Designated Areas: A Review of Problems and Policies

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The maldistribution of medical manpower is a universal problem.¹⁻³ Few countries have achieved a satisfactory distribution despite the use of various controls and incentives. In the United Kingdom attempts have been made to influence the distribution of general practitioners through the twin policies of negative control (exercised by the Medical Practices Committee) and financial incentive (in the shape of the initial practice and designated area allowances). For a while these measures appeared to work, for between 1948 and 1961 the number of under-doctored (designated) areas steadily declined. But 1961 was the turning point, and from then onwards an increasing number of areas became designated, containing more and more practitioners. By 1966 one in four of all general practitioner principals was practising in a designated area. Since 1971 there has again been a decline in the number of designated areas, mainly reflecting an increase in the total number of general practitioners during this period.

In the continuing search for a satisfactory solution there is a long-term need to consider the objectives as well as the means of manpower policy. Since 1948 the objective has been to produce sufficient numbers of general practitioners to ensure an average list size of no more than 2500 in each medical practice area. But why is such a list size assumed to be the optimum, and why is it assumed to be equally valid in all parts of the country? Why is an adequate number of doctors judged only in terms of the size of a community, ignoring its demographic and socio-economic composition, its patterns of illness and death, and its provision of other health services? The answers to such questions depend on an understanding of the objectives of general practice, and without this no rational decisions can be made about manpower requirements and distribution. But this is a long-term task, and the immediate practical problems remain of devising methods of negative control and/or incentives that will enhance the distribution of doctors relative to population.

We have recently studied the effectiveness of distribution policies in general practice. Our methods included a survey of a one-in-ten sample of all principals in England in 1969-70, surveys of all executive council clerks and local medical committee secretaries in 1972, and analyses of the most recent non-confidential data collected by the Medical Practices Committee. Many of the results of these studies have been published,³⁻⁵ and in this paper we review some of the problems of current policies and suggest possible remedies.

Problems of Current Policies

MEDICAL PRACTICE AREAS

Medical practice areas are the administrative units in distribution policies, for these are the areas that general practitioners may be forbidden or encouraged to enter by the Medical Practices Committee. There are, however, difficulties in using the areas for this purpose. Firstly, they vary considerably in size. In 1973 almost one in ten of the 1459 English practice areas contained one principal and a further fifth contained between two and four doctors. At the other extreme, 12% of the areas contained 30

or more principals. These variations present problems in administering policies such as the designated area allowance. In a single-area city, for example, it is obviously unfair to doctors in those parts of the city with large lists and heavy work loads to be denied the allowance simply because the average list for the entire city is below 2500. It is equally indefensible for all the doctors in a large town to receive a designated area allowance, even though many may be practising with small lists in attractive neighbourhoods.

A second difficulty is the overlap between medical practice areas and other geographical units in the administration of health and social services. The practice areas have developed haphazardly without any consistent relationship to other administrative areas, and during the recent reorganization of the National Health Service the opportunity was missed of standardizing the boundaries of practice areas with those of the new health districts, with possibly deleterious consequences. Unless the practice areas can be made to coincide with the new health districts there is a risk that data on health needs and services collected on a district basis may be of little use in progressing beyond simple patient-doctor ratios in determining a desirable number of practitioners.

A third problem is the inflexibility in adapting the boundaries of the practice areas to cope with population movements. Boundary changes that have been made in recent years have mainly concerned the amalgamation of smaller areas, not the rationalization of practice areas with catchment populations. Consequently anomalous situations have arisen of patients residing in restricted areas while being registered with practitioners in designated areas.

FINANCIAL INCENTIVES

Another set of problems concerns the use of financial incentives, the most important of which is the designated area allowance. The coverage of this allowance (now £1150 or £750 depending on the average list size in the area) has increased substantially since its introduction in 1966. The cost has risen from £1.1m in 1967-8 to £3.3m in 1972-3, and by October 1972 a third of all unrestricted principals in England were receiving an allowance. The initial practice allowances, payable to doctors commencing practice in designated areas, are far less common. In 1972 I.P.A.s were received by only 225 principals in England at a cost of £0.3m.

We cannot say conclusively how effective these allowances have been, but there is little evidence that they have substantially affected the distribution of general practitioners. Financial incentives could in principle achieve a desired distribution if the payments were large enough, but the income differentials required to achieve this would probably be so great as to be quite unacceptable to the profession and the Government. The differentials that are acceptable, and which are incorporated in the existing allowances, are much less important to many general practitioners in choosing a practice location than are professional and personal considerations. The existence of family ties with an area is a strong motivational factor for many doctors, and the perceived opportunities for practising good medicine weigh heavily with younger general practitioners. Most respondents in the national survey regarded the current level of the designated area allowance as far too low to offset these other considerations.³

A further reason for doubting the effectiveness of the designated area allowance is that it actually incorporates a disincentive effect. This is because an area must be designated for a specified

period of time before the allowance is payable, and also because the allowance ceases after the elapse of a concessionary period following de-designation. A doctor moving into a designated area during the qualifying period cannot, therefore, be sure of ever receiving the allowance, and even if he does is at risk of losing it within a few years if the area reverts to an open classification. Moreover, established doctors in a designated area have an obvious incentive in trying to maintain its designated status by keeping newcomers out. So not only is the designated area allowance of dubious value in augmenting the flow of doctors into these areas; it may actually be counterproductive to its purpose. The experiences of general practitioners, executive council clerks, and local medical committee secretaries in our surveys confirm this conclusion,^{3 5} and so do our analyses of distribution patterns before and after 1966. Changes in distribution are more likely to have been caused by the increases and decreases in the total number of practitioners than by the introduction of small financial payments.

NEGATIVE DIRECTION

A third issue is the operation of negative direction by the Medical Practices Committee. This is the committee's main way of controlling the distribution of general practitioners, and it works through the classification of practice areas on the basis of list size and a restriction on the entry of doctors into areas with low average lists (restricted areas). The degree of rigour with which the restriction is enforced may vary from time to time. For example, it may or may not extend to replacement entries, though in principle it invariably covers new entrants.

It is difficult to judge how effective the policy of negative direction really is because the deliberations of the Medical Practices Committee are confidential and it is not known how decisions are reached about admitting practitioners to particular areas. Some tentative conclusions may nevertheless be drawn from available information. Of the net inflow of 222 principals in England during the year ending October 1973, 99 (45%) went into restricted areas and four (2%) into intermediate areas. This particular year represented a higher net inflow into restricted areas and a lower flow into designated areas than previous years, and there may therefore be adequate explanations. On the face of it, however, there is some cause for concern about the policies currently operated by the Medical Practices Committee.

There are, of course, external limitations imposed on the committee. One such limitation is simply the number of doctors seeking new positions at any point in time, for unless new doctors are entering general practice or existing practitioners are trying to move, there can be no "raw material" to divert from one area to another. A further, more important, limitation arises from the restrictions that are placed on the committee's freedom to revise the practice areas in accordance with changing needs and circumstances.

In the early years of the N.H.S. the committee enjoyed extensive freedom to make such revisions, largely because these carried no widespread implications for the remuneration of practitioners. It was only with the introduction of the designated area allowance in 1966 that the definition and classification of practice areas became politically important, for what had started off as no more than rough guidelines to enable the M.P.C. to identify areas with a relative shortage or surplus of doctors then became so closely identified with the payment of money that much of the flexibility left the system. It was no wish of the committee that the areas were adopted in 1966 as the basis for administering the designated area allowance, and the consequent limitations on its freedom to revise the areas has seemingly been an encumbrance to the committee ever since.

Conclusions

As well as the long-term need to devise distribution policies in relation to the outputs expected from primary medical care, there

is also a short-term need to review the size and boundaries of the medical practice areas, the nature of existing financial incentives, and the operation of policies of negative control. In doing this, a central decision must first be made about the continuation of the two financial incentives and the use of medical practice areas as the basis for their administration. If the areas are to be thus used, then 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 allowances or to tie them to some yardstick other than the M.P.C.'s classification, then the way would be clear for a more flexible approach to many of the problems described above.

DESIGNATED AREA ALLOWANCE

The designated area allowance is costly and of no proved effect, and should be withdrawn. There is no evidence that it has materially affected the distribution of general practitioners and there is some evidence that it has actually been counterproductive. At best it functions as a very modest compensation for doctors practising in less attractive parts of the country. In recommending the withdrawal of this allowance, however, two qualifications must be made. Firstly, it is important that a "no detriment" principle should be observed—that is, that no doctor should actually be worse off as the result of an administrative decision. Secondly, there may be a case for retaining an incentive, at a much higher level, in the small number of areas with a history of very large lists. The recent reductions in the number of designated areas have occurred principally among areas with average lists between 2500 and 3000. Practice areas with average lists above 3000 have not diminished at all in recent years as a proportion of the total, and it may therefore be desirable to create a special incentive in such places.

INITIAL PRACTICE ALLOWANCES

In contrast to the designated area allowance, the initial practice allowances seem to have achieved some success, and there is no obvious reason why they should not continue as an instrument of local manpower policy in small, selected areas. Since these allowances are received by relatively few doctors there would probably be no serious political difficulties in continuing to tie them to the M.P.C.'s practice areas.

IDENTIFICATION AND CLASSIFICATION OF PRACTICE AREAS

If the designated area allowance ended, the identification and classification of practice areas could become more flexible. Boundary changes could be made without the existing financial constraints, and area classifications could be made to suit local circumstances and needs. Possible guidelines for change have emerged from our studies. In principle, medical practice areas should be so drawn as to minimize the overlap with catchment populations, to produce areas which aggregate up to the boundaries of the new health districts, and to contain between about 20 and 30 principals—that is, normally with a population between about 50 000 and 75 000. There may be good local reasons why these guidelines should be ignored in particular cases, but in the absence of obvious contraindications they seem to us to offer a reasonable basis for a revision exercise.

The classification of practice areas is more complex. The view was widespread among the doctors, the executive council clerks, and the local medical committee secretaries in our surveys that list size alone is a poor indicator of manpower needs, but there was little consensus of opinion about alternative indicators. The withdrawal of the designated area allowance will not in itself provide solutions, but it should enable the Medical Practices Committee to adopt a broader, more experimental approach to

classification. An alternative approach might be to abandon the concept of a national standard or criterion of classification and to allow local autonomy in determining manpower needs. The family practitioner committee, for example, in conjunction with the area health authority and the local medical committee, might assume responsibility for its own classification system, based on detailed knowledge of the locality.

MEDICAL PRACTICES COMMITTEE

The restoration of the committee's freedom to amend boundaries would go some way towards improving the impact of negative direction, especially when the supply of general practitioners is increasing, but the rigour with which the policy is administered is a matter in which the committee must monitor its own activities. If, for whatever reasons, a large proportion of the net annual increase in the number of general practitioners is allowed to flow into the restricted areas, then the effect of the policy is neutralized. Nevertheless, a fairly tight restriction over the admission of principals to areas with low average lists, coupled with a reasonable flexibility in defining those areas, would in our judgement do much to improve the distribution of family doctors at times when they are increasing in number. When the number of general practitioners is declining the impact of negative control is necessarily weaker for there is clearly no way of controlling the areas which lose doctors—through, for example, death or retirement.

The committee might also try to specify a clearer definition

of maldistribution. We have shown elsewhere³ the weaknesses of assessing distribution in terms only of the proportion of principals in designated areas, yet it remains a traditional measure of the supposed degree of maldistribution. There is a strong case for incorporating other indices of dispersion, and for attempting to specify the tolerable limits of maldistribution. There will never be an identical average list size in each practice area, but how much deviation must occur from this ideal before intervention is justified? Above all, there now remains the need for a sustained debate about the objectives of general practice and the resources required to achieve them, for until we can assemble some statement of objectives, however crudely articulated, there is little prospect of progressing towards more rational policies for the location of manpower.

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Central Committee for Hospital Medical Services

At the meeting of the Central Committee for Hospital Medical Services on 22 May the Chairman, Dr. C. E. Astley, welcomed Mr. N. Watson, who had replaced Dr. J. A. Ford as the second observer from the H.J.S. Group Council.

The C.C.H.M.S. rejected a recommendation from its Subcommittee on Private Practice that eventual withdrawal of N.H.S. pay beds was inevitable and that industrial action to oppose their constitutional removal was unacceptable. It resolved, instead, not to accept removal of private facilities from N.H.S. hospitals as inevitable and called for an assessment of the profession's willingness to resist Government policy on this score.

Members of the committee reporting on regional opinions about the resumption of discussions on consultants' contracts stated that many consultants deplored the breach between the B.M.A. and H.C.S.A.

The Committee broadly approved the Merrison Report and the conclusions of the B.M.A. working party which had studied it in detail.

Negotiating Subcommittee

The chairman of the Negotiating Subcommittee, Mr. A. H. Grabham, referred to future negotiations on the consultant contract. The Subcommittee had adopted, he said, a suggestion that he and Dr. G. B. S. Roberts be authorized to undertake unofficial talks with officials of the Department of Health, without commitment on either side, about negotiating the items in the Secretary of State's letter of 17 April (26 April, p. 202).

In addition, the subcommittee had recommended that small working groups might be established to consider such matters as the medical assistant contract, fees for categories I and II services, emergency recall fees, cars, and telephones. The subcommittee had also thought, he went on, that a working

party might look at modifications to the distinction awards system and the Secretary of State's ideas on career service supplements.

The Committee approved the suggested working parties which would report back to the Negotiating Subcommittee and the parent committee. A special group, chaired by Mr. T. M. Henneby, was set up to consider the advantages and disadvantages of an item-of-service contract.

Hospital Pay Beds

The Chairman recalled that, during her statement in the House of Commons on 5 May (10 May, p. 346) about the Government's proposals for phasing out private practice from N.H.S. hospitals, the Secretary of State had announced her intention to reduce straight away some pay beds which were known to be underutilized. The reduction applied only to hospitals with six or more approved private beds.

The Secretary of State, Dr. Astley explained, intended to operate the following formula: (i) where the occupancy, averaged over 1972 and 1973, was less than 60%, it was proposed to reduce the number of beds by 20%; (ii) where occupancy, averaged over the same years, was 40% or less, the number of beds would be reduced to a level which would produce a notional occupancy in those years of at least 60%. The changes were estimated to produce an overall reduction of about 10%. It was proposed that the reductions should take effect on 1 July. Dr. Astley added that the Department would like consultants to adopt a policy of common waiting lists as a preliminary to further discussion on the phasing out of pay beds.

After Mrs. Castle's statement the Subcommittee on Private Practice was convened on 15 May. The subcommittee, a joint committee of the Joint Consultants Committee and the C.C.H.M.S., is chaired by Mr. R. Myles Gibson.