.7	4	18.3
Medical advice to other statutory authorities	5.9	10.7	27.1	56.3	421	3.3	4	26.7
Child Health	19.6	19.2	28.0	33.2	407	2.7	4	40.7
Health service planning and evaluation - acute services	6.6	7.8	26.5	58.9	409	3.4	4	26.3
Health service planning and evaluation -priority groups	3.8	4.5	21.7	70.0	419	3.6	4	21.0
Joint planning	4.1	11.0	33.9	51.0	416	3.3	4	24.9
Health information and monitoring	3.5	7.1	20.4	69.0	422	3.5	4	21.9
Health promotion/ health education	2.8	8.5	22.0	66.7	423	3.5	4	21.8
Education and Training	4.6	10.2	40.4	44.8	413	3.2	4	25.1

* Respondents were asked to indicate "your personal belief about the priority you would prefer a community physician to attach to each one" of the tasks/responsibilities listed in the table.

One point which should be borne in mind in the interpretation of these results is that the modal classes and low coefficients of variation in Table 15 indicate a tendency for community physicians to claim that all the tasks are given a high priority. Variations in job types explain some of the differences in priorities given to the various responsibilities. Not all community physicians, for instance, are involved in education and training of trainees.

One of the most interesting results is the relatively low priority given to communicable disease control and environmental health by over a quarter of community physicians. Table 15 also shows that, with the exception of health service planning for priority client groups, more respondents attach the highest priority to communicable disease control than to any other task. This polarisation may reflect an element of specialisation in community physician appointments or may be related to the content of training; we noted earlier, for example, that 21 per cent of community physicians lack specific experience in communicable disease control.

The results of the survey indicate that the proportion of community physicians with responsibilities for child health may be decreasing. In 1977, an estimated 94 per cent of community physicians had responsibilities in this field (Donaldson and Hall, 1979) as compared with the 74 per cent implied by the 1986 survey results.

Table 16 summarises the respondents beliefs about the appropriateness of the different areas of responsibility for the specialty as a whole. The main points are summarised as follows.

★ The variation in normative beliefs is on average lower than that for personal priorities, that is, there is a fair degree of consensus within the specialty as to what community physicians should be doing.

★ Respondents tended to view all the listed tasks as important to the specialty, but 80 per cent thought that advising health authorities was a very important responsibility in community medicine.

★ Child health was cited as a very important responsibility for community physicians by one-third of respondents.

★ Opinion was divided on the appropriateness of medical staffing for the specialty.

There is greater consensus within the specialty in its beliefs about the appropriateness of the listed tasks than is revealed in its work practices. This is to be expected bearing in mind the variety of jobs held by community physicians. It would be interesting, however, to know the tasks in which there is a particular consensus between current priorities and normative beliefs. Table 17 lists each of the ll areas of responsibility and gives the proportion of respondents who gave lowest or highest scores for both priorities and beliefs. The key points are listed below.

★ Few community physicians gave the listed tasks no priority and believed them to be inappropriate to the work of a community physician.

★ Nine per cent of community physicians thought medical staffing was inappropriate to their particular job and to community medicine.

TABLE 17

CORRESPONDENCE BETWEEN PRIORITIES AND BELIEFS

TASK		TASK GIVEN HIGH PRIORITY AND BELIEVED TO BE VERY IMPORTANT	TASK GIVEN LOW PRIORITY AND BELIEVED TO BE INAPPROPRIATE
	N	%	%
Control of communicable disease and other environmental health	417	36.9	1.7
Medical Staffing	408	9.3	8.9
Medical advice to health authorities	422	55.4	0.1
Medical Advice to other statutory authorities	416	32.2	2.2
Child health	404	18.5	7.4
Health service planning and evaluation - Acute	405	30.1	3.2
Health service planning and evaluation - priority groups	417	42.9	1.4
Joint planning	412	27.2	1.7
Health information and monitoring	419	32.2	0.7
Health promotion and health education	420	34.5	0.5
Education and training	407	19.2	0.7

★ Fifty-five per cent of community physicians gave medical advice to health authorities high priority in their work practice and in their beliefs about what the specialty as a whole should be involved in.

★ Although a quarter of respondents give the control of communicable diseases no priority in their current jobs, 37 per cent believed this task should be a high priority for community physicians and stressed its importance in their current work.

The tasks given the highest priority in both the current work of community physicians and in their beliefs regarding the tasks which are most appropriate to the specialty of community medicine are advising the health authority and the planning and evaluation of services for priority client groups. There is also a high level of commitment to the control of communicable diseases. The priorities and beliefs of individual community physicians can be contrasted with statements made by the Faculty of Community Medicine on the key functions of the specialty. The Faculty place emphasis on disease prevention, health promotion and community physicians' role as advocates of healthy public policies (Faculty of Community Medicine, 1986b). The survey respondents, however, gave these tasks less priority and stressed the advisory and planning functions of the community physician.

One of the problems with this type of analysis is that it does not allow us to identify differences between types of community physicians in the priorities they attach to the various tasks. A simple way of identifying such differences is afforded by focusing on those community physicians with relatively straightforward work arrangements. The analysis of current priorities and normative beliefs was repeated using the subset of community physicians with one full-time job, which we identified in section 5.2. This revealed some distinct similarities and differences between DMOs, district based SCMs and SCMs employed in regional health authorities in the priority which they attach to certain tasks. All three groups, for example, identify the provision of medical advice to health authorities as a high priority in their current work and an important task for community medicine generally. There is also a consensus that planning and evaluation of acute services and services for priority client groups are important responsibilities for the specialty. A further area of consensus is on the responsibility for child health services, which a quarter of all SCMs in the subset believe to be inappropriate for a community physician. The main differences in the priorities and beliefs of this group of respondents can be summarised as follows.

★ Communicable disease control is a high priority for community physicians working in district health authorities, but is not given such an emphasis by regional community physicians in either their current priorities or normative beliefs.

★ Thirty-eight per cent of district SCMs have no responsibility for medical staffing, as compared with 4.4 per cent of DMOs and 13.3 per cent of regional SCMs. One-quarter of district SCMs believe that medical staffing is an inappropriate task for community physicians to be involved in.

★ Regional SCMs are less likely than district SCMs to be involved in advising local authorities and health promotion activities.

Whilst a description of the pattern of variation in community physicians' work priorities and normative beliefs is valuable, further analysis is needed if we are to explain this variation. We have already noted that some of the differences may be explained by the grade of the community physician's job and whether she/he is employed by a regional or a district health authority. Date of entry to the specialty may also be significant. A series of interviews reported by Lewis (1986), for example, revealed that community physicians who worked in public health prior to 1974 believe their role in health promotion and disease prevention to be an important one, whereas those who trained in community medicine after that date think that their epidemiological skills are more appropriately applied to health service planning. These and other explanatory factors are analysed in more detail below.

6.3 Differences between priorities and beliefs

The survey respondents were given the opportunity to explain any differences between their current priorities and the tasks they believed should take priority. Not all of the respondents completed this section of the questionnaire, and those who did produced a wide range of comments with varying amounts of detail. Nevertheless, some distinct themes can be identified in the explanations. One of the most common explanations which community physicians gave to account for differences between their current priorities and normative beliefs was that there was some division of tasks between the community medicine staff working in their employing authority. Some illustrative comments are listed below.

Obviously community medicine covers a wide range of activities and most community physicians' jobs will only cover some of these. Naturally I hope that my colleagues will cover other areas which I personally regard as very important, but which I do not happen to cover myself.

The differences stem from differences in responsibility eg. for an RMO, control of communicable diseases is not normally top priority, whereas it would be if I was DMO or MOEH.

I am an information specialist, but I do not think that every community physician needs to be one.

These statements suggest that a division of labour may evolve through historical practice and individual interests, may be organised on the basis of grade or seniority, or may be due to specialised job descriptions. In several health authorities there is only one community physician which

undoubtedly limits the range of tasks which can be performed.

One community physician and a secretary for a 250,000 population (three local government districts and a county council) can't do it all!!!

Staffing constraints also limit the time which can be devoted to different tasks.

Insufficient time means that too much is done on a crisis management basis. I would wish to be more proactive, especially to undertake special studies to suggest alternative ways forward.

Resource constraints were also cited as a reason for the differences between work priorities and normative beliefs.

I am dragged into medical staffing problems because other people seem incapable of sorting them out.

We have so few resources as yet that it is impossible to pay much time to health promotion.

We are short of resources - both money and influence.

A number of community physicians pointed out that the priority they gave to particular tasks varied over time, according to demands. In other cases, the community physician was in the process of changing the relative balance of time or effort given to different tasks. The following comments were typical.

It is not possible at a point in time to assign priorities to a range of tasks. It is part of our job to plan our workloads so that appropriate emphasis can be given to each task at the correct time.

My personal beliefs reflect long term goals for where I should like to put my efforts, whereas existing priorities are likely to shift every few months as tasks come and go. I do not feel there is any conflict between them, simply a shifting balance.

The problems posed by organisational structures and new managerial arrangements emphasised by the Faculty of Community Medicine (1986) in their evidence to the Acheson Inquiry were echoed in the comments made by individual respondents. Some community physicians, for example, noted that the new managerial structure had resulted in some tasks, which had previously been the responsibility of community medicine, being reallocated to other professionals. Medical staffing, health promotion and involvement in the medical advisory machinery were all mentioned in this context.

The role of community medicine has been severely damaged by the Griffiths changes as interpreted in this district.

The main difference is that I believe community medicine should be taking a leading role in the organisation and management of Health Promotion/Health Education and in my authority this has been given to the Assistant General Manager who is not medically qualified.

Poor relationships with local authorities were also noted, but whilst some community physicians felt that this hampered their advisory activities, others felt that advising local authorities was time consuming and could be more effectively performed by a GP or other clinician.

A further group of responses consisted of comments relating to the appropriateness of specific responsibilities for the specialty. The following comments are examples of the points which were made.

I think I spend too much effort providing advice which might be more appropriately delivered by clinicians if they could agree amongst themselves.

I do not believe there is role for community medicine in Child Health other than in planning and evaluation, as with other acute services.

The work of a community physician should be to act as a public health advocate, independent of the bureaucratic constraints of health authorities.

The role of epidemiology and planning needs to be enhanced for SCMs.

Occupational health should be more closely associated with Community Medicine with which it has much in common.

There is a degree of consensus about the central tasks in which community physicians should be involved (advising health authorities and service planning for priority client groups, for example), but there is also considerable diversity in opinion about the priority which should be given to other areas of interest. In summary, the priorities given by community physicians to their defined areas of responsibility (Table 15) vary between individuals and also within individual work practices over time. Whilst it is inevitable that there will be some differences of opinion within specialties, in the case of community medicine this has undoubtedly contributed to its diffuse identity. This diversity of opinion raises a number of questions about the future of community medicine and how the specialty should develop. Some of these issues will be discussed in our concluding section.

6.4 Multivariate Analysis

There are many factors which might explain the observed variations in community physicians' priorities and beliefs. These include: personal characteristics and preferences; training and experience; the nature and location of jobs; characteristics of areas in which community physicians work; and random or unidentifiable elements. We used multivariate analysis to examine the relationships between potential causal factors such as those listed above and the ratings recorded for priorities and beliefs about work-related tasks. The technique used was the polychotomous ordered Probit model, which is particularly suitable for analysing variables that are coded in a distinct and hierarchical form, such as the responses to questions about work-related priorities and beliefs (Missiakoulis, 1983). On the whole, the results were disappointing, the models showing a poor

fit, so our comments on this analysis will be brief. The most interesting results from the prediction equations relating to current work priorities are set out below.

★ Employment in public health prior to 1974 is positively associated with the planning of child health services.

★ Part-time workers are less likely to attach priority to advising health authorities, joint planning and health education.

★ Age has a positive association with responsibility for medical staffing and advising local authorities and a negative link with information and monitoring activities.

The model predictions were also poor in explaining variations in beliefs about the responsibilities of community medicine, but the main points are summarised below.

★ Previous experience of general practice is positively linked with medical staffing and the management of child health services.

★ The number of clinical medical officers employed in an authority increases the probability that community physicians believe child health is an important task for the specialty.

★ Age has a negative association with health education and health promotion.

The negative associations between age and the priorities and beliefs attached to the tasks of health promotion and information and monitoring indicate that there is a difference between the older community physicians who would previously have practised as MOsH and those who have trained since 1974. It is these tasks which have been particularly emphasised in debates about the future of community medicine (see for example Faculty of Community Medicine, 1986; St. George, 1985; Shaw, 1987).

Further details about the multivariate analysis are available from the authors on request.

CONCLUSIONS 7

7.1 Introduction

In section 2 we outlined the difficulties which have beset community medicine and some of the areas in which their claimed expertise has been challenged. The results of the survey show that there is considerable diversity in the tasks, jobs and responsibilities performed by community physicians and that community physicians are making specialist contributions in a number of areas. For individual community physicians this variety does not present a problem, but for the specialty as a whole it has led to confusion about its main function. As a relatively new specialty, it is difficult to ascertain whether the diffuse identity which community medicine currently presents is the product of a period of transition or has more deep seated causes. As the community physicians who have trained in community medicine since 1974 replace those who entered the specialty at its inception a clearer consensus may emerge as to the tasks and responsibilities which community physicians should be engaged in.

Three key issues have been addressed in this report: the organisation of community medicine in English Health Authorities, the characteristics, professional training and experience of community physicians, and the priorities and beliefs which community physicians attach to the various tasks and responsibilities in which they are involved. Our conclusions are discussed under these headings.

7.2 The organisation of community medicine

Since the formation of the specialty of community medicine in 1974 there have been two significant organisational changes in the NHS. Whilst community physicians were given a defined role in the management of the NHS following its reorganisation in 1974, this has not been the case with the recent organisational changes of 1982 and 1984 and has led to uncertainty about the function and status of community medicine. This uncertainty is also the product of the origin of the specialty in three disciplines, each of which lacked the prestige of hospital based medical practice. The most recent organisational development has been the introduction of general management at all levels from the unit to the regions. Health authorities have adopted different models of managerial organisation and this, together with the fact that some community medicine posts (such as DMO) have disappeared or have been renamed, makes it difficult to generalise about the impact of the reorganisation on the community medicine. Trends in the employment of community physicians indicate a decrease in the number of managerial and consultant grade posts since 1976, but an increase in the number of part-time contracts and vacant posts. Over the same period the number of trainees in community medicine has risen, but there remain significant regional variations in trainee appointments which are persistent even when standardised for the size of the region's population.

Accountability arrangements in community medicine are complex. The distinction between managerial and professional accountability has meant that some community physicians are accountable to different people for their performance. Considerable uncertainty still exists about the implications of the Griffiths management arrangements for individual accountability arrangements.

Following the Griffiths managerial changes, health authority chairmen were asked to ensure that adequate arrangements were made for medical advice to be made available to the authority. Community physicians have typically provided this advice and it is this task which they give highest priority to in their work practice. The limited number of responses from health authorities did not allow us to analyse the structure of management boards in detail. In some authorities, however, the DMO no longer has a place on the management team and the implication is that medical advice will be provided by the consultant and general practitioner representatives. At present, the quality and critical content of community physicians' advice to health authorities, is influenced, if not constrained, by the standing of the specialty in a health service dominated by the clinical specialties. In the continuing debate about the most appropriate role for community medicine, attention should also be given to the form of organisation which would best facilitate the effective performance of that role.

7.3 Characteristics, training and experience

Three-fifths of community physicians worked in public health prior to 1974, 17 per cent are over 60, and over 30 per cent have received no further training in their specialty since 1974. An important point to consider is the extent to which the specialty will change over the next few years as the proportion of community physicians who have specifically trained in community medicine increases and the older public health doctors retire. The most significant change is likely to be an increasing proportion of community physicians without specific training in environmental health. Skills in communicable disease control and environmental health should be recognised as complementary and interdependent. A number of community physicians identified that their advisory relationship with the local authority was either tenuous or problematic. In their evidence to the Acheson enquiry, the Institution of Environmental Health Officers note that, for the most part, relationships between community physicians and local authorities are satisfactory and that where liaison is poor it is individual personalities that are at fault. The Faculty of Community Medicine's Charter for Action (FCM, 1986b) endorsed the World Health Organisation's (WHO) Targets for Health for All 2000 and encouraged its members to develop a programme of partnership with other professions and organisations in pursuit of these health objectives.

In view of the various problems, which have been

outlined, regarding relationships between community medicine, health and local authorities, and other professions, a clearer remit may be called for, or some greater recognition given in the training of community physicians to the organisational environment in which they are expected to operate.

Analysis of the characteristics of community physicians revealed a wide variety of job types and working arrangements. The majority of community physicians have one full-time job as a SCM or DMO, but 28 per cent have more than one job. Multiple jobs may afford some integration of the different functions of the specialty. The alternative interpretation would be that there may be instances where the demands of different jobs conflict with one another. More information is needed on this subject.

7.4 Community physicians' priorities and beliefs

Medical advice to health authorities is given the highest priority by community physicians in their current work practice and in their beliefs about the responsibilities of the specialty as a whole and we have already noted that organisational arrangements may not facilitate this role. The planning of services for priority client groups was thought to be a high priority for the specialty by 70 per cent of the respondents. Interestingly, community physicians have not assumed a high profile in the longstanding debate on community care and the rundown of long-stay institutions.

The control of communicable diseases, environmental health, and health promotion and education were also stressed as important responsibilities for community medicine. The Faculty of Community Medicine's support of the WHO Health for All programme has also underlined the community physician's role in health promotion (Faculty of Community Medicine, 1986b). Many health conditions or needs have multiple causes which are derived from social and environmental conditions, rather than being attributable to characteristics specific to an individual's lifestyle and physical or psychological make-up. The practice of community medicine is typically focused on a population as opposed to the individual and potentially offers the breadth of vision necessary to counterbalance the individualistic focus typical of the clinical specialties. Following the lead by the Faculty of Community Medicine, individual community physicians should be in a position to act as local advocates of multi-disciplinary health promotion. The priorities and beliefs of individual community physicians, however, do not appear to favour this role.

The collection and interpretation of information to define the state of the public health is a further task which community physicians believe is an important skill of the specialty, although older community physicians gave this task a lower priority than the more recently qualified ones. The AMA (1986) rather unfairly pointed out that little interest has been shown by health authorities in compiling health profiles of their catchment populations, although they do legitimately claim that this need not be a uniquely medical exercise. Local authorities are becoming increasingly interested in documenting the health and social needs of their residents and community physicians may have a contribution to make in their advisory capacity. The use of information in the management of the NHS has also been emphasised in recent years. This may offer an opportunity for community physicians to consolidate their expertise in this area. The collection and interpretation of data, however, have resource implications. Resource constraints were frequently noted in the explanations of community physicians for differences between current work practice and beliefs about which tasks they should be involved in. The performance of certain responsibilities in community medicine may be constrained by inadequate, or poorly organised resources: further investigation should clarify the extent of the problem.

The diffuse identity of community medicine hinges on confusion in the use of the terms public health and the public's health. The former has typically been associated with the epidemiological work of the MOH, but has subsequently been defined in broader terms. The latter term relates to community medicine's focus on the health of populations. The majority of the "new" public health functions are not specifically medical. Although community physicians may have a role to play in the development of multi-disciplinary public health policies, they are one of many sources of expertise in the public health field. In contrast, the contribution which community physicians have to make in identifying, and providing information on the nature and determinants of ill health in the population has been underplayed.

The role of the community physician has been challenged in the fields of management, child health, environmental health, and information services. In view of this, it might be appropriate for the specialty to encourage and facilitate formal specialisation. This could be either in the initial training of community physicians or at later stages in their careers and would replace the present ad hoc arrangements. A more radical suggestion for the future of community medicine is outlined by McCarthy (1985) who sees the specialty at a crossroads with skills in preventive medicine on the one hand and those of planning and evaluation on the other.

As long as prevention and health promotion are regarded as of secondary importance to the treatment and caring sectors of the health service, community medicine is likely to continue to be preoccupied by the amount of influence it has in the planning and delivery of health care.

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APPENDICES

Appendix I

COMMUNITY PHYSICIANS IN ENGLISH HEALTH AUTHORITIES*
September 1985

Grade	Employment Status			Total
	Full-time	Part-time	Honorary	
RMO/DMO	185	-	-	185
SCM	241	28	48	317
SMO	23	9	1	33
	449	37	49	535

* excluding locums and aggregating joint appointments
Source: DHSS Statistics

Appendix II

SURVEY OF COMMUNITY PHYSICIANS: RESPONSE RATE

	Total
No. of Questionnaires Received	525
No. Rejected	33
No. of Cases	493
No. of People	482
No. Honorary	38
No. Community Physicians	444
Estimated Population (see Table 1)	560
Response Rate	86%

Appendix III

JOB TITLES AND CATEGORIES OF COMMUNITY PHYSICIANS

CATEGORY	JOB TITLES	FREQUENCY	
GENERAL MANAGER	Regional General Manager	1	
	District General Manager	10	
	Deputy General Manager	1	
	Assistant General Manager	6	
	Unit General Manager(Community)	17	
	Unit General Manager(Medical Services)	2	
	Assistant Unit General Manager	1	38
MEDICAL MANAGER	Unit Medical Officer	3	
	Director of Community Medicine	16	
	Chief/Community Medical Adviser	8	
	Regional Director of Clinical and Scientific Services	2	
	Senior Medical Adviser/Officer	8	
	Regional Medical Officer	9	
	Regional Medical Director	3	
	District Medical Officer	133	
	District Medical Adviser	1	183
SPECIALISTS IN SCM's COMMUNITY MEDICINE	(Generic)	122	
	SCM's with the following specialist functions:		
	- child care/health	28	
	- social services	11	
	- environmental health	31	
	- operational performance	6	
	- information and research	17	
	- planning	28	
	- cancer	1	
	- liaison	7	
	- community	4	255
MISCELLANEOUS MEDICAL	Occupational Health Administrator	2	
	Medical Officer, Environmental Health	30	
	Community Physicians	5	
	Deputy Medical Officers	1	
	Clinical Medical Officer (only if another post held too)	2	
	Child Health Manager	2	
	Consultant in Obstetrics/Perinatal Epidemiology	2	
	Port Medical Officer	2	46
POLICY PLANNING AND INFORMATION	Regional Planning Manager	2	
	District Information Systems Manager	2	
	District Planning and Review Manager	7	
	Corporate Planning Officer/ Director of Planning	8	
	Manager, Health Policy Analysis Unit	2	
	Policy Development Manager	2	
	Regional Statistician	1	
	Director of Health Policy Analysis	4	28
QUALITY ASSURANCE	Patient Services Manager	4	
	Director, Quality Assurance and Health Promotion	4	
	Consumer and Operation Research Officer	1	
	Director of Service Evaluation	1	
	Director of Performance and Standards	1	11
ACADEMIC	Director of Research Organisation	1	
	Senior Lecturer in Community Medicine	11	
	Professor in Community Medicine	2	
	Research Associate	2	
	Honorary Community physician	2	
	Honorary Lecturer	8	
	Honorary Professor in Community Medicine	1	
	Honorary Consultant in Community Medicine	2	39
MISCELLANEOUS	Designated Alternate Proper Officer	2	
	Clinical Teacher	2	
	Uncertain	1	5

ADDITIONAL EXPLANATION OF TASKS AND RESPONSIBILITIES IN COMMUNITY MEDICINE

TASK/RESPONSIBILITY	EXPLANATION
Control of communicable disease and other environmental health	The role of the 'proper officer'; the 'proper officer's' links with the Public Health Laboratory service and the Communicable Disease Surveillance Centre; liaison with environmental health officers and local authority eg.about pollution hazards.
Medical staffing	Including disciplinary issues and medical manpower planning
Medical advice to Health Authorities	Ensuring that health authorities are provided with medical advice of appropriate quality as and when necessary
Medical advice to other statutory authorities	Medical advice and support to local agencies in connection with such functions as environmental health, personal social services and housing (but excluding education)
Child health	The planning and management of the health surveillance(including developmental screening and immunisation) of pre-school and school age children; advice and support to local education authorities.
Health service planning and evaluation - Acute services	Contributing to the planning of appropriate health services and evaluating the outcome of such acute services.
Health service planning and evaluation - Priority groups	Contributing to the planning of appropriate health services and evaluating the outcome of hospital and community services for the elderly infirm, the mentally and/or physically handicapped and the mentally ill.
Joint planning	Collaboration with SSD's, FPC's and voluntary organisations
Health information and monitoring	Includes collation and processing of health monitoring data; assessing and reporting on the state of health of the local population; analysis and interpretation of epidemiological data; epidemiological research
Health promotion/Health education	Includes general preventive activities other than those covered in child health
Education and training	For example acting as tutor to, or co-ordinating the training of trainee community physicians

KING'S FUND INSTITUTE

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide a balanced and incisive analyses of important and persistent health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. Many of its projects focus on trying to determine whether health care systems achieve their objectives. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data, One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

The Institute adopts a multidisciplinary approach and seeks to make timely and relevent contributions to policy debates. A high priority is placed on carefully researched and argued reports. These range from short policy briefings to more substantial and reflective policy analyses.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral and it is prepared to launch and support controversial proposals.

Further details about the Institute and its publications can be obtained from:

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