THE DESIGNATED AREAS PROJECT
STUDY OF MEDICAL PRACTICE AREAS

Final Report

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SECTION ONE

INTRODUCTION

Since the introduction of the National Health Service in 1948, access to general medical services has been one of the legitimate expectations of citizenship. It is guaranteed by law, and the government has the statutory responsibility of ensuring that services are distributed in a way that enables such expectations to be fulfilled. The spatial patterning of resources which existed in 1948 was, however, the legacy of a long process of unco-ordinated development, and the Minister of Health was presented from the outset with a patchy distribution of services, in general practice as much as in hospital care. Since a major aim of the 1946 National Health Service Act was to secure a more equitable spread of resources, various procedures were instituted to eliminate the relative deprivation experienced by patients in certain parts of the country; but none has fully succeeded in ensuring equal access to care irrespective of residential location.

The problem is not unique to Britain. Many countries, whatever their methods of employing and controlling medical personnel, have experienced similar imbalances between the distribution of population and of medical services. In many cases the attempts to improve the situation have met with little consistent success. Glaser, for example, concludes his international survey of distributional policies thus: 'the severe rural-urban imbalance of the medical profession remains in under-developed countries and the imbalance in favour of the cities may be increasing in the developed countries. Probably neither high pay nor ideal facilities can attract doctors into country towns and rural areas in sufficient number.'* Eveline Burns, writing as an economist, reaches a similar conclusion.** 'It is difficult to see how the problem of maldistribution can be resolved without the direct involvement of government. The resources of the thinly populated or poorer areas must be supplemented if they are to offer the remuneration and, more importantly, the other conditions of employment that appeal to professionals.' Burns then describes three main methods of government involvement in distributional policies: direct government employment of professionals and provision of facilities in under-supplied areas; the offer of special inducements to doctors to practise in such places; and the use of negative control.

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* W.A. Glaser. Paying the doctor: systems of remuneration and their effect. Johns Hopkins Press, 1970.

** E.M. Burns. Health services for tomorrow: trends and issues. Dunellen, 1973.

Distributional policies during the first twenty years of the National Health Service in Britain centred principally upon the powers of negative direction operated by the Medical Practices Committee and upon the supposed inducement effects of the initial practice allowances in attracting doctors setting up in general practice in poorly endowed localities. Following the BMA's Charter for the Family Doctor Service in 1965 a new financial incentive was introduced in the form of an addition to the basic practice allowance for family doctors practising in areas designated with large average lists. This incentive, known as the designated area allowance, was (and still is) subject to certain administrative requirements, and was priced by the Review Body on Doctors' and Dentists' Remuneration in its seventh report in May 1966 at £400 per year. Initially the profession reacted favourably, but increasingly throughout 1967 many detailed criticisms of the new allowance were advanced, and by 1968 the BMA, in a memorandum of evidence to the Review Body, was arguing the case for a completely new scheme to overcome the persistent problems of maldistribution.

At this juncture, in the summer of 1968, the University of Kent was invited by the Department of Health to submit proposals for a short research project on the effectiveness of the incentive allowance in attracting GPs to designated areas. The proposals were accepted and the pilot investigation started early in 1969. The project was completed in 1971 and the final report submitted to the Department in December of that year. An abbreviated version of the report was published in 1973.* In the report the authors were able to cast some light upon the issues of greatest concern to the Department and their work seems generally to have made a useful contribution to clarifying the problem of the designated areas. The book has been favourably reviewed and some action has been taken on the report by the Review Body on Doctors' and Dentists' Remuneration, the Medical Practices Committee and the Department of Health. At the same time, however, the report raised several important questions about the assumptions underlying the designated area and allied policies and about the concepts used in discussing the nature and remedies of maldistribution. The recommendation was made that further study of these and related matters should precede any substantial modifications either to the amount of the allowance or to the conditions governing its payment.

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* J.R. Butler, in collaboration with J.M. Bevan and R.C. Taylor. Family doctors and public policy. Routledge and Kegan Paul, 1973

Following the establishment of the Health Services Research Unit at the University of Kent in 1971, these questions were further discussed in the Unit's proposed research programme for 1972-73. The proposal was made, and accepted by the Department, for a modest follow-up study to examine in detail the suitability of existing medical practice areas as the primary territorial units in distributional policies; to collect further evidence about the effectiveness of financial incentives in attracting doctors to unpopular areas; and to consider the possible impact upon existing policies of the National Health Service reorganisation. It was envisaged that information for the study would come from existing statistical material, from special surveys of executive councils and local medical committees, from individual doctors and from other published commentaries and reports. The study was expected to last for 18 months from the appointment of a Research Fellow, culminating in the presentation of a final report by May 1974.

The Research Fellow was appointed in November 1972 and the study began immediately. Of the possible sources of material described in the application, three were eventually used. First, a survey was made in March-May 1973 of all executive council clerks in England to obtain their views about the issues in question and to collect factual information about the practice areas within their jurisdiction. Secondly, a similar survey was conducted among local medical committee secretaries in May-October 1973. Thirdly, the statistical reports submitted by executive councils to the Medical Practices Committee were abstracted and reanalysed in new ways to provide hitherto unavailable statistical information about practice areas. This final report consists in large part of a presentation and discussion of the material drawn from these sources.

As the study progressed through 1973, discussions continued with various bodies about the implications of the original designated areas report and the policy options which may be available in the future, and these discussions have informed the conclusions and implications contained in this report. Contacts of this nature are regarded as of central importance in maximising the relevance and usefulness of research reports, for it has been a major objective of this study to drive the conclusions through to the point where their implications for decisions are as clear as possible. A second important backcloth to the study has been the development of proposals for the reorganisation of the National Health Service. When the study began, the White Paper (Cmnd.5055) and the Grey Book had recently been published and

during the course of the study the Bill was introduced into Parliament, the Act became law, the shadow authorities were formed and a host of major and minor developments took place. Reorganisation has impinged upon the study in relation to the standardisation of administrative units and the nature of the relationship between central and local bodies, and these considerations have also shaped the development of the study in some degree.

The structure of the report is simple. In the next section we present a summary of the findings, conclusions and implications of the study. Section three sets out the nature of the problem with which the study has tried to grapple. Section four describes the administrative framework within which the designated area policies are set and discusses the potential impact which NHS reorganisation might have. The fifth and sixth sections present the results of the analysis of MPC records and of the EC and LMC surveys. The final section is a discussion of conclusions and implications.

We are very grateful to many people who have helped the study in various ways. We should like particularly to thank Mr. L.F. Hayllar, Dr. A.McD.Maiden, Dr. J.C. Cameron, Dr. D.L. Gullick, DHSS Staff, Mr. J.R. Knighton, Mrs. E. Browne and our colleagues in the Unit. The executive council clerks and local medical committee secretaries who completed our questionnaires are too numerous to name individually, but to them we are especially grateful.

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SECTION TWO

SUMMARY OF THE REPORT

SECTION THREE: THE NATURE OF THE PROBLEM AND THE OBJECTIVES OF THE STUDY

1. The basic objective of this study has been to examine further the administrative machinery and policies aimed at channelling family doctors to areas where they are most needed.

2. The report of the original study found little evidence that the designated area allowance had substantially influenced the spatial distribution of family doctors. One reason was the low place which modest financial considerations seemed to have among doctors' priorities in choosing where to work. The allowance also has potential disincentive effects.

3. Two questions raised by the original study require further investigation. The first is whether list size is a sufficiently good indicator of the demand for primary care and hence, indirectly, of the need for manpower. The second is whether the existing medical practice areas are the most appropriate territorial units in the administration of the designated area and allied policies.

4. In addition to these two central questions, two other issues forced their attention upon the investigators. One is the potential disincentive effect of the designated area allowance. This is important because if areas are deliberately kept designated, then the number of designated areas and the number of doctors practising in them may be poor evidence of the inability to attract doctors to needy places. The second issue is the effect of National Health Service reorganisation on manpower policies.

SECTION FOUR: THE ADMINISTRATIVE FRAMEWORK

1. The original machinery designed to redress the imbalance in the provision of general medical services was set up under the 1946 National Health Service. It comprised:

   a. A central body (the Medical Practices Committee) with powers of negative control over the location of family doctors.

   b. A local administrative network (executive councils).

c. Local professional representation (local medical committees).

d. The passage of information from executive councils to the Medical Practices Committee to enable the Committee to fulfil its functions.

To this basic machinery was added the initial practice allowances in 1952 and the designated area allowance in 1966.

2. Medical practice areas were first delineated by executive councils in 1948, following very broad guidelines from the Medical Practices Committee. Boundaries can in principle be changed according to the wished of the MPC but in practice the Committee invariably works within a framework of consent from family practitioner committees and local medical committees. Most of the initiative on boundary changes comes from the MPC itself, but may originate locally among FPCs or LMCs.

3. The origins of the system of classifying practice areas are obscure. An average list size of about 2,500 has always been the basic criterion of designation, but this figure has never systematically been justified. The use of practice areas to regulate two important allowances has created a stifling rigidity in the classification of areas.

4. The NHS reorganisation may affect the distribution of primary medical manpower in a number of ways. With the creation of new territorial units and the modification of old units, the moment is opportune to review the coverage of medical practice areas. Unless the attempt is made to harmonise the boundaries of practice areas and health districts, many of the opportunities of reorganisation may be lost. The circular sent by the MPC in October 1973 to EC clerks and JLC secretaries requesting them to set up joint working parties to review the delineation of practice areas is an encouraging development.

SECTION FIVE: MEDICAL PRACTICE AREAS - A STATISTICAL ANALYSIS

1. An important part of the study is the location, abstraction and collation of the best available data about medical practice areas. Data for this part of the study were drawn from a survey made of the reports submitted by executive councils to the MPC, from the annual list of practice areas

prepared by the Committee, and from DHSS statistics compiled from EC returns. The three sources of information differed somewhat in the time period covered and in the definitions used, but most of the data are comparable.

2. The total number of practice areas in England decreased between 1966 and 1973, due to amalgamations. Since 1971 the designated areas have declined in number, both absolutely and as a proportion of all areas, probably as a result of a steady increase in the number of principals in the country as a whole. Since 1966 there has also been a decline in the average list size in designated areas. These two statistics taken together offer encouraging evidence of a recent improvement in both the extent and the depth of the problem of designated areas.

3. Between 1969 and 1972 there was a net increase of 874 family doctors in England, of which 367 were net inflows to areas designated at the time of admission. By 1972, 26 per cent of all principals in England were working in designated areas, compared with 32 per cent in 1971 and 34 per cent in 1970.

4. At October 1972, 6,257 principals were receiving a designated area allowance at a total cost of £3.4m. Between 1970 and 1972 the number of doctors receiving the allowance increased by 25 per cent and the total cost increased by 87 per cent.

5. Not all regions benefited to the same extent by the increased number of doctors. The gain between 1970 and 1972 was below average in the North, Yorkshire/Humberside and the East Midlands and above average in East Anglia and the West Midlands. The regions with the highest proportions of principals in designated areas in 1972 were the East Midlands (51 per cent), the North (45 per cent), the West Midlands (41 per cent) and Yorkshire/Humberside (40 per cent).

6. Of all practice areas in England, almost one in ten contained only one principal in 1972-3 and a further fifth contained between two and four doctors Over half the areas had fewer than ten principals. At the other extreme, 12 per cent of the areas contained 30 or more principals. The size of areas varied considerably with their classification. The majority of

restricted areas were small and the majority of small areas were restricted. Conversely, the majority of designated and open areas were relatively large and the majority of large areas were designated or open. Designated and open areas contained, on average, about 20 principals each, whereas restricted areas had only a quarter as many.

7. One reason for these variations in size lies in urban/rural differences, but the operation of the overspill rule also makes it unlikely for designated areas to be very small. Doctors locally will also seek to maximise the coverage of the designated area allowance and this too will tend to increase the size of such areas.

8. Of all practice areas in England, 63 per cent had average lists below 2,500 in 1972-3, 21 per cent had average lists between 2,500 and 2,749, and 16 per cent had average lists above 2,750. Seventeen per cent of the designated areas had average lists in excess of 3,000. Of the 267 areas qualifying for the designated area allowance, 8 per cent had average lists below 2,500, 40 per cent had lists between 2,500 and 2,749, and the remaining 52 per cent had average lists above 2,750.

9. A rough estimate, based on the size of areas in the MPC survey and allowing for an average inflation of 4 per cent, suggests that the elimination of designated areas with average lists above 2,600 would require well over 300 extra doctors. More than a quarter of these would be needed in designated areas with average lists above 3,000.

10. There is an important relationship between the size of practice areas and the range in their average list size. The larger the area the smaller is the dispersion of average list size. The detailed figures offer a guide to optimum area size under certain conditions. If, for example, the size of areas should be such as to distinguish localities with substantially differing patient/doctor ratios, then the maximum number of doctors in an area would be about 20. If there are many more than this, the ratio will tend to move towards the national average and will lose sensitivity. In fact about 60 per cent of principals are practising in areas with 20 or more doctors.

SECTION SIX: THE EXECUTIVE COUNCIL AND LOCAL MEDICAL COMMITTEE SURVEYS

1. Surveys were made among all EC clerks and LMC secretaries in England to ascertain their views about the central issues in the study. Response rates of 93 and 82 per cent respectively were achieved.

2. Clerks and secretaries were first asked whether they considered the existing boundaries of their practice areas to be adequate for the purpose of ensuring a fair distribution of family doctors. The majority of respondents (13 per cent of clerks and 61 per cent of secretaries) found the existing boundaries satisfactory, the main reason being the ease with which they can be changed if desired. About one in ten of the clerks and one in four of the secretaries expressed a clear dissatisfaction with their boundaries, the major problem being that of 'fringe' areas in urban localities.

3. Clerks were asked whether any existing practice areas would straddle the new FPC boundaries and if so, whether the practice areas should be revised to achieve coterminosity. Of the 108 executive councils represented in the survey, 43 contained practice areas which it was thought would fall across two or more FPC areas. Of the clerks in these 43 ECs, 8 could see no reason for revision and 35 felt that revision was needed. Of the remaining 65 clerks in the survey, 13 argued the case for revision, even though they felt that reorganisation would not present any overlap of practice area and FPC boundaries. In all, therefore, 48 clerks took the view that practice area boundaries should now be revised.

4. The LMC secretaries were asked whether they felt the present system of classifying the practice areas was satisfactory, and if not, what changes they would like to see introduced. Exactly two-fifths of the secretaries felt either that the present basis of classification was satisfactory or that no feasible alternative could be found. However, an almost equal proportion took the contrary view that other factors (i.e. in addition to or instead of average list size) should be considered. The factors included population characteristics, workload and morbidity indices, practitioners' characteristics and area characteristics. Some secretaries gave more than one answer.

5. Both clerks and secretaries were questioned on their views about incentives to practise in designated areas. Of the 108 EC clerks in the survey, only 17 considered the designated area scheme to have been effective in whole or in part. Sixty-nine of them explicitly referred to the ineffectiveness of the designated area allowance, 46 of these believing it to have had a disincentive effect. The initial practice allowances were held in somewhat higher regard. Of the LMC secretaries, only one in ten rated both the designated area and initial practice allowances as effective, and a further one in ten rated one or other as effective. However, more than half the secretaries considered that neither allowance had been effective, the main reasons being the inadequate amounts, the short periods of payment, and (in the case of the designated area allowance) the disincentive effect.

6. Differing questions were put to the EC clerks and LMC secretaries about the NHS reorganisation. The clerks were asked about the relationships they would like to see in the new service between the FPC, the AHA and the MPC; the secretaries were asked about the advantages they saw in reorganisation for providing better care in under-doctored areas. Among the clerks there was no great enthusiasm for reorganisation. The prevailing view was one of immense satisfaction with the status quo. Most clerks, however, accepted reorganisation as inevitable and expressed the hope of close co-operation with the new health authorities. There was a marked undercurrent in the replies of fear of domination by the AHA and a substantial minority of the clerks would press for statutory recognition of the FPC in all matters concerning general practice, including planning. The minority of clerks who positively welcomed the reorganisation hoped particularly that the AHAs would stimulate the provision of practice accommodation in health centres or group practices.

7. Of the LMC secretaries, three-quarters could see no advantages in reorganisation, at least as it might affect the quality of care in under-doctored areas, although a majority of these gave no substantive reasons for their pessimism. Where reasons were offered, they centred around the problems of the extra burden falling on GPs through their involvement in DMCs and DMTs and of the absence of additional financial investment in the service. The reasons given by the minority of secretaries who saw potential advantages in reorganisation were split almost equally between

the promise of better information systems to identify need, the more rational establishment of priorities, the potential benefits for community care, and the closer relationships that might emerge with hospitals.

SECTION SEVEN: CONCLUSIONS

1. Medical practice areas serve two distinct purposes: they provide the means whereby the Medical Practices Committee exercises its statutory functions and they determine the distribution of an annually increasing sum of money. In considering questions of optimum size or method of classification of areas, the prior decision must therefore be taken of the purpose which those areas are intended to serve.

2. The overriding consideration is whether the areas will continue to be used as the basis for the payment of the designated area allowance. If so, then many changes which would be desirable in principle are unlikely to be effected because of the financial interests at stake. But if a prior decision is taken either to abolish the allowance or to tie it to some yardstick other than the MPC's classification of a designated area, then the way would be clear for a more flexible approach.

3. The evidence about the effectiveness of the designated area allowance is somewhat equivocal. There is very little specific evidence that it has worked and there are in fact a number of reasons why it is unlikely ever to achieve substantial success, at least in its existing form. On the other hand there is no doubt that the plight of the designated areas has improved in recent years, and it may be supposed that part of this improvement is due to the two inducement allowances. Out view is that both the incentive and the disincentive effects of the designated area allowance are probably quite small, and that the allowance is for the most part neutral. Its phased withdrawal would little affect the prevailing patterns of manpower distribution.

4. If the allowance were to be withdrawn it would be important to observe the 'no detriment' principle. There may be a case for retaining a substantial allowance in places with a proven history of very large

lists, but the choice of such places must be divorced from the MPC's classification of areas. There may also be a case for the introduction of an entirely new compensatory payment for doctors in unattractive areas, but such a payment would have no connection at all with the existing designated area allowance.

5. The withdrawal of the designated area allowance would enable the Medical Practices Committee to determine the definition and classification of practice areas for its own purposes, without the constraint of any financial consequences. The areas could then be assessed for their suitability in fulfilling their original purposes.

6. The smaller practice areas are generally intermediate and restricted and appear still to be suited to their original purpose of negative control. Larger areas, however, which tend to be designated or open, are much less suited to their purpose. Many of them are too large and too heterogeneous to identify substantial variations in patient/doctor ratios within them, and many no longer bear any relation to the catchment areas of their practitioners. Practice area boundaries should in principle be drawn in a way that will minimise fringe areas, that will produce coterminous boundaries between practice areas and the new health districts, and that will yield a target size of between about 20 or 30 doctors.

7. There is a fairly widespread view that average list size alone is a poor indicator of manpower needs, but there is little apparent unanimity about alternative bases for classifying practice areas. Suggestions about possible alternatives fall into three main categories: amendments to the statistical basis of classification; the substitution of list size by other more relevant criteria; and the transfer of responsibility for classification from the central body to the local powers (possibly FPCs acting in collaboration with AHAs). The latter solution has much to commend it, but the devolution of control in this way would run counter to much other contemporary policy. It is likely that for many years the need will remain for a central body to monitor the distribution of GPs <u>between</u> areas, although there may be scope for greater local initiative in arranging the deployment of manpower <u>within</u> areas.

8. Three observations are made about the relevance of information. Firstly, one of the strong arguments in favour of coterminosity of practice area and health district boundaries is the resulting synchronisation of geographical units within which information systems will eventually operate and health needs and services be appraised. Secondly, decision-making at the national level could be improved if the basic information about practice areas collected routinely by the MPC could be processed and published in the way that has been done in this report. Thirdly, there are gaps and imperfections even in this information which would be worth the expenditure of time and effort to overcome.

SECTION THREE

THE NATURE OF THE PROBLEM AND THE OBJECTIVES OF THE STUDY

The basic objective of this report is to examine further the effectiveness of the administrative machinery and policies in channelling family doctors to areas where they are most needed. The areas in question are known as medical practice areas and their boundaries are determined and constantly reviewed by the Medical Practices Committee in close collaboration with executive councils and local medical committees. An area is considered in principle to be short of family doctors (i.e. to be designated) if the overspill of patients above an average of 2,500 per principal exceeds 2,500, which is the point where one incoming doctor could set up a viable new practice. This formula, known as the 'overspill rule', forms the basis of a decision by the MPC to designate an area, but other qualitative factors may be and often are taken into consideration by the Committee. The extent to which the Committee departs from the purely statistical criterion of average list size in deciding the classification of practice areas is not officially known, but some indication is given in Section 5 which reviews the dispersion of average list sizes within each type of area.

General practitioners working in areas which have been designated for a continuous period of at least three years are eligible for the basic designated area allowance (currently £490 per annum), which is paid to all principals in the area for as long as the area remains designated and for a concessionary period of three years following de-designation.* In addition a higher allowance (of £750 per annum) has been paid since 1970 to principals in areas which have been continuously designated for at least one year with an average list size in excess of 3,000 patients. The higher allowance continues to be paid for a concessionary period of two years after list sizes have fallen below the stipulated average for the area; most doctors will then continue to be eligible for the basic allowance.

The report of the original study found little evidence that the allowance had substantially influenced the spatial distribution of family doctors, although the points were made that the conceptualisation of the problem is still very inadequate and that in any case insufficient time may have elapsed since the introduction of the allowance to permit a realistic assessment of its impact. There was a feeling of scepticism among the doctors. Those

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* Under regulations introduced in 1968, 'once an area has been continuously designated for a period of at least three years, a single break in designation occurring subsequently and lasting for not more than 12 months will be ignored.'

not receiving the allowances were often critical both of the amount and of the regulations governing its payment. Those who did receive the allowance tended to regard it as a compensation for a choice made voluntarily rather than an inducement. Almost all agreed that the size of the allowance (£400 when the survey was done) represented far too small a proportion of a GP's income to constitute an effective inducement for him to move to an area where he would not otherwise have gone.

Evidence produced in the report for the failure of the allowance was of various kinds. The upward trend in the proportions of patients and doctors in designated areas, begun in 1962, continued unabated from 1966 (when the allowance was introduced) to 1970. The total number of designated areas increased from 241 in 1966 to 320 in 1970, and those areas which qualified immediately for the allowance in 1966 fared no better in terms of losing their designation than those without instant qualification. Indeed, they fared somewhat worse. And during the single year of 1968 twice as many open areas became designated as vice-versa. These quantitative results, combined with the subjective feelings of the doctors in the survey that the allowance had not worked, are not consistent with any widespread or successful impact of the allowance. Moreover, the few hopeful signs which the report found in the current situation may stem more from general trends in the supply and movement of family doctors than from the effects of any specific policy. For example, the recent arrest and reversal of the growth in the number of designated areas (which, as Section 5 demonstrates, has continued at least until 1973) probably owes as much to the net increase in the number of practitioners as to any specific distributional policies, and the slight reduction in recent years in the range of list sizes between designated and restricted areas is part of a trend which can be traced back at least to 1961, fully five years before the introduction of the designated area allowance.

One reason cited in the report for the apparent failure of this particular allowance is the lowly place which financial considerations seem to have among doctors' priorities in choosing specific localities in which to work. A very large financial inducement would probably produce a desired result but reasons of politics and equity limit the proportion of total income which such inducements can form. This is particularly true where the inducement payments are deducted from a total or target sum of money available for the remuneration

of all doctors. In the absence of substantial cash gains (or their equivalent in non-monetary endowments) most doctors appear to be attracted towards an area by virtue of previous contacts they have had with it, for example through their own or their spouses' families, through professional contacts or through their medical schools. Moreover, not only does the designated area allowance fail to increase substantially the flow of doctors into designated areas, in some cases it appears positively to hinder the process. The rule whereby the allowance lapses following a concessionary period after de-designation means that existing practitioners in an area have a good incentive to see that the area stays designated, and those who might otherwise have contemplated a move to such an area will have good reason for wishing to avoid the prospect of a drop in income after as little as three years. The dilemma is that the higher the allowance the stronger are such disincentives, for the greater is the amount at stake. Some evidence of the reality of the disincentive effect was gathered in the original study, but not much. Nor was the report able to analyse the effect of disincentives on the trends in the numbers of designated areas because of the lack of any information about marginally designated areas.

Considerations such as these led the authors of the original report to argue the need for a reappraisal of the scheme and of the concepts used in defining the problem before tinkering with the mechanics of it. The report mentioned specifically in this context the need to clarify the concept of maldistribution (thereby specifying the hallmarks of a desirable distribution); to reconsider the utility of a uniform average list size as the primary indicator of manpower sufficiency; to examine the problems associated with a fragmented responsibility for decision-making; to assess the appropriateness of the existing medical practice areas (and the mechanisms by which they are derived and amended) as territorial units for the purpose of administering the designated area and allied allowances; and to look carefully at the true implications of the conventional statistics of practice areas.

Of these various issues, two were considered sufficiently important to justify the expenditure of further research time. The first stems from the assumption, inherent in existing distributional policies, that list size is a sufficiently good indicator of the demand for primary care and hence, indirectly, of the need for manpower. The reason for trying to attract more doctors into particular localities can only be that the existing workload

is assumed to justify extra manpower, and since the mechanisms of intervention are activated only when a predetermined patient/doctor ratio is achieved, it follows that list size must either be officially accepted as a valid indicator of the point where workload justifies more doctors, or be recognised as an inadequate indicator but the best that can realistically be used. In fact the inadequacies of patient/doctor ratios as the sole indicator of manpower sufficiency are easy to establish. As Dickinson puts it, 'it reminds one of attempts to measure supply and demand by counting buyers and sellers'.* It is concerned exclusively with the quantitative relationship between the numbers of doctors and of patients, not with any qualitative features of the relationship. On the supply side it is important to remember that the commodity of ultimate interest is not manpower per se but medical care services. It is services, not manpower, that are demanded, supplied and utilised, and any issue of shortage is the shortage of services. Medical manpower is a means of providing services, but not the only means. Other goods and services in addition to medical care may promote good health, and other personnel in addition to general practitioners may supply medical care. If therefore the objective of the system is the promotion of health, the concern with resources must include, but not be confined to, the availability of family doctors. Furthermore, the relationship between general practice manpower and services, even if quantifiable for one time and place, may differ spatially and temporally. Changing technology, the modification of capital equipment, the development of medical science, the introduction of new forms of practice organisation - all these may alter the relationship between the input (the family doctor) and the product he delivers (medical care). Nor are family doctors sufficiently homogeneous that they can readily be aggregated together. They differ in age, experience, training, competence, diligence and, doubtless, many other qualities which invalidate the easy assumption that any groups of doctors will be as adequate in a particular situation as any other group.

Just as on the supply side the relationship between the availability of manpower and the maintenance of health is variable, so on the demand side the relationship between the size of a community and its aggregate need

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* Quoted in R. Fein. The doctor shortage: an economic diagnosis. The Brookings Institution, 1967.

(and demand) for care is complex. Much depends upon the health status and socio-economic characteristics of the community. Areas with a high risk of occupational disease, retirement resorts with large numbers of elderly people, and new towns containing a young population with a high birth rate may each, for differing reasons, generate a higher demand for services than places without such characteristics. It is known, too, that even when confronted with apparently similar patterns of clinical morbidity, people vary appreciably in the way they respond to perceptions of ill health and in the kind of help they seek. In sum, the chain from the supply of family doctors to the use of family doctors to the delivery of medical care services to health maintenance is complex. The assumption that a pre-determined average list, applied uniformly throughout the country, can reasonably be used to identify areas with manpower deficiencies is too simple.

The second important issue stems from the use of medical practice areas as the administrative unit in distributional policies. It is within practice areas that GPs are either forbidden or encouraged to enter by the MPC, and it is the practice area that may be designated by the Committee, with consequent financial advantages to those working therein. The principle of dividing the country into territorial units for the purpose of assessing local manpower requirements (however that may be done) is obviously reasonable. When the concern of policy embraces not only the aggregate supply of doctors but also their distribution, then the appropriate units of administration must include not only the entire country but also sub-areas of it. The definition and identification of appropriate sub-areas is, however, a complex business. A variety of considerations will enter into the selection of area units and the choice of units will in turn affect the apparent success of distributional policies. A country divided into only six areas, for example, may find it easier to maintain specified staffing levels in each area than a country with sixty areas. On the other hand if each of the six areas contained, say, ten million people, they would doubtless be considered too large to yield sensitive indicators of the level of manpower provision for the entire population of each area. An acceptable patient/doctor ratio for the area as a whole (assuming for the time being that that is taken as the criterion of manpower sufficiency) would probably conceal very large and undesirable variations between sub-area zones. At the other end of the scale it would theoretically be possible to define the appropriate area as the catchment area (or alternatively the practice population) of each

individual practice, the aim then being to ensure that no individual doctor's list size deviated from the national average by more than a prescribed amount.

In reality the medical practice areas in England vary substantially in size, though none is as large as a region and only a handful contain no doctors at all. They do vary, however, from large country boroughs with populations of up to 300,000 people and 100 or more doctors, down to small housing estates and sub-divisions of rural districts. About one-tenth of English practice areas at any moment in time contain only one principal. These variations clearly present problems of equity and control in administering and evaluating such policy measures as the designated area allowance. For example, a practice area covering an entire county borough may, by virtue of its small average list size, fail to qualify for any inducement allowances, yet it may contain sectors with a manifest shortage of family doctor services and excessively high demands upon those who do practise there. It is clearly inappropriate in such cases to define the entire borough as a single practice area, for it would matter little to either doctors or patients in the hard-pressed areas that there were other practitioners elsewhere in the borough with sufficiently small lists to maintain the overall average below the criterion of designation. The converse situation, equally indefensible, would be one in which all the practitioners in a large borough received a designated area allowance, even though many may be practising with small lists in attractive neighbourhoods. The problem of size, in short, is that of identifying areas that are neither so small that their classification is inherently unstable nor so large that they fail to delineate major variations in patient/doctor ratios within their boundaries.

But size is not the only factor in a rational definition of medical practice areas. Equally important is the extent to which areas coincide with other territorial units in the administration of health and social services. The existing classification makes it difficult to obtain information about the needs of populations of medical practice areas and the extent to which such needs are met, partly because areas do not always correspond with other units for which demographic and other relevant data are regularly collected, and partly because they are not identical with planning units for other services. The consequent difficulty in obtaining even basic data for practice areas of a kind that will contribute to a more rational assessment of the need for family doctors is doubtless one reason

why, in the past, little progress has been made in moving beyond simple patient/doctor ratios in determining desirable staffing levels.

A third factor of importance in many localities is the failure to adapt the boundaries of practice areas to meet new needs arising from population movements. The problem has been most marked in the so-called 'fringe areas' on the periphery of county boroughs, where patients who have moved out from the inner suburbs, and who may now be living in restricted areas, remain registered with doctors whose surgeries are still located nearer to the city centres, often in designated areas. Since the classification of practice areas is determined by the average number of patients on the lists of doctors practising in those areas, not by the population residing in them, a distorted view of the manpower situation may emerge from such places. Anomalies are frequently excused on the grounds of freedom of choice for patients, but in reality patients in fringe areas often have little choice but to travel long distances back to the city centre, thereby augmenting the lists and income of practitioners who have small incentive to move out and who may in any case be forbidden to set up practices in the outlying residential areas if they are classified as restricted.

These two central issues, of defining the considerations upon which judgements of manpower requirements should be based and of identifying more suitable boundaries to medical practice areas, formed the starting point of the study reported here. It soon became apparent, however, that the other problems outlined in the original report could not be ignored. Two in particular came to impinge directly upon the concerns of the study. The first is the problem of the disincentive effect of the designated area allowance, described on a priori grounds in the original report but for which little hard evidence was amassed. The reality of the disincentive effect is important in making sense of traditional indicators of change in manpower distribution, for if areas are deliberately kept designated by practitioners not wishing to forfeit the allowance, then the annual statistics of the number of designated areas and the proportions of doctors and patients in them may be very poor indicators of the inability to attract doctors to needy places. The question of the size of areas is also important here, for as we show in Section 5, a small area could maintain a fairly large average list size (as much as 3,000) and still remain non-designated. If this is happening on any extensive scale, the tally of designated areas ceases to have much meaning.

The second consideration mentioned in the original report which impinged upon the concerns of the present study is that of organisation and structure. The distribution of decision-making power in this area among a number of separate bodies was discussed in the original report as a possible barrier to comprehensive planning, but when that report was submitted (December 1971) the proposals for National Health Service reorganisation were still under consideration. As the present study developed the main themes of reorganisation emerged and their relevance became apparent. In particular the goal of an integrated planning cycle, starting with the assessment of needs at district level and working up through areas and regions, is directly relevant to the problem of assessing the need for medical manpower and to the issue of the relationship between practice areas and other administrative units. If there is eventually to be a systematic appraisal of total health needs within health districts and areas, might this not hold important implications for the definition of practice areas and for the basis on which they are classified? The role of an independent Medical Practices Committee may also require re-examination in the light of the area health authority's responsibility for developing a comprehensive and integrated health care system, <u>including</u> those aspects of the family practitioner services which involve other parts of the unified NHS or the personal social services. If manpower planning in general practice is increasingly to be integrated within the wider planning processes of the health service, then any revisions that may be made to the practice areas must take cognisance of the mechanisms of those processes and of the scope of the information fed into them.

SECTION FOUR

THE ADMINISTRATIVE FRAMEWORK

INTRODUCTION

The machinery designed to redress the imbalance in the provision of general medical services was set up under the 1946 National Health Service Act. This Act provided for (1) a central body with certain powers of control over the location of family doctors, (2) a local executive network to administer the family practitioner services, (3) local professional representation, and (4) the passage of relevant information from the local network to the central body about local manpower needs. These provisions were subsequently augmented by certain financial allowances, notably the initial practice and designated area allowances. The 1973 National Health Service Reorganisation Act did little to alter the formal structure, but by creating new opportunities for integrated planning and administration of services it carried direct implications for the processes by which GP manpower policies are formulated.

The purpose of this section is first to summarise the main features of the administrative framework, and secondly, to discuss the possible impact of the 1973 Act.

THE CENTRAL BODY (MEDICAL PRACTICES COMMITTEE)

The central body established by the 1946 National Health Service Act is the Medical Practices Committee. Section 34(2) of the Act states:

> 'With a view to securing that the number of medical practitioners undertaking to provide general medical services in the area of different Executive Councils or in different parts of those areas is adequate, the Minister shall constitute a committee to be called the Medical Practices Committee for the purpose of considering and determining applications.'

The Committee comprises a chairman, 'who shall be a medical practitioner' and eight other members, six of whom are medical practitioners. Five of the six must be 'persons actively engaged in medical practice.'* The chairman and members are appointed by the Department of Health in consultation with representatives of the medical profession. The secretary and staff are provided by the DHSS, usually civil servants seconded for a number of years.

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* National Health Service Act 1946, Ch.81, Sixth Schedule: Medical Practices Committee

The 1946 Act also established the right of the Committee to refuse the admission of practitioners in over-doctored areas and the duty to admit doctors in areas specified by them.

> 'The Medical Practices Committee may refuse any such application on the ground that the number of medical practitioners ..... is already adequate, and, if in the opinion of the Committee additional practitioners are required for any area or part but the number of persons who have made applications exceeds the number required, the Committee shall select the persons whose applications are to be granted and shall refuse other applications.
>
> Before selecting any persons ..... the Medical Practices Committee shall consult the Executive Council concerned, and that Council shall, if a Local Medical Committee has been formed .... consult that Committee before expressing their views on the persons to be selected.' (Section 34(3)).

Provision was also made for a final appeal to the Minister. The Medical Practices Committee remained unaffected by the 1973 National Health Service Reorganisation Act.

THE LOCAL ADMINISTRATIVE NETWORK (EXECUTIVE COUNCILS)

The requirement for executive councils to consult with the Medical Practices Committee and the local medical committee was, as indicated above, written into the 1946 Act. The executive councils themselves were established under Section 31, which required one Council to be set up for each local health authority. (It is of some interest that the Act failed to allow for subsequent changes in local government areas by requiring executive councils to adjust their boundaries accordingly. Consequently, councils such as Middlesex and Kent, which included London boroughs, survived unchanged following the creation of the Greater London Council.) Executive councils were replaced under the 1973 Act by family practitioner committees* with ostensibly similar functions and with boundaries corresponding to the new local authorities. These new committees are, however, sub-committees of the area health authorities and the fear has been expressed by clerks of the old ECs that much of their significance in planning functions will be eroded in the new system (see Section 6).

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* References to the family practitioner committees in the remainder of this section should be taken to include the former executive councils unless the context clearly implies otherwise.

Executive councils consisted of 30 members, half of whom were appointed by the local professional committees, 7 by the Secretary of State and 8 by the corresponding local health authority. The new family practitioner committees also contain 30 members, half appointed by the professions, 11 by the AHA and 4 by the matching local authority. Relating to the Medical Practices Committee is only a part of the functions and activities of the family practitioner committees (or the former ECs). As executive bodies of the central Department they enter into contracts with individual practitioners and administer their terms of service. They are responsible for general medical services by ensuring that each person is accepted by a general practitioner, if necessary using powers of allocation. They investigate complaints against doctors and administer pharmaceutical, ophthalmic and dental services.

The full-time chief of a family practitioner committee is the administrator of family practitioner services (known formerly as the executive council clerk). He is the chief finance, administrative and executive officer, acting as the secretary to the committee and its sub-committees and advising them on the management and administration of general medical, pharmaceutical, dental and ophthalmic services.

LOCAL PROFESSIONAL REPRESENTATION (LOCAL MEDICAL COMMITTEES)

Local medical committees are elected by general practitioners, until 1974 within each executive council area but since April of that year within each area health authority. Larger areas are normally subdivided into local constituencies. Nominally, the function of the LMCs is a consultative one: under section 34(3) of the 1946 Act executive councils (family practitioner committees) are required to consult with local medical committees on such matters as the appointment of doctors to single handed practices. In reality the influence of an LMC over such matters as the fixing of practice area boundaries may be greater than that of the family practitioner committee, for it is rare for the Medical Practices Committee to push through boundary changes against the wishes of a local medical committee.

LMC members may also exert influence in other ways. Eight members of the family practitioner committee are appointed by the LMC and general practitioners are represented on the area health authority, the district medical committee, the district management team and the area and regional

advisory committees. At national level, each LMC sends delegates to the annual conference of local medical committees from which the General Medical Services Committee is elected. Some members of that Committee in turn form part of the profession's negotiating team on matters of remuneration and conditions of service.

The role of the local medical committee is therefore of some importance in counter-balancing the centralised perspectives of the MPC. Decisions which, from the national viewpoint, may seem rational and desirable could fail to be implemented unless the benefits are perceived locally. An obvious example of this in recent years has been the failure to divide large county boroughs into smaller medical practice areas where such division might involve the eventual loss of the designated area allowance for many doctors.

THE PASSAGE OF INFORMATION

The principal Act required executive councils to supply such information as may be necessary for the Medical Practices Committee to fulfil its functions.

> 'Regulations shall make provision ... for requiring Executive Councils to make reports, at such times and in such manner as may be prescribed, to the Medical Practices Committee as to the number of medical practitioners required to meet the reasonable needs of their area and the different parts thereof and as to the need for filling such vacancies.' (Section 34 (8)).

The Medical Practices Committee set about its task in 1948 by requesting information from ECs about any 'manifestly under-doctored districts in their area'.* The information requested included the population of each district, the number of patients on each doctor's list, any important topographical features of the district, and the estimated number of additional doctors required. Towards the end of that year (1948) the Committee again wrote to executive councils requesting information for <u>all</u> districts, the districts being defined having regard to the practices of doctors and the centres from which they practise'.** The requisite information included

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* Medical Practices Committee: Circular MPC 1/48 (July 1948)

** Medical Practices Committee: Circular MPC 5/48 (November 1948)

the size and distribution of the population, the number of doctors and assistants together with personal and professional details about them and their practices, special factors such as seasonal population increases which might affect the demand for care, and any 'special difficulties of an area - its communications, etc.'

By the following year (November 1949) the Medical Practices Committee, whilst stressing its intention that the EC reports should in no way be standardised, had nevertheless decided upon 'certain minimum information which it requests councils to submit'.* Much of it was statistical, concerning the size of the population and the number of doctors and certain characteristics of their practices, but the opportunity was given for councils to offer more impressionistic comment. 'In any case where the population is not evenly distributed or for geographical or other reasons, it is suggested that a brief description of the area ..... should be given. Moreover, any information as to inadequacy of the service in any respect in an area including special inconvenience to patients or doctors should be brought to our notice.' Commenting upon this, the MPC remarked in an appendix to its first annual report:

> 'The Act and Regulations clearly lay upon this Committee the duty of deciding whether or not in an area or part of an area there is an adequate number of doctors ... In arriving at its decision the Committee pays due regard to all information provided by an Executive Council. Indeed it relies almost exclusively upon such information. The opinion of an EC also is regarded of the highest importance by the Committee.'**

In subsequent years the convention has developed whereby executive councils submit detailed information to the MPC every three years, supplemented by summary reports in the interim years. Both sets of returns show, for each practice area, the number of principals; the number of full-time assistants; the total number of patients; the average number of patients per principal; the number of units of rural practice payments; the number of dispensing patients, temporary residents and elderly patients; the cost of maternity medical service payments; and the number of hours per week spent by doctors on hospital or other commitments where provided. Some of this information has been utilised in the statistical analysis of practice areas described in the next section of this report.

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* Medical Practices Committee: Circular MPC 2/49

** Medical Practices Committee: Circular MPC 6/48.
Reprinted as Appendix I of First Report, June 1949

MEDICAL PRACTICE AREAS

An early use made of the information supplied by executive councils was in the identification and classification of medical practice areas. The origins of these areas are obscure. The request from the Medical Practices Committee in July 1948 for information from executive councils about 'any manifestly under-doctored districts' implies that some informal subdivisions of ECs may have existed prior to 1948. There appears, however, to be no formal record of these districts and the need for them would not arise within the context of manpower distribution because the government had no responsibility for this prior to the passage of the 1946 Act. The MPC therefore accepted the delineation of district boundaries proposed by the executive councils and published its first survey of districts as Appendix III to its first report in June 1949.*

By the following November the Committee had decided not only to call for certain minimum standardised information from the executive councils but also to specify criteria for sub-dividing large areas.

> 'Usually it will not be necessary to sub-divide a compact urban area of less than 100,000 population and even larger "hundred doctor"** areas may be presented as a single area. In larger urban areas, especially the Cities, Councils will consider that sub-division may be desirable as practice conditions vary considerably in different parts of such. The overlap of practices makes any precise splitting up of the area impracticable and therefore a broad classification by Postal Districts, Police Divisions, Parliamentary Divisions, etc. or combination of such, or whatever method may seem best to the Council must suffice. It is important, however, that such Sub-Divisions should not be too circumscribed but should be large enough to present a broad picture of the position. Maps are often helpful in a proper understanding of the area. County areas, of course, require other treatment; sub-divisions by local authority areas or combinations of these are generally most useful. Here again, however, a broad picture should be presented whenever possible. On the other hand "single practice areas" in rural districts should be presented in detail for individual consideration.'***

This is scarcely an explicit statement of guidelines in fixing practice area boundaries; but it must be remembered that at this time the Committee was still particularly sensitive to criticisms from the profession. The

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* Medical Practices Committee: Appendix III of First Report, June 1949

** This sentence is a little ambiguous for it would seem to imply an average of only about 1,000 patients per doctor.

*** Medical Practices Committee: Circular MPC 2/49

directive left almost unlimited discretion in the hands of executive councils and it is hardly surprising that the areas thus defined varied so much in size and composition. In this respect they have changed very little (see Section 5). Boundaries can in principle be changed according to the wishes of the Medical Practices Committee; in reality, however, the Committee rarely imposes its decisions without the full consent of the family practitioner committee concerned, which in turn will have consulted the appropriate local medical committee. Such changes as have been made in recent years have mainly concerned the amalgamation of smaller practice areas (hence the trend noted in the next section towards a reduction in the total number of areas). The really important changes, especially the sub-division of large boroughs into smaller practice areas, have been much rarer. In one recent such case the Committee's attempts to divide the borough succeeded only when its classification changed from designated to open and division was then the only way of preserving the designated area allowance for those doctors with large lists in the undermanned sectors.

The initiative on boundary changes usually originate from the Medical Practices Committee but may come from family practitioner committees, local medical committees or even individual doctors if they feel unreasonably overworked. There is no set machinery for initiating change. Proposals may arise locally where it is evident that changing circumstances render old boundaries inappropriate. A new motorway through the middle of an area may make access difficult; the closure of a railway line may enable the amalgamation of areas; the development of a new town or even a small housing estate may make it expedient to hive-off the area until it is developed and provided with appropriate medical care.

Local medical committees may request a change in boundaries when they consider such changes may operate to their advantage. In these cases the MPC would solicit the views of the family practitioner committee for it is that committee which the MPC has a statutory obligation to consult. Informal contacts may exist between the MPC chairman and the chairmen or secretaries of local medical committees, but formal communication is through the FPCs.

Most of the initiative in boundary changes comes from the MPC itself, for FPCs and LMCs do not readily think in terms of possible improvements and often resist proposals by the MPC. The Committee might seek change when there are too many small areas or, more commonly, when a practice area

is so large that it needs dividing in order to exercise control over the differing patient/doctor ratios. Family practitioner committees are frequently exhorted by the Committee to rationalise their areas, as for example in connection with the NHS reorganisation; but the MPC has found it a struggle to persuade committees to accept change, especially in county boroughs. Committees are seen as somewhat conservative, denying the need for change, and occasionally even compelling the MPC to use its legal powers to enforce boundary revisions.

Just as the origins of the practice areas are obscure, so too are the origins of the system of classifying areas. Following the first submission of information by executive councils in 1948, the Medical Practices Committee was able to classify the districts as 'needy', 'open', 'doubtful' or 'closed' although there were no standard criteria to distinguish them. More order was imposed in the next four years when the classifications were revised on the basis of further data supplied by ECs. A major change took place in 1952 following the Danckwerts award, when the Committee was asked to specify clear criteria for the classification of districts (or medical practice areas as they were now called). Under the new system, areas with average lists in excess of 2,500 were classified as 'designated' and doctors wishing to set up practices in such places were strongly encouraged; areas with average lists between 1,500 and 2,500 were called 'intermediate'; and areas with average lists below 1,500 were classified as 'restricted' and normally closed to new entrants, even as replacements for outgoing practitioners.

The classification of practice areas has been revised several times since 1952, most recently in 1964. An average list size of 2,500 (taken in conjunction with the 'overspill rule') has, however, always been the basic criterion of designation, modified where appropriate by other conditions prevailing in the area. But the reasons for the original choice of this list size as the basic criterion of designation are unclear. It seems to have been accepted by the profession in 1952 as a reasonable guide to the maximum number of patients for whom a doctor can properly care and was rapidly enshrined as part of the folk-lore of general practice. It is, however, questionable whether it remains a valid indicator and whether it should be applied uniformly to all areas regardless of their size, population density, or demographic and epidemiological characteristics. In fact, the

Medical Practices Committee has periodically reviewed the usefulness of this definition of a designated area, especially when the national average list size approaches 2,500 but no proposals have been made to the General Medical Services Committee or the Health Departments of England and Scotland. The desire to substitute or augment list size by other criteria (such as workload, population structure, morbidity patterns, etc.) has failed to overcome the practical problems of obtaining consensus over relevant criteria and measuring and monitoring them in the practice areas. The proposal to vary the average list size required to designate an area encounters the problem that the designated areas are used not merely for the purpose of negative control but also as the basis for two important allowances - the initial practice and designated area allowances. What started off as no more than rough guidelines to enable the MPC to identify areas with a severe shortage of doctors has now become so closely identified with the payment of money that much of the flexibility has gone out of the system. Suddenly, the definition of a designated area or the precise location of an area boundary becomes important, and therefore difficult to change, even though it may have been based originally upon little more than guesswork or expediency. As the recent history of the practice areas shows, their use in regulating a component of remuneration has created problems of rigidity in the determination of area boundaries, inflexibility in the definition of an under-doctored area, and lack of comparability in relating practice areas to other territorial units in the administration of health and welfare services.

NATIONAL HEALTH SERVICE REORGANISATION

Although it is yet too early to assess the full impact of National Health Service reorganisation on the issues with which this report is concerned, it is apparent that reorganisation could affect the distribution of primary medical manpower in a number of ways.*

First, there will be changes in territorial units and boundaries which carry implications for the ways in which under-doctored areas are identified and corrective policies applied. Secondly, there are potential advantages to be had for the under-doctored areas as a result of comprehensive, integrated planning for health care. There is a chance of a better distribution of

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* See also Section 6 for an account of the views of executive council clerks and local medical committee secretaries towards reorganisation.

resources within and between regions, areas and districts, and there is a chance that areas with multiple deprivations will attract a greater share of resources than in the past. This is because the new structure will provide for

> ' ... a single administering body locally which will draw its funds from one source, and will take a wide, unbiased and constructive view of the priorities across the whole range of needs served by the hospitals.'*

Thirdly, the emphasis on long-term future planning, as well as on day-to-day management tasks, is well-suited to the problems of manpower planning in general practice where, for a variety of reasons, short-term solutions and quick results are not easy to come by. Ultimately, however, the calibre and imagination of the officers appointed to operate the new machinery, and the ways in which each sees his tasks and responsibilities in relation to those of others, will to a large extent determine how well the hopes and expectations of reorganisation will be fulfilled.

In practice there is a great deal which will remain unaltered in the administration of general medical services, especially where the Medical Practices Committee is involved. As the White Paper (Cmnd.5055) clearly stated, 'the work of the Medical Practices Committee will remain unchanged in the new structure'. The committee itself defends the continuation of the status quo, pointing out that it is the only central body (apart from the DHSS) concerned with manpower planning in a situation where some central adjudication of need is essential. Locally, too, there is little structural change, with the LMCs continuing to function (at area level) and the family practitioner committees inheriting the functions of the former executive councils. There are, however, some minor innovations which affect the links between an AHA and its FPC. One is in membership, for a number of professional and lay members may serve on both bodies, and it is a legal requirement that one of the eleven FPC members appointed by the AHA must also be a member of the Authority. Another link is in the field of planning and development, for the administrator of family practitioner services is accountable in this part of his work to the area administrator, although in all other respects he is accountable to the FPC itself. A third link is that FPC staff are

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* 'National Health Service Reorganisation: England'. Cmnd.5055, HMSO 1972, para. 9.

actually employed by the AHA and may have the opportunity of transfer to all parts of the health service. Nevertheless, all of the essential functions of the former executive council clerks have been taken over by the FPC administrator.

A major change which reorganisation does make to the status quo is in the geographical units used in the administration of health and local government services. The harmonisation of AHA (and there FPC) boundaries with those of metropolitan districts and non-metropolitan counties brings about change in the areas within which family practitioner services are administered. The 116 former executive councils in England have been transformed into 90 family practitioner committees. Wholly new territorial units have been created and old units modified. The chief impact of these boundary changes has been on the old county boroughs which, in addition to losing many local government powers and responsibilities, have also ceased to define the boundaries within which the family practitioner services are administered. Former boroughs falling within the new metropolitan counties (these being Greater Manchester, Merseyside, South Yorkshire, Tyne and Wear, West Midlands and West Yorkshire) have usually formed the core of the new metropolitan districts, with wide-ranging powers in local government (including public health, housing, education and social services) and with corresponding health authorities (and therefore family practitioner committees). Boroughs coming within the new non-metropolitan counties have usually constituted a larger proportion of the non-metropolitan districts, but these, unlike their metropolitan counterparts, have fairly circumscribed powers and responsibilities and they do not have a corresponding area health authority. In some cases the new authorities are created through the merging of existing counties (e.g. the three divisions of Lincolnshire; Herefordshire and Worcestershire; Cambridgeshire and Huntingdonshire) or existing boroughs (e.g. Birkenhead and Wallasey; Bootle and Southport; Warley and West Bromwich; Dewsbury and Huddersfield). Here the geographical units in the administration of family family practitioner services are larger than formerly. In London, by contrast, there is a fragmentation of units, for the five executive councils in the London area (based more or less on the old county boundaries prevailing before the 1963 London Government Act) have been split among 16 family practitioner committees, one for each area health authority in the capital.

The basic operational units in the new service are the health districts, these being defined as 'the smallest population for which comprehensive

health care can be planned, organised and provided'.* Districts will aggregate up to health areas, albeit with the proviso that district boundaries should not be drawn at the expense of ignoring the realities of so-called 'natural boundaries' and patient flows.

With the creation of this new pattern of districts, areas and regions the moment is opportune to review the coverage of the medical practice areas, many of whose boundaries are arbitrarily determined, creating units inappropriate to their purpose. An example of this is seen in the case of 'fringe areas' (see page 62). Because there is no geographical restriction on the freedom of patients to choose their doctor or of doctors to accept patients, there is a distinction between the area throughout which a doctor's practice extends, referred to here as a 'catchment area', and the 'medical practice areas' classified by the Medical Practices Committee. The two units, although often coterminous, are not identical, for whereas the boundaries of a GP's catchment area are often indistinct and overlapping with others, the medical practice areas should normally have clearly specified boundaries and a defined population. (In fact, in many rural practice areas the names appear to relate only to the location of the doctors' surgeries, without a clearly defined hinterland). In many cases, of course, the catchment areas may spill across one or more practice area or even executive council area. Where this occurs it is usual for the EC within which the greater part of the doctor's patients reside to have chief responsibility for administering that doctor's contract, even though his surgery may be located elsewhere. The problem of the fringe areas may be exacerbated in the new service where practice area boundaries overlap not only those of the new health districts but those of the health areas also. Reorganisation therefore presents both the need and the justification for reshaping the practice areas into viable units, coterminous where appropriate with the health districts. Unless this is attempted it may be difficult to reconcile the concept of comprehensive planning within one set of units with a parallel but autonomous system of GP manpower planning within an entirely different set of territorial units.

There may, for example, be problems in instituting information systems. Adequate information about the health needs of populations and the functioning of services is an essential input to the planning process generally and in

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*NHS Reorganisation Circular HRC (73) 4, DHSS, 1973

particular to the district management and health care planning teams in determining priorities. At present, in fact, a good deal of information is already collected about the family practitioner services and is available to the MPC and the DHSS. What reorganisation can theoretically offer is the chance of linking this type of information with epidemiological and demographic data about populations in order to improve the basis on which decisions about manpower requirements are made. A beginning has been made, at least, with elementary population and service data, in the profiles assembled by the joint liaison committees for the new health authorities. There is a chance that much of this information could be used to proceed beyond simple patient/doctor ratios as the basis for establishing GP manpower requirements, but the reorganisation plans make no mention of this opportunity. There is no recognition of the medical practice areas in any of the reorganisation documents and there is consequently no legal requirement that the boundaries of the areas should harmonise with those of other administrative units. In default, much of the potential utility of the information may be lost because of the need to assemble and present data for areas other than those within which they were collected.

The most promising recent development has been the MPC circular, sent to EC clerks and area JLC secretaries in October 1973, requesting their co-operation in 'setting up a working party to consider and recommend the delineation of practice areas in the new Health Authority area to be constituted on 1 April'.* A working party would be set up in each area and the MPC would then consider the recommendations and classify the various parts of the new areas as appropriate. The circular pointed out that the proposal arose from a suggestion from the Management Committee of the Society of Clerks of NHS Executive Councils and was designed to 'seize the excellent opportunity of rationalising in some instances the delineation of practice areas and so enable the committee (and the new Health Authorities) to readily identify the local needs ... for additional practitioners'.

This initiative on the part of the Medical Practices Committee contravened the wishes of most members of the General Medical Services Committee, who wanted changes to be left until the family practitioner committees were in full operation. But, as the MPC's chairman pointed out, 'failure to do so would lead to unacceptable delays in the admission of doctors to the list and the

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* Medical Practices Committee: Circular MPC, 2 October 1973

filling of practice vacancies, which would have been against the interests of doctors and patients alike'.* And in fact the response appears to be encouraging. By the middle of March 1974 returns had been received from about 80 of the 98 health areas in England and Wales, although their contents are not known to us.

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* British Medical Journal. Supplement of 23 March 1974, 27-28

SECTION FIVE

MEDICAL PRACTICE AREAS: A STATISTICAL ANALYSIS

INTRODUCTION

An evaluation of how well a system is working must start with a clear description of the system itself. In the case of the medical practice areas, a certain amount of statistical description was included in the report of the original designated areas study, showing for example the distribution of practice areas by classification, the numbers of principals and patients in each type of area, the number of areas qualifying for the designated area allowance, and the changes over time in the number and classification of areas. The original study, however, was more concerned with individual practitioners than with areas and the information about areas was drawn either from published or from easily accessible non-published sources. No attempt was made to collate data in entirely new ways.

The present study, being concerned more with practice areas than with practitioners, requires a more careful scrutiny of what is known about the areas. It has therefore been an important part of the study to locate, abstract and collate the best available data about areas, and it is with the results of that exercise that this section of the report is concerned. The object of the section is to describe the characteristics of practice areas as clearly as possible, thereby providing a backcloth against which the suitability of areas for their task can be evaluated.

The section falls into three major parts. In the first part the sources of the data are described, terms are defined, sources are compared, and deficiencies and limitations are highlighted. The second part is concerned with updating relevant statistics from the original report and with illustrating major recent trends. The third part presents new material to show in greater detail than has hitherto been available certain characteristics of the structure of practice areas. Throughout the section the material relates to England only unless otherwise specified.

SOURCES

The information presented in this section is drawn from three sources. It is a matter of regret that complications in describing the material arise inevitably from the fact that the sources relate to slightly different time periods, employ slightly differing definitions, and in other minor ways fail to achieve full comparability.

The most important of the three sources is a survey that was made of the reports submitted by executive councils to the Medical Practices Committee. Councils are expected to submit detailed surveys of the manpower situation within their areas every three years and to supplement these in the intervening years by shorter annual reports. The triennial survey reports happen to include summaries for each medical practice area arranged in a comparable form to that of the shorter annual reports, thereby making it possible to collect certain standardised information for all practice areas within a twelve month period. By kind permission of the Medical Practices Committee access was gained to the non-confidential parts of the executive councils' returns and information relevant to the study was extracted. This source is referred to throughout the section as 'the MPC survey'.

The second source, used for some of the tabulations in this section, is the list of practice areas and their classifications produced annually (and updated quarterly) by the Medical Practices Committee. This source is referred to as 'the MPC lists'.

The third source of information is the statistics compiled by the Department of Health and Social Security from EC returns about manpower trends in the general medical services. Some of these statistics have been published either in the Annual Reports of the Department (up to 1971) or in the annual Health and Personal Social Services Statistics since that date; others are unpublished but have been made available by the Department. This third source is referred to throughout this section as 'the DHSS tabulations'.

Date of information

The time period covered by the material used in this section differed somewhat from source to source. In the case of the MPC survey, the object was to gather reports for each executive council submitted during the year ending April 30th, 1973. (In order to avoid a deluge of reports arriving at the same time, the MPC asked executive councils to submit their reports at quarterly intervals throughout the year). In fact this objective was not fully achieved, for only 97 per cent of all practice areas were included in reports submitted to the MPC between July 1972 and April 1973, the remaining 3 per cent of areas (all located in Cumberland, Westmorland and Walsall) being covered in reports submitted prior to July 1972 (Table 1).

In all, data relating to 31 per cent of practice areas came from reports submitted in July 1972, 26 per cent from reports in October 1972, 22 per cent from reports in January 1973 and 18 per cent from reports submitted in April 1973. The median date to the nearest month was September 1972. In view of the fact that the MPC notified executive councils in October 1973 of its intention not to call for further survey reports until 1975, the data from this source are almost as up-to-date as possible.

The second source of information (the MPC listing of practice areas) relates to the first of January each year, the most recent year used in this section being 1973. The number of areas included in the MPC list differs very slightly from the number produced by the MPC survey, the reason lying partly in the differing time periods covered by the two sources and partly in the exclusion from the MPC survey of areas containing no principals. (Areas with no doctors were very few in number but were excluded because of the desire to avoid introducing zero values into the calculation of average list sizes).

The third source of information (the DHSS tabulations) relates to the first of October each year. This means that the latest tabulations available from this source (relating to 1st October 1972) were one month later than the median date of the MPC survey. The Department's tabulations cover England and Wales up to 1969 but England only since that date.

Definitions

As with dates, there was a lack of exact comparability between the three sources in the definition of certain items. We deal here with the definition of unrestricted principals, patients, and average list size.

Executive councils were instructed to include in their returns to the MPC all unrestricted principals for whom the majority of their patients were registered with the council. Those in partnerships or in single-handed practices with lists of 700 patients or more were always included, but single-handed doctors with lists of less than 700 were included only if their practices were building up or if they worked in isolated rural areas. A full-time equivalent statistic is derived for principals receiving less than the full basic practice allowance (i.e. with less than 1,000 patients). Assistants were entered only if they were full-time.

The numbers of patients submitted to the MPC were those registered with the unrestricted principals in main practices. Place of residence is disregarded, as it is also when calculating unadjusted average list size. However, patients resident within an EC area but registered with doctors outside were entered under 'fringe practices' as well as being counted among the patient population of the area in which they were registered. There is no element of double-counting here because the doctors and patients in fringe areas were always clearly distinguished in the EC returns, but the distinction is useful to make and will be illustrated later in the section.

The numbers of patients suffer a degree of inflation because of delays in transferring the records of patients who change doctors or in notifying deaths and emigration. For the purpose of this section, the numbers of patients are taken simply as the unadjusted totals submitted by ECs as being 'patients of principals in main practices'.

The average list size used in analysing the MPC survey data is the same as that employed by executive councils in their returns to the Committee. It is calculated by dividing the number of patients (as defined above) by the number of full-time equivalent principals and assistants. The full-time equivalent is derived by adjusting for principals with lists of less than 1,000 patients and by counting two full-time assistants as the equivalent of one full-time principal. In fact, the number of full-time assistants recorded in the MPC survey was quite small: 71 in designated areas, 79 in open areas, 59 in intermediate areas, 31 in restricted areas; this means that in most areas the technique of counting two assistants as one equivalent principal has a nil or minimal effect upon the average list size. Nevertheless, it should be noted that this method of calculating average list size is not strictly comparable to that used in the DHSS tabulations, where the average is taken simply as the mean number of patients per unrestricted principal. Nor can the classification of a practice area be deduced solely from the average list size submitted by executive councils. In the case of designated areas, for example, the overspill rule states that an area cannot be thus classified until the excess of patients above an average of 2,500 is itself 2,500. In all areas the MPC may take other factors into account in deciding the appropriate classifications and in addition some adjustment is invariably made for the inflation factor. This is done by deflating the average list size in each EC by the percentage by which the patient numbers exceed the

national average inflation. This 'excess' inflation, which varied between ECs in 1972/3 from 1 per cent to nearly 16 per cent, is based on population estimates and is applied uniformly to all practice areas within each executive council.

Comparability of statistics

The reports submitted by executive councils to the Medical Practices Committee are intended to serve administrative rather than statistical ends. Although the Committee provides guidelines on definitions, it is not to be expected that the reports would be as precise as the statistical returns made to the DHSS, or that tabulations derived from the two sources would be identical. In fact, the total number of principals listed in the MPC survey proved to be very close indeed to the number contained in the DHSS tabulations (Table 2). The net difference between the two sources was a mere 16 doctors out of a total of almost 20,000, and although the gross differences were somewhat greater within each class of area, the percentage distribution between the different classes was identical (to the nearest whole number) in the MPC survey and the DHSS tabulations. The small variations seem reasonably to be explained in terms of differences between the two sources in the definitions used and the time period covered. The fact that the MPC survey data relate, in effect, to five different points in time creates an obvious risk of double-counting of principals who moved from one EC to another during the year.

There was a much larger discrepancy between the MPC survey and the DHSS tabulations in the number of assistants. As mentioned above, the MPC survey identified a total of 240 full-time assistants compared with 567 assistants recorded in the DHSS tabulations for October 1972. The source of the discrepancy is not clear, but it may lie in the inclusion in the DHSS tabulations of all assistants in contrast to the MPC's practice of recording only full-time assistants in the summaries. The number of patients appearing in the MPC survey was, in total, about 1 million (2 per cent) larger than in the DHSS tabulations (Table 2). Unlike the distribution of principals, the MPC survey recorded the larger number of patients within each class of practice area as well as in total. In designated areas the excess was 1.4 per cent,. in open areas 1.7 per cent, in intermediate areas 3.5 per cent and in restricted areas 4.3 per cent. The differences between the MPC and the DHSS statistics may partly be explained by the time differences as well as by inflation. The DHSS figure is itself higher than the estimated home population, a further reflection of the inflation factor in patient registers.

RECENT TRENDS

The original report of the designated area study (submitted to the Department in December 1971) gathered together statistical information from various sources relating to changes over time in the classification of practice areas, the distribution of principals and patients, the payment of the designated area allowance, and other related matters. Some of these statistics were subsequently updated in the published version of the report. In this part of the section they are again revised to show longer-term trends and to include recent material which was not previously available.

In interpreting the trends a cautionary warning must first be given. Changes in the number of doctors or patients in designated areas relate to areas which are constantly changing status and boundaries. One is therefore dealing with a constantly shifting base. For example, when the number of doctors in the country is increasing at a faster rate than the number of patients, and some of these extra doctors are moving into designated areas, two conflicting trends might appear. On the one hand some areas will become de-designated, which will tend to decrease the number of GPs in designated areas; other areas, by contrast, whilst attracting some extra doctors, will not receive sufficient to cause their de-designation and hence the number of practitioners in designated areas will tend to increase. The difficulty is that the methods by which the statistics are collected are such as to offer no means of separating out these trends, for they fail to show changes over time in the same areas.

Some rough judgment can be formed by considering net changes in the total number of doctors together with changes in the number of designated areas, but even this may not yield any clear-cut indication, for area boundaries are changed, some areas are amalgamated and others divided. It will be seen from this example, however, that an increase in the number of GPs in designated areas, taken in isolation, cannot necessarily be interpreted as an adverse trend. By similar reckoning a fall in patient/doctor ratios in designated areas may not necessarily be evidence of any improvement, for it may be accompanied by a deterioration in the national manpower position and a consequent spread of designation resulting in a lower mean ratio for designated areas as a whole.

The point in making these observations is not to dismiss the available statistics as meaningless, but rather to show their limitations.

The number of practice areas

First, Table 2.1 in the original report, showing the classification of practice areas at 1st January 1966-1970, is updated in Table 3. The figures in the table are drawn from the MPC lists and therefore (for reasons stated above) differ slightly from the number of areas recorded in the MPC survey. The table illustrates the steady decline in the total number of practice areas (of about 15 per cent) between 1966 and 1973 due to amalgamations. The designated areas increased slightly as a proportion of the total from 1966 to 1969, remained constant at 20 per cent for a further two years, and have since declined both absolutely and as a proportion. The restricted areas, by contrast, display a contrary trend: they decreased somewhat as a proportion of the total until 1969, since when they have increased to the stable figure of 36 per cent. Intermediate areas have increased steadily, in both absolute and relative terms, in almost each year between 1966 and 1973; open areas have declined, also in absolute and relative terms, but at a somewhat faster rate.

The major reason for the declining proportion of designated areas since 1971 has probably been the steady increase in the number of unrestricted principals in England since about 1969. Between October 1970 and 1971 there was a net increase of 1.4 per cent in the stock of principals, with a further increase of 2.1 per cent between 1971 and 1972 (Table 4). This rate of increase was faster than the rise in population, with a resulting decline in the ratio of patients to doctors. The trend figures on average list size are set out in Table 5, which updates Table 1.1 in the original report. Because of the arrangement of the Department's statistics of patient/doctor ratios, the figures in this table refer to England and Wales up to 1970 and to England only from 1970 onwards. They are drawn from the DHSS tabulations and therefore make no allowance for restricted principals or assistants. The table shows the decline in the average list size in England and Wales since 1969 and in the designated areas since 1966. In England alone the decrease in the average list size between 1970 and 1972 was 2.3 per cent in the country as a whole and 0.7 per cent in the designated areas. The trend in the designated areas is particularly encouraging because since 1969 the average began to fall in England and Wales also. In the restricted areas, by contrast, average lists have risen each year since 1968 in England and Wales, thereby reducing the range between the averages of designated and restricted areas from 952 in 1969 to 841 in 1972.

These trends are interesting. In the original report of the designated area study a distinction was drawn between the extent of the designated areas (measured by the number of such areas) and the depth of the problem (measured by the number of additional principals required to de-designate an area). The evidence available when the original report was submitted indicated two broad trends in the post-war period. Up to about 1961 a substantial improvement was noted in the extent of the problem, for the number of designated areas declined. But average list sizes in those places which did remain designated stayed as high as ever and those in restricted areas stayed as low as ever. Between about 1962 and 1970 (the latest date covered in the original report) the patterns switched: there was during this time a growth in the number of designated areas but, during the latter part of the period, a decline in their average list size. The evidence now available suggests that since about 1969 the dominant trends have shifted yet again, with the proportion of designated areas decreasing simultaneously with a decline in the average list size of those remaining designated. This would certainly appear to be a favourable trend, although without knowing the circumstances under which areas were apparently de-designated it is difficult to be sure of the precise dynamics at work in the situation.

As the number of designated areas has fallen over the past few years, so too has the number of principals working in designated areas. The ambiguity of this must again be stressed, for if there has been a decrease in the number of designated areas over a period of time there must in fact have been an increase in the number of doctors in those areas which were designated at the beginning of the period. Table 6, showing net changes in the number of principals, gives some indication of this. Between 1969 and 1972 there was a net increase of 874 family doctors in England, and of this number 367 (42%) can be attributed to net flows to areas designated at the time of admission, causing some to be de-designated and others to improve their patient/doctor ratios. It is against this background that changes in the numbers of principals in designated areas must be viewed. In 1970 these areas in England contained 6,438 principals, but the figure fell to 6,177 in 1971 and 5,099 by 1972. As a proportion of all principals in England these figures represented 34 per cent in 1970, 32 per cent in 1971 and 26 per cent in 1972 (Table 4).

However, because the designated area allowance, once awarded, continues to be paid for a concessionary period of three years following de-designation,

the number of principals in receipt of the allowance has continued to rise. The probable delays in formally deciding whether or not an area should be de-designated may be a further factor underlying the trend. The figures are set out in Table 7. In October 1970, 4,985 doctors were receiving either Type 1 or Type 2 allowances (the DHSS figures do not distinguish the two allowances for that year). By 1972 the number had increased to 6,257 (a rise of 25 per cent), even though at that time there were only 5,099 principals actually in designated areas. At that date (October 1972) 32 per cent of all unrestricted principals in England were in receipt of one or other of the allowances. The Type 1 allowance accounts for by far the larger proportion of payments: more than nine out of every ten doctors receiving an allowance had the Type 1. The number of doctors receiving an initial practice allowance is very much smaller, although the percentage increase between 1970 and 1972 (17 per cent) is similar to that for the designated area allowance (Table 7).

The costs of the two allowances are also shown in Table 7. Between 1968-9 and 1971-2 expenditure on the designated area allowances rose from £1.4m. to £3.4m. By March 1972 the annual expenditure was averaging about £548 per doctor receiving an allowance. The total cost of the initial practice allowances is less than a tenth of the designated area allowance, but it too has risen between 1968-9 and 1971-2, by £124,000 (81 per cent).

One aspect of the designated areas problem with which the original report was much concerned was that of its geographical dimensions. Data were presented showing the geographical spread of designated areas and, to the extent that it was possible, the way in which changes over time had affected different parts of the country. It was shown, for example, that although the proportion of principals in designated areas had fallen slightly across the country as a whole between 1969 and 1970, only two of the standard regions (the East Midlands and the South East) had experienced a similar decline. Table 8, which updates Table 3.5 in the original report, shows the numbers of <u>all</u> principals and the proportions of principals in designated areas in each standard region in 1970, 1971 and 1972 and also the percentage change between 1970 and 1972.

In England the number of all principals increased by 3.5 per cent between 1970 and 1972. The North, Yorkshire/Humberside and the East Midlands increased by a lesser percentage; the South East, South West and North West

increased by a comparable percentage; and in East Anglia and the West Midlands the increases were somewhat greater than the national rate. With this, there was a decrease of 21 per cent in the number of doctors in designated areas in England, which, taken together with the decrease in the number of designated areas and in the average list size of those remaining designated, indicates a favourable trend. But the percentage change in each region varied considerably around this figure. Four regions experienced a percentage decline lower than that for the whole country: East Anglia (4 per cent), the North West (14 per cent), Yorkshire/Humberside (17 per cent) and the North (20 per cent). In one region, the East Midlands, there was actually an increase in the number and proportion of doctors in designated areas, due to the re-designation of some urban areas; this is a finding which on the surface suggests a set-back to the modest improvements in the region noted between 1968 and 1970. The three remaining regions (the South East, South West and West Midlands) each did rather better than average, reducing their principals in designated areas by larger relative amounts than the country as a whole. These figures reinforce the conclusion from the original study of the advisability of a continuous monitoring of available statistics in order to spot potentially undesirable trends at an early stage.

THE NUMBER AND LOCATION OF PRACTICE AREAS

Much of the current available information about the number and location of the medical practice areas has already been presented. To summarise:

- at 1st January 1973, 16 per cent of all practice areas in England were designated, 24 per cent were open, 24 per cent intermediate, 36 per cent restricted (Table 3).

- at October 1972, 26 per cent of all unrestricted principals in England were working in designated areas, 36 per cent in open areas, 26 per cent in intermediate areas, and 12 per cent in restricted areas (Table 4).

- at October 1972, 29 per cent of all NHS patients were registered with doctors practising in designated areas, 37 per cent with doctors in open areas, 24 per cent in intermediate areas, and 10 per cent with doctors in restricted areas (Table 2).

These figures, taken together, clearly indicate disparities in the size of different types of areas, a point discussed in greater detail below.

- on average during the year April 1972-73 the counties contained 55 per cent of all unrestricted principals in England and 54 per cent of principals in designated areas; the county boroughs contained 27 per cent of all principals and 41 per cent of principals in designated areas; Greater London had 18 per cent of all principals but only 5 per cent of principals in designated areas (Table 13).

These figures indicate that the designated areas themselves, and the principals working in them, were more than proportionately concentrated in the county boroughs, and were considerably under-represented in the Greater London Area.

Tables 9 and 10 add further detail to the picture of the geographical distribution of practice areas and principals. Table 9, which is drawn from the MPC survey, shows the classification of practice areas within each standard region; Table 10, which is based on the DHSS tabulations, gives the distribution of principals by type of practice area within each region. From the information in Table 9 it is seen that the regions differed considerably in their distribution of practice areas in 1972-73. In the North West three-quarters of the practice areas were designated or open and fewer than one in ten was restricted. In three regions (Yorkshire/Humberside, East Midlands, West Midlands) about half the areas were designated or open, but the mixed characters of these regions is shown in the fact that at least a quarter of the areas were restricted (one-third in the case of the East Midlands). In the North and the South East about two-fifths of practice areas were designated or open; the North also had a high proportion of restricted areas (45 per cent). The remaining two regions (East Anglia and the South West) have always had low average lists, and this is reflected in the table in the low proportions of designated and open areas and the high proportion of restricted areas (as many as two-thirds in the South West). Expressing the percentages the other way, more than two-thirds of all designated areas in the country (68 per cent) were situated in the North West, Yorkshire/Humberside and the East and West Midlands.

Table 10 should be read in conjunction with Table 9. The comparison shows, first, the similarity in the ranking of the regions in each table, with Yorkshire/Humberside, the East and West Midlands and the North West having the

highest proportions of designated/open areas and of principals working in those places, and with East Anglia, the South East and the South West having the lowest proportions. But more important than this, the tables show that in almost every region there was a higher proportion of principals in designated areas than of designated areas themselves and conversely a lower proportion of practitioners in restricted areas than of the areas themselves. In the case of intermediate areas (and to a lesser extent open areas also) the proportions were very much closer. These findings are a further indication (more marked in some regions than in others) of the disparities in the size of areas, especially of designated and restricted areas. It is to this matter that the analysis must now turn.

THE SIZE OF PRACTICE AREAS

The size of a practice area may be classified in terms of, inter alia its acreage, population or number of practitioners. The latter two would yield comparable results between areas if the ratio between population and practitioners were the same in each area, but given the substantial range in list sizes which actually exists, a choice must be made between the two. For the purposes of this section, the number of doctors practising in an area has been chosen as the indicator of its size, partly because this accords with the traditional way of thinking about size and partly because the number of patients, if that were chosen, would be the number registered in the area, not living there.

Table 11 contains the information extracted from the MPC survey about the relationship between the size and the classification of practice areas. Taking all areas together, almost one in ten were single-doctor areas and a further fifth contained between two and four doctors. Over half the areas had fewer than ten principals. At the other end of the size scale, 12 per cent of areas contained 30 or more principals, 5 per cent contained 40 or more, and 2 per cent had 50 or more doctors. (There were in fact 12 areas with at least 75 doctors each). These figures are considerably at odds with the 'ideal' area size recommended by the Medical Practices Committee of about 30 doctors.

However, it is clear from Table 11 that the size of areas varies considerably with their classification. To put the point simply, the majority of restricted areas are small and the majority of small areas

are restricted; conversely, the majority of designated and open areas are relatively large and the majority of large areas are designated or open. For example, whereas more than nine out of every ten restricted areas contained fewer than ten principals, the proportion fell to between 20 and 30 per cent in the designated and open areas. Conversely, about two-fifths of designated and open areas had at least 20 principals compared with only 4 per cent of restricted areas. A different facet of the same relationship between area size and classification is expressed in the bottom row of Table 12, showing the mean number of principals in each type of area. Designated and open areas contained, on average, about 20 principals each, whereas restricted areas had only a quarter as many.

These figures merely describe a situation; they cannot offer explanations. But other aspects of the study suggest possible explanations for this marked variation in size. There is, for instance, a geographical factor involved. County areas with relatively dispersed populations will tend to yield small practice areas (especially where area boundaries substantially follow those of rural districts), and it is known that restricted areas tend to be located disproportionately in predominantly rural localities. Large towns and boroughs, on the other hand, which for politico-historical reasons have tended to remain as single practice areas, are much more likely to have large lists and hence to be designated. The influence of the geographical factor is illustrated in Tables 12 and 13, which show the distribution and average size of each type of area in the counties, the county boroughs and in Greater London. Regardless of the area classification, practice areas in county boroughs and Greater London contained, on average, at least twice as many principals as those in the counties and in some cases three times as many. This, coupled with the greater concentration of restricted areas in counties than elsewhere and the larger proportion of designated areas in boroughs than in counties, doubtless explains a large part of the variation in size between designated and restricted areas.

There are, however, other influences at work. The nature of the overspill rule, for example, makes it virtually impossible for a one-doctor area to be designated, for the list would need to be at least 5,000. By the same reckoning the minimum average list per doctor for a two-doctor area to become designated would be 3,750, for a three-doctor area 3,333, and for a four-doctor area 3,125. Designated areas, in other words, are

inherently unlikely to be very small. Closely related to this is the volition of the local medical community. Local medical committees are understandably anxious to secure the designated area allowance for as many practitioners as possible and will therefore wish to keep the designated areas as large as is consistent with their continuing designation. The same pressures may, of course, work to diminish the size of an area if the fragmentation of, say, a large intermediate area would create new, smaller designated areas; but even in this situation the fragmentation would in principle probably be done in such a way as to optimise the coverage of the designated areas. Evidence about the nature and extent of professional control over the admission of new doctors to areas is presented in Section 6.

The distribution of principals by size and class of area is shown in Table 14 which, like the previous two, is based upon data from the MPC survey. It shows, for example, that almost two-thirds of principals in restricted areas, but less than a tenth of those in designated or open areas, were working in practice areas with fewer than ten doctors; and only a fifth of principals in restricted areas, compared with more than twice that proportion in designated or open areas, were working in areas with more than 30 doctors. The percentages in Table 14 obviously spread farther down the table than in Table 11, for a small number of areas, each containing a large number of doctors, will inevitably constitute a larger proportion of doctors than of areas. Conversely, small areas will tend to constitute a higher proportion of areas than of doctors.

THE AVERAGE LIST SIZE IN AREAS

The basis for the classification of practice areas is their average list size. The Medical Practices Committee commonly takes other evidence into account in reaching decisions about classification, but it seems generally to be assumed that most areas fall within the normal range of list size for their classification. In order to examine this assumption, and also to describe the distribution of areas <u>within</u> the classification ranges, a tabulation was made from the MPC survey data relating the classification of areas to their average list size. This is the first time such information has been available and it is set out in Table 15.

The table gives the percentage of areas of each type falling within the given list size bands. The range between 2,500 and 2,749 is shown in

intervals of 50 because designated areas falling within this range are at greatest risk of becoming de-designated and are therefore of special interest.* Taking all areas together, 63 per cent (containing 58 per cent of all unrestricted principals) had average lists below 2,500; 21 per cent (with 29 per cent of principals) fell within the 'marginal' range between 2,500 and 2,749; and 16 per cent (containing 13 per cent of all principals) had average lists above 2,750. There were obviously considerable variations between area types. Of the restricted areas only a third ostensibly fell within the normal criterion of restriction (i.e. with an average list below 1,800) although almost nine out of every ten restricted areas had average lists below 2,500. Of the intermediate areas a similar proportion (84 per cent) apparently had average lists below 2,500, but the bulk of these fell within the band 2,100 - 2,499 which is in fact outside the normal criterion for this type of area. About half the open areas ostensibly fell within the appropriate criterion (i.e. with average lists between 2,100 and 2,499) but the other half all had lists above 2,500 and almost one in five had average lists in excess of 2,600. The negligible number of designated areas with average lists below 2,500 can be discounted; what is rather more interesting is that 40 per cent came within the range 2,500 - 2,749 and 42 per cent within the range 2,750 - 2,999. Seventeen per cent of the designated areas had lists in excess of 3,000.

A separate analysis (not shown in Table 15) of the 267 areas which according to our estimates qualified for the designated area allowance at the time of the survey showed that 8 per cent had average lists below 2,500 (these areas having been de-designated since qualifying); 40 per cent had lists between 2,500 and 2,749; 37 per cent had lists between 2,750 and 2,999; and the remaining 15 per cent had lists above 3,000. These percentages are very similar to those for <u>all</u> designated areas, whether qualifying for the allowance or not.**

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* There is no officially accepted definition of a 'marginal' designated area. The nearer the average list size comes to 2,500, the greater is the risk of de-designation with the addition of one or two extra principals; hence the special interest in areas falling within the range 2,500 - 2,749. In fact, however, the best definition of a marginal area may be that in which the addition of <u>one</u> extra principal would cause de-designation. On this basis, areas with average lists as high as 3,000 could be marginal if they contain only a few doctors. Of the 247 designated areas in the MPC survey, just over a quarter were marginal on this definition.

** Of the 267 qualifying areas in the survey, 224 were designated, 40 open and 3 were restricted. Thus, of the 247 designated areas in the survey 91 per cent qualified for the allowance.

The data in Table 15 confirm the conclusions drawn from the original study about the variability of list sizes within area types, but one must be cautious before concluding either that there is widespread misclassification of areas or that the Medical Practices Committee very frequently classifies on a basis other than list size. Virtually all the apparently misclassified areas with average lists in excess of 2,500 can be explained by the inflation factor which, as pointed out elsewhere in this section, is taken into account by the Committee in its decisions. The effect of allowing for inflation may be considerable. A 10 per cent deflation in an area with an ostensible average list of 2,750 would yield a 'true' average of 2,475; and a 6 per cent deflation of an original list of 2,650 would yield a corrected figure of 2,490. It is probable that almost all the open areas with average lists above 2,500 can be justified by virtue either of the inflation factor or of the overspill rule, for it is unlikely that doctors would willingly accept an 'open' status for areas which should strictly be designated.

Table 16 gives the percentage distribution of principals by the classification and average list size of areas. This, together with the preceding table, highlights the fairly large proportion of areas with largish lists - what we have called the 'depth' of the problem. Forty-two per cent of designated areas (containing 35 per cent of all 'designated' principals) fell within the range 2,750 - 2,999 and a further 17 per cent of designated areas (with 8 per cent of principals in such areas) had average lists of 3,000 or more. These figures suggest that the most urgent need continues to be that of channelling manpower resources to areas with high lists, although in doing so the impression will be given (at least in the short term) of a worsening situation. This is because the majority of high list areas require several more doctors before they can be de-designated and for a while the proportion of principals in designated areas will rise. In fact only just over a quarter of the designated areas in the MPC survey were marginal in the sense that the addition of only one extra doctor would probably cause de-designation.

A rough estimate, based on the size of areas in the MPC survey and allowing for an average inflation of 4 per cent, suggests that the elimination of designated areas with average lists above 2,600 would require well over 300 extra doctors. More than a quarter of these would be needed in designated areas with average lists above 3,000 and over half in areas with

average lists between 2,750 and 3,000. To reduce the average list size in all designated areas to 2,500 would require a net addition of some 540 doctors to the 5,065 already practising in designated areas at the time of the MPC survey (an increase of 11 per cent). This can be compared with thee results of an exercise undertaken by the Medical Practices Committee, relating to March 1967, in which it was estimated that an extra 686 doctors would be needed to reduce the average list size in all designated areas to 2,500, an increase of 13 per cent on the 5,377 doctors then practising in designated areas.

Taking the DHSS figure of 120 net admissions to designated areas in 1972 (Table 6), it may just be possible to eliminate all areas with average lists in excess of 2,600 within three years. This estimate is based on the very optimistic assumptions that the trend of net admissions to designated areas continues and that the extra numbers go to the worst areas (i.e. those with the highest list sizes). It disregards changes in vocational training requirements and the trend towards increased outside commitments. Moreover, there is strong evidence (see page 43) that the recent improvement in recruitment has been greater in marginally than in chronically designated areas, which adds to the unlikelihood of substantially reducing the number of high-list areas within the near future.

The regional distribution of practice areas by average list size is set out in Table 17. The basic impact of this table is clearly similar to that of Table 9 which presented the regional distribution of areas by their classification. The South East and South West, for example, had the highest proportions of areas with average lists below 2,500 and the lowest proportions with average lists in excess of 2,750. But a number of interesting details emerge from the table which illuminate the inter-regional variations in list size. The North had a very high proportion of areas with lists below 2,100: almost as high, in fact, as the South West. The South East, by contrast, had a low proportion of such areas: almost as low as the North West, although in the South East the situation was eased by the considerably larger proportion of areas in the range 2,100 - 2,499. At the other end of the range the East Midlands had at least twice as many areas with lists above 3,000 as virtually every other region, and it had the second highest proportion of areas with lists above 2,750. (The North West ranked first on this measure, with exactly a third of its areas averaging over 2,750). It is, however, interesting to see East Anglia in third rank. In the 'marginal' range between 2,500 and 2,749, the regions with the greatest relative number of

areas were the West Midlands, the North West and Yorkshire/Humberside; those with the smallest proportions were the North, East Anglia and the South West.

The table also illustrates the important point of the dispersion of list sizes within regions. In most regions at least 10 per cent of areas had average lists below 1,800 and 20 per cent had averages of 2,750 or more. Such variability within regions restates the point that the larger the unit the less capable it is of discriminating local patterns. For this reason any manpower policies based upon regional averages would almost certainly be inadequate.

AVERAGE LIST SIZE AND SIZE OF AREAS

Information presented so far has dealt with the size of practice areas (measured in terms of the number of principals) and with the average list size in areas. How do these two statistics relate to each other? The MPC survey enables the question to be answered for the first time.

Tables 18 and 19 give the distribution of practice areas and of principals in the MPC survey by size (number of principals) and average list size. Note that these tables, unlike most others in this section are in absolute numbers, not percentages. The most important conclusion is seen immediately in the overall shape of Table 18: the dispersion of average list size decreases as the size of area increases. Among the smallest areas (1-4 principals) the average list size ranged from under 1,800 to more than 3,500, and only two-fifths of these areas fell within the centre of the range (between 2,100 and 2,750). As the size of areas increases so also does the proportion of areas coming within this central range. For example, of areas with 5-9 principals, 53 per cent came within this range; of areas with 10-19 principals, 64 per cent came into the range; and among areas with more than 40 principals the proportion was at least 90 per cent. Correspondingly, the number of areas at the extremes of the range decreased with increasing area size and almost no areas with more than 20 principals had average lists either above 3,000 or below 1,800.

Separate analyses made for each class of area showed that the basic 'inverse pyramid' shape held good for each area type, albeit with the designated areas pushed very much farther to the right of the table and the intermediate and restricted areas located nearer to the left.

Table 19, giving the distribution of principals by size and by average list of areas, is included to show the relative importance of the larger areas. As in Table 18 the larger the practice areas the greater the proportion of doctors working in areas with average list size clustering around the national mean. Conversely, the smaller the area the greater the proportion of principals in areas with area averages dispersed more widely around the national mean.

The information in Tables 18 and 19 was not available at the time of the original study, but the major conclusion to be drawn from the tables, that the dispersion of average list size decreases as the size of areas increases, was predicted on the basis of other data. It was shown, for example, how regional or even county patient/doctor ratios will obscure smaller areas of severe shortage, since it is in the nature of the mean that the low will offset the high values. What the original study was unable to do was to give any indication of an optimum area size. Table 18 does not supply a clear-cut answer but it does offer guidelines. If, for example, the size of areas should be such as to distinguish localities with substantially differing patient/doctor ratios, then the maximum number of doctors in an area would be about 20. If there are many more than this, the ratio will tend to move towards the national figure and will lose sensitivity. In fact at the time of the MPC survey almost a quarter of the practice areas (containing 60 per cent of all unrestricted principals) contained 20 or more doctors, suggesting that perhaps the most pressing need is a critical review of these larger practice areas.

It should be understood that these conclusions about a desirable area size are based solely upon the premise that practice areas should in principle be sufficiently small to identify major variations in average list size between reasonably distinct localities. There may, however, be other considerations (e.g. of stability or local circumstances) which support an argument for larger areas, and these cannot be ignored. What is suggested here is that the starting point in any decision about the location of practice area boundaries should be the size required to make a reasonably discriminating assessment of local needs, and this size should then be enlarged only in the light of additional considerations which are deemed to carry greater weight.

THE DISPERSION OF INDIVIDUAL LIST SIZES

Much of the information about list sizes discussed so far in this section has concerned the average list size in practice areas. That average, by its very nature, says nothing about the dispersion of individual list sizes within areas. Some information on this point was gathered in the original designated areas study, the report of which drew attention to the fairly wide range in list sizes of doctors in different types of practice areas. Of the doctors responding to the survey, for example, about a fifth of those in designated areas were in practices with fewer than 2,500 patients per doctor and conversely, about 40 per cent of doctors in non-designated areas had average lists above 2,500. In attempting to clarify the accuracy of these results it proved impossible to collect details of list size for every single doctor represented in the MPC survey, but unpublished tabulations were kindly supplied by the DHSS. They are summarised in Table 20.

The table confirms the finding from the original study about the wide dispersion of individual list sizes within each type of area. In designated areas 7 per cent of principals had lists below 1,900 and a further 22 per cent had lists between 1,900 and 2,500. In all, therefore, almost one in three doctors in designated areas had individual lists below the normal threshold of designation. In open areas the median list size was 2,495 which means that nearly half the doctors in these areas had lists above this figure (and almost one in five had lists in excess of 3,000). By definition these doctors would be ineligible for the designated area allowance, except during the concessionary period following de-designation. Even in intermediate areas a third of the principals had individual lists above 2,500 and in restricted areas the figure was 13 per cent. Among principals in all non-designated areas, 38 per cent had lists above 2,500, a figure very close to the 40 per cent estimated from the original study.

These results, as the original report pointed out, do not invalidate the arithmetic of the MPC in calculating mean list sizes, nor do they imply an undue delay on the Committee's part in revising the classification of areas as the doctor/patient ratios change. All they show is that by classifying an area principally on the basis of its mean list size, many individual doctors will have actual list sizes outside the defined range for the area. The discrepancy, which will be greater the larger the area and the more non-statistical factors are taken into account, assumes financial significance at the border between open and designated areas, and for these reasons needs careful assessment.

SECTION SIX

THE EXECUTIVE COUNCIL AND LOCAL MEDICAL COMMITTEE SURVEYS

METHODS

Both surveys covered all the executive council areas in England, excluding the Scilly Isles. The total of 116 areas comprised 47 counties and 69 county boroughs.

A covering letter and questionnaire were sent to each EC clerk and LMC secretary (see Appendix). Twelve respondents combined the roles of clerk and secretary within their areas and they tried, as far as possible, to wear the appropriate hat in completing each questionnaire. The EC and LMC questionnaires covered similar ground, but the wording of the questions differed somewhat. The first question, common to both forms, asked the respondents to comment on the suitability of existing medical practice area boundaries. The second question on the EC form solicited views on the general effectiveness of the designated area scheme; the LMC clerks were asked for more specific comments on the current basis for the classification of practice areas and on the effectiveness of the designated area and initial practice allowances. Two factual questions to the EC clerks, about the number of areas under their jurisdiction which qualified for a designated area allowance and about the relationship between the boundaries of medical practice areas and family practitioner committee areas, had no equivalent in the LMC questionnaire. Lastly, both sets of respondents were invited to comment on the reorganisation of the NHS, the LMC secretaries in general terms, the EC clerks with specific reference to working relationships between the FPC, the AHA and the MPC.

Most questions were open-ended, leaving respondents as free as possible to express their views. It is important in this connection that the questionnaires were addressed personally to the clerks and secretaries, and there was no specific request that they should consult their respective committees before replying. In the case of the EC clerks in particular it was felt that their personal views would be more valuable in relation to the objectives of the study than the formal views offered by a full council, for they have an almost unrivalled experience of the problems and difficulties of administering the family practitioner services and are well placed to evaluate the policy developments about which they were asked. The clerks' replies made it clear that in almost every case they were expressing their personal views, not those of their councils. The LMC

secretaries, on the other hand, are in a somewhat different position, most of them being honorary, part-time officers only. As a rule, therefore, they consulted with their committees before replying , and merely reported the committees' views on the questions.

The first mailing to the EC clerks was on March 21st 1973 and to the LMC secretaries on May 21st 1973. Forty reminders were sent on April 30th to clerks who had not yet replied, and one month later telephone calls were made to four clerks of large executive councils whose replies were still outstanding. Follow-up reminders were sent to 44 LMC secretaries on September 7th, and in addition a letter was sent to all LMCs from the British Medical Association asking for their co-operation in the survey. We are grateful to the BMA for this intervention, which doubtless had a substantial impact upon the response rate.

The response rates for the two surveys are shown in Table 21. The proportion of completed questionnaires returned by the EC clerks was 93% and by the LMC secretaries 82%. One positive refusal came from each group, and the remainder failed to reply or keep their promise of replying. In both surveys the response rates were a little higher in the counties than in the boroughs. There was little difference between respondents and non-respondents in the number of designated areas falling within their jurisdiction, but the response rates in both surveys were somewhat lower from clerks and secretaries in undivided boroughs than in divided boroughs or counties.*

THE BOUNDARIES OF PRACTICE AREAS

The first question put to the EC clerks was:

> 'Do you consider the present boundaries of medical practice areas within your Executive Council satisfactory for the purpose of ensuring a fair distribution of family practitioners in all parts of the Executive Council? If not, please state what changes you would like to see.'

The same question was put, with very slight modifications, to the LMC secretaries.

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* A county borough is said to be 'divided' if it contains two or more medical practice areas. An 'undivided' borough is thus one in which the whole of the EC area is also one single practice area.

Before reporting the detailed replies a distinction must be drawn between the area throughout which a doctor's practice extends, referred to here as a 'catchment area' and the 'medical practice areas' classified by the Medical Practices Committee. Some respondents made this distinction quite clearly in their replies, but others may have been referring mainly to the problems of catchment areas, not medical practice areas as intended. The two units, although often coterminous, are not identical, for whereas the boundaries of a GP's catchment area are often indistinct and overlapping with others (reflecting the freedom of patients to choose their doctor), the medical practice areas should normally have clearly specified boundaries and a defined population. (In fact in many rural practice areas the names appear to relate only to the location of the doctors' surgeries, without a clearly defined hinterland.) In many cases, of course, catchment areas may spill across one or more practice area or even executive council area. Where this occurs it is usual for the EC within which the greater part of the doctor's patients reside to have chief responsibility for administering that doctor's contract, even though his surgery may be located elsewhere.

Summary of replies

A summary of the replies is given in Table 22. Differences in the type of answer offered by the two groups of respondents has necessitated the construction of different response categories. The majority of respondents (73 per cent of the clerks and 61 per cent of the secretaries) found the present boundaries satisfactory. An additional 16 per cent of the clerks thought the boundaries were generally acceptable, albeit with some unavoidable deficiences. The most commonly expressed reason for being satisfied with the present boundaries was that of flexibility in being able to amend them when desired. About one in four of the secretaries and one in ten of the clerks expressed a clear dissatisfaction with their boundaries. In both surveys a slightly higher proportion of respondents from county than from borough areas were dissatisfied. The main reasons for dissatisfaction were the problems of fringe areas (particularly those adjoining neighbouring ECs), the failure to adjust area boundaries to keep pace with population movements, the overlapping of catchment areas within urban localities, and the heterogeneity of existing areas.

Area boundaries satisfactory

Respondents whose replies to the question took the form of a brief comment about the satisfactory nature of the present boundaries formed the largest single group in both surveys - 39 per cent in each case. But whereas among

the clerks the proportion was considerably higher from the boroughs than from the counties (58 per cent compared with 13 per cent), among the LMC secretaries the higher proportion of these replies came from the counties (43 per cent, compared with only 36 per cent from the boroughs). In part, as Table 22 clearly shows, these differences merely reflect variations between the two groups of respondents in their willingness to explain why they were satisfied. If, for example, the first two rows in each half of the table are combined, then an almost identical proportion of clerks and of secretaries in county areas were basically satisfied: the only difference is that rather more of the clerks offered an explanation for their views. In the county boroughs, however, the variations in response between clerks and secretaries were more pronounced: 76 per cent of the clerks expressed satisfaction (with or without comment) compared with 56 per cent of the LMC secretaries. Moreover, the difference persisted in both divided and undivided boroughs. In the undivided boroughs, 83 per cent of the EC clerks and only 49 per cent of the secretaries were satisfied with existing boundaries, and in divided boroughs the respective proportions were 64 and 46 per cent. It would appear, therefore, that in county boroughs the EC clerks were happier than the LMCs to preserve the status quo, and in particular they were more content to see the undivided boroughs remain as single medical practice areas.

Area boundaries satisfactory; explanation given

Respondents who explained in some detail why they felt their area boundaries were satisfactory represented 34 per cent of all the EC clerks and 22 per cent of the LMC secretaries (Table 22). For the reasons discussed above the proportion was very much higher for county than for borough clerks, but only a little higher for county than for borough secretaries.

A major reason given for satisfaction was the flexibility of the system. Boundaries can in principle be changed without difficulty provided there is agreement between those concerned. The Medical Practices Committee has the ultimate responsibility to approve area changes, but most of the clerks (especially of county ECs) stressed that the Committee usually - even invariably - agreed with the recommendations of executive councils. Others mentioned that the MPC itself frequently initiates boundary changes by suggesting possible revisions to ECs and LMCs. The Committee theoretically has the power to implement whatever changes it wishes, but in practice it always works through the medium of persuasion.

Many of the clerks of borough ECs stressed the flexible nature of the system of medical practice areas. Changes which had recently been introduced into boroughs or which were proposed for the near future sprang mainly from the needs of new housing developments, but other reasons were also mentioned. Of the five clerks of divided boroughs replying under this head, three reported that the division had been recent and had occurred after much thought and deliberation about the total needs of the borough. One complained that the MPC had refused permission to create a separate area, but two stated that their area boundaries were entirely satisfactory because they had resisted MPC proposals for change.

The problems facing the county boroughs and conurbations are very different from those of the counties with their extensive rural districts. The metropolis itself is a special case because many of the London ECs had yet to adjust their boundaries to coincide with those of the GLC area. At the time of the survey three of the councils followed the old boundaries of Middlesex, Surrey and Kent, and the Inner London Council covered the old LCC area; but the North East London EC was created to fall within the GLC boundary. Some of the changes reported by the London clerks concerned the transition from electoral wards or even the old boroughs to the new Greater London Boroughs. Outside the metropolis, most clerks in undivided boroughs stressed the compact nature of their areas as a virtue.

> 'The present County Borough area is treated for Medical Practices Committee purposes as one practice area. Being a small compact Borough, problem areas are generally not difficult to identify, when adequate provision can be made.'

> 'X County Borough is a similar area for Medical Practices Committee purposes. Because it is a heavily populated urban area with some practices having more than one surgery and some practitioners having patients all over the borough, this policy seems to be correct as there is a fair distribution of practitioners in all parts of the Council's areas. Splitting the area would at the present time cause many anomalies.'

A number of clerks of county ECs mentioned changes which had been made in the recent past. Others were in the process of overhauling their boundaries and others again intended to do so in the near future.

> 'Our boundaries have been reviewed to take account of population expansion and the gradual absorption of villages into more urban areas as the process of expansion proceeds.'

Examples were also given of county areas which had been divided because they were too large, and one clerk mentioned a comprehensive review of practice areas which led to a new division into area groups in order to yield 'a more realistic assessment of a fair distribution of medical practices in view of the movement of the population'.

The reason most commonly given by the LMC secretaries for their satisfaction with the existing boundaries was simply that they could be altered whenever this was felt to be necessary. Instances were cited where changes made were on the initiative of the LMC, or at least with its agreement.

> 'We are quite satisfied with the way practice areas are defined. We think they are satisfactory for encouraging, if not ensuring, a fair distribution of family practitioners in all parts, and that we think so is not surprising as, in fact, the boundaries used are of our own devising. The Executive Council, guided by the LMC and its appointed members, recommend how the divisions should be made and these have always been accepted by the Medical Practices Committee. When carried out in this way it can be ensured that local knowledge, both professional and lay, is of paramount importance.'

It was also pointed out by several secretaries that the present boundaries, though not always ideal, were the best in the circumstances, and that the very concept of an optimum area definition was a chimera.

> 'The boundaries of medical practice areas are probably as satisfactory as can be achieved when one considers the average radius of any one practice, which must mean that it is likely to draw on a very varied population. There can be no improvement which deals with the problem on an area basis. If the problem were dealt with by individual practices a better result would be obtained but the administrative problem would be too great for contemplation.'

Secretaries in undivided boroughs tended to echo their clerks in pointing to the small and compact nature of the boroughs as a virtue.

> 'I can only answer this question in relation to my own medical practice area which is a densely populated county borough. The definition is satisfactory and ensures a fair distribution of general practitioners within the whole area because the area is geographically 'small' and most practitioners therefore will accept patients from at least 80% of the area.'

One secretary made the interesting point that the EC has the power to withhold approval of premises, and in this way can exercise a form of negative direction <u>within</u> a practice area.

> 'The whole town is regarded as one unit and this seemed to the Committee to be satisfactory in ensuring a fair distribution of doctors in the town, particularly as the Executive Council can, in consultation with this Committee, withhold approval of premises under the Rent and Rates Scheme if an incoming doctor selects a small district in the town which may be less inadequately doctored than other districts.'

No other respondent mentioned this: on the contrary, several specifically mentioned the impossibility of having selective controls within an area.

Dissatisfaction with present boundaries

In all, 29 of the EC clerks and 23 of the LMC secretaries expressed some dissatisfaction with their existing boundaries (Table 22). These figures include the 17 clerks who felt there were unavoidable deficiencies, but exclude the 10 secretaries who thought that area boundaries were irrelevant. Their replies are considered later. The various causes of dissatisfaction are summarised in Table 23 (for the clerks) and Table 24 (for the secretaries). Both sets of replies are classified by the respondents' areas (county or county borough), and the clerks' replies are further classified by whether the problems were thought either to be unavoidable or to justify a change of boundaries. In both tables the number of replies exceeds the number of respondents because some respondents gave more than one reason.

The problem of the so-called 'fringe areas' was most frequently mentioned by the clerks as a cause of dissatisfaction with existing boundaries. The phrase describes a situation in which a doctor's catchment area extends through two or more medical practice areas or even executive council areas. Fringe areas typically occur where new housing estates are built on the outskirts of a large town or city and the population, though largely resident outside the borough boundary, remains for the most part registered with doctors inside the borough. In such situations the classification area may bear little relation to the actual catchment areas of the practice, and since the practice area is classified by the MPC on the basis of the average number of patients on the doctors' lists, not by the population residing in the area, a distorted view of the manpower situation may emerge. The following extracts illustrate the problems of fringe areas and population movements.

'The precise boundary bears little reality to general medical practice. The centre of the town has been progressively depopulated and families move three to six miles outside the borough to villages that become urbanised, and consequently all local doctors are also on the (neighbouring EC) lists to enable them to retain their patients who move into the urbanised rural areas.'

'In some instances a single classification covering the whole county borough acts unfairly on the patient since large council housing estates tend to be built on the periphery of the town, whereas the surgeries tend to be concentrated in a more central location. When this happens, it involves the patient in a considerable travel problem to get from one of the peripheral estates to central surgeries. This could represent a considerable demand on patients' time particularly in the case of mothers and young children. When this happens the single classification should be altered and the area divided to try to encourage surgery development on some of the peripheral housing estates.'

A fairly typical example of the problems posed by fringe areas is that of a county borough which is designated, but surrounded by restricted areas in the adjoining county. This occurs because patients moving from the borough to the peripheral areas (perhaps as a result of rehousing schemes) remain registered with doctors in the borough. The problem here is not necessarily one of shortage but of artficial boundaries creating inappropriate classifications.

'All practitioners have contracts with the adjacent executive councils and patients residing in the fringe areas are on the lists of this council's GPs. The fringe urban-rural areas are restricted. There must be co-operation with abutting executive councils otherwise the strict adherence to local authority boundaries for surgeries and deemed practice areas could upset the existing balance of the local manpower available to the potential patients in the area.'

A second stumbling block mentioned by the clerks in the satisfactory division of urban areas is the overlap of doctors' catchment areas within densely populated zones. All of the clerks who mentioned this problem regarded it as unavoidable because it arises from the nature of urban areas and the basic freedom of patients to choose their doctor.

'The vast majority of doctors have patients in every part of the town, and furthermore, when moving home the patients themselves display a strong loyalty and desire to remain registered with the same doctor. It would therefore be extremely difficult, if not impossible, to divide the town into practice zones, and to attempt to force patients to register with other practitioners.'

> 'The present method (single practice area) is not the optimum but the heavy concentration of doctors' surgeries in the town centre makes the present method of classification more meaningful and less misleading than attempting to split the town into districts.'
>
> 'Obviously they (medical practice areas) cannot be ideal because of the considerable amount of over-lapping between practices and also between areas with adjoining Executive Council areas. This position is, of course inevitable if patients' freedom of choice of practitioner is to be maintained.'

The freedom of patients to choose their family doctor and the freedom of doctors to accept or reject patients are basic rights under the NHS Acts, at least in theory. Most of the clerks regarded this freedom as of greater importance than the rationalisation of boundaries; but the resulting administrative difficulties were of concern to some.

> 'While doctors can have patients where they like (even in a restricted area provided they do not have a surgery there) it is impossible to give a clear-cut medical practice area served only by certain practices because there are always a few patients on other doctors' lists, the latter doctors being regarded as mainly serving another medical practice area.'

Although it was generally agreed by the clerks that such difficulties are largely unavoidable, one or two pointed out the benefits of a voluntary rationalisation of catchment areas.

> 'Voluntary zoning of practices in urban areas would, if operated widely enough, save an enormous amount of doctors' time in travelling, and thereby make far greater use of the available medical manpower.'
>
> 'It is interesting to see the reactions of doctors who have been shown a map of an area indicating the location of their patients. They have often been surprised at the spread of their practice areas and by mutual discussion amongst themselves have found it possible, on a purely voluntary basis, to effect some rationalisation of the distribution of patients between the various practices.'

The difficulties encountered in rural areas were mentioned by both clerks and secretaries (Tables 23 and 24). The secretaries' replies seemed to some extent to contradict each other. One wrote of the unwillingness of a single-handed practitioner in a large rural area to take a partner; another of the difficulties facing doctors wishing to expand their practices to cope with encroaching urbanisation; and the third regretted the constraints imposed in large, restricted rural areas.

> 'The single-handed doctor has to cover a large rural district and with nearly five and a half thousand patients does not find the financial benefits which would accrue on taking a partner sufficient to enable him to take a partner to meet his requirements until several years have elapsed.'
>
> 'Some of the rural areas which are becoming more urbanised are leading to practices which are probably too big and the doctors there are reluctant to take on the extra work. The only way this can be remedied is for the doctors in the area to take on new partners or for new practices to be formed. It is difficult to see how this can be done without some measure of compulsion or greater encouragement to the doctors.'
>
> 'Another difficulty arises where rural practitioners with list sizes of about 2,700 persons wish to take a partner but are precluded from so doing because their rural area is classified as restricted. Restricted areas should not only be restricted in the addition of principals but also very much in size. We have one - the only - doctor in a rapidly growing commuter village who is becoming more and more grossly overworked every year and yet, because he is in a restricted area, the MPC will not allow him to publish a suitably-worded request for assistance.'

The rural practices allowance takes account of the difficulties of sparsely populated areas by compensating doctors for their smaller lists and greater travelling distances. The designated area scheme, on the other hand, was not specifically designed to meet the problems of rural areas, which seem to spring as much from an unwillingness as from an inability of existing practitioners to take new partners.

The difficulties encountered in remote rural areas were also mentioned by the EC clerks, especially those in the counties. Some of these difficulties spring from the limitations placed by the doctors on their catchment areas.

> 'There seems to be a current tendency for doctors to redraw their boundaries so that their patients are nearer to their own surgery and this, I feel, if continued, will leave pockets of the population in rural areas who are at present on the lists of doctors in the nearest town, without a doctor. There will not be a sufficient number of patients in these areas to attract a new doctor and, although I would not want to restrict a doctor's freedom of action, it would seem that doctors in certain isolated areas may have to be encouraged to retain patients in these areas on their lists.'

Others wrote more generally about the unavoidable problems of isolated areas.

> 'In a large area interspersed by small towns, it is obvious the present medical classification does not fit all needs, but at the same time it is difficult to envisage an ideal practice area boundary particularly in rural areas.'

'It would be extremely difficult in such a rural and, in parts, sparsely populated areas this, to lay down hard and fast boundary lines beyond which individual medical practices may not operate.'

Seven of the clerks and 14 of the secretaries felt that the existing boundaries created practice areas of an inappropriate size - usually too large. The views of the EC clerks who were concerned about the large size of their practice areas are typified in the following reply.

'In my view, efforts should be made to reduce the size of the practice areas. By doing this, a much clearer indication would be given of those particular areas where additional doctors were really required. There can be no doubt that many doctors at present working, for example, in large designated areas, are quite capable of coping with their workload because that particular part of the area in which they practise has a smaller patient/doctor ratio than other parts of the same area.'

Similar views were expressed by the LMC secretaries, as the following case illustrates.

'Some years ago a single urban district in the area was designated and the doctors practising in that district received a Type 2 designated area allowance. This district was subsequently amalgamated with two other single districts, thereby reducing the overall list size in the first district to under 3,000 persons per doctor. The amount of the workload in the first district didn't decrease and quite naturally the doctors in this district felt aggrieved at subsequently receiving a smaller designated area allowance payment. The point is made that an additional doctor in one particular area will not have the effect of reducing the workload in another area.'

The replies of many secretaries were briefer.

'The areas are too large and conceal within them considerable variations of distribution of doctors.'

'It is not satisfactory when boundaries cover too large an area, because there are frequently variations in different sections of this area.'

'In the larger medical practice areas doctors are not necessarily directed to the areas of the town requiring additional practices and certain parts of the town should not, perhaps, be classified as designated.'

One clerk felt that the MPC was encouraging ECs to introduce larger areas under pressure from the DHSS.

'I suspect that the MPC have pressed Councils to introduce larger areas because they would be administratively tidier. I also suspect that there was a feeling in the DHSS that the creation of

> larger practice areas would result in fewer designated areas with a consequent reduction in the payment of the various area allowances. In other words, I think the Department of Health's duty to save public money may well have become somewhat confused with the MPC's duty to secure an even distribution of family doctors.'

No such specific comment came from an LMC, although one secretary felt that the MPC did have a consistent policy.

> 'Some degree of uniformity in population of practice areas would seem to be more logical. We believe that the MPC takes the view that population groups of about 60,000 are suitable for classification.'

The problems of areas that are too small were clearly of less concern to clerks and secretaries than those resulting from large areas. The clerks tended to mention in this connection the need to ensure a sufficient choice of doctors; the secretaries were more concerned with the rapid changes in classification which may occur in smaller areas. The following are the replies of, respectively, a clerk and a secretary.

> 'I would prefer the practice areas to be larger in size in order to enable patients to have a wider choice of doctors. A possible objection to this suggestion would be that medical centres in the large towns or villages of population would result in patients living in rural areas being involved in considerable travelling to see their doctors.'

> 'We had much discussion of this question about a year ago. We thought that the "practice areas" were too small, with the result that the addition or subtraction of even one doctor resulted in a change of classification, and that these changes in consequence were unnecessarily frequent.'

At any event, it is clear that boundary changes, however ideal, will not readily be made if they threaten to reduce the number of doctors receiving the designated area allowance.

> 'Some revision ought to be undertaken having regard to the development of urban roads and clearways but this is going to be difficult if not impossible because redrawing a line may deprive someone of entitlement to the designated area addition.'

> 'The one medical practice area system (i.e. in a county borough) tends to hide the grossly underdoctored small areas. If we removed these type 2 areas from the calculations, the remainder of the areas would be in danger, in the future, of losing type 1 status.'

Four of the LMC secretaries were critical of practice area boundaries which, by following local government or other administrative boundaries, lead

to artificial or unrealistic divisions. Rational solutions to remove such anomalies may, however, be vetoed unless a consensus can be reached. The problem discussed above, of introducing changes which might affect the payment of the designated area allowance, was also mentioned in this context.

> 'Two years ago the clerk of the Executive Council and myself tried to put them into more geographical areas but this brought an outcry from some doctors in designated areas as they would have lost their allowance if amalgamated.'

> 'Much thought has been given to trying to define different boundaries for practice areas, but this has proved to be difficult in a Metropolitan Area. Solutions to such difficulties has not been made easier by the awareness of the effect of changing boundaries, and hence classification, on the designated area allowance. The consideration of boundaries has in most cases arisen out of an awareness that practice areas are too large. Within these large areas, especially in those which are designated it is possible for individual practitioners or partnerships to enter into arrangements which prejudice the fair distribution of family practitioners in all parts of the area. In large areas, it is quite possible for an additional doctor, or additional doctors, to be introduced into a part of the area where there is no need for extra doctors. These arrangements are made possible by the Group Practice Allowance, the Designated Area Allowance and in some cases by the Initial Practice Allowance (Type C). In this way, the medical manpower in one part of the practice area may be augmented without it having the slightest effect on the list sizes of 75-80% of the practitioners in the same practice area. Taken all over however, the average list size may drop below 2,500 (or have a surplus which is not considered sufficient to warrant the introduction of another principal) and the area is soon reclassified "open" from "designated". To ensure a fair distribution of family doctors in all parts of a medical practice area it is necessary either to reduce the area of such practice areas or to introduce a greater degree of control over the arrangements for admitting additional doctors to the list. If practice areas were reduced in size so as to contain 10 or 12 principals, a fairer distribution of family practitioners could be achieved.'

The irrelevance of boundaries

Ten of the LMC secretaries gave replies to the question about practice area boundaries which indicated neither satisfaction nor dissatisfaction with existing boundaries, but which expressed the view that the issue of boundaries is irrelevant to the distribution of family practitioners (Table 22). One reason given was that doctors' catchment areas, extending beyond practice area boundaries, are unaffected by those boundaries.

'I do not consider that the existence of these boundaries plays any significant part in the distribution of practitioners. In my own town practitioners are frequently on the list of three different Executive Councils.'

'I am doubtful whether the boundaries of the medical practice area play an important part in ensuring a fair distribution of general practitioners within that area. To think that alterations in the boundaries of any of the districts of the new county will have any influence on the distribution of general practitioners within that area, is illusory.'

More fundamentally, a few secretaries questioned the concept of a 'fair distribution' and the utility of attempting to identify geographical units for the purposes of assessing manpower distribution.

'This question uses the word "fair". We wonder to whom the distribution is to be deemed fair: the doctors, the patients or planners. We consider that a GP no less than anyone else must be entitled to decide for himself where he lives and works, and whether he wishes his priorities to be professional, financial, or domestic. Only a system which allows him to make that choice freely can in our opinion be regarded as fair.'

'In our view any attempt to define medical practice areas on an arbitrary geographical basis is bound to create anomalies for some doctors so far as their identification with a particular doctor/patient ratio is concerned.'

Similar views were expressed by some of the EC clerks. The following replies came, respectively, from the clerk of a county EC in the South-east, the clerk of a Metropolitan EC, and a clerk in an area of chronic manpower shortage.

'The boundaries as fixed and later amended, enable the Council to assess the medical manpower situation in each classification area, but they do little, I think, to ensure a desirable distribution of doctors in all parts of the country. They do of course prevent the admission of doctors in areas where there are considered to be sufficient doctors, but this does not necessarily ensure that doctors will seek to commence practice in designated areas.'

'While it is often administratively convenient to operate a system based upon clearly defined criteria and recognizable geographical boundaries, a greater degree of flexibility in assessing applications for inclusion in the Medical List could well be helpful in some, if not all, areas.'

'No matter how we carve up the area the answer remains that we must be designated. We are a small urban area, industrial and somewhat unpleasant in environmental terms.'

Principles of delineation

When medical practice areas were first proposed by the MPC, the guidelines for sub-dividing executive council areas were flexible, not to say vague, resulting in a great variety of size and conditions in them. Respondents were not specifically asked to describe the principles on which their area boundaries were or should be determined, but a number of the EC clerks did so spontaneously. Table 25 shows the summary results and the following extracts illustrate the replies.

> 'The present classification areas based on postal districts were chosen so as to facilitate practitioners applying for vacancies to identify the geographical location of the practice. However, as postal districts are not coterminous with Borough boundaries it has become necessary to redefine classification areas so that they do not cross Borough boundaries and thus the areas of the new Area Health Authorities, and this exercise is being undertaken this summer. The new classification areas will be based on electoral ward boundaries.'

> 'This executive council has from the early days of the health service regarded the ward divisions of local authority areas as suitable for units of area. The experience in recent years has suggested to the Medical Practices Committee that the individual ward is too small an area to be used for classification purposes, and the policy of the MPC is to treat larger areas such as those of the Greater London Boroughs as the preferable unit of classification, or an over-riding preference, where possible, of groups of about 30 doctors to each district area.'

> 'I wonder whether a more accurate picture could be gained of the medical manpower of an area if the practice areas of executive councils were to be made coterminous with one or more local government polling districts. The electoral registration officer would I believe be able to supply the estimated population of the polling district(s) and this figure could then be regarded as the patient potential of the particular practice area. The number of doctors whose main surgery premises lay in that area could be extracted from the Council's own records, together with the number of patients actually on their lists, and the question of whether the area was "over- or under-doctored" could then be determined on the resultant two sets of figures, i.e. patient potential and patient registration. Even under this method the problem would remain as to how to deal, without a great deal of administrative work, with that element of patients included in the doctors' lists who were not actually residing within the practice area itself and vice versa, that is, patients living in the practice area but on the lists of doctors outside the practice area.'

BOUNDARIES AND THE REORGANISATION OF THE NHS

The reorganisation of local government and of the National Health Service, both of which became effective on 1st April 1974, involves the revision of many traditional administrative boundaries, and, in some cases, the creation of entirely new territorial units. These changes are bound to affect the administration of general practice, for whereas the old executive councils were based on the former counties and county boroughs, the new family practitioner committees established by the area health authorities correspond with the boundaries of those authorities. The AHAs are coterminous with the new local government counties and metropolitan districts, or, in the case of London, with one or more of the London boroughs.

The effect of these changes on the medical practice areas classified by the Medical Practices Committee differs between counties and county boroughs, and between urban and rural areas. But the very process of reorganisation, involving as it has done the adjustment and realignment of existing territorial units and the creation of wholly new units, provides both the opportunity and the justification for rationalising practice area boundaries to take account of population movements between executive council areas, the isolation of many rural areas, the inappropriate size of many areas, and so on. In order to provide some background information about the relationship between the boundaries of the medical practice areas and those of the new Area Health Authorities, the EC clerks (but not the LMC secretaries) were asked the following question:

> 'Will any existing medical practice areas straddle the new boundaries of the Family Practitioner Committees? If so, do you consider that the boundaries of these practice areas be redrawn?'

Summary of replies

The clerks' replies are summarised in Table 26. Of the 108 executive councils represented in the survey, 43 (40 per cent) contained practice areas which it was thought would, as a result of reorganisation, fall across two or more FPC areas; 62 ECs (57 per cent) contained no such areas; and in 3 ECs (3 per cent) the position was unclear at the time of the survey. Of the 43 ECs with overlapping practice areas, 24 were in counties and

Catchment areas

The reason most frequently given to justify the redrawing of practice area boundaries was the need for viable areas which would correspond more closely than at present to the actual areas of residence of patients registered with doctors practising within a health area. This problem of fringe areas is not new. The view that it would be desirable to redraw boundaries in order to eliminate fringe areas is merely an extension of the dissatisfaction which several clerks felt about these areas. Reorganisation may have provided a new opportunity for reconsidering the definition of practice areas in these localities, for there is now no overriding justification for continuing to observe the old division between the county borough and its surrounding county. But new fringe areas may also appear where new boundaries have been created, and some old ones will remain. The following example was given of overlap along new boundaries.

> 'The medical practice areas as such will straddle the new boundary in many places by virtue of the fact that doctors' practices are not confined to boundary lines. We find that neighbouring FPCs will be 'responsible' for partnership practices actually sited within the county because the majority of registered patients are in the 'outside' county area, and vice-versa.'

An essential prerequisite to the definition of viable medical practice areas is the availability of up-to-date information about the location of patients. Some clerks reported exercises which had already been carried out in anticipation of reorganisation.

> 'Some interesting work has already been done by a number of ECs on the distribution of patients in particular practice areas and there is no doubt that at present a number of different doctors are covering the same areas, which is obviously wasteful of scarce resources.'

Others specified the relevant data needed for area definition.

> 'Ideally one would expect that the FPC would assemble all relevant data concerning an area, such as details regarding age and distribution of population; geographical factors such as motorways, railway lines, large open spaces, quality of public transport; and the age and state of health of existing doctors, etc. and that this data would be available to the AHA.'

Area and district boundaries

A second reason given to justify the redrawing of practice area boundaries was to make them coterminous with other standard territorial units. Not all clerks accepted this as a valid reason for change, but to some it was clearly an important consideration. The health district was mentioned more often than the area as the unit with which practice area boundaries should harmonise, especially where it was felt that the AHA boundary was artificial and cut substantially across patient flows.

> 'The question of districts is at this moment under review. The boundaries under the new local government legislation bear no relation to patient flows. In my view the area served by a district hospital would influence the size and pattern of areas as considered by the Medical Practices Committee.'

> 'We are currently fighting the battle of the districts - especially an appreciable overlap problem. No existing medical practice area will straddle the new boundaries of the FPC, except (possibly) in the overlap areas and these are not yet finally determined.'

> 'Our present medical practice areas will not straddle the new boundaries of the FPC but I consider that practice areas should be redrawn where overlap between adjoining family practitioner areas occurs so that practice areas should not straddle district health boundaries.'

Where there is no such conflict or problem of practice areas overlapping district boundaries, there is no reason why medical practice areas should not be coterminous with health districts and, therefore, in most cases with health areas also. To harmonise district and practice area boundaries does not of course mean that the practice area must necessarily be as large as the district, merely that the practice areas should always aggregate up to be coterminous with the districts. The question of size is also an important consideration in this regard. One clerk expressed concern about the possible difficulties confronting an AHA if the practice areas were too small:

> 'If the area health authority wishes to plan its manpower on the basis of health service districts or the new local government districts, it will probably run into difficulties through planning on the basis of districts which are large compared with the present classification areas.'

But others appeared to welcome the tendency towards larger practice areas, though none actually suggested that they should be as large as the health districts.

> 'It could well be that there will be a tendency in the future for the classification of areas to become enlarged and more in line with the boundaries of districts and this in turn should help to achieve integrated planning.'

> 'Many present boundaries will have to be redrawn. For the purpose of the MPC classification it will probably be convenient for the new FPC to survey each district council area as a separate entity, though this does not mean that it will be possible for each district to carry a single classification.'

Integrated planning based on reliable information was cited as another cogent reason for coterminosity of practice areas and health district boundaries.

> 'It is desirable, for forward planning purposes, for practice areas to be based on these districts as far as possible. This does not mean that each district should be regarded as one complete practice area because many would, in my view, be far too large for this purpose. However, there would be nothing to preclude a sub-division of the districts for practice area purposes. Once again, it would be desirable that the practice areas should not straddle the boundaries of the new districts, bearing in mind the viable practice area proviso.'

> 'I feel it might well be advantageous to consider redrawing MPC area boundaries, where necessary to be coterminous (perhaps in groups) with Districts; I feel that this would result in the production of more reliable information on which the Family Practitioner Committee and MPC would base their classification of areas.'

To sum up this section on reorganisation and boundaries, the overlap of practice area boundaries with those of other health service units, where this was likely to occur as a result of reorganisation, was not regarded as a major headache by most of the clerks replying in the survey. The system for changing the boundaries of practice areas is regarded as flexible at least as far as procedure is concerned (though in practice it may not always be easy to get a consensus among interested parties), and in this important respect the practice areas differ both from the health areas (the boundaries of which are tied to local government units), and from health districts (of which the boundaries, once determined, will presumably be changeable only under the most extreme circumstances). Among clerks who felt that

a redefinition of boundaries was needed within the territory of their jurisdiction (about two-fifths of the total) the most frequently mentioned reasons were the need to follow more closely the catchment areas of doctors' practices and the desirability of achieving coterminosity of practice area and health district boundaries.

CRITERIA FOR CLASSIFYING MEDICAL PRACTICE AREAS

The delineation of boundaries is not the sole administrative problem surrounding the medical practice areas. Considerable dissatisfaction has been expressed in the past about the use of average list size as the dominant criterion in the classification of areas. Since this issue appeared to be at least as relevant to the medical profession as the matter of boundaries, a question to this effect was included in the LMC survey (but not in the EC survey). The question was worded as follows.

> 'Do you consider that the present system, whereby areas are classified as designated almost exclusively on the basis of an average list size of 2,500 is sufficient to identify areas which are in need of extra doctors? If not, what changes would you wish to see introduced?'

Summary of replies

The secretaries' replies are given in Tables 27 and 28. Table 27 shows that, in total, exactly two-fifths of the LMC secretaries represented in the survey felt either that the present basis of classification was satisfactory, or that no feasible alternative could be found. There was no great difference between the county and the borough LMCs in this respect. However, 44 per cent of secretaries took the view that other factors (i.e. in addition to or instead of average list size) should be considered. The proportion of secretaries responding in this way was somewhat higher in the boroughs than in the counties (49 per cent against 37 per cent). Of the remaining secretaries, 8 per cent felt that the use of average list size as the major criterion was correct in principle but needed modification in application, and 8 per cent had no comment to offer.

The views of the 42 secretaries who thought that factors additional to (or instead of) list size should be taken in account in classifying the areas are elaborated in Table 28. Some of the secretaries gave

more than one classifiable answer. Almost half of these secretaries mentioned the workload and/or morbidity of the area as a relevant factor, the proportion being twice as high among the borough as among the county secretaries. On the other hand a classification based upon the characteristics of the doctors in the area (age, sex and outside commitments) appealed to relatively more county than borough secretaries.

Present criteria satisfactory

About two-fifths of the secretaries in both counties and boroughs were satisfied with the present system or could see no feasible alternative (Table 27). Several respondents pointed out, however, that classification is not based exclusively on average list size.

> 'We are informed that designation almost exclusively on the basis of an average list size of 2,500 is not the present system, for if it were there would be many more areas designated than are at present designated, thus bringing the system into even further disrepute.'

Although there can be no certainty in any individual case of the exact process by which the Medical Practices Committee arrives at a classification, it is true that the Committee normally has access to a fairly wide range of information about areas. The reports and surveys which ECs are obliged to submit to the Committee include a number of items of information relating to workload: rural practice payments, maternity medical services, 'dispensing patients', temporary residents, patients over 65 and patients in fringe and in limited or restricted practices*. Executive councils also have the opportunity of informing the MPC of GPs' outside commitments and of any development plans in the area.

In assimilating all of this information, allowance is made for doctors receiving less than the full basic practice allowance, and for the artificial inflation of lists resulting from delays in transferring patients' registrations from one practitioner to another.

Some secretaries expressed doubts about the accuracy of information supplied to the MPC and about the weight actually given to it. The suggestion was also made that the Committee is too secretive in its deliberations over these matters.

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* Fringe practices are those in which a majority of patients are registered with an EC other than that making the report. Restricted practices are those of single-handed principals with lists of less than 700 patients, who provide restricted services owing to age, ill-health, private practice, domestic or other commitments.

'The Medical Practices Committee in London supposedly takes into consideration other positions and appointments (i.e. Clinical Assistantships) held by General Practitioners in the area based on data collected by the Executive Council when taking decisions as to whether an area should remain designated or not; in practice the data at their disposal is often far from complete or accurate. Clearly if an assessment is to be made as to whether an area is under-doctored or not it must be based on accurate and complete information covering all the outside appointment and other interests of General Medical Practitioners in the Area.'

'We do not consider that the present system is sufficient to identify areas which are in need of extra doctors. During the current year there have been three instances in which the Medical Practices Committee have rescinded their previous decisions to de-designate areas on being pressed by the LMC to substantiate their reasons for re-classifying the areas. My Committee feels that all the factors taken into account by the Medical Practices Committee in re-classifying an area should be made known to the LMC and that the dates fixed for the re-classification of practice areas should allow sufficient time for the LMC to consider and comment on the proposals before they are implemented.'

But for many secretaries it was precisely these kinds of difficulties that inclined them to support the existing method of classification, for although it may be somewhat insensitive it does at least have the advantages of being easily understood and readily applicable throughout the country.

'I think that the present system is as fair as you can get. Once you start to introduce other complications, you get special pleading. The areas which have a lot of old-age pensioners, like Eastbourne, want this loading. Areas which have immigrants want the proportion of patients who do not speak English to be taken into consideration. Areas that have 30% of their patients turnover every year want this to be taken into consideration. I have no doubt that areas who cannot think of any other way to qualify for more money, will spend a great deal of ingenuity once they realise the concept of designated area is radically open to negotiation.'

Use of other criteria

From 42 LMCs came the suggestion that other factors in addition to or instead of average list size should form the basis of area classification (Table 27). The suggestions have been arranged in four main groups in Table 28.

The first group of factors (population characteristics) is further divided into four principal aspects. Demographic considerations were

mentioned by ten secretaries, especially the age structure of the population. It was pointed out that above-average proportions of the elderly and of the very young will increase the demand on doctors. Socio-economic features (also mentioned by ten secretaries) included the occupational structure, income levels and unemployment rates. It was suggested that problem areas might be identified by illegitimacy, truancy and crime rates, housing amenities and immigrant populations. Population density was mentioned by eight secretaries as a possible consideration, especially for its bearing on travelling times. Sparsely populated rural areas require more travelling time, and hence may need relatively more practitioners. Against this, however, high population densities and high-rise flats were mentioned as causative factors in stress and ill-health. The need to take account of temporary residents, especially in the popular holiday resorts, was mentioned by four secretaries.

The second group of factors (area characteristics) cannot be divorced entirely from the population structure, but it merits separate consideration as being independent from the medical system and unlikely to change very rapidly. Climate, geographical location, the legacies of decades of industrialisation and the rapid development of modern urban zones were typical of the features mentioned as relevant. The Review Body on Doctors' and Dentists' Remuneration, in fixing the original value of the designated area allowance in 1966, explicitly rejected the Health Department's suggestion that the amount of the allowance should vary with the character of the area; but the LMC secretaries felt that environmental factors were likely to be of some importance to many applicants for vacancies. The unattractiveness of the area was described by one secretary as 'the biggest cause of failure' of doctors to settle in an old industrial borough.

> 'The poor quality of the education system and the lack of social amenities are always the stumbling blocks that I have met when interviewing prospective assistants or being chairman of the committee appointing a doctor to a practice vacancy. When one sits with lay members on an appointing committee, in an area like this, it is difficult to make them understand how a town like this can appeal to someone who has not lived there all his life.

Whilst the notion of 'unattractiveness' may have meaning in relation to particular people and specific areas, it is clearly difficult to define universally. As one secretary put it, 'it would need someone with great insight to truly define an unattractive area because standards differ'. Others however felt that it should be feasible.

> 'Clearly some areas of the country are less attractive to doctors as areas in which they wish to settle and remain for the rest of their lives. There should be some means of identifying "unattractive" areas.'

The same view was implicit in the comments made by several secretaries that the designated area scheme had failed to help the unattractive areas. An LMC in the West Midlands, for example, complained that many attractive areas in its locality were designated whilst several unattractive and difficult areas were not.

Next, 13 replies were received suggesting that the personal and professional characteristics of doctors in an area should be given some weight in deciding manpower requirements. The basic point here is that for various reasons practitioners differ in their capacity to cope with similar workloads.

> 'There is in a personal service such as a general practitioner provides, a wide variation in the capability of the individual doctor adequately to look after a list of patients and one doctor may have more patients then his neighbour, yet still adequately care for all of them.'

Age is an obvious variable. There is no official retiring age for GPs, and an elderly practitioner may carry considerably less than a normal full-time load yet be treated for statistical purposes as though he were full-time.

> 'The committee (i.e. the LMC) also considers that the age of principals within an area should be considered. If several doctors are approaching normal retiring age, it would be reasonable to expect that they would want a smaller workload and under these circumstances this area might well require further doctors to maintain an efficient service.'

Likewise the sex of a doctor may influence workload levels. The case of a married woman GP with domestic responsibilities was cited as an illustration. But the most common reason for GPs having low lists was felt to be the range of their outside commitments (such as industrial appointments or private patients), and these, it was suggested, must clearly be considered in deciding manpower needs. In fact the MPC does record the outside commitments of doctors, but some respondents felt that insufficient attention was paid to them.

> 'I have always felt that the classification of areas purely on average list size is unfair and, although the Medical Practices Committee give lip service to outside appointments, I feel they do not really take these appointments into enough consideration. I feel that workload of all kinds should be the criterion for classification.'

The fact that a list of 1,000 patients qualifies for the full basic practice allowance (and hence is regarded as a full-time practice) means that some practitioners in an area may have very much larger lists than the area average. It doubtless often happens in such cases that doctors with individual lists well in excess of 2,500 are denied a designated area allowance because the area average is reduced by others with low lists caused by more extensive commitments elsewhere.

This depression of the average by low list doctors is resented in both designated and restricted areas.

> 'For example a doctor who is really working part time is included as a full-time practitioner, i.e. this doctor would lower the average list down and yet the active doctors in the area would be carrying a high workload, hence though the area may be restricted the active doctors may have list sizes of 3,500. Also, doctors may have part-time occupations, i.e. hospital sessions or other committee work which entail them being taken away from their practices for considerable lengths of time: this is not taken into account at all. I should like to see part-time occupations taken into account. As things stand at the moment, these areas may never become derestricted because as the list size grows these doctors are able to take in another doctor so that the area is only opened up for one day and then restricted.'

At the same time, however, several secretaries felt that GPs should not be discouraged from accepting hospital appointments. The proper solution lay in taking due account of such appointments in deciding target manpower levels.

> 'The arbitrary use of a set figure (e.g. 2,500) is most unsatisfactory and is one which satisfactorily inhibits doctors from taking on commitments, especially in hospital, since it will deny them the opportunity of increasing their partnership size to cater for these other commitments. In one practice, one of the partners spends a very considerable amount of time in National Health Service administration while his partners all have hospital appointments and they have kept their lists low in order to be able to undertake these activities. We have already been informed that there could be considerable difficulty in obtaining permission from the Medical Practices Committee for a further practitioner to come into the area, even to replace retiring principals.'

The same point was also made in general terms by a number of the EC clerks in response to a different question. One clerk, writing in the context of the reorganised NHS, put it thus.

> 'Where general medical practitioners undertake considerable commitments in hospitals and clinics, and in consequence will also be part-time employees of the AHA in this respect, the proportion of the time spent on NHS work should be taken into account by the FPCs and AHAs in assessing manpower commitments and in making reports to the MPC.'

The last set of factors which secretaries wished to see reflected in the classification of areas was local morbidity and workload levels. It was felt that it should be possible to identify increased workloads resulting from above-average morbidity.

> 'It is considered that an allowance scheme based on morbidity coupled with individual doctor's list sizes would be more appropriate. For instance, it is well-known that there is a prevalence of chest diseases such as bronchitis and pneumoconiosis in the north of England and the frequency of consultation is, therefore, probably higher in the north than in the south.'

In all, 20 secretaries mentioned this as a relevant factor, and some even outlined the ways in which morbidity and workload might be measured.

> 'There are no doubt a number of indices which might be used to measure the workload of an area. For example, the National Insurance sickness claims might be used or alternatively the prescription frequency figures as published by the Pricing Bureau. It would not be possible to break down these figures into practice areas, but there should be no great difficulty in relating them to Executive Council Areas.'

> 'If a measurement of workload could be defined by the aforementioned (or any other) indices it would then be possible to redefine the family practitioner "establishment" of an area more accurately. For example, a practitioner in, say, Beckenham might be capable of looking after 4,000 patients, whereas a practitioner in, say, Accrington, with twice the workload per patient might be capable of looking after only 2,000 patients. Between these extremes there would clearly be bands perhaps equivalent to 500 patients. If it could be assumed that "average remuneration" corresponded with "average workload" then one of the difficulties of achieving a fair distribution of doctors could be eliminated.'

Average list size should be different

In addition to the 42 secretaries who felt that factors other than average list size should be considered in classifying areas, eight secretaries believed that the use of list sizes was correct in principle but needed modification in application (Table 27). Two were critical of the present 'overspill rule' whereby the total excess of patients in an area above an average of 2,500 must itself be 2,500 before the area can be designated.

> '2,500 represents roughly the distribution of patients per doctor throughout the country. It is felt that whenever this ratio is exceeded, re-classification should take place. At present, the MPC will not re-classify an area as "designated" until a further 2,500 patients are "free" to constitute the nucleus of a fresh practice.'

Three secretaries suggested an increase in the upper limit to 3,500 to identify areas of greatest need; one suggested a three-tiered system with average lists of 2,200, 2,600 and 3,000; and two wanted a lower threshold of designation. Several expressed their view that because conditions varied so greatly from area to area a single figure 'cannot fairly be applied to the whole country'.

The interesting suggestion that the mean list size should be replaced either by the median or by the percentage of 'oversize' practices would avoid the worst distortions caused by small practices, and would therefore be one way of allowing for doctors with extensive outside commitments. The following extracts elaborate the idea and also make the point that it is as important to prevent over-doctored areas as under-doctored ones.

> 'Average list size is not a good measurement of an over-doctored or under-doctored area. A better factor to use is the proportion of doctors that have over or under a certain number of patients on their list. For instance, one might say that, in an area where at least 50% of the GPs had over 3,000 patients on their list (averages for partnerships), then that area was under-doctored on the basis that one in every two doctors would probably be very busy and perhaps reluctant to take on new patients.'

> 'Perhaps more important, it is necessary to identify the over-doctored populations and ensure that more doctors do not go to those areas, thus increasing the number available for practice where they are needed. It should be possible for instance not to allow any further doctors into an area until all the doctors in that area had say at least 2,500 patients. If areas were drawn small, this should not result in hardship to either doctors or patients.'

The views of EC clerks

No separate question was included in the EC survey about the appropriate criteria for classifying practice areas, but several clerks nevertheless offered spontaneous comments, all of which had some echo in the secretaries' replies. As a postscript to this section, the clerks' responses are summarised briefly.

The need to take account of the outside commitments of general practitioners was mentioned by several clerks. As an independent contractor the GP is entitled to take whatever additional jobs he wishes and he is under no obligation to inform his EC of them. But since some practitioners are anxious to give an adequate service to their patients, they tend to limit their lists as they take on additional outside commitments. Such a situation, as the clerks pointed out, can create difficulties for an executive council. When an area is in danger of becoming de-designated it is therefore common for the EC and the LMC to invite doctors to state the number of hours they spend on outside commitments so that the EC at least has the chance to persuade the Medical Practices Committee that there remains a shortage of doctors and that the area should stay designated. But several clerks, like some of the secretaries, were not satisfied that such information is (or could be) handled systematically by the Medical Practices Committee.

> 'I am a little uneasy about taking into account the work done by practitioners outside the National Health Service unless this is uniform throughout the country and I know of no means for compelling anyone to declare outside involvements except when provided under Statute.'

A number of clerks questioned the use of average list size as the major component in classification, and several pointed to the consequent potential injustice in paying the designated area allowance to <u>all</u> principals in eligible areas. One remedy proposed for this was an increased capitation fee in respect of patients over 2,500, but the opposite view was also expressed that there should be a <u>lower</u> capitation fee for patients in excess of 2,500 in order to tempt doctors to take on new partners and discourage large lists. There was criticism also of the 'overspill rule' and of the lack of flexibility involved in the scheme.

> 'The present system of arriving at the classification "designated" can achieve anomalous results between MPC areas of varying numbers of doctors i.e. the multiplication of the excess patients over 2,500 by the number of doctors in the MPC area.'

INCENTIVES TO PRACTISE IN DESIGNATED AREAS

It was not an original objective of either survey to plumb in depth the views of clerks or secretaries about the effectiveness of the designated

area scheme in meeting its declared objectives, but it soon became clear that the question of incentive payments is inextricably bound up with the purpose of the areas. The original study of the designated areas, involving a survey of some 2,000 general practitioners, had indicated that the current level of the designated area allowance was too low to act as an effective incentive, and in any case the regulations governing the payment of the allowance were such that it often had the reverse effect to that intended. But these conclusions were based upon the replies of individual doctors, and for that reason they may lack the broader perspectives that might be taken by executive councils and local medical committees. It was therefore decided to ask both clerks and secretaries for their opinions on the effectiveness of what is loosely called the 'designated area scheme' - including, that is, the designated area and initial practice allowances.

The question in the two surveys differed somewhat. The question put to the clerks was:

> 'What are your views on the effectiveness of the designated area scheme and the present method of incentive payment in securing an adequate number of family practitioners in all parts of the executive council?'

The question put to the secretaries was more specific:

> 'Do you consider that (a) the designated area allowance and (b) the initial practice allowance have been effective in securing a better distribution of family practitioners in all parts of the country? If not, what measures would you consider effective to induce doctors to practice in unattractive areas?'

There appeared at the time to be good reasons for differentiating the two allowances in the second survey but in practice they were not wholly justified. It may have been better to use an identical question in both surveys.

Summary of replies

The clerks' and secretaries' replies are summarised in Tables 29, 30 and 31. Tables 29 and 30, giving the clerks' views of the effectivness of the scheme, show that only 17 of the 108 clerks considered the designated area scheme to have been effective in whole or in part. On the other hand a much larger number explicitly referred to the ineffectiveness of the

designated area allowance, 46 of them (43 per cent of all respondents) believing it to have had a disincentive effect. The initial practice allowance was held in somewhat higher regard, although it was thought it could be made more effective by increasing the amounts and by changing the conditions governing their payment. Various other possible incentives were mentioned in addition to financial ones.

Table 31, giving the secretaries' views on the effectiveness of the two incentive payments, shows that only about one in ten respondents rated both allowances as effective, and a further 10 per cent rated one or other as effective. In this latter case, however, the designated area allowance was rated very much lower than the initial practice allowance. More than half of the secretaries considered that neither allowance had been effective, and almost a sixth claimed insufficient knowledge on which to base an opinion. In all, 65 secretaries had doubts about one or both of the allowances, and the reasons for their doubts (where these were given) are elaborated in Table 32. About a third of those offering a reason (17 out of 54) thought the amounts were insufficient; 14 thought the periods of payment were too short; and 20 commented on the disincentive effect (especially with regard to the designated area allowance).

Designated area scheme effective

Seventeen clerks (16 per cent of respondents) thought that the designated area scheme, in one aspect or another, had been wholly or partially effective; and 20 secretaries felt that either one or both of the allowances had had an effect. In both surveys respondents rated the initial practice allowances very much more highly than the designated area allowance (of which more is said later). Only two clerks and one secretary specifically mentioned this latter allowance as being effective.

In general the secretaries gave briefer answers than the clerks. Apart from those who merely answered 'yes', the reasons given by the secretaries for approving the incentives were that they had helped to keep doctors in designated areas and that they were at least 'a step in the right direction'. Statements such that, 'nothing else is likely to be more effective' or that 'they are better than nothing' are included here, though they are scarcely expressions of unqualified enthusiasm.

More specifically, the Type C initial practice allowance was thought to have been particularly effective, although doubts were expressed about its possible abuse and about its future effectiveness if it failed to keep pace with inflation.

The EC clerks who considered the scheme effective tended to give fuller replies. It is not always clear in the answers which of the two payments is in question, but since the number of clerks replying in this way is relatively small, the inability always to distinguish is much less important than that success for either payment is limited.

> 'Since the introduction of additional payments for practice in a designated area, my council has not had to advertise any practice vacancies. Those vacancies which have occurred have been within partnerships and the incoming new practitioners have been introduced by the remaining partners in each case.'

> 'The general impression is that the incentive payments offered to practitioners who qualify in respect of setting up in designated areas is an inducement to doctors and tends in due course to secure an adequate number of family practitioners in the area so that the designation qualification is ultimately removed.'

In some areas the improvements in recruitment had taken time to materialise and in others they had been confined to particular localities, especially new housing estates and other areas of rapid population increase.

> 'Only in the past year or so can the designated area scheme and the associated incentive payments be seen in this area to have been partly responsible for an increase in available medical manpower.'

> 'It is particularly successful in new housing estates. In established areas, however, the growth of a single-handed practice is slow and its success problematical.'

> 'In areas where there is a rapidly growing population, it has been useful in attracting general practitioners and also encourages existing partnerships to take further partners, but in areas which have been designated for some considerable time, with little change in the medical population, the Designated Area allowance has become part of their income and I feel that they tend to discourage further practitioners coming into the area.'

The designated area allowance

Overwhelmingly, respondents in both surveys considered the designated area allowance to have been a flop, at least in terms of its overt objectives (for it has undoubtedly augmented the income of a large number

of general practitioners). Again, the EC clerks gave rather fuller replies than the LMC secretaries. Almost two-thirds of the clerks (69 out of 108) thought that the impact of the allowance was at best doubtful and at worst positively counter-productive. The reasons given were that the amount is too small, that the three-year qualifying period is too long, that the quality of new entrants had deteriorated, and (mentioned by almost half of all the clerks) that it has a serious in-built disincentive both for existing doctors in an area to take new partners and for prospective doctors to move to a designated area. The LMC secretaries were also concerned about the disincentive effect: 20 of the 54 secretaries who gave reasons for believing the allowance to be ineffective mentioned this, and 14 thought the periods of payment were too short (which is a form of disincentive).

The disincentive effect arises from the regulation whereby the designated area allowance ceases to be payable when three years have elapsed from the time an area is de-designated (i.e. when the overspill below an average list of 2,500 itself falls below 2,500). The disincentive is two-fold: it discourages existing doctors in an area from taking new partners (being obviously unwilling to put their own and their colleagues' allowances in jeopardy) and it discourages prospective doctors from moving to a designated area, with the risk of being party to their own financial loss within at most three years. This is in addition to the loss of capitation fees which would occur whether the area was designated or not. In a developing area the financial loss due to taking on a partner would soon be compensated by the growing number of patients but not in static or declining areas. The clerks' views are illustrated in these replies.

> 'I believe the designated areas incentive allowance to be quite wrong. This obviously creates a dis-incentive for any doctor or group of doctors in the area to contemplate the engagement of additional partners during the three-year run-up period, unless it is absolutely necessary. A few doctors making such appointments could mean the loss of the designated area allowance of £490 p.a. to every one of his colleagues in the area. This particular allowance could well be abolished.'

> 'I share the view of many colleagues and others in that the introduction of the designated area allowance has perhaps acted more as a disincentive to the introduction of new principals in general practice than to encourage their entry, in view of the fact that existing practitioners in the areas are enjoying the allowance and, quite naturally, wish to continue to enjoy the allowance.'

'The allowance is not very effective, in fact, quite the reverse. It is a financial advantage for the existing doctors to ensure that they do not increase the numbers of their partnerships and lose the "designated" classification.'

'Doctors in an area which is designated are quite happy to restrict their numbers to the point where the designated area payment will still be continued, thereby voluntarily accepting a high workload rather than allow one more doctor to come in and so lose the additional payment.'

'The present designated area scheme is muddled. The system of payment to GPs already in the area is an incentive to them to perpetuate a shortage of doctors - if one takes a partner, thirty might lose the designated area payment.'

The secretaries' views about the disincentive effect are illustrated in these replies.

'I agree there are some areas more in need than others, but the whole scheme of designated areas has a built-in DISINCENTIVE to attract doctors. A doctor moving into an area which is 'designated', being attracted by the extra payment, can expect his new colleagues to view him with some disfavour, as he puts their 'designated area payments' in jeopardy. In any case if his entry does decide the MPC to reclassify the area as non-designated he loses the extra payment that attracted him! Established doctors have an interest in KEEPING OUT the doctors that the payment is meant to attract. Can idiocy go further?'

'As soon as an area nears its maximum numbers consistent with its remaining designated, the payment discourages entry therein. Doctors in the area discourage entrants by various methods. Removing one's worst patients only, refusing to allow newcomers to join existing rotas, etc. It is difficult to see how a payment can work if it stops when the number of doctors reaches a figure which bears no direct relation to the workload.'

It is certainly understandable, and probably quite reasonable, that doctors should seek to use the scheme to their best advantage even though this may run counter to its objectives. In that case it is the scheme, not the doctors, that is at fault. In addition, as mentioned above, the desire to keep newcomers out may be powerfully reinforced by the wish to avoid offending colleagues by causing them a drop in income. The attitude of established doctors towards taking on new partners is important in this context because they can very effectively control the inflow of manpower. It is difficult for a doctor to start up a new single-handed practice, in spite of the financial incentives, and one rarely succeeds. Almost the only way in is through existing practices, the partners of which can obviously decide for themselves how many new colleagues to accept. The point is made by these replies from clerks.

'The only way in which additional doctors may be introduced is by existing practices taking in an additional principal.'

'Except for the relatively few advertised vacancies these days, entry into general practice is normally by joining in partnership with doctors already practising in the area.'

'It is almost impossible for a new single-handed entrant to provide the sort of facilities available in partnerships or group practices with modern accommodation and ancillary helpers.'

A number of replies recognised that the disincentive effect of the allowance becomes operative mainly in the marginal situation, that is, as the average list for the area approaches the 2,500 mark. The following replies were made by clerks.

'The incentive payment arrangement in "designated" areas is only partially effective, i.e. to the point where one further additional doctor admitted to the list would result in the area losing its designated status. In certain "designated" areas throughout the country the doctors not wishing to lose their designated area payments, and subject to their individual and local circumstances, avoid the last straw that would break the camel's back.'

'It is effective until the situation is reached when the designated area allowance may be lost by the introduction of a further practitioner. There is a tendency for doctors in such a designated area wishing to take in additional doctors to ask, "Will it affect the designated area allowance?".'

'The list size is now falling towards 2,500 and the eventual loss of designated area status and the designated area payment appears to be having a reverse effect - partnerships seem disinclined to take on an extra partner in case they are the ones to cause the area to lose its designated status and cause their colleagues in the area to lose the allowance.'

'In an area where the average list is high, e.g. over 3,000, the designated area scheme could be said to act as an incentive to practitioners. Where an area is on the borderline, the scheme could act as a disincentive since the practitioners in the area will realise that if perhaps only one more practitioner was admitted to such a Council's medical list, the designated area allowance would be lost resulting in a financial loss of something in the order of £500 per annum for each practitioner.'

Many criticisms of the disincentive effect, like those quoted above, stem largely from a priori reasoning. In the very nature of things it is difficult to produce hard evidence of the effectiveness of any incentive schemes because of the multiplicity of factors involved and the consequent uncertainty in identifying which of a number of possible factors had

produced an observed change. Nevertheless a few clerks came up with specific cases in support of their argument.

> 'Two doctors were admitted to the medical list causing the area to become "open". So great was the resentment of the remainder at the prospect of losing the allowance after the concessionary period that pressure was brought and the newcomers left within a year to 14 months after their arrival.'

> 'I have been consulted on a number of occasions by representatives of doctors about the effect the introduction of an additional doctor would have on the classification of the area concerned. I have known doctors deliberately refrain from taking an additional partner until they could be sure that by doing so the designated classification would in no way be affected. In other words, the payment of designated allowances in some areas can act as a disincentive to the introduction of new partners.'

> 'The Council's officers have even been criticised for feeding information to a doctor wishing to establish himself in a "designated" area.'

In addition to the alleged ineffectiveness of the allowance, further criticism centred on the fact that its payment to all doctors in an eligible area, irrespective of their personal list size, is unfair. Examples were given of doctors receiving the allowance in spite of maintaining very small lists, and of districts desperately in need of doctors remaining without them whilst GPs in other parts of the areas continued to draw their allowances. This particular problem was considered in an earlier section on the size of areas. It may be worth just adding the point made by one clerk that the problem is really one of balance, for as well as trying to attract additional manpower it must also be an objective of policy to discourage existing doctors in a designated area from moving elsewhere.

Finally, almost a third of the LMC secretaries who explained why they thought the allowances had been ineffective (but only six of the clerks) gave the low levels of payment as a contributory reason. One might perhaps expect the LMCs to be more concerned than the ECs with this particular aspect, and the depth of feeling of the profession's part is revealed in the epithets chosen to describe the amounts - 'trivial', 'derisory', 'ludicrous'. Often a comment about the amount of the designated area allowance is linked with the disincentive effect.

> 'High and permanent financial inducement to practitioners entering unattractive areas would be the only effective method.'

'A sliding scale of inducement payments would make it easier to recognise that, within the areas that are under-doctored, some are worse off than others. A sliding scale would also, perhaps, make it easier to pay a rate considerably higher than is at the moment paid to those relatively few areas where not only is the need for new doctors painfully acute, but the natural attractiveness of the area so small that the likelihood of applicants is remote.'

'Money inducements need to be very much higher and should last for a considerably longer period than the present 3 years. The qualifying time for payment is too long and, when paid, the allowances continue for too short a time. For the first reason an area remains unattractive in the time immediately prior to formal designation, and, for the second reason, the incoming new doctors may to some extent be discouraged because their entry would diminish the designated area.'

The initial practice allowances

Several respondents who questioned the efficacy of the designated area allowance believed the initial practice allowances to be reasonable and took a favourable view of them. Twenty clerks (19 per cent) and 19 secretaries (20 per cent) thought that the IPAs were basically effective and few clerks or secretaries roundly condemned it. These results contrast starkly with opinions about the designated area allowance. The IPAs were mentioned as being preferable to the designated area allowance, as being particularly effective in areas of new housing development, and as an encouragement to enlarge existing partnerships.

'On two occasions recently the Council has found it necessary to create new single-handed practices and the initial practice allowance has proved an invaluable asset in making this financially attractive to the incoming doctor.'

A number of clerks made reference to the different types of initial practice allowances. From the remarks reported above on the difficulty of starting single-handed practice it is not surprising that most IPAs are of Type C, paid to entrants to partnerships. (In 1972, 179 out of 227 initial practice allowances paid out were Type C). One would therefore expect the Type C allowance to be mentioned as more effective than any of the others. Several secretaries singled it out for favourable mention and some clerks also attributed a recent increase in doctors in their areas directly to the Type C IPA. Type D, though less common, was regarded as particularly helpful in areas of new housing development.

Criticism of the initial practice allowance was of two main kinds: the LMC secretaries tended to regard it as open to abuse; the EC clerks were critical of the amounts payable. The concern of the secretaries is illustrated in these replies.

> 'The IPA has not helped to attract doctors as hoped. It is used as a source of income by doctors who have no intention of staying in an area. It means that doctors can enter an area and "de-designate" it having claimed an IPA. They may obtain further income from hospital posts as well. They contribute little to reducing the workload and may make little impact on the area at all.'

> 'The initial Practice Allowance has been too widely distributed to doctors who have no real intention of building a permanent practice.'

> 'There have been instances in which attempts have been made to misuse this allowance and there would be advantages both to the doctors and to the Executive Council in a tighter system of control, with particular reference to what constitutes "an effective addition to the medical manpower".'

The clerks' views about the financial inadequacies of the allowance are reflected in these replies.

> 'The Types A, B and C initial practice allowances seem to work quite well but I am sure that my doctors who are in receipt of these allowances would say that they are not high enough.'

> 'The financial incentives are not sufficient to enable a single-handed practitioner to build up a well-paid practice in a short time.'

> 'The grant of an IPA (of Type A) is a licence to starve.'

> 'The Type D allowance is quite inadequate. Only recently, a much advertised opportunity to start a new practice in a new area with Type D allowance and with potential unlimited, including a health centre, produced a very small number of applicants.'

> 'The designated area addition should be withdrawn forthwith. The money thus saved should be used to augment the initial practice allowances. The latter are woefully inadequate.'

This latter suggestion, of financing an increase in the initial practice allowances by scrapping the designated area allowance, was mentioned by several clerks, although one or two conceded that it would be politically difficult to do. Alternative suggestions for improving the IPA included one of using the allowance in a very specific way to offset the loss of income for a doctor building up a single-handed practice.

> 'I would suggest that a more attractive scheme to encourage doctors to set up a single-handed practice in a designated area (other than a Type D area) would be to make payment of a guaranteed gross income, which would be reduced each quarter by the amount of NHS income receivable and continue in payment, subject to build-up of list in relation to local circumstances to a specified figure, when the allowance would cease.'

The secretaries also offered suggestions for administrative change.

> 'I think that instead of the money being spread over all the practitioners in the town, who then have a vested interest in maintaining designation, it should be concentrated far more as a dowry on the new entrant, which he would be able to put into the practice kitty and should be forfeited if he left the area within five years. Experience with gratuities and bribes of this nature to doctors in the armed forces show that a sufficiency who have joined for five years stay on for longer for the purposes of the services.'

> 'The initial practice allowance is likely to increase the number of GPs in a practice area. Type D however is the one which ought to be used more often. With a little modification, it could be made available in a greater number of practice areas and the experience of the doctor might be varied. Some of the most experienced GPs may have had fewer than 2 years hospital experience and in any event, 2 years hospital experience a decade previously is unimportant when compared with many years of general practice. Apart from clinical experience there is clearly a need for doctors interested in creating new practices to have a knowledge of administration, forward planning and to have imagination in visualising suitable units for the provision of primary health care. There are doctors who, having participated in planning and later seen a project successfully launched will want to move on to another challenging situation.'

Non-financial incentives

The results of the survey of general practitioners in the original study showed very strongly that non-financial factors were generally much more important than financial considerations in influencing a doctor's choice of practice location. The same point was made by respondents in both the present surveys. The unattractiveness of an area, for example, was mentioned as an overwhelming deterrent, although few clerks or secretaries would admit that their own areas were doomed in this respect. One clerk complained that

> 'the position was not helped by the then Ministry of Health describing under-doctored areas as "unattractive areas" which is not the best term to use when trying to attract applicants to apply for vacancies or new doctors to set up practices in an area.'

Another clerk commented, with perhaps a hint of resignation, that 'we are industrial and somewhat unpleasant in environmental terms'. Of the LMC secretaries, seven commented specifically on the importance of environmental factors in attracting doctors, mentioning in particular the climate and the availability of social, cultural and educational amenities. Even with vastly improved working conditions, it was felt that, since wives were said to make the decisive choice, drab surroundings would be sufficient reason for reluctance to practise in these areas whatever the inducements. As one secretary put it, 'many would prefer to live in a salubrious area and forego the extra money.'

The provision of first-class practice facilities was quite widely mentioned as a further important, non-financial incentive, especially by the secretaries. Nursing support, access to diagnostic facilities and hospital beds, deputising services and vocational training opportunities were all cited in this context. The point was made that if such facilities are to be effective in attracting extra manpower they must be provided at a more generous level than the average: merely to bring them up to average standard is not sufficient to compensate for the unpleasant environment.

> 'Massive District Nurse support, with full-time nursing staff in treatment rooms in the surgery premises. Help with finding good clerical staff. One District Nurse to be provided with transport to check on requests for home visits to assess the urgency and whether a home visit is really needed or not. Open access to X-ray and pathological facilities if not already in existence should be arranged. All the above I would regard as fairly necessary factors to induce doctors to practise in unattractive areas. There are many other marginal factors that could be brought into play, such as access to general medical and/or obstetric beds; open access to physiotherapy; real nursing attendants for those patients who needed it (i.e. up to 16 hours out of 24).

> 'My suggestion would be that the Department of Health should provide superior married accommodation and excellent vocational training schemes, with special financial inducement to do the vocational training in the area where the doctors are most needed. In other words the most money poured into vocational training should go into areas like Wigan and Walsall and not Wessex or Kent.'

One important aspect of practice facilities (mentioned specifically by six clerks and eight secretaries, almost all of them in county boroughs) is that of practice premises. The lack of special help with accommodation in certain areas was felt to be a major deterrent, especially to young doctors. At present executive councils have no funds to provide surgery accommodation, and the scheme for reimbursement of rent and rates has had the undesirable

side-effect of reducing the differential in net income between attractive areas with high rents and rates and the unattractive areas with lower levies. The more expensive areas have become almost as accessible financially as the cheaper (and often under-doctored) localities. It was suggested that capital funds should be made available to acquire practice premises which could then be made available on favourable terms to incoming practitioners.

> 'The form of incentive which might be more effective (than the present allowance) would be the provision by the Executive Council of suitable practice and residential accommodation in designated areas in order that new doctors may be encouraged to enter practices without having an initial commitment. There would be no question of rent and rates reimbursement to the doctor, and after, say a period of four years when he might be regarded as established, it would be reasonable to expect him to purchase the property from the Executive Council at the price paid for it.'

This latter proposal would to some extent cushion the young doctor from inflation of property prices, althcugh in addition to practice premises the high cost of residential accommodation could have become a significant factor in the South. Looking to the future, several clerks expressed the hope that the Area Health Authorities would not only continue the work done hitherto by Local Authorities in the building of health centres, but would extend the programme to the building of practice accommodation in general.

> 'Area Health Authorities may seek to solve the problem of shortages in their own area by a readiness to make practice accommodation available to a degree hitherto unknown.'
>
> 'One can anticipate the future provision of surgery accommodation by the AHA and FPC in consultation whereas in the past this was possible in a limited manner mainly through the provision of health centres by local government authorities.'

In fact this was regarded as one of the chief tasks of the AHA where general practice is concerned.

> 'I seriously doubt the ability of the AHA to influence the situation unless they are willing to accept that a first requisite of increased medical manpower is the provision of absolutely first-class practice accommodation.'

Pursuing a different line of thought, eight of the LMC secretaries felt that doctors might be persuaded to work in unattractive areas provided it was for a limited period only. If movement to more attractive places were made easier for GPs who had spent some time in, say, a designated area, then more doctors might contemplate a spell of several years in an under-doctored part of the country.

> 'It has always seemed to me that just as in the old days a doctor would practice in an industrial area in order to make enough money to buy himself into a more pleasant area, so such a system could be incorporated into our present-day Health Service. For instance, if it was very difficult to persuade a doctor to go to a given area and financial inducement was not enough, it might be possible to devise a scheme whereby he could be persuaded to go for say, ten to fifteen years with the promise that at the end of that time if he wished to make a move, every effort would be made to help him. Currently it is very difficult to change one's place of practice, and you tend to be stuck with what you started.'

> 'It should be possible to devise some means of ensuring that after serving a reasonable period in a designated area doctors would be able to practise without financial detriment, in other more attractive areas.'

Suggested ways of achieving this objective included: a deliberate policy of preferential treatment for doctors serving in designated areas when considering applicants for more attractive areas; a restoration of the right to sell the goodwill of a practice; and the provision of a lump-sum benefit after a specified number of years.

> 'An alternative which might be explored is the payment of an allowance similar in some respects to a military short service commission, allowing a tax-free benefit after a period of, say 5 years, possibly geared in size to the practitioner's qualification and experience, coupled with a special concessionary arrangement for the financing of purpose-built premises.'

There may be undesirable side-effect from such policies. It would be difficult to put a premium on short-stay service without placing the long-serving practitioner at a totally unfair disadvantage, and the eventual possibility of unattractive areas being served almost exclusively by young doctors staying for short periods of time before moving to more appealing localities is distinctly undesirable. In any case there is no certainty that, by encouraging greater mobility through the designated areas, there will be a better supply of doctors at any moment in time. It is difficult to predict whether the increased losses would, in fact, be outweighed by higher recruitment.

Lastly, a few clerks and secretaries gave replies about incentives which can only be classified as 'miscellaneous'. It was pointed out that the supply of doctors to particular areas may be governed by factors largely unrelated to the designated area scheme, especially by manpower conditions

prevailing at national and even international level. The total number of doctors coming forward to apply for vacancies in designated areas depends in part upon the total number available nationally, the number of new graduates from medical schools, their choice of post-graduate specialisms, and their perception of relative opportunities in different medical fields. It also depends on net migration of medical manpower which in turn may be influenced by recruitment policies in high-income countries and the structure of opportunities in low-income countries. One area, for example, was designated for over four years prior to 1971, but, according to the clerk:

> 'The special allowance payable during this period failed to attract additional doctors. The change came mainly as a result of the greatly increased remuneration attracting Commonwealth doctors to this country while, at the same time, the loss of doctors due to emigration largely ceased.'

In connection with recruitment policies it was felt as a matter of urgency that the quality of family practitioners must be maintained. A number of replies contained complaints about the lack of adequate training of doctors entering designated areas, many of whom have qualified overseas and lack the background and experience which general practice demands. A clerk wrote:

> 'Executive Councils should be given greater powers over the selection of new single-handed practitioners in designated areas. At present any fully registered doctor can commence practice in designated areas even if he has no previous knowledge of the area or previous experience in general practice.'

The desirability of GP trainee schemes was mentioned and the hope expressed that new training opportunities would attract young graduates to general practice, especially group practices. The view that single-handed practice should be discouraged was expressed by one secretary in the following way.

> 'The only adequate inducement would be financial, and this should only be offered to existing partnerships rather than to "bribe" new single-handed General Practitioners to set up in the area. In our experience the presence of single-handed practitioners only delays and impedes progress in the development of General Practice which more rapidly and effectively takes place in a stable Group Partnership set-up'.

NATIONAL HEALTH SERVICE REORGANISATION

The point was made in Section 4 that the reorganisation of the National Health Service may affect the distribution of primary medical manpower in a number of ways. It therefore seemed apposite to ask respondents for their views about reorganisation, particularly as it might affect the question of resource-distribution. Of primary interest were the clerks' opinions about the changes which reorganisation might bring about in the mechanisms for manpower planning in general practice and the relationships which they would like to see existing between the interested authorities. The EC clerks were therefore asked the following question.

> 'What relationship would you like to see in the reorganised health service between the Family Practitioner Committee, the Area Health Authority and the Medical Practices Committee with respect to manpower planning in general practice and supporting services?'

A somewhat different question was put to the LMC secretaries who, if was felt, would be less interested in the relationships between decision-making authorities than in the issue of quality of care. The question put to the secretaries was this:

> 'What advantages, if any, do you see in the forthcoming reorganisation of the NHS for the purpose of providing better care in under-doctored areas?'

The replies form the two groups of respondents overlap to some extent, but for the most part they are treated separately in this section. Since the clerks gave very much fuller replies than the secretaries they occupy the major part of the section.

Summary of replies

The replies are summarised in Tables 33, 34 and 35. Table 33 summarises the features which the clerks would like to see in the reorganised NHS with respect to manpower planning in general practice. There was no great enthusiasm for reorganisation: the prevailing view was one of immense satisfaction with the status quo, especially in terms of relationships with the Medical Practices Committee and local medical committees. Most clerks however accepted reorganisation as inevitable and expressed the hope of close co-operation with the new health authorities. There was an undercurrent of fear of domination by the AHA and a substantial minority would

press for statutory recognition of the FPC in all matters concerning general practice, including planning. It was stressed that the willing co-operation of the GP would be the cornerstone in the successful running of the NHS. A majority of clerks agreed that the administration of supporting services (such as the attachment of nurses and para-medical staff) should be the concern primarily of the AHA and the district management team, but a few felt that this too should fall within the province of the FPC.

The minority of clerks who positively welcomed the restructuring of the service hoped that AHAs would stimulate the provision of practice accommodation in health centres or group practices; that greater opportunities would be provided for GPs to participate in hospital and public health work; that there would be a free exchange of information between the AHAs and the FPCs; and that the local voice would carry more weight in negotiations with the Medical Practices Committee over such matters as the classification of practice areas.

Of the LMC secretaries, three-quarters could see no advantages in reorganisation, at least as it might affect the quality of care in under-doctored areas, although a majority of these gave no substantive reasons for their pessimism (Table 34). Of the 25 secretaries who explained why they felt there would be no advantages, eight pointed to the extra burden falling on general practitioners through their involvement in DMTs and DMCs, and 6 felt that improvements could only result from extra investment in the service, of which there was no hint in any of the multiplicity of documents or circulars. The general point was also made that there was no guarantee of patients getting a better deal, and several secretaries (including some who had attended reorganisation courses) reported widespread bewilderment and confusion about what was happening. One commented that 'nobody seems to know exactly what the DMTs are going to do and how they are to operate.' *

The reasons given by the 22 secretaries who saw potential advantages in reorganisation are elaborated in Table 35. They are split almost equally between the promise of better information systems to identify need, the more rational establishment of priorities and allocation of resources, the benefit to community care, and the closer relationsip that might emerge with hospitals.

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* Readers are reminded that the LMC survey was conducted during the Summer of 1973, after the publication of the White Paper (Cmnd.5055), the 'Grey Book' and the National Health Service Reorganisation Bill.

Several respondents qualified their statements, for example by pointing out that reorganisation itself would not improve things unless accompanied by a willingness and determination to make the new system work.

General satisfaction with existing arrangements (pre-reorganisation)

The view most commonly expressed by the EC clerks was that, given the independent contractor status of the general practitioner, the existing system of influencing the number and distribution of GPs had worked, and that it was hoped the relationship between executive councils, local medical committees and the MPC would continue into the future. A total of 52 clerks (48 per cent) gave answers that were classified in this way: 18 of them were clerks of county ECs and 34 of county borough ECs. The following extracts illustrate these responses, highlighting especially the links with the MPC, the LMCs and the LAs.

> 'The present relationship between the Executive Council and the Medical Practices Committee would be difficult to improve in effecting a good distribution of medical manpower in general practice, and I would like to see it continue.'

> 'The local relationship between the Local Medical Committee and the Executive Council is excellent and the lay members of the Executive Council readily accept the advice of the medical members who in turn take notice of the lay point of view.'

> 'With regard to manpower planning of supporting services, of recent years there has been good liaison at chief officer level with the Local Authority and hospital and efforts have only been limited by lack of resources. There appears to be no problem in identifying needs and determining priorities.'

Two clerks stressed the importance of good personal and working relations, opining that if these had been adequate in the past, the need for reorganisation would now be much less.

> 'I can see no useful purpose being served whatsoever by the so-called 'unification' of the service. We have built up a very high degree of liaison between one authority and another and it is my personal opinion that the degree of liaison, if any, is dependent almost entirely on the personalities and goodwill of the senior officers of the various bodies.'

> 'It is a pity that the getting together which has taken place in recent months, and which I have advocated for so many years, was not introduced many years ago. Had this been so, there would have been no question of unification.'

Medical Practices Committee

The Medical Practices Committee was singled out for high praise by the clerks. It was explained that a continuing role for the Committee is essential if planning is to be retained on a national scale and if national needs and priorities are to be safeguarded in an impartial manner.

> 'I see nothing wrong in (the EC/MPC relationship). We in this area have received nothing but good at the hands of the MPC whom we regard as our friends, who listen to us with patience and forebearance, and almost invariably concur in our recommendations. If my letter does nothing more than record our debt of gratitude to the Medical Practices Committee as an efficient, humane and effective administrative body I shall remain content.'

> 'I hope that the overriding authority of the Medical Practices Committee to secure as far as possible within the statutory provisions a fair distribution of general practitioners over the country will remain.'

> 'I do not see the role of the Medical Practices Committee changing appreciably after 1st April 1974, and have no reason to doubt that their functions will continue much as at present.'

Implicit in the continuing functioning of the MPC is the maintenance of the traditional relationship between the Committee and the new family practitioner committees. Indeed, there was a great strength of feeling among the clerks that the FPC should be the only local body to deal with the Medical Practices Committee.

> 'It is obvious that with the continuing autonomy of the Medical Practices Committee, the same relationship must prevail, as it does at the present time between Executive Councils and the Committee.'

> 'Whilst it is admitted that the AHA of the future must be consulted about the planning of the FP services, I strongly consider that this is the main duty of the new FPC in conjunction with the MPC in exactly the same way as the ECs and MPC work at the moment.'

The reason for retaining the FPC's monopoly in dealing with the MPC lies in the close relationship that was seen to exist between day-to-day administration and longer-term planning. Part of the FPC's administrative duties involves the collection and interpretation of the basic information that is essential to planning, and this puts the committee in an obviously privileged position.

> 'The Family Practitioner Committee holds one of the keys to the future planning of the National Health Service, and not only from the manpower planning viewpoint. Like executive councils, FPCs will have records for each health service patient registered within their area. They will know where these patients are located and they will know whether the doctor works in a group, whether he has any outside commitments, how old he is and whether he is or is not accepting more patients on his list.'

A logical extension to this argument, advanced by several clerks, is that the FPC should also have the responsibility for planning and organising the family practitioner services. This however moves into the issue of relationships between the FPC and the AHA, and is therefore considered in a later section.

Local medical committees

The EC clerks felt that one of the most crucial links was that between an executive council and the profession's local representatives. Changes in the manpower situation in an area, and proposals to influence such changes, are of direct concern to practitioners in the area and therefore of direct concern to the professional committee. The statutory obligation of ECs to consult formally with LMCs on matters affecting manpower policies continues in the reorganised service, but there is more to it than that. What was stressed was the importance of getting the voluntary agreement and co-operation of GPs to local policies and plans. One clerk put the point thus:

> 'The practitioners and contractors will still retain their independent status and unless general practitioners are in agreement with policies and plans for development of services there will be little point in proceeding with them since there can be no compulsion on a practitioner to practise say from a new health centre.'

The professional membership of executive councils and the tradition of mutual trust were mentioned as two reasons for the harmonious relationship generally felt to exist, but some clerks felt that the independent status of the GP limits the degree of manpower planning possible.

> 'Manpower planning of such independent contractors is necessarily limited. It is unlikely that the medical profession would agree to go further than it has done already (i.e. the power of the Medical Practices Committee to refuse applications to practise in certain areas), in accepting curtailment of the right of a general medical practitioner to choose his area of practice.'

For similar reasons the AHA was seen by some clerks to be neither acceptable nor effective where matters of manpower planning are concerned.

'I cannot see the Area Health Authority being concerned with positive manpower planning in general practice - the independent contractor status of general practitioners will not permit this.'

'The subject of medical manpower is a very delicate one within each area, and one with which the local medical profession is intimately involved. The only adequate machinery is that of the Family Practitioner Committee and the Local Medical Committee where there will be the largest representation of medical advice and knowledge. The AHA with its small medical representation would not be the proper body to deal with medical manpower planning.'

Area health authorities

The replies quoted above suggest a measure of diversity among the clerks in their views about the future relationship between the AHAs and the FPCs. This reflects in part the uncertainty prevailing at the time of the EC survey (March/April 1973) about the composition and functioning of the new authorities, but most clerks were clearly of the view that every effort should be made to ensure close collaboration between the two bodies. The importance of collaboration was stressed equally by those who felt the FPC should have primacy over all planning decisions affecting family practitioner services and those who conceded primacy to the AHA. In between were those who saw the planning function as a joint responsibility, with obvious implications for collaboration.

At least one clerk explicitly accepted that the AHA would take over the major planning functions from the executive councils.

'There will be little change in the relationship between the FPC and the MPC in day-to-day working in respect of filling vacancies, submission of returns and routine admissions to medical lists. However, in 1974 the AHA will be the body responsible for our policies on planning and organisation of the family practitioner services including manpower planning and all other relevant developments, and will take over this part of the functions of executive councils. Clearly therefore the relationship between the AHA and the FPC will need to be joint consultative.'

But few other clerks would readily resign this part of their function to the AHA; they feel that planning, in particular medical manpower planning must 'remain firmly the function of the FPC and the MPC'. The following extracts elaborate this view.'

'The adequacy of manpower and supporting services in the family practitioner sphere would almost certainly appear to be the prime responsibility of the FPC working also in close co-operation with the MPC so far as general medical practitioner services are concerned. I would like to see the FPC taking this responsibility - reporting to and consulting with the AHA on allied matters, e.g. nursing and health visitors attachments, health centres, post-graduate training, etc. I feel it should be recognised that the FPC will be inheriting this field, the experience of ECs and their predecessors, the Insurance Committees, extending back for 61 years.'

'The District Management Team will submit its plans and recommendations to the AHA and insofar as those plans affect the contractor services, the AHA will wish to ensure that they are generally acceptable to the family practitioners and, therefore, consult the FPC and the local professional committees. The work of drawing up the survey of general medical practitioner manpower and recommending the classification of areas must remain with the FPCs but before submitting their proposals to the MPC they should consult the AHA.'

The hope of close and good relations between the FPC and the AHA was a recurring theme in the replies of both clerks and secretaries. Regular consultations and the exchange of information were seen as the key to co-operation. The following replies were from clerks.

'The relationship which we should like to see in the reorganised Health Service between the FPCs, the AHAs and the RHAs would be one in which there was a close and continuing relationship and a free flow of information between the parties, supplemented by occasional consultation at officer or member level so that no single one of the three authorities concerned would make major decisions in relation to planning without consultation with the other two.'

'This (i.e. communication) can perhaps be best achieved by requiring the FPC to forward to the AHA copies of all annual and triennial reports required by regulation to be submitted to the MPC. The latter Committee, in turn, should be required to let the AHA have copies of any comments made or decisions taken, on such reports.'

'It would be greatly in the AHA's interest to supply the FPC Administrator with the agenda and papers of the Team of Officers and empower him to be in attendance at their meetings on those occasions where he considers matters pertaining to his part of the service will be under consideration.'

The development of good relationships has other potential advantages: for the clerks it was one possible way of preventing a domination of the NHS by any one authority or interest-group; for the secretaries it held the promise of greater scope for local initiative in policy planning and of the development of community-based care. The clerks' fears of a concentration of power in limited quarters is reflected in these replies.

'It is to be hoped that the relationship between the AHA and the FPC would be such as to alleviate fears expressed in some quarters that planning might be dominated by any one particular branch of the service.'

'The AHA should not become hospital orientated to the detriment of the community services. There must be full and proper consultation between the AHA and the FPC on all matters affecting the FPC services. The regional Hospital Board only paid lip service to consultation in the past and this must not be continued by the AHA. The AHA should defer to FPC and MPC over planning provided this is not at variance with the overall plan.'

'I would like the FPC to become regarded as one of the primary advisers of the AHA, but recognise that this role may be difficult to achieve in the face of alternative channels of advice open to the AHA e.g. Local Medical Committee, Area Medical Committee, Area Medical Officer, Area Management Team, to say nothing of the professional membership of the AHA itself.'

One remedy recommended by the clerks to alleviate this fear and suspicion that the family practitioner, the FPC, and its administrator might be left out in the cold is some statutory role for the FPC and its administrator in the planning cycle. There were various suggestions as to the form this might take.

'There should be more involvement by the Family Practitioner Committee in manpower planning, etc. than is suggested in the "Grey Book" on Management and there should be statutory requirements to this effect in the NHS Reorganisation Act.'

'If the Family Practitioner Committee is to play a proper part in the planning processes it should be clearly stated that participation in such processes is one of its statutory responsibilities.'

'There must be provision for the Administrator, Family Practitioner Services, who will be well aware of the views of the FPC, to be much involved in the deliberations of the Area Team of Officers in the planning of general practitioner services. This involvement I regard as absolutely essential.'

'Planning will be an important feature in the new health services. In this respect I feel that this matter has been underrated in that the Administrator of the FPC is not a full member of the Management Team and he will, therefore, not be able to play a full part when these matters are considered.'

A total of 44 clerks (41 per cent of those replying) expressed the view in one form or another that the FPCs should have greater rights and responsibilities in the planning process than seems likely at present. In many cases the replies seem to contain a veiled pessimism that this will not in fact come about, and some gloomy forecasts were made about the future. On the other

hand there was a genuine feeling that greater co-operation, liaison and exchange of information at a local level should do much to offset any structural inadequacies, and a minority of clerks clearly looked to the new unified service for improvements in a variety of fields. For example, the fact that FPC staff are employed by the AHA should give them wider career opportunities in the health service and should at the same time offer to the FPC the prospect of obtaining better qualified and more experienced administrators from other parts of the service.

Hospital services

The apprehension expressed by respondents of a health service dominated by the hospital sector has already been discussed. The hospitals are likely to remain the most costly (and therefore the most powerful) component in the NHS even following reorganisation, and for that reason the relationship between hospital and non-hospital services requires careful evaluation. Six of the LMC secretaries focused on this relationship as one of the positive potential advantages of reorganisation. It was felt that GPs and patients alike could benefit from a freer access to hospital beds, diagnostic facilities, and other services such as radiology and physiotherapy; and it was hoped that the increased scope for GP/hospital appointments might ultimately remove the organisational barriers between hospital work and general practice.

> 'In time health care may be provided by teams of clinicians supported by nursing, welfare and administrative staff. It could be that no distinction be made between hospital work and practice work and that clinicians are able to move from one field to the other. If that were to come about, it is just possible that young doctors would find an interest in working to provide health care both in hospital and in the community at one and the same time.'

> 'Since the AHA also controls hospitals, it could make available parts of hospital buildings for GP work. It would also be possible, since Hospital Medical staff and GPs would be working for the same authority, for hospital staff to do some GP work on a locum or assistant basis as a temporary measure while more GPs were being awaited in the area.'

> 'It may be easier to arrange for a combination of general practice and clinical assistantships in hospitals which, coupled with an initial practice allowance, might in some areas encourage doctors to start new single-handed practices.'

The importance of good relationships between family practitioner and hospital services and of access by GPs to hospital facilities was also stressed

by several clerks. One considered that 'vastly improved hospital facilities and improved relations with consultants' was essential in attracting GP manpower in his area; others saw it as essential to the success of reorganisation:

> 'If the reorganised service is to produce the desired result of providing the patient with a comprehensive service with the available resources, this can only be achieved by the closest co-operation and co-ordination of the primary and consultant services.'

One aspect of special concern to the clerks was the enhanced future opportunities for GPs to take an active part in hospital work by means of part-time appointments. It was hoped that joint appointments between hospitals and general practice would help recruitment, particularly of young doctors. The attraction would lie both in the added interest and experience gained in clinical work and in the financial help while building up a practice.

> 'Area health authorities should offer openings to doctors of good standing over the whole range of primary, secondary and preventive care (i.e. joint appointments of some kind), so that the appointed doctors would be in a reasonable position, over a number of years, to build up a reasonably good standard general practice. Doctors so appointed would be receiving or improving their experience in one or more of the other fields to their own advantage and to the eventual advantage of their patients, when they had built up a reasonable sized list to allow them to concentrate largely or completely on their practice.'

> 'The NHS Reorganisation Bill provides that the FPCs will discharge all the existing functions of the present Executive Councils. Nevertheless, in the re-organised health service the FPCs will not be operating in water-tight compartments. Increasingly, doctors in general practice are doing work in hospitals and for local authorities, particularly outside the London area, and in some instances, for example any proposed development by the AHA of improved community health services or hospital services, will tend to increase the "outside commitments" of general practitioners (i.e. commitments outside of general practice but nevertheless within the health service). The effect of this is that more doctors would be needed for ordinary day-to-day general practice work.'

The need for more vocational training schemes for general practitioners, possibly involving the co-operation of the district general hospital, was mentioned. Hope was expressed that the AHA would be instrumental in promoting such schemes.

'I would hope that the links between the area health authority and the family practitioner committee will be both close and effective in securing the provision locally of an adequate vocational training scheme for general practice which will then serve as a natural source from which many of the area's future needs may be met.'

Supporting services

One common point of contact between the new authorities is the facilities at present provided by local authorities which affect the working conditions of general practitioners. The co-ordination of these services is one objective of reorganisation. The availability of nurses, health visitors and paramedical staff, whether formally attached to a practice or not, obviously affects the workload of the general practitioner, and so does the provision of ambulance services, transport schemes, day centres, residential homes, maternity and child welfare clinics and so forth. A small number of secretaries pointed out this particular advantage of reorganisation.

'The concept of community care teams may go a long way towards eliminating past deficiencies in general medical services, particularly in areas of high population density.'

'We are also promised attachments of district nurses, health visitors and social workers. These attachments could give the doctor help by taking non-medical problems off his shoulders.'

'In the reorganised NHS, where an Area Health Authority will be responsible for managing all parts of the service within its area, it should be much easier to make many services available, since certain services, such as District Nursing, which are now under the control of the Local Authority and therefore subject to the whim of a Health Committee, can be used in whatever way the AHA sees necessary at the time.'

'A forward-looking AHA should be prepared to devote a greater share of its financial resources towards providing community care than has been the case in the past; if this is the case then the improved facilities (i.e. premises, staff, equipment including ECGs etc.) should in themselves act as an attraction to doctors seeking positions in General Practice.'

'On the broader aspect of care in under-doctored areas, it is to be hoped that the patient care groups set up in each health district will identify patients' needs and be able to procure the resources to meet these needs. Much will depend on the enthusiasms with which local doctors take up this challenging role.'

A greater number of clerks (29) made some reference to these ancillary services, mentioning the ease with which they (in contrast to general practitioners) can be planned.

> 'Manpower planning of supportive services can be more effectively controlled than can independent medical contractors and decisions on these would need to be taken by the Area Health Authority in consultation with, and with the co-operation of, Family Practitioner Committees.'

The obvious point was made that creating vacancies is not quite the same thing as filling them; and one clerk questioned the extent to which the AHA would exert any control.

> 'I would doubt whether either the AHA or the FPC will have much impact upon the manpower planning for the supportive services; as I understand it they will not be training bodies for the various paramedical professions, and so their impact is not likely to extend beyond helping to create demands for the future which will then become incorporated in the national manpower budgets and forecast estimates.'

But the majority of clerks who wrote about supporting services accepted that their planning would be the responsibility of the Area Health Authority, and they emphasised again the importance of close collaboration between all the authorities involved.

> 'If the reorganised service is to produce the desired result of providing the patient with a comprehensive service with the available resources, this can only be achieved by the closest co-operation and co-ordination of the primary and consultant services and any fragmentation of the management structure must be deplored.'

> 'In relation to supporting services, e.g. for practice attachment schemes where other disciplines are involved, direct consultation with the Area Team of Officers and with the Area Health Authority will be necessary.'

One way in which this might be done is through a special joint committee, involving the AHA, the FPC and the local authority, to be responsible for the planning of services ancillary to general practice. It was not clear from the replies on this matter how such a committee would be distinguished from, or complementary to, a sub-committee of the Joint Consultative Committee.

> 'One main problem is the exlusion from the reorganisation of the NHS of the social services departments.'

> 'The social services should be involved by setting up a joint planning committee to include representatives of the local government services.'

Two of the secretaries drew out the possible implications of this kind of collaborative approach for the under-doctored areas.

> 'By spotlighting deficiencies in social and paramedical services and planning their elimination, conditions of work in under-doctored areas will improve and this will tend to lessen the disincentive. Nevertheless, social factors will continue to play a large part in a doctor's choice of working environment for it is usually his social environment too. Deficiencies in this will require monetary compensation.'

> 'The greatest advantage of the NHS Reorganisation in providing better care in under-doctored areas will be the exposure of those localities where until now, Local Authority attachments, etc. have been inadequate, and where such provisions are more likely to be available under a forward-looking management.'

Local initiative

A few respondents looked to reorganisation to provide them with more freedom of action at local level. There was a certain amount of impatience with the restrictions placed by the Medical Practices Committee over the classification of areas, vacancies and appointments. Criticisms voiced of the MPC were that it is too remote, too inflexible, that it is ineffective, that not enough attention is paid to local conditions. Clerks in attractive areas with few problems could see little point in the restrictions placed upon them by the MPC at national level.

> 'Our problem is to keep doctors out. I should like to see the AHA as strong as possible with the meximum degree of autonomy. If AHA planning is going to be really effective and controllable at regional and departmental level would this not include controlling the distribution of general practitioners?'

There were a few complaints from clerks of insufficient contact between the MPC and the local situation; of an excessive reliance by the Committee on national, quantitative standards; and of unilateral decisions taken by the Committee without local consensus.

> 'One would, however, like to see a much closer liaison between the staff of the Committee and the new FPC and AHA by means of visits by MPC staff to particular areas to acquaint themselves of problems and difficulties at first hand.'

'There are some doubts about the possibility of the MPC participating effectively in medical manpower planning at the local level, since their various guidelines and "norms" seem to have been set with national re-distribution in mind.'

'Any decision of the Medical Practices Committee regarding the designation of medical practice areas should be subject to the consensus agreement of the area health authority, family practitioner committee and the local medical committee.'

The preferred solution for these clerks would be the transfer of authority from the centre to the locality.

'It could well be that in the long term greater authority will be vested in the district and the role of the Medical Practices Committee will contract to that of an advisory committee in planning matters; but nevertheless it would continue with the function in relation to medical appointments.'

'A more flexible approach to the whole question of medical manpower will be necessary. The authority of the Medical Practices Committee should, in stages over a number of years, be passed to RHAs or AHAs or even FPCs.'

The disadvantages of reorganisation

About three-quarters of the LMC secretaries saw no advantages at all for the under-doctored areas in the NHS reorganisation; of these about a third gave reasons for their pessimism (Table 34). Six secretaries felt that improvements could only come through the availability of additional resources, and since reorganisation fails to guarantee any extra money it could make no difference to the under-manned areas.

'I cannot see any advantage in the forthcoming reorganisation of the NHS in providing better care in under-doctored areas. As mentioned above, the inducements are primarily financial, and I do not know of extra money being provided in this reorganisation.'

'I do not believe (as a member of a Joint Liaison Committee) that there is anything in the new set-up which will help the situation in the designated areas. The patients may benefit individually from the better social care they will receive but there can be no fundamental change in medical care.'

'I do not see how you can get better care in under-doctored areas unless you attract more doctors to that area, and I am blessed if I can see how the forthcoming reorganisation is going to influence this.'

Some secretaries believed that, far from things improving as a result of reorganisation, they would actually get worse. The reasons given for this view were the exclusion of the social services from the new administrative structure, the revision of practice area boundaries upsetting existing classifications, and the fear of domination by the hospital sector.

> 'Regions will be largely staffed by Hospital Board personnel and Areas will be staffed largely by HMC and Local Authority personnel. The role of the Family Practitioner Committee will be gradually reduced.'

> 'Unless the DHSS establishes a firm policy of emphasis on community health, I foresee the lion's share of available resources being diverted into the hospital and especially the teaching hospital services.'

Each of these complaints was echoed to a greater or lesser degree in the clerks' replies. What was unique to the secretaries was the fear that so many doctors in the new service would be spending so much time in management and administration that the patients would suffer from clinical neglect.

> 'The new reorganisation cannot change the shortage of doctors. In fact it may make it worse. If doctors are involved at all the levels of management envisaged their patients will suffer. If we neglect to take part our opinions will go unheard and again the patients may suffer. I think that the reorganisation will be irrelevant to day-to-day care of patients for some time to come.'

> 'I visualise a vast amount of time spent on committees and I anticipate that the administrative proportion of the health service will vastly increase, there being not much change in the number of coalface workers.'

Gloomy predictions were made of the decline of the family doctor service and of the personal doctor-patient relationship.

> 'In my opinion it is the beginning of the end for general practice as we know it today. I can foresee that the future scheme will be hospital dominated and the personal touch which still exists notwithstanding what many people may say to the contrary, between the general practitioner, i.e. family doctor and his patients, will be a thing of the past.'

And finally it was alleged that, with sufficient goodwill, most of the improvements could have been achieved without the 'managerial revolution'.

> 'I am far from convinced that anyone will benefit by the NHS reorganisation except administrative staff who will have more jobs to spread around. Most of the alleged improvements could be achieved, given goodwill between public health staff, hospital staff, general practitioners and administrators, without all the bloody nonsense that is planned. And without goodwill no plan will work.'

SECTION SEVEN

CONCLUSIONS

INTRODUCTION

The starting point of this study was the need expressed in the original report to reassess some of the concepts, assumptions and practices involved in approaching the designated area scheme. These were laid out in Section Three. There is a need to clarify the concept of maldistribution, to consider the utility of the existing basis of classification of practice areas, to examine problems arising from the fragmented responsibility in decision-making, to assess the suitability of practice areas for their task, and to judge the utility of conventional statistics.

The study has obviously not been able to consider each of these points exhaustively. It has, however, assembled material pertinent to them and in this concluding section we draw the various strands together into some brief concluding remarks. It should be emphasised very clearly that these remarks are merely our own personal comments on and evaluations of the material. Others may well draw different conclusions.

THE ORDER OF THE ARGUMENT

The issues of fixing practice area boundaries, of determining the criteria for the classification of areas and of deciding the future of incentive payments are intimately bound up with each other and cannot be considered in isolation. The matter can be put simply in the following way. Although the study revealed an awareness, at both central and local level, of the inappropriateness of many existing practice areas and of the deficiencies of the current method of classification, and although there was evidence of a fairly widespread willingness to change, nevertheless the point was often made that the amount of change that could be enforced would be controlled by the effect it had upon financial rewards. Let us examine this point in more detail.

Medical practice areas were originally defined as a way of providing broad indications of need. Their boundaries were fixed more or less by local choice and their basis of classification was unsophisticated; but it was sufficient to enable the Medical Practices Committee to identify broad areas in which there were enough doctors, and to prevent the entry of new doctors into those places. The Committee also had the freedom to

change area boundaries and to review the basis of classification as the need became apparent. With the introduction of the initial practice allowances these issues assumed a little more importance, but they were still of relatively minor interest. It was only with the introduction of the designated area allowance that the definition and classification of practice areas assumed major political importance, and although some people at the time recognised the error of basing the payment upon the areas used by the MPC, the decision was nevertheless taken to do just that.

In short, practice areas serve two distinct purposes: they provide the means whereby the Medical Practices Committee exercises its statutory functions, and they determine the distribution of an annually increasing sum of money amongst general practitioners. If therefore we are concerned with questions of the optimum size or method of classification of areas, we must first decide the purpose which those areas are intended to serve. An ideal size of area for one purpose may be far from ideal for another purpose. The overriding consideration, however, is whether the areas will continue to be used as the basis for the administration of incentive payments, especially the designated area allowance. If they are to continue serving this purpose, then many changes which would be desirable in principle are unlikely to be effected because of the financial interests at stake. If, however, a prior decision is taken either to abolish the allowance or to tie it to some yardstick other than the MPC's classification of a designated area, then the way would be clear for a more flexible approach to the problems described in this report. The starting point, then, must be the allowance.

THE DESIGNATED AREA ALLOWANCE

There are two separate questions to be asked about the designated area allowance: whether it should continue to be paid, and if so whether it should continue to be tied to the MPC classification of designation. With regard to the first question, we take the view that the allowance should be judged on its effectiveness. The evidence, however, is equivocal. The report of the original designated area study found little evidence of success by 1971 and in fact set out a number of reasons why it was unlikely ever to achieve substantial success at least in its existing form. Foremost among these

were the disincentive effects inherent in the regulations governing the allowance and the relatively small impact which modest financial inducements have upon a doctor's choice of practice location. The present study has provided extensive further evidence of perceived disincentive effects, amounting virtually to counter-productivity, and has revealed a widespread feeling of scepticism and antipathy towards the allowance on the part of EC clerks and LMC secretaries. There is, on the other hand, some evidence of partial success, for there has been a reasonably good net inflow of doctors into designated areas since 1969 and a reduction in the number of such areas since 1971. Areas <u>are</u> becoming de-designated, a fact which is not easily reconciled with the confident assertion of many EC clerks and LMC secretaries that practitioners hold an absolute control over the entry of new doctors to their areas and deliberately ensure that they remain (just) designated. The answer may be that there are in effect two kinds of designated areas: those in comfortable and attractive places where the loss of the allowance would far outweigh the benefits brought by incoming colleagues, and those in rougher, more difficult places where the existing doctors would give more than a few hundred pounds for the relief of reinforcements.

There can be little doubt that the plight of the designated areas has improved in recent years, and it may be supposed that part of this improvement is due to the availability of the two inducement allowances. But our own opinion is that both the incentive and the disincentive effects of the designated area allowances are probably quite small and may have been exaggerated. It is a neutral allowance for the most part, and the movement and distribution of doctors is determined primarily by other factors, especially the total supply of doctors in relation to the pattern of vacancies. The original report noted how the decline in the total number of doctors had gone hand-in-hand with an increase in the number of designated areas, including many attractive places for which the allowance was never intended at all. It seems probable that the reverse trends evidenced in the past three to four years are part of the same basic dynamic and that they have been little affected by the small financial inducements available.

We reached the conclusion, then, that a phased withdrawal of the designated area allowance would little affect the prevailing patterns of manpower distribution throughout the country, and that the question of whether it should continue to be tied to the MPC classification of designation is therefore redundant. This conclusion, as we argued above, has important implications

for the way we approach the question of size and classification of areas, but before moving on to that question we must tie up some of the loose ends around the conclusion.

First, we accept the BMA's argument about the importance of the 'no detriment' principle - that is, that no doctor should actually be worse off financially as a result of an administrative or policy decision. The allowance might reasonably cease to be payable to doctors for the first time from a given date, but safeguards would be needed for doctors currently in receipt of it at that date. It may be sufficient to phase out the payments as areas cease to be eligible, but additional safeguards may be considered necessary. These might take the form of a continuing payment on a personal basis, possibly for as long as the doctor remains in the same area or practice.

Secondly, we are sympathetic with the argument, advanced by some of the EC clerks, that the allowance should not be scrapped entirely, but should be substantially scaled down and retained (possibly at a higher level of payment) only in areas with a proven history of very large lists. The statistical material discussed in Section 5 confirmed the continuing need to channel manpower resources into these areas, and if such areas were the only ones to attract an incentive payment the scheme might yield some benefits. It would, however, be necessary to look very closely at the wisdom of continuing to link such a payment with the MPC areas. Our strong preference would be for the DHSS, in consultation with the interested parties, to decide the appropriate areas independently of any MPC classifications, possibly using more flexible criteria of eligibility.

Thirdly, we have not infrequently encountered the view, particularly among the doctors, that the designated area allowances should really be seen as a form of compensation for doctors working in unattractive areas rather than an inducement for more doctors to move to undermanned areas. These two interpretations are quite distinct in their implications and although we believe the Review Body has never taken the view that the allowance should be a compensatory payment, it may nevertheless be regarded as reasonable to introduce a compensatory allowance. However, in the event of a decision to introduce an entirely new allowance of this nature, two consequences seem to follow. One is that the allowance would have no explicit connection with

issues of manpower distribution. It would be concerned solely with measures of attractiveness, not of manpower needs, and it would therefore be divorced from areas which the Medical Practices Committee will continue to recognise for its own separate purposes. The second consequence is that an allowance of this kind should probably be taken into account when computing the average intended income of general practitioners. The designated area allowance is not so regarded - at least in principle - for the Review Body has clearly stated its view that that particular allowance should be 'an additional payment the cost of which should not have to be found from within the total of existing remuneration'.* It would be difficult in our view to sustain a similar argument with respect to any compensatory payment.

Fourthly, it was the view of a number of EC clerks and LMC secretaries that the initial practice allowances, in contrast to the designated area allowance, have been quite effective, and we can see no reason why they should not continue to be used as an instrument of local manpower policy in small, selected areas. There is, however, a need to strengthen some of the allowances, and the proposed increase in the Type D allowance for new housing developments is a welcome step in this direction.

THE BOUNDARIES OF PRACTICE AREAS

Our argument so far, that the designated area allowance should be phased out, or at least substantially scaled down, carries with it the important consequence of enabling the Medical Practices Committee to determine the definition and classification of practice areas for its own purposes, without the constraint of any financial considerations. We take the view that the decision in 1966 to link the designated area allowance with the MPC medical practice areas was wrong, partly because the areas themselves have in many cases proved to be unsuitable for the job and partly because the financial interests involved have seriously curtailed their potential to adapt. We believe that the members of the Medical Practices Committee are particularly conscious of this latter constraint. The withdrawal of the designated area allowance would largely remove the constraint and would clear the way for a new approach to the definition and classification of practice areas in the light of the purpose they were originally intended to serve. An alternative way of achieving the same objective (though not one with which we ourselves

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* Review Body on Doctors' and Dentists' Remuneration, Ninth Report, Cmnd.3600, HMSO, 1968.

could agree) would be to continue the allowance but to base it on criteria and zones entirely separate from those used by the Medical Practices Committee.

The remainder of this concluding section is based upon the premise that, in one or other of these ways, the financial constraint is removed and the practice areas can be evaluated without regard to consequences of remuneration. We recognise, however, that strong pressures exist to preserve and even extend the designated area allowance, and that its imminent withdrawal is improbable. The retention of the allowance would not significantly disturb the scope of our conclusions but it would presumably diminish the chances of effecting desirable changes. We begin by looking at the issue of practice area boundaries.

The smaller practice areas (in terms of the number of doctors they contain) are generally intermediate and restricted and appear still to be suited to their original purpose of negative control. This control operates not only to encourage the deflection of manpower away from restricted areas into those less well supplied, but also to prevent unfair competition to doctors in places where the population may be widely scattered and the financial rewards relatively low for the amount of work done. For this reason it is desirable that the restricted areas should remain small.

Larger practice areas, on the other hand, which tend to be designated or open, are much less suited to their purpose. Two major problems have emerged. Firstly, many of these areas, especially the former county boroughs, are too large and too heterogeneous to identify substantial variations in patient/doctor ratios within them. This point emerged not only from the surveys of EC clerks and LMC secretaries but also from the statistical analysis relating the size of area to the range of average list sizes within them. Secondly, many areas no longer bear any relation to the catchment areas of their practitioners. Although the principle of free choice for both doctors and patients precludes any precise coincidence of medical practice areas and doctors' catchment areas, nevertheless population movements and new housing developments have rendered many old boundaries obsolete. This applies particularly to the former county boroughs and the problems of fringe areas around them.

In addition to these particular problems in designated areas, the recent reorganisation of the National Health Service may create new difficulties and anomalies in all areas unless the opportunity is grasped of rationalising the

boundaries of practice areas and those of other geographical units in health service administration. It is estimated that about two-fifths of former executive councils contained practice areas which overlap the new FPC boundaries and an unknown (but probably high) proportion of practice areas overlap the new health district boundaries. Unless some degree of coterminosity is introduced, there is a danger of two parallel but separate planning systems emerging, one for general practitioner manpower and one for other health services.

There is encouraging evidence that those involved in the decision-making processes are recognising and responding to these problems. At central level the request by the Medical Practices Committee for working parties to be established locally for the purpose of rationalising practice areas within FPC areas reflects a conscious recognition of the need to respond to reorganisation and an appreciation of the opportunities which rationalisation could offer. At the local level, the survey of EC clerks showed that although a majority of them were antagonistic to the NHS reorganisation itself, nevertheless more than two-fifths accepted the case for a revision of medical practice area boundaries on the grounds either of the need for coterminosity with health districts or areas, or of the desirability of corresponding more closely with the actual areas of residence of patients.

The detailed guidelines of revision are not for us to specify. They are presumably being examined in the local working parties. But on the evidence assembled in this study, certain broad indicators emerge. Medical practice area boundaries should in principle be drawn in a way that will minimise fringe areas and the overlap of catchment areas; they should in principle produce areas which aggregate up to health districts; and they should ideally contain between about 20 and 30 doctors (i.e. normally with a population between about 50 and 75 thousand). We must emphasise again that there may be very good local reasons why such guidance should be ignored, but in the absence of over-riding contra-indications we suggest they would form a reasonable basis for a revision exercise.

THE CLASSIFICATION OF PRACTICE AREAS

The way in which areas should be classified as designated, open, intermediate or restricted is in many respects as important as the way in which their boundaries are fixed. We have not, however, been able to throw much

new light onto this. The prevailing view seems to be that list size alone is a poor indicator of manpower needs, but there is little apparent unanimity of agreement on alternative indicators and even if there were, these would in any case be very difficult to monitor.

A uniform average list size is clearly easy to administer and can be seen to be relatively impartial. Doctors can know where they stand. But the list size that heralds designation (2,500, taken in conjunction with the overspill rule) was based originally on no deep consideration of its suitability for this purpose and may well be outmoded in many instances. Moreover, being an average figure, it can conceal extreme disparities in the list sizes of individual practitioners within the area and in the case of larger areas it may conceal important differences between the average list sizes of distinct localities.

Various alternatives have been suggested, falling into three main types. Firstly, amendments have been suggested to the statistical basis of classification. If for example, the median list size is used instead of the mean, or if the criterion is taken to be a given proportion of practices in excess of a particular size, then it has been suggested that some of the anomalies of the present method would be eliminated. This is only partially true. A brief analysis of list sizes suggests that in this particular situation the median has no advantage over the mean, but we do agree that a measure of the proportion of outsized practices is useful. For example, an area with a mean list size of 2,400 but a large proportion of practices containing 3,000 or more patients might reasonably be considered to need more doctors, even though it would not at present be designated. In this example, however, the major fault would probably lie in the excessive size and heterogeneity of the area. As a general rule the smaller an area the less likelihood there would be of major differences emerging between each measure. In an area of 20 doctors, which we have suggested as a desirable size, it is unlikely that the mean, the median and the proportion of large practices would yield very different indications of manpower needs.

A second type of amendment suggested to the method of classifying practice areas is the substitution of list size by other more relevant criteria. The list of possible criteria is familiar: the proportion of old and young patients, morbidity and mortality rates, workload, doctors' outside commitments and so on.. The principal difficulties involved in this

approach are those of obtaining a consensus of opinion about the utility of each factor as an indicator of manpower needs and of measuring and monitoring changes in them at reasonably frequent intervals. There is, however a third possible approach to the question of classification which overcomes both of these difficulties, namely, to abandon the concept of a national standard or criterion of classification and leave it to the local powers (presumably the FPCs) to decide their own manpower needs in the light of the detailed knowledge of their own localities. Family Practitioner Committees would probably differ on the basis of their judgements, but each would be able to classify its practice areas in terms relevant to the local situation. Such an approach, it has been argued, would make much more sense than a continuing search for acceptable national standards to apply throughout the whole country.

A number of subsidiary points must be made about this approach before setting it in the context of current national policy. Firstly, although it would be virtually impossible to implement as long as the areas are used to regulate the designated area allowance, it becomes a reasonable possibility if (as we have argued should be the case) the allowance is divorced entirely from the MPC practice areas. Secondly, this may well be a matter in which the FPC could work in close collaboration not only with the LMC but also with the AHA. The AHA is concerned with all aspects of health service planning and it seems logical that this should include a concern about the number and distribution of general practitioners. Thirdly, if the principle of local autonomy is accepted, there is no obvious reason why it should not extend to the determination of practice area boundaries also. The result, it is true, would be the transfer to local control of a very large part of the functions currently performed by the Medical Practices Committee. It has even been suggested to us that the MPC would become redundant. We feel, however, that the need would remain for a central independent body to exercise the powers of negative control within the areas classified locally, and it is logical that this should fall to the MPC. Fourthly, the main argument we have heard against this approach is that all FPCs would consider themselves to be short of doctors and the entire country would be designated. There is no doubt that some committees would apply much more liberal definitions of need than others, but there is no evidence that all committees would seek automatically to attract as many doctors as they could. Family practitioner committees are responsible bodies and the results of the survey of EC clerks clearly

showed an awareness and acceptance of the notion of sufficiency in this context. If, however, it is felt that some safeguard should be established, then the MPC could be given the power to monitor the activities of FPCs in this regard and to intervene in cases of serious divergence from normal standards.

For all its attractiveness, however, the devolution of control in this way would run counter to much other contemporary policy. The assumption of local autonomy in the definition and classification of practice areas may be widely acceptable only at a time of obvious surplus of general practitioners, and although recruitment to the profession is again increasing, we are clearly nowhere near an obvious surplus. The need therefore remains, as expressed in current policies, for certain minimum levels of central control to maintain a degree of balance between need and supply. The Central Manpower Committee, set up to advise the DHSS in 1972, provides this balance in the hospital field and the powers of negative control operated by the Medical Practices Committee ensures a parallel degree of balance in general practice. It is likely that for many years the need will remain for a central body to monitor the distribution of GPs between areas, although there may be scope for greater local initiative in arranging the deployment of manpower within areas.

INFORMATION

We conclude the report with three comments about the relevance of information to the issues discussed above.

Firstly, one of the strong arguments in favour of coterminosity of practice area and health district boundaries is the resulting synchronisation of geographical units within which information systems will eventually operate and health needs and services be appraised. One of the persistent difficulties in evaluating the designated area scheme is the lack of relevant information within practice areas about manpower needs, movements and so forth. There is a chance that in future a more coherent information system will develop, but it will relate at the local level to the health district. Thinking and planning about services locally will take place within districts and unless practice areas can be made to aggregate up to district boundaries, the value of such information for general practice manpower planning will be diminished.

This point assumes even greater significance if much of the responsibility for defining and classifying practice areas is transferred from central to local control.

Secondly, decision-making at the national level could be improved if the basic information about practice areas collected routinely by the MPC could be processed and published in the way we have done in Section 5. All of the information contained in that Section was already available in the MPC records and it would not be too difficult for it to be transferred routinely to punched cards for periodic analysis.

Thirdly, there are gaps and imperfections even in this information which would be worth the expenditure of time and effort to overcome. Some items of data on the MPC records, which we were asked not to collect, should in our opinion be publicly available. For example, the deflation factors which the MPC apply to average size lists before determining the classification of an area are not generally known, nor is the extent known to which doctors' outside commitments are taken into account. As a result, as shown in Section 5, there may be fairly wide divergencies between the apparent patient-doctor ratio in an area and its classification. A further gap in the information available is the listing of areas qualifying for the designated area allowance and, where appropriate, the length of time for which they will continue to qualify. This particular piece of information will clearly be irrelevant if the designated area allowance is withdrawn, but if the intention is to use the allowance as a bait, then it is remarkable that there is apparently no easily accessible listing of qualifying areas.

The most serious imperfection in the existing data, as we explained at some length in Section 5, arises from the failure to identify changes over time within the same areas and to plot the flows of doctors between areas. By taking annual aggregates of each class of area it is very difficult to assess the real significance of changes in, say, the number of doctors practising in designated areas and it is quite impossible to identify the gross and net movements from one type of area to another. The linking of information for the same area over a number of years may be a complex operation, but it should be feasible to trace year-to-year changes. One way of doing this would be through the Doctor Index tabulating, for each doctor, the classification of his practice areas in the previous year against that of the current year. Even this simple operation, if performed for those who remained in the same practice as well as those who moved during the year, would offer an important improvement on our present information.

Table 1. Dates of EC reports to the Medical Practices Committee, by classification of area (England)

(Source: MPC survey)

Date of EC report	Number of areas by classification				All areas
	Designated	Open	Intermediate	Restricted	
Pre- July 1972	2	5	4	28	39 (3%)
July 1972	70	106	108	162	446 (31%)
October 1972	92	93	76	125	386 (26%)
January 1973	49	98	79	97	323 (22%)
April 1973	34	52	74	105	265 (18%)
Total	247	354	341	517	1,459 (100%)

Table 2. Comparison of MPC survey and DHSS tabulations: numbers and distributions of unrestricted principals and patients (England)

(Source: MPC survey; DHSS tabulations)

	Classification of areas				
	Designated	Open	Intermediate	Restricted	All areas
Number of principals:					
MPC survey	5,065	7,098	5,218	2,410	19,791
	(26%)	(36%)	(26%)	(12%)	(100%)
DHSS tabulations	5,099	7,171	5,121	2,384	19,775
	(26%)	(36%)	(26%)	(12%)	(100%)
Number of patients (millions):					
MPC survey	14.3	17.9	11.9	4.8	48.9
	(29%)	(37%)	(24%)	(10%)	(100%)
DHSS tabulations	14.1	17.6	11.5	4.6	47.9
	(29%)	(37%)	(24%)	(10%)	(100%)

Table 3. Classification of practice areas at 1st January 1966-1973 (England)

(Source: MPC lists)

Year	Number of areas by classification				All areas
	Designated	Open	Intermediate	Restricted	
1966	241 (14%)	662 (38%)	253 (15%)	572 (33%)	1,728 (100%)
1967	274 (16%)	612 (36%)	278 (16%)	557 (32%)	1,721 (100%)
1968	318 (19%)	534 (32%)	289 (17%)	517 (31%)	1,658 (100%)
1969	332 (20%)	467 (29%)	329 (20%)	493 (30%)	1,621 (100%)
1970	320 (20%)	424 (27%)	330 (21%)	505 (32%)	1,579 (100%)
1971	320 (20%)	374 (24%)	320 (20%)	562 (36%)	1,576 (100%)
1972	285 (19%)	347 (23%)	319 (22%)	532 (36%)	1,482 (100%)
1973	238 (16%)	347 (24%)	355 (24%)	526 (36%)	1,466 (100%)

Table 4. Number of principals by classification of practice areas, 1st October 1969-72 (England)

(Source: DHSS tabulations)

Year	Number of principals by areas				All areas
	Designated	Open	Intermediate	Restricted	
1969	6,435(34%)	7,294(39%)	3,377(18%)	1,795(9%)	18,901(100%)
1970	6,438(34%)	7,090(37%)	3,546(18%)	2,025(11%)	19,099(100%)
1971	6,177(32%)	7,174(37%)	3,968(20%)	2,055(11%)	19,374(100%)
1972	5,099(26%)	7,171(36%)	5,121(26%)	2,384(12%)	19,775(100%)

Table 5. Average number of patients per principal, by classification of practice areas (England and Wales up to 1970; England only 1970-72)

(Source: DHSS tabulations)

Year and coverage	Average list size by classification of areas				All areas
	Designated	Open	Intermediate	Restricted	
England and Wales:					
1966	2,845	2,483	2,165	1,813	2,455
1967	2,840	2,493	2,185	1,842	2,474
1968	2,819	2,475	2,204	1,818	2,478
1969	2,817	2,488	2,216	1,865	2,479
1970	2,791	2,480	2,223	1,884	2,460
England:					
1970	2,791	2,486	2,228	1,893	2,478
1971	2,781	2,458	2,250	1,910	2,460
1972	2,771	2,458	2,247	1,930	2,421

Table 6. Net admissions of unrestricted principals by classification of area during years ending 1st October 1970, 1971, 1972

(Source: DHSS tabulations)

Classification of practice area	Net increase in the number of principals Years ending October 1970	1971	1972
Designated	+138 (70%)	+109 (40%)	+120 (30%)
Open	+ 24 (12%)	+126 (46%)	+172 (43%)
Intermediate	+ 9 (4%)	+ 32 (12%)	+ 77 (19%)
Restricted	+27 (14%)	+ 8 (3%)	+ 32 (8%)
Total	+198 (100%)	+275 (100%)	+401 (100%)

Note: The table gives the net change after deducting withdrawals from the sum of first admissions and re-admissions. In the case of an admission the classification of the practice area is that at the time of admission; in the case of a withdrawal the classification of the practice area is that at the previous 1st October or date of admission whichever was the later.

Table 7. Number of principals in receipt of designated area and initial practice allowances 1970-72, and costs 1968/9-1971/2 (England)

(Source: DHSS tabulations; HC270, May 1973)

	Number of principals in receipt of allowance		
	October 1970	October 1971	October 1972
Designated area allowances: (1)			
type 1	)	5,598	5,802
type 2	) 4,985	429	455
Both types	4,985	6,027	6,257
Change on previous year		+ 21%	+ 4%
Initial practice allowances:	191	192	225
Change on previous year		-	+ 17%
	Cost of allowance (£000) fiscal years, ending March:		
	1968-9	1969-70	1970-1	1971-2
Designated area allowance	1,435.1	1,799.9	2,552.4	3,365.4
Change on previous year		+ 24%	+ 43%	+ 32%
Initial practice allowancee	154.3	216.2	274.1	278.6
Change on previous year		+ 40%	+ 27%	+ 2%

(1) In 1971 and 1972:

Type 1 £490
Type 2 £750

Table 8. The proportion of principals in designated areas, by standard regions, at October 1970-72 (England)

(Source: DHSS tabulations)

Standard region	All principals (Numbers)			Percentage of principals in designated areas			Percentage change 1970-72	
	1970	1971	1972	1970	1971	1972	All areas	Designated areas
North	1,315	1,333	1,348	57	50	45	+2.5	-19.6
Yorkshire/ Humberside	1,919	1,938	1,959	50	46	40	+2.1	-17.4
East Midlands	1,351	1,367	1,386	44	47	51	+2.6	+18.5
East Anglia	702	720	731	17	16	15	+4.1	-4.2
South East	7,441	7,556	7,713	20	20	13	+3.7	-31.2
South West	1,723	1,743	1,783	8	6	4	+3.5	-49.3
West Midlands	2,004	2,047	2,117	66	56	41	+5.6	-34.0
North West	2,644	2,670	2,738	42	42	34	+3.6	-14.3
England Total	19,099	19,374	19,775	34	32	26	+3.5	-20.8

Table 9. Classification of practice areas by standard regions (England)

(Source: MPC survey)

Standard region	Percentage of areas by classification				All areas (=100%)
	Designated	Open	Intermediate	Restricted	
North	20	20	15	45	130
Yorkshire/ Humberside	28	24	19	29	156
East Midlands	28	19	17	36	138
East Anglia	8	14	28	50	78
South East	10	34	32	24	423
South West	2	10	21	67	263
West Midlands	23	26	23	28	137
North West	40	36	18	6	134
England, Total	17	24	23	36	1,459

Table 10. Distribution of principals by classification of practice areas and standard regions (England)

(Source: DHSS tabulations 1972)

Standard region	Distribution of principals (%) by areas				All principals (=100%)
	Designated	Open	Intermediate	Restricted	
North	45	27	15	13	1,348
Yorkshire/ Humberside	40	40	12	8	1,959
East Midlands	51	28	11	10	1,386
East Anglia	15	19	40	26	731
South East	13	40	35	12	7,713
South West	4	36	26	34	1,783
West Midlands	41	34	20	5	2,117
North West	34	40	23	3	2,738
England, Total	26	36	26	12	19,775

Table 11. Practice areas by classification and number of unrestricted principals (England)

(Source: MPC survey)

No.of principals in area	Percentage of areas by classification				All areas
	Designated	Open	Intermediate	Restricted	
1	-	-	1	25	9
2 - 4	2	5	14	48	22
5 - 9	20	24	30	19	23
10 - 19	34	31	30	4	22
20 - 29	23	17	12	1	11
30 - 39	13	12	7	2	7
40 - 49	3	6	3	1	3
50 - 59	2	2	2	-	1
60 +	3	2	1	-	1
No.of areas (=100%)	247	354	341	517	1,459

Table 12. Mean number of principals per area, by classification of area, in counties, county boroughs and Greater London

(Source: MPC survey)

Local authority type	Mean number of principals per area, by classification of areas				All areas
	Designated	Open	Intermediate	Restricted	
Counties	15.5	14.5	10.6	3.7	9.2
County boroughs	33.1	32.6	35.0	5.5	32.5
Greater London	29.0	31.3	31.5	33.4	31.5
England, Total	20.5	20.0	15.3	4.7	13.6

Table 13. Distribution (%) of principals and practice areas by classification of area in counties, county boroughs and Greater London

(Source: MPC survey)

	Distribution (%) of principals and practice areas by classification of areas				All areas/ principals (=100%)
	Designated	Open	Intermediate	Restricted	
Counties					
principals	25	32	26	17	10.926
areas	15	20	23	42	1,183
County boroughs					
principals	39	43	18	*	5,369
areas	38	43	16	2	165
Greater London					
principals	7	37	41	15	3,496
areas	8	37	41	14	111
England Total					
principals	26	36	26	12	19,791
areas	17	24	23	36	1,459

* Less than 1%

Table 14. Distribution of principals by size and classification of practice areas (England)

(Source: MPC survey)

No.of principals in area	Distribution of principals (%) by areas				All areas
	Designated	Open	Intermediate	Restricted	
1	-	-	-	5	1
2 - 4	-	1	3	29	5
5 - 9	7	8	14	29	12
10 - 19	23	22	27	11	22
20 - 29	27	21	19	6	20
30 - 39	21	21	16	11	18
40 - 49	7	13	9	7	10
50 - 59	5	5	6	2	5
60+	10	9	6	-	7
No.of principals (=100%)	5,065	7,098	5,218	2,410	19,791

Table 15. Practice areas by average list size and classification of practice areas (England)

(Source: MPC survey)

Average list size of area	Percentage of areas by classification				All areas
	Designated	Open	Intermediate	Restricted	
Under 1,800	-	-	-	32	12
1,800 - 2,099	-	-	13	31	14
2,100 - 2,499	1	48	71	25	37
2,500 - 2,549	2	12	4	2	5
2,550 - 2,599	4	11	2	2	4
2,600 - 2,649	10	7	2	1	4
2,650 - 2,699	11	5	2	1	4
2,700 - 2,749	13	4	1	1	4
2,750 - 2,999	42	11	3	3	11
3,000 - 3,249	11	2	1	1	3
3,250 +	6	-	1	1	2
No.of areas (= 100%)	247	354	341	517	1,459

Table 16. Distribution of principals (%) by average list size and classification of practice areas (England)

(Source: MPC survey)

Average list size of area	Distribution of principals (%) by areas				All areas %
	Designated	Open	Intermediate	Restricted	
Under 1,800	-	-	-	23	3
1,800 - 2,099	-	-	14	48	9
2,100 - 2,499	2	60	78	25	45
2,500 - 2,749	55	35	6	3	29
2,750 - 2,999	35	4	1	1	11
3,000 - 3,249	6	1	-	-	2
3,250 +	2	-	-	-	1
Total no. (=100%)	5,065	7,098	5,218	2,410	19,791

Table 17. Practice areas by average list size and standard region (England)

(Source: MPC survey)

Standard region	Percentage of areas by list size						All areas (=100%)
	under 1,800	1,800 - 2,099	2,100 -2,499	2,500 -2,749	2,750 -2,999	3,000 +	
North	25	16	23	16	15	5	130
Yorkshire/ Humberside	9	16	31	24	15	5	156
East Midlands	13	8	29	21	16	13	138
East Anglia	10	13	42	14	13	8	78
South East	4	12	53	22	8	1	423
South West	23	23	33	13	6	2	263
West Midlands	12	12	31	30	10	5	137
North West	3	8	29	27	22	11	134
England, Total	12	14	37	21	11	5	1,459

Table 18. Practice areas by average list size and number of unrestricted principals (England)

(Source: MPC survey)

No.of principals in area	Average list size of area (number of areas)							Total
	under 1,800	1,800-2,099	2,100-2,499	2,500-2,749	2,750-2,999	3,000-3,249	3,250 +	
1 - 4	134	89	124	50	28	12	20	457
5 - 9	28	53	118	58	51	17	9	334
10 - 19	6	38	135	70	56	11	2	318
20 - 29	1	11	70	61	17	3	-	163
30 - 39	-	10	50	35	12	-	-	107
40 - 49	-	4	26	11	2	-	-	43
50 - 59	-	-	9	9	-	-	-	18
60+	-	-	11	7	1	-	-	19
Total	169	205	543	301	167	43	31	1,459

Table 19. Distribution of principals by size and average list size of practice areas (England)

(Source: MPC survey)

No.of principals in area	Distribution of principals by average list size of area (number of principals)							Total
	under 1,800	1,800-2,099	2,100-2,499	2,500-2,749	2,750-2,999	3,000-3,249	3,250 +	
1 - 4	285	215	327	110	62	27	40	1,066
5 - 9	196	371	826	406	357	119	63	2,333
10 - 19	82	511	1,895	990	767	157	24	4,426
20 - 29	22	262	1,720	1,472	399	66	-	3,941
30 - 39	-	345	1,710	1,180	394	-	-	3,629
40 - 49	-	178	1,157	490	89	-	-	1,914
50 - 59	-	-	491	490	-	-	-	981
60+	-	-	877	546	73	-	-	1,496
Total	585	1,882	9,003	5,684	2,141	369	127	19,791

Table 20. Distribution of principals by classification of practice areas and individual list size (England)

(Source: DHSS tabulations 1972)

Individual list size*	Distribution of principals (%) by areas				All areas
	Designated	Open	Intermediate	Restricted	
Under 1,600	3	8	14	24	10
1,600 - 1,899	4	8	13	23	10
1,900 - 2,499	22	34	40	40	33
2,500 - 2,999	37	32	22	9	28
3,000+	34	18	11	4	19
No.of principals (=100%)	5,099	7,171	5,121	2,384	19,775

* Individual list is taken as the personal list size for single-handed practitioners and the practice average for those in partnerships or group practices.

Table 21. EC and LMC surveys: response rates

Response status	Type of EC/LMC		
	Counties	County boroughs	Total
EC clerks			
Completed returns	46 (98%)	62 (90%)	108 (93%)
Refusals	-	1 (1%)	1 (1%)
Non-response	1 (2%)	6 (9%)	7 (6%)
Total	47(100%)	69(100%)	116(100%)
LMC secretaries			
Completed returns	40 (85%)	55 (80%)	95 (82%)
Refusals	-	1 (1%)	1 (1%)
Non-response	7 (15%)	13 (19%)	20 (17%)
Total	47(100%)	69(100%)	116(100%)

Table 22. EC and LMC surveys: satisfaction with existing practice area boundaries

Degree of satisfaction	Type of EC/LMC		
	Counties	County boroughs	Total
EC clerks			
Area boundaries satisfactory; no further comment	6 (13%)	36 (58%)	42 (39%)
Area boundaries satisfactory; explanation given	26 (57%)	11 (18%)	37 (34%)
Area boundaries generally satisfactory but some unavoidable deficiencies	7 (15%)	10 (16%)	17 (16%)
Area boundaries not satisfactory and should be changed	7 (15%)	5 (8%)	12 (11%)
Total	46 (100%)	62 (100%)	108 (100%)
LMC secretaries			
Area boundaries satisfactory; no further comment	17 (43%)	20 (36%)	37 (39%)
Area boundaries satisfactory; explanation given	10 (25%)	11 (20%)	21 (22%)
Area boundaries not satisfactory	11 (28%)	12 (22%)	23 (24%)
Area boundaries irrelevant	1 (2%)	9 (16%)	10 (11%)
No/other comments	1 (2%)	3 (6%)	4 (4%)
Total	40 (100%)	55 (100%)	95 (100%)

Table 23. EC survey: reasons for clerks' dissatisfaction with existing boundaries

Reasons for dissatisfaction	Problems unavoidable		Boundaries should be changed		
	Counties	County boroughs	Counties	County boroughs	Total
Fringe areas	2	5	2	4	13
Overlapping catchment areas	2	4	-	-	6
Remote rural areas	3	-	2	-	5
Size: too large	1	1	2	1	5
too small	1	-	1	-	2
Change would cause loss of designation	-	2	-	-	2
Other reasons	-	1	3	1	5
Total replies	9	13	10	6	38
Total clerks replying	7	10	7	5	29

Table 24. LMC survey: reasons for secretaries' dissatisfaction with existing boundaries

Reasons for dissatisfaction	Type of local medical committee		
	Counties	County boroughs	Total
Boundaries are artificial/out-of-date	1	3	4
Unhelpful to rural areas	3	-	3
Size: too large/heterogeneous	5	5	10
too small/unstable	2	2	4
Other reasons/no reason	3	4	7
Total replies	14	14	28
Total secretaries replying	11	12	23

Table 25. E.C. Survey: criteria on which area boundaries are based and should be based

Criteria for boundaries	Type of executive council		
	Counties	County boroughs	Total
Boundaries currently based on:			
Parliamentary constituencies and/or electoral wards	3	4	7
Local government boundaries	3	-	3
Postal districts	1	1	2
Arterial roads, natural boundaries, topographical features	1	3	4
Doctors' catchment areas	2	1	3
Boundaries should be based on:			
Specified size (e.g. number of GPs)	3	-	3
Local government areas	2	-	2
Total replies	15	9	24
Total clerks replying	10	8	18

Table 26. EC survey: extent of overlap between medical practice area and FPC boundaries, and clerks' views about the desirability of change

Extent of overlap and desirability of change	Type of executive council		
	Counties	County boroughs	Total
MPAs will straddle FPC boundaries:			
but no need to redraw boundaries	5 (11%)	3 (5%)	8 (7%)
boundaries need to be redrawn:			
minor changes only	8 (17%)	-	8 (7%)
problem of fringe areas	6 (13%)	2 (3%)	8 (7%)
other reasons	3 (7%)	6 (10%)	9 (8%)
no/uncertain reasons	2 (4%)	8 (13%)	10 (9%)
Sub-total	24 (52%)	19 (31%)	43 (40%)
MPAs will not straddle FPC boundaries:			
thus no need to redraw boundaries	19 (41%)	30 (48%)	49 (45%)
but boundaries still need redrawing	2 (4%)	11 (18%)	13 (12%)
Sub-total	21 (46%)	41 (66%)	62 (57%)
Don't know yet/no comment	1 (2%)	2 (3%)	3 (3%)
Total	46 (100%)	62 (100%)	108 (100%)

Table 27. LMC survey: secretaries' views on criteria of classification of areas

Secretaries' views	Type of local medical committee		
	Counties	County boroughs	Total
Present criteria satisfactory/ no feasible alternative	17 (43%)	21 (38%)	38 (40%)
Average list should be different/ modified formula	3 (7%)	5 (9%)	8 (8%)
Other factors should be considered	15 (37%)	27 (49%)	42 (44%)
No comment/no direct experience	5 (13%)	2 (4%)	7 (8%)
Total	40 (100%)	55 (100%)	95 (100%)

Table 28. LMC survey: criteria on which the classification of areas should be based

Criteria for classification	Type of local medical committee		
	Counties	County boroughs	Total
Population characteristics:			
demographic	2	8	10
socio-economic	2	8	10
density, urban/rural	5	3	8
temporary residents	2	2	4
Area characteristics:			
environmental/amenities	2	6	8
traffic considerations	1	2	3
Characteristics of practitioners			
age/sex structure	2	3	5
outside commitments	4	4	8
Workload/morbidity	4	16	20
Other factors	3	2	5
Total replies	27	54	81
Total secretaries replying	15	27	42

Table 29. EC survey: views of clerks about the effectiveness of the designated area scheme

Clerks' views	Type of executive council		
	Counties	County boroughs	Total
Scheme wholly or partly effective	6	11	17
Initial practice allowance only effective	12	8	20
Initial practice allowance could become effective if changed	10	8	18
Designated area allowance ineffective	28	41	69
No comment/insufficient knowledge	11	11	22
Total replies	67	79	146
Total clerks replying	46	62	108

Table 30. EC survey: reasons for doubting effectiveness of the designated area and/or initial practice allowances

Clerks' reasons	Type of executive council		
	Counties	County boroughs	Total
Amounts insufficient:			
designated area allowance	2	4	6
initial practice allowance	6	6	12
Disincentive effect:	22	24	46
Criteria for payment	-	10	10
Other factors more important			
accommodation	1	5	6
health centres	1	2	3
trainee schemes/ selection of entrants	1	4	5
non-financial factors	1	6	7
Total replies	34	61	95
Total clerks replying	28	41	69

Table 31. LMC survey: secretaries' views on the effectiveness of the designated area and initial practice allowances

Secretaries' views	Type of local medical committee		
	Counties	County boroughs	Total
Both allowances effective	6 (15%)	4 (7%)	10 (11%)
Initial practice allowances only effective	5 (12%)	4 (7%)	9 (9%)
Designated area allowance only effective	1 (3%)	-	1 (1%)
Neither allowance effective	19 (47%)	32 (58%)	51 (54%)
Effect only marginal	-	4 (7%)	4 (4%)
Other comment	-	5 (9%)	5 (5%)
No comment/insufficient knowledge	9 (23%)	6 (11%)	15 (16%)
Total	40 (100%)	55 (100%)	95 (100%

Table 32. LMC survey: reasons for doubting effectiveness of the designated area and/or initial practice allowances

Secretaries' reasons	Type of local medical committee		
	Counties	County boroughs	Total
Amount insufficient	8	9	17
Period of payment too short	5	9	14
Disincentive effect	10	10	20
Other factors more important:			
accommodation	1	7	8
environment	2	5	7
professional facilities	3	8	11
No reason given	4	7	11
Total replies	33	55	88
Total secretaries replying	25	40	65

Table 33. EC survey: features which clerks would like to see in the reorganised NHS with respect to manpower planning in general practice

Desired features	Type of executive council		
	Counties	County boroughs	Total
Present satisfactory system to continue	18	34	52
Present relation with MPC to continue	13	14	27
Present relation with LMCs and other local bodies to continue	5	6	11
Consultation/collaboration with AHAs	12	16	28
Greater powers for FPCs in planning	22	22	44
AHA/FPC co-operation with supporting services	15	14	29
AHA/FPC co-operation with hospital facilities	2	6	8
AHA provision of practice accommodation	2	5	7
Greater local initiative	9	4	13
No comment	-	5	5
Total replies	98	126	224
Total clerks replying	46	62	108

Table 34. LMC survey: secretaries' views on advantages to under-doctored areas resulting from NHS reorganisation

Secretaries' views	Type of local medical committee		
	Counties	County boroughs	Total
No advantages:			
additional resources not forthcoming	2 (5%)	4 (7%)	6 (6%)
no evidence of improvement	1 (3%)	5 (9%)	6 (6%)
domination by DHSS/hospital sector/other sector	1 (3%)	4 (7%)	5 (5%)
extra work	1 (3%)	7 (13%)	8 (9%)
no reason given	21 (52%)	24 (44%)	45 (47%)
Advantages	11 (27%)	11 (20%)	22 (23%)
No comment	3 (7%)	-	3 (3%)
Total	40 (100%)	55 (100%)	95 (100%)

Table 35. LMC survey: reasons given by secretaries for believing NHS reorganisation to be advantageous

Reasons for advantage	Type of local medical committee		
	Counties	County boroughs	Total
Identification of need	5	2	7
Establishment of priorities	2	3	5
Community care	2	4	6
Hospital services	2	4	6
Local initiative	3	1	4
Total replies	14	14	28
Total secretaries replying	11	11	22

APPENDIX

Covering letter to Clerks of Executive Councils

University of Kent at Canterbury
Health Services Research Unit

Director
Professor Michael Warren

Cornwallis Building
The University
Canterbury
Kent

21st March 1973

Dear

Medical Practice Areas

We are currently engaged on a modest research project, financed by the Department of Health and Social Security, to investigate certain aspects of current policies aimed at securing a fair distribution of general medical practitioners throughout the country. In particular we are concerned with the ways in which medical practice areas are defined, and with the criteria which are applied in deciding whether more doctors are needed within a practice area. These issues are of some importance even under the present structure of the NHS, and are likely to assume an added significance from next April.

Our main purpose in writing to you is to invite your comments and opinions about these issues. In addition we are also asking the opinions of Local Medical Committees, the Medical Practices Committee and the British Medical Association.

On the attached paper are listed five questions about which we should be interested to hear your views. We would welcome as full an answer to each question as you feel able to give, and also any other comments which you wish to make. Your replies will be treated in confidence, and you will not be personally named or identified in any reports of the study.

We appreciate that this request will make some demands upon your time, but this is an important study in which large numbers of people are interested. We are most grateful for your help, and will look forward to hearing from you at your earliest convenience.

Yours sincerely,

J.R. Butler
Senior Research Fellow

APPENDIX

Questionnaire to Clerks of Executive Councils Ref.....

UNIVERSITY OF KENT AT CANTERBURY

HEALTH SERVICES RESEARCH UNIT

MEDICAL PRACTICE AREAS

1. Do you consider the present boundaries of medical practice areas within your Executive Council satisfactory for the purpose of ensuring a fair distribution of family practitioners in all parts of the Executive Council? If not, please state what changes you would like to see.

2. What are your views on the effectiveness of the designated area scheme, and the present method of incentive payments in securing an adequate number of family practitioners in all parts of the Executive Council?

3. Do any medical practice areas in your Executive Council qualify for the designated area allowance at present? If so, how many, (a) at the lower type 1 allowance (b) at the higher, type 2 allowance.

QUESTIONS 4 and 5 RELATE TO THE FORTHCOMING REORGANISATION OF THE NATIONAL HEALTH SERVICE

4. Will any existing medical practice areas straddle the new boundaries of the Family Practitioner Committees? If so, do you consider that the boundaries of these practice areas be re-drawn?

5. What relationship would you like to see in the reorganised health service between the Family Practitioner Committee, the Area Health Authority and the Medical Practices Committee with respect to manpower planning in general practice and supporting services?

APPENDIX

Covering letter to Secretaries of Local Medical Committees

University of Kent at Canterbury
Health Services Research Unit

Cornwallis Building
The University
Canterbury
Kent

Director
Professor Michael Warren

21st May 1973

Dear

Medical Practice Areas

We are currently engaged on a research project, financed by the Department of Health and Social Security, to investigate certain aspects of current policies aimed at securing a fair distribution of general medical practitioners throughout the country. This follows from a study, now completed, of the factors influencing family doctors in their choice of area for setting up practice. In the present study we are concerned with the way medical practice areas are defined, and with the criteria which are applied in deciding whether more doctors are needed within a practice area. These issues are of some importance even under the present structure of the NHS, and they are likely to assume an added significance from April next year.

Our main purpose in writing to you, as Secretary of the Local Medical Committee, is to invite your comments and opinions about these issues. In addition we are also asking the opinions of the British Medical Association, the General Medical Services Committee, the Medical Practices Committee and Clerks of Executive Councils.

On the attached paper are listed four questions about which we should be interested to hear your views. We would welcome as full an answer to each question as you feel able to give, and also any other comments which you wish to make. Your replies will be treated in confidence, and you will not personally be named or identified, in any reports of the study.

We appreciate that this request will make some demands upon your time, but this is an important study in which a large number of people are interested. We are most grateful for your help and will look forward to hearing from you at your earliest convenience. Enclosed is a stamped addressed envelope for your reply.

Yours sincerely,

J.R. Butler
Senior Research Fellow

APPENDIX

Questionnaire to Secretaries of Local Medical Committees

UNIVERSITY OF KENT AT CANTERBURY

HEALTH SERVICES RESEARCH UNIT

MEDICAL PRACTICE AREAS

1. Do you consider the present boundaries of the medical practice area(s) to be satisfactory for the purpose of ensuring a fair distribution of family practitioners in all parts of the area? If not, please state what changes you would like to see.

2. Do you consider that the present system, whereby areas are classified as designated almost exclusively on the basis of the average list size of 2,500 is sufficient to identify areas which are in need of extra doctors? If not, what changes would you like to see introduced?

3. Do you consider that (a) the designated area allowance and (b) the initial practice allowance have been effective in securing a better distribution of family practitioners in all parts of the country? If not, what measures would you consider effective to induce doctors to practise in unattractive areas?

4. What advantages, if any, do you see in the forthcoming reorganisation of the NHS for the purpose of providing better care in under-doctored areas?