

SEDGE: System for Equitable Distribution of General Medical Practitioners in England.

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Why does inequity matter? Something to do with the British sense of fair play, I suppose. Look at two imaginary but realistic areas. The *first* is an inner-city deprived area, with a population of 20,000, and has 14 full-time equivalent GPs. The average list size is 1,428

patients, which is theoretically “over-doctored”. The *second* area is an affluent, leafy suburb with a population of again 20,000 served by 8 FTE GPs. The average list size is 2,500 patients, which appears to be “under-doctored”.

The reverse is true. The first area needs more GPs; it is not over-staffed. And the second area is not genuinely under-doctored. In the first area, patients are likely to have difficulty getting appointments to see their GP, whose workload is probably underestimated. In the second area the GPs look after a larger population but have a larger income and often seem to manage. The paradox is apparent, and another is described in para 27 below.

An ideal list size of 1,000 is now being talked about by the medical profession. The actual average list size per full-time GP in areas in England is about 2,200 in March 2026. The timeline for achieving this

ideal is uncertain, as GPs are retiring or leaving the profession at a rate that exceeds the production of new GPs needed to accommodate the increasing population.

There remains a national shortage of GPs, and there are no means of discouraging GPs to work in over-doctored areas, while encouraging them to work in under-doctored areas.

A national system designed to achieve an equitable distribution of GPs in England is still not anywhere to be seen. DHSC has confirmed in recent

policy advice from NHS England for managing applications to join the England performers list, including GPs, that the function of establishing validity alone will continue to be the responsibility of DHSC.

Conspicuous by its absence is any mention that GPs are not being told where they can or cannot work. Adoption of SEDGE would help to solve that problem.

HISTORY

The story begins – for the purposes of this paper - on 23 July 1946, with the House of Commons debates, as recorded in Hansard in the National Archives, of the National Health Service Bill 1946.

The debate at Report Stage on Clause 34 of the NHS Bill 1946 was a significant moment in the House of Commons, highlighting the contentious nature of the proposed changes to the distribution of general medical practitioners. The Minister of Health - Nye Bevan – proposed an amendment to limit the right of doctors to get on the list in an area where there were enough GPs in that area before the appointed day, which was seen as a necessary control over the movement of GPs. The principle had been debated at Second Reading and in Standing Committee.

However, the debate shifted to the ideological basis of the clause, which was linked to the abolition of the GP's right to sell his goodwill and the new doctor's right to buy it.

This shift in perspective raised concerns about the future of the medical profession and its independence and freedom.

The debate was marked by differing opinions on the necessity of control over the distribution of GPs and the implications of the proposed changes.

The debate concluded on the question “That the words proposed to be left out stand part of the Bill”. On a division the House voted with Ayes 277 and Noes 128: Nye Bevan won this battle.

MEDICAL PRACTICES COMMITTEE FOR ENGLAND AND WALES

Section 34 of the NHS Act 1946 created the Medical Practices Committee for England and Wales (MPC), which held its first meeting on 15 July 1948, and then met almost every week until 2001 when abolished by the Health and Social Care Act 2000.

The MPC was given the duty of ensuring that every area of England had an adequate number of GPs, which was interpreted by the MPC and the Ministry of Health as a duty to secure an equitable distribution of GPs. The MPC could reject applications to join the local medical list if it assessed that the area already had enough or more than enough doctors.

The MPC was thus given discretionary power to refuse such applications on grounds of adequacy with the GP having the right to appeal against the MPC's decision to the Minister.

This power of 'negative direction' as it was called, did not permit the MPC to push GPs to work in an under-doctored area.

But, there were inducements: GPs could find under-doctored areas and be given incentives to go there, in a process administered by the MPC, agreed with the Ministry. These Designated Area Allowances were also applied in the New Towns, where rapid population growth had not yet justified the presence of GPs.

To enable it to function, the MPC made an initial assessment of the adequacy, in terms of average list

size, of about 1,250 areas in areas in England, with the help of the then NHS Executive Councils. Areas where the average number of patients per GP was below 1,700 were classified as 'Restricted', meaning newcomers would rarely be allowed go there, other than in exceptional circumstances. Areas with average patient lists between 1,700 and 2,200 were called 'Intermediate', meaning some applications would be agreed, if justified; others would not. Those areas with average lists of over 2,200 were classified as 'Open' and the MPC was not empowered to refuse an application that was valid. Those that were severely under-doctored, with average lists greater than 2,500 were called 'Designated', and extra inducement payments, administered by the MPC with the agreement of DHSS/DH/DHSC, were made to GPs to work in these.

The NHS Executive Councils, later FPCs then FHSAs then part of PCGs/ PCTs and other NHS bodies in conjunction with their Local Medical Committees, handled GPs applications, recommending acceptance or refusal by the MPC. A few tweaks, to take account of rurality, temporary residents, deprivation, and percentage of elderly patients in the assessment of adequacy, helped the MPC to come to decisions. That did not, however,

include adding an artificial number of extra patients for elderly and for deprivation (though a rurality weighting was applied) until very much later.

FAMILY DOCTOR CHARTER

In 1966, came the Family Doctor Charter, designed to solve some of the problems in primary care. One aspect was to use the MPC to ensure that the influx of new GPs from overseas worked where they were most needed by deflecting them from over-doctored areas, thereby encouraging them to go to under-doctored areas. The late Kenneth Day, a long-serving MPC member, effectively led the process in Birmingham and elsewhere in the West Midlands. The work continued for many years: I was only involved towards the end.

INVERSE CARE LAW

The inverse care law as described by Dr Julian Tudor Hart in his seminal article in 1971 in the Lancet is that:

‘The availability of good medical practice tends to vary inversely with the need for it in the population served.’

The MPC discussed this at the time, but I cannot find any record of the

Minutes of the MPC at the National Archives...

... I obviously have not looked hard enough. A review 50 years later published in the Journal of the Royal College of General Practitioners concluded that the Inverse Care Law still applied, and other think tankers have recently since written to the same effect.

DESIGNATED AREAS

In 1986, an important milestone was reached by the MPC. The last area classified as Designated, with average list of over 2,500 was Spennymoor in Co Durham, which was finally reclassified as Open, meaning it was no longer severely under-doctored.

There have been no areas in England classified in this way ever since.

And, areas classified as Open became increasingly rare over the years until the MPC was abolished.

ALFRED

In 1996, the MPC became more aware that it should do more about some deprived areas where the

average list size appeared to merit a Restricted classification. That was because the deprivation payments, although acknowledged by the MPC to be important, were not added to the number of patients in area or practice lists.

The MPC set about remedying this discrepancy by introducing ALFRED, a contrived acronym for adjusted lists for really equitable distribution. The methodology was simple: data on under-privileged areas and practices, that is those that scored highly on the Index of Multiple Deprivation were available, and practices received payments for High, Medium and Low deprivation. For each patient in the high category, 3 extra patients were counted: for those in the medium category, an extra 2 patients, and for those in the in low category an extra one patient was added.

The effect was to make areas and practices much more likely to be allowed additional GPs by the MPC. Before implementing ALFRED, the MPC consulted Professor Sir Brian Jarman, the recognised expert on deprivation payments, and then sought the views of NHS bodies. All approved.

Along with then members of the MPC, I claim credit for this innovation. In the late 1990s, after I had moved on, the MPC devised a

similar scheme for counting elderly patients, the percentage of which was always known but which had hitherto not been translated into extra patients; this was long overdue.

By this time, however, the DHSS/DH/DSHSC was determined to do away with the MPC, for reasons that never became apparent, at least to me. The group think of officials involved had been passed down since 1948. In the Health and Care Act 2000 the MPC was abolished, with effect from early 2001.

That might not have mattered too much were it not for the fact that DH/DHSC saw absolutely no need for anything to replace the MPC, and has remained adamantly opposed to the very idea.

There is therefore no form of control over where GPs work, apart from some attempts by DHSC to introduce financial incentives to work in selected areas.

Areas in this context are now called Primary Care Networks. PCNs are soon to be translated into Neighbourhoods. There will probably be about 1,250 Neighbourhoods in England, coincidentally about the same number of the MPC's 1948 areas, which were adjusted over time.

SHORTAGE OF GPs

In March 2026, a national shortage of GPs is widely recognised. The average list size of fully qualified full-time equivalent GPs hovers around 2,200 patients.

But that disguises the fact that there are parts of the country where the average list size is below 1,400 contrasting with others where the average list size is 2,700 or even more.

Paradoxically, some fully qualified GPs cannot find a job, and don't know how to find under-doctored areas.

The paradox was identified by Professor Becks Fisher, now at the Nuffield Trust, and supported by other think tankers.

Lords Hunt and Warner, both former Ministers at DHSS/DH/DHSC, were alerted to the situation and proposed amendments to the Health Bill of 2020 that were debated in the House of Lords in 2021. The Minister for the DHSC in the Lords had clearly not been properly briefed and totally ignored the proposed amendments.

NEXT STEPS

If the principles set out in this paper were to be considered worth considering further, the next step

might be to seek Ministerial endorsement. That might be achieved by means of a more positive answer to a second PQ by Lord Hunt of Kings in the Lords, tabled on 16 March and due to be answered on 30 March.

The lengthy reply to a first PQ from Lord Hunt of Kings Heath about SEDGE, given by the DHSC Lords Minister in February described all manner of steps being taken to improve the supply of GPs but singularly failed to address the specific issue.

Again, DHSC officials are apparently trying to avoid any discussion, having not fully briefed Ministers.

SPECIAL HEALTH AUTHORITY

Creating an arm's length body, such as a Special Health Authority, would be relatively easy, probably not requiring primary legislation, would help to solve the problem, and would be cost neutral. I suggest the SEDGE agency, an acronym for System for Equitable Distribution of GPs in England.

Setting up SEDGE as a Special Health Authority might be a fairly straightforward process. Other means

are available. Neighbourhoods, rather than practices or single GPs, would submit applications, which would then be routed through ICBs.

Staff of SEDGE could be a Clerk and two Deputies. Membership would comprise seven people, one from each of the 7 NHS regions. Five of them would be GPs and two would be lay people, with the positions advertised, and a chair would be required.

There would be no need for meetings: emails to and from the Clerk would suffice, and business could be conducted rapidly. If only 4 members responded, and they were equally split, the Chair would have a casting vote on whether to agree or refuse an

application to increase or reduce the FTE number of GPs on the local Medical List.

Running costs of SEDGE might be in the region of £500,000 a year, with salary and on-costs, plus fees for members: I recall that was the cost in 1996.

CONCLUSION

In SEDGE, I have proposed a solution to a problem that is given little attention, for various reasons. Those might include the absence of any opportunity for shroud waving, and with few winners and losers immediately apparent. I intend to persevere, with the encouragement of Lord Hunt of Kings Heath.

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