Date: 28 February 2001

Venue: Committee Room 3, National Assembly for Wales

Title: NHS Resource Allocation Review - Emerging Findings Report

1. Purpose

1.1 The Committee is asked to consider the NHS Resource Allocation Review Emerging Findings Report - " Targeting Poor Health: Preliminary Report of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources " (see Annex A).

2. Timing

2.1 The National Steering Group will need to consider the implications of the structural and policy changes arising from the National Plan. Also there is a need to fully integrate the resource allocation review into the National Plan implementation. This will have implications for the timetable for the final report of the review which is being considered. A verbal update will be given at the meeting. The National Steering Group meeting on 26 April will concentrate on the National Plan / RAR implications.

3. Background

3.1 On the 16 February 2000 the Health and Social Services Committee agreed to set up a review of the current arrangements for allocating financial resources to the NHS in Wales. The review team was required to present its Emerging Findings Report to the Health and Social Services Committee by 31 December 2000 and a final report for consultation by 31 March 2001 with a view to recommended changes to the main formula being introduced progressively from 2002-3.

3.2 Professor Peter Townsend, was appointed to oversee the review and a National Steering Group was set up to oversee the review. Professor Townsend updated the Committee on 21 June 2000 on the progress of the Review. To take forward the Review at the working level a Project Review Group (PRG) was set up to consider the outcomes of the Task Groups and identify issues for consideration by the NSG. The Task Group review process is very inclusive and has been set up to ensure full participation across Wales underpinned by evidence based research work led by expert research team

3.3 A research team, headed by Dr David Gordon of Bristol University, was appointed to provide expert research support in certain key areas. The research team has produced a preliminary independent report which addresses issues of poor health and inequalities in health. The research team's final report will be published in tandem with the final report of the Review.

4. Compliance

4.1 The allocation of NHS resources is authorised by the NHS Act 1977, Part IV, Section 97.1 which was included in the National Assembly for Wales (Transfer of Functions) Order 1999 which transferred the functions to the Assembly. The establishment of a Steering Group and a Working Group is covered by The Government of Wales Act 1998, Part II, Section 40 to facilitate the functions under the NHS Act. These functions have been delegated to the Minister for Health and Social Service. There are no issues of regularity or propriety. The Assembly Compliance Office is content.

5. Action

5.1 The Committee is asked to note the progress and confirm the approaches taken.

Jane Hutt

Minister for Health & Social Services

Contact Point:

Nick Patel, Project Director Resource Allocation Review, ext 3780

Annex A

NHS Resource Allocation Review

Targeting Poor Health :

Preliminary Report (Emerging Findings Report) of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources

NHS Resource Allocation Review: Emerging Findings

Report to the Health and Social Services Committee 28 February 2000

Contents

Introduction

1. The purpose of this report is to:

- report to the Health and Social Services Committee of the National Assembly for Wales on the progress of the Review of the arrangements for allocating resources for health and health services established by the Committee on 16 February 2000
- set the Review in the context of the Assembly's corporate policies and strategies
- outline the complementary types of work that have been undertaken and the approaches being considered
- preview the issues to be addressed in the final report.

Background and terms of reference

2. The terms of reference of the Review (Annex 1) were endorsed at the meeting of the National Steering Group on 26 May 2000 and reported to the Committee on 21 June. These require advice to the Committee on the most appropriate means of allocating available resources in accordance with health need and specify a number of issues to be addressed in meeting this remit, including socio- economic disadvantage and the costs of providing services in remote or rural areas.

Conduct of Review

3. A chart illustrating the structure of the Review is at Annex 2. It has been designed to ensure that the final report draws on

- the practical expertise and insights of the NHS, local government and Assembly officials
- the best available scientific research into area based resource allocation and the socio-economic determinants of health
- an up-to- date account of trends in the allocation of resources and the factors determining change as well as categories of distribution
- geographical and professional representation.

4. The Review is headed by Professor Peter Townsend of the London School of Economics and Bristol University who is an international authority on poverty and inequality and chairs the National Steering Group.

5. The research input on area inequalities in health is provided by a team headed by Dr David Gordon of Bristol University. The team will produce an independent report, looking in detail at issues of poor health and inequalities in health, as well as evaluating options for resource allocation mechanisms, which will be published in tandem with the final report of the Review.

6. The service input prepared on the basis of research information as well as administrative and professional experience is being provided by a series of Task Groups (remit and membership at Annex 3) responsible for addressing each of the requirements of the terms of reference. There have been a series of workshops and seminars designed to promote a shared understanding of the underlying issues and the options for the future.

Context for review: poor health and inequalities in health in Wales

7. The central objective of the Review is to recommend a means of resource allocation to distribute health service resources in accordance with health need, building on the basis of previous allocation. This will address the need to allocate resources to sustain, improve and develop the hospital, community and primary care services needed to discharge statutory responsibilities to provide a universal health care service. The Review will address the balance between expenditure distributed by a population formula and expenditure distributed by other means, within the current legislative framework (including changes arising from the 2001 Health Bill). The final report will set this objective in the context of the Assembly's wider policies for improving health and addressing poor health and its specific objective of addressing inequalities in health status.

8. The consensus emerging from the Review is that we need to proceed through a dual strategy - for action both within and beyond the NHS/health care system. Both represent challenges for imaginative investigation and development. The aims of this strategy will be to sustain and improve health, target poor health, reduce health inequalities and provide equal access to services. This approach will address both:

- inequalities in health experience – rooted in socio economic conditions which need to be addressed by action outside the NHS and by the NHS working in partnership with others

- inequity of access to services and inequitable distribution and quality of services which need to be addressed by action within the NHS, facilitated by a resource allocation process which accurately captures health need.

9. The final report will evaluate the implications of the 'reducing inequalities' dimension, in addition to responding to poor health, for both strands of the dual strategy. In effect the inequalities objective has given added impetus to the objective of ensuring that the formula in association with other measures does in practice achieve what has always been its key function of distributing resources equitably in accordance with need.

Scope of Review

10. The Review will look at resource allocation processes in the context of the whole of the Welsh health budget of £3.1billion in 2001-2. Some 64% of this is currently distributed by means of a weighted capitation based population formula and the remainder by other means as described in Chapter 3. The formula approach applies only after prior decisions have been taken eg

- Step 1: decisions about the total sum available for the NHS in Wales

- Step 2: assessments of the forecast cost of non cash limited expenditure, such as payments to contractors which are determined by demand rather than budget planning decisions

- Step 3: decisions on the quantum and basis of allocation for each component – by formula or otherwise – based on the need for sustainable funding and on national priorities

- Step 4: decisions by health bodies on the allocation of funding at local level.

This is an iterative process where the implications of decisions feed back at each level.

11. In serving the principles of equity at every level of decision making there is a need to balance

- the need to fund the existing NHS infrastructure which supports universal access to services and support stable, long term planning and professional development
- the need to fund new developments at national, regional and local level, to respond to unmet need and new pressures – eg new drugs and treatments
- to change investment patterns to deliver improvements in performance eg on hospital activity and waiting lists.

12. Chapter 3 will examine the existing breakdown of the budget in detail, including how it has changed over time. It will suggest that, in reviewing the process for sharing the budget between geographical areas it is important to take into account

- the balance between different components of expenditure within the health budget
- the way resources within each component are spent by NHS agencies on the ground
- how expenditure by NHS agencies has developed in relation to complementary types of expenditure by other agencies eg the social services budgets of local authorities.

These issues need to be given as much attention as the detail of the formula dealing with area inequalities in determining the overall effectiveness of the budget in responding to health need and tackling health inequalities.

13. The potentialities of the formula are important but limited in practice. For example, the formula approach distributes expenditure between areas and populations on the basis of the existing balance of spending (at an all Wales level) between different components of the health budget (the expenditure blocks used by the current formula are shown on page 25 of the report of the research team). The formula does not therefore assist in the evaluation of whether the present balance of expenditure eg between secondary and primary care or between acute and community services, is the right one or what changes in balance might produce better outcomes in terms of improving health, or addressing poor health and inequalities in health status. These issues are discussed further in Chapter 3.

Chapter 1: Inequalities in health

1.1 This chapter summarises the detailed work of the research team in relation to the underlying problem of poor health and inequalities in health within Wales and by comparison with other regions. The implications of these issues for Assembly policy within and beyond the health system are discussed in Chapter 2. The final report will elucidate:

- what the NHS can do directly about this

- what the NHS can do in partnership with other agencies
- what others can do themselves
- what the Assembly corporately can do.

1.2. The key problem is that although the overall health of the population has improved consistently over the past 50 years, as measured by overall mortality and morbidity rates, the gap in health between 'rich' and 'poor' people and 'rich' and 'poor areas' has widened. The health of the 'rich' has improved at a much faster rate than the health of the 'poor'. This is of course a phenomenon that applies in many countries of the world at the present time and not only in the UK, although the rate of change varies sharply and deserves intense investigation.

1.3. For Wales these issues will be addressed in detail in the report of the research team which will draw on the widespread consensus that these inequalities in health and early death are rooted in poverty and inequality in material well - being. In 1980 the Black Committee on Inequalities in Health concluded that

> 'while the health care service can play a significant part in reducing inequalities in health, measures to reduce differences in material standards of living at work, in the home and in everyday social and community life are of even greater importance'

Sir Donald Acheson in his report 'On the State of Public Health' for the year 1990, said

> 'the issue is quite clear in health terms: that there is a link, has been a link and, I suspect, will continue to be a link between deprivation and ill health' and 'analysis has shown that the clearest links with the excess burden of ill health are:
>
> low income
>
> unhealthy behaviour and
>
> poor housing and environmental amenities'.

Links between poverty and health

1.4. Research has consistently shown that poverty is related to worse health outcomes. For example the 1990 Breadline Britain survey found that poor people were 1.6 times more likely to suffer from long standing illness, 5.4 times more likely to suffer from feeling isolated and 5.5 times more likely to feel depressed. The health gap is even larger if survey respondents' intensity and history of poverty is taken into account. At an area level there is a very close relationship between high rates of poverty and high rates of premature mortality.

1.5. The independent research team chaired by Sir Donald Acheson in 1998 elaborated this reasoning as follows:

> 'the weight of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as to the material environment and lifestyle. It follows that our recommendations have implications across a broad front and reach far beyond the remit of the Department of Health. Some relate to the whole Government while others relate to particular Departments'. 'Independent Inquiry into Inequalities in Health, 1998'.

Child deprivation and links with health

1.6. The links between poverty in children and worse health outcomes are well documented – babies born to poor families are at much greater risk of

- prematurity, low birth weight and infant mortality
- illness and disability
- injury and accidents.

Changes in the socio-economic profile of Britain in the past two decades have had a particular impact on households with children – the proportion of lone parent households, children in families with no earner and the proportion of households with children living in poverty have all increased. The recent Poverty and Social Exclusion Survey of Britain showed that 18% of British children were suffering from multiple deprivation.

> 'the links between poverty and child health are extensive, strong and pervasive.....virtually all aspects of health are worst among children living in poverty than among children from affluent families (Reading, 1997).

The new 2001report of the Academy for Learned Societies in Social Sciences – Health Inequalities: Poverty and Policy – adds to the weight of evidence to support these conclusions.

Estimates of human costs

1.7. The draft research report will include a number of ways in which the human cost of poverty, deprivation and inequality have been estimated at the UK level:

- 62% of deaths under 65 which occurred in the 'worst health' areas would not have occurred if these areas had the same mortality rates as the 'best health' areas
- in the period 1991-93 the years of potential life lost to men aged 20-64 in social class 5 was three times greater than to men in social class 1.

1.8 The Rowntree Foundation estimated the potential to save lives by reducing wider inequalities in society:

- redistributing wealth to reduce inequalities to 1983 levels would prevent around 7,500 deaths a year
- achieving full employment would prevent some 2,500 deaths a year
- achieving the Government's target of eradicating child poverty within a generation would save the lives of around 1,400 children under 15 each year.

It is nonetheless true that saving these lives would involve government and many other institutions in a range of long-term as well as short-term radical measures.

The Welsh legacy of ill –health

1.9 The legacy of ill – health in Wales was set out in detail in the Better Health Better Wales consultation paper published in May 1998 which described the patterns of disease in Wales and the inequalities in health status within Wales and between Wales and other countries, including

- life expectancy in Wales among the worst in Europe
- death rates from heart disease in Wales and the UK substantially higher than in many European countries
- Wales has amongst the highest rates of cancer registrations in the EU
- consistently poor health in the South Wales Valleys – in Blaenau Gwent the death rate for heart disease for people under 65 twice the rate for Ceredigion
- death rate from strokes around a quarter higher in Merthyr Tydfil than in Anglesey
- Wales has a much higher percentage of people reporting a long term limiting illness than in Great Britain as a whole – with the highest levels in the South Wales valleys.

Chapter 2 of the draft research elaborates on and updates this analysis

- mortality rates from heart disease in 1998 were worse in Wales than in England, Scotland or Northern Ireland
- mortality rates from cancers in 1998 were worse in Wales and Scotland than in England and Northern Ireland
- excess mortality for Wales in respect of diabetes and respiratory diseases.

1.10 The draft report of the research team also provides some analysis of regional variations in morbidity comparing Wales with regions within England. This provides a more complex picture with Wales on some measures worse than all the regions quoted but on others better than the Northern and Yorkshire and North West regions.

Inequalities within Wales compared to those within other regions

1.11 The draft report of the research team (page 73) quotes a study which ranks all British parliamentary constituencies by mortality, poverty and avoidable death. On these measures the Rhondda ranks as the ‘worst’ Welsh constituency with Monmouth as the best. Within Britain, on these measures, there are 76 constituencies with worse health than the Rhondda and 126 constituencies with better health than Monmouth.

1.12 Using the ratio of ‘best’ to ‘worst’ unitary authority areas for all age mortality rates, the report (page 74) compares inequalities within countries. On this basis inequalities between areas within Wales are less extreme than those within England or Scotland.

1.13 The scope of action to tackle poor health and inequalities in health within Wales is discussed in Chapter 2.

Chapter 2: Policies Relevant to Action

2.1. This chapter outlines the policies through which the Assembly can take action to address poor health and inequalities in health, including

- policies targeted directly at poor health
- policies which benefit health indirectly – eg where better health is one of a number of outcomes of policies targeted eg at employment or community development
- policies pursued within and outside the health system – the dual strategy for action (Introduction para 8).

2.2 The research report will also identify factors outside the Assembly's remit which impact on health outcomes by operating on the distribution of income and opportunity in society including through tax and benefit arrangements, employment patterns etc.

The UK policy context

2.3. Both the Blackand Acheson reports contained a large number of wide-ranging recommendations but both placed greatest emphasis on material and income measures. Thus the Acheson report contained 39 recommendations, 10 dealing with the need to introduce more adequate incomes for vulnerable groups, and another 10 dealing with material factors of housing, diet and environment.

2.4 The UK government has not yet directly addressed the recommendations to raise levels of benefit but has addressed a number of other issues, in successive White Papers and in measures concerned with schools, free school meals and health action zones for example. For the National Assembly there is less scope for direct action in relation to the incomes of the worst off beyond calling the attention of the UK government to policies relating to social security and taxation, but policies to increase employment, employability and the incomes of those in work fall within the scope of the Assembly's economic and education and training policies discussed below.

2.5 Policies since the Black and Acheson reports have focused on action both within and beyond the health system including:

- recognising the strength of the evidence of the links between socio economic disadvantage and deprivation and poor health
- the broad scope of policies relevant to reducing inequalities
- the importance of long and short term strategies
- the role of primary health services in improving the health of the worst off
- the inadequacy of attention to the health needs of ethnic minority groups
- the importance of up-to-date and accurate data on health at the local level.

Action beyond the NHS: Better Health Better Wales and other Assembly strategies

2.4 In Wales the broad public health agenda mapped by Acheson was addressed in the Better Health Better Wales consultation paper followed by the Strategic Framework document of October 1998 which charted a

strategy of joint action by the NHS and other agencies to promote health and tackle the causes of poor health.

2.5 In developing a broad strategy for the NHS and its partners Better Health Better Wales placed Wales at the forefront of the population health approach. This was reinforced by the development of a national strategy to promote health and well being, proposals for which were published in March 2000 and an action programme to implement it published in November 2000.

2.6 This approach is supported by wider action which contributes to promoting health by building the capacities of individuals and communities through Assembly strategies including

- Communities First
- Strategic Framework for Children and Young People and Extending Entitlement:Supporting Young People in Wales
- Sure Start/Children and Youth Partnership Fund
- Better Homes for People in Wales
- Joint Flexibilities Guidance
- Carers' Strategy
- Substance Misuse Strategy
- Sexual Health Strategy.

The final report will include examples of action taken under these strategies and an indication of sums committed and numbers affected.

2.7. The Assembly's new Inequalities in Health Fund -£17 million over three years 2001-02 - 2003-04 - is designed to stimulate new action to reduce health inequalities by targeting resources at the most deprived areas in Wales. The initial priorities have been set as measures to tackle Coronary Heart Disease and dental health in these areas.

2.8 The proposal for the Fund emerged from the Review workshop on 19 July 2000 and parallel work in England. The National Steering Group discussion in October agreed that if it proved impracticable in the short term to implement quickly through a strengthened or new formula a top sliced inequalities fund approach could be used as an interim option. The Fund spans both strands of the dual strategy in that it is open to groups both within and outside the NHS to apply for funding for direct action to tackle inequalities in health and inequities in access to health care services.

2.9 Other elements of the Assembly's Better Wales programme are also highly relevant to reducing economic and social inequalities eg by spreading economic prosperity for example through the Objective 1 programme. These include the equal opportunities and employability dimension of the responsibilities of the Council for Education and Training and all the aspects of education policy which promote inclusion and equal opportunities by levelling up standards of attainment and participation across Wales. The final report will include more detailed examples here.

Action within the health system

2.10 Although there is a consensus that the NHS itself can have only a limited impact on the incidence of disease there is increasing recognition that access to effective treatment can have a major impact on the severity of disease, its impact on quality of life and its fatality. The research report provides details of how

- medical intervention increases life expectancy

- by improving equity of access to services the NHS can reduce the impact of inequalities in health status.

2.11 Chapter 5 of the draft research report provides evidence for example that access to treatments varies considerably across groups in society for example men living in more affluent areas were more likely to receive coronary revascularisation surgery despite having less need as measured by mortality rates. The draft goes on to discuss factors which contribute to these inequities in the receipt of health care, including

- patient variations in health care seeking behaviour
- doctor-patient interactions at a primary care level
- variations in primary care referral patterns
- variations in levels of investigation
- deciding on treatment options
- patient preferences.

2.12 This underlines one of the key limitations of the resource allocation formula - it can only be an enabling mechanism which can be reinforced by the NHS or other agencies. What matters is what the NHS does with the resources it receives both to promote and sustain health and to address these inequities in the receipt of servcies. If the distribution mechanism can be made more equitable in relation to an accurate measurement of relative need this will enable health bodies to address inequities in access to services and ensure that for any health need the quality of treatment received is as good for all areas and social groups. The distribution mechanism alone will not ensure that this action is taken or that it is effective.

Improving Health in Wales

2.13. Improving Health in Wales gives a new impetus to action by the NHS to achieve fair access to effective services. Previously the Service had been working to address poor health, both directly and indirectly, through broad health service priorities including:

- the 15 health gain targets set out in Better Health Better Wales
- improving primary care
- addressing inequities in access to health care caused by the supply of services
- improving the quality of treatment and hence outcomes through clinical governance
- human resource policies – the NHS's own staff
- development of Health Improvement Plans.
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2.14. Tackling inequalities was identified as a priority for the NHS in Wales by the Health and Social Services Minister, Jane Hutt, in a speech to the Assembly in July 2000 which identified tackling health inequalities as one of three fundamental principles along with promoting primary care and preventative action and breaking down barriers between professional groups.

2.15. Improving Health in Wales, the plan for the NHS and its partners launched in February 2001, sets out how this will be delivered through changes which

- strengthen the role of the NHS as an advocate for community health development and as a partner in the social, economic and environmental development of Wales
- require direct action by the NHS to ensure equitable access to effective and appropriate health care according to need
- make the NHS, as the largest employer in Wales, an exemplar in workplace health.

2.16 Detailed plans include

- by 2002 targets for the reduction of current inequalities through the Health Improvement Programme process
- action targeted at disadvantaged communities
- by December 2002 training and education programmes to ensure that all staff have greater awareness of the need for cultural and gender sensitivity in services
- equity audits of health and health care profiles between and within health care communities and the production of equity profiles
- a review by the Chief Medical Officer of the public health function and an enhancement of the public health role of all health professionals
- a fresh strategy building on Better Health Better Wales by 2002.

2.17. The role of the Resource Allocation Review is to support these changes by making recommendations for a process which will distribute NHS resources more fairly across Wales. The amount of resources available and how they are distributed across the components of the health budget are set out in Chapter 3.

Chapter 3 The distribution of NHS resources in Wales

3.1 The Chart at Annex 4 summarises the distribution of the Assembly's health budget for 2001-2002 and the way it is allocated. In summary, of the £3.1 billion total:

- 64% (£1.994 billion) was distributed to health authorities on the basis of a weighted population formula (of which
- 58% was the discretionary allocation
- 4% was the ring-fenced/protected services allocation
- 2% was the GMS cash limited allocation)

- 25% (0.77 billion) was distributed to health authorities not by formula (of which

- 15% is added to the the health authority allocation (13% is for prescribed drugs,2% for protected services)
- 10% is for demand led Family Health Services)

- 4% (about £120 million) was distributed to NHS Trusts – not by formula –for capital, education and training and R&D.

- 7% was distributed to other bodies – not by formula – detailed below.

In principle this distribution relates to considerations of equity as follows:

- 64% is allocated in proportion to the distribution of population to five health authorities, weighted for age and sex and relative ill health, as discussed in para 4.11

- this formula approach is not currently used for resource allocation below health authority level but it is being used to benchmark the existing distribution of expenditure through the resource mapping process discussed in para 4.7.

3.2 The final report will provide more detail on each category and explain changes in distribution in recent years. It will also consider the options for applying a formula approach to more categories than at present in the light of the recommendations of Task Group E.

3.3. The major change in distribution since 1991 when the present formula was introduced is that the share of the overall health budget allocated to health authorities has increased from some 72% to 79% now. The share of the budget which is held at the centre as revenue is considerably less than it is in England. In Wales this is less than 8% in England it is over 15%.

3.4 Of the 25% of the budget which is currently allocated to health authorities but not by formula the 3 major elements are:

- ring fenced and protected Hospital and Community Health Services (£68 million) of which the largest is SIFT (Service Increment for Teaching). This is central funding for the excess costs incurred by hospitals arising from undergraduate medical education. Its allocation is therefore directly determined by the amount of training undertaken by Trusts. The majority of funding is provided to the University Hospital of Wales which has the principal teaching function

- provision for GP prescribed drugs (£390 million) based on forecast spend in line with trend for drug inflation and increased demand

- Family Health Services (payments to primary care contractors) (£260 million) which is again based on forecast spend in line with trend.

The scope for bringing the drugs and FHS budgets into a formula approach is discussed in para 4.3. The

treatment of ring-fenced and protected services is being addressed by Task Group D as discussed in para 4.4.

Key trends since 1996-97

3.5. The table - 'Wales Health Budgets - Key Trends since 1996-97' on the following pages demonstrates key trends in Health budgets between 1996-97 and 2001-02 expressed both in cash terms and at constant 1999-00 prices. Budgeted provision for health has increased from £2.197 billion in 1996-97 to £3.100 billion in 2001-2, an increase of 41% cash/25% at constant prices. The major developments in this period are:

- following modest growth in 1997-98 and 1998-99 the main elements of the health budget have shown fairly steady upward growth (some 5% per annum at constant prices) and relatively small changes in their overall percentage share of the total

- the £2.527 million budget for Hospital and Community Health Services revenue has grown by some 44% cash/28% at constant prices since 1996-97 (after an adjustment to neutralise the effect of the transfer in of drugs prescribing expenditure in 1999-00)

- the £77 million budget for capital has been squeezed in order to allow adequate provision for health authorities' revenue requirements but the current budget provides for this to be increased in future years and "Improving Health in Wales" makes clear the commitment to do so

- the fastest growing budget has been for GP prescribed drugs which has increased at around 11% a year cash/8% at constant prices; over the last three years this has been some 9% per year. This budget was transferred in 1999-2000 from central non cash limited management into health authorities' cash limited discretionary allocations. This change was intended to encourage more active management of this expenditure. (From the table, it would appear that the 'ringfenced and protected services' allocation to health authorities, 'education and training' and the 'other health services' budgets have had higher increases than 'drugs prescribing' but those figures are distorted by the effect of budget transfers and recategorisation).

Wales Health Budgets - Key Trends since 1996-97 (cash)

Wales Health Budgets - Key Trends since 1996-97 (constant prices)

Disposition of budgets in 2001-02

3.6. The health budget is broken down for budget purposes into the following main blocks. The final report will attempt to supplement these budget categories with more meaningful analysis of how the budget is spent to finance different services and specialties drawing on the resource mapping work being reviewed by Task Group A.

A. Hospital and Community Health Services Revenue £2.527 million

of which

£1.999 billion is distributed to health authorities via the main allocation formula (within this £198 million is protected for all - Wales or regional services. Of this 66% is allocated by formula and 34% to host authorities according to the location of services). This is an increase since 1996-97 of 44% cash/28% at constant prices. The final report will include details of each protected item and the basis of distribution which has developed pragmatically over time, normally following discussions between the Welsh Office/Assembly and health authorities with a view to achieving the most equitable basis for distribution

£390 million is distributed on the basis of forecast actual expenditure, for GP drugs prescribing – an analysis of how the current pattern of expenditure compares with a population or weighted capitation formula distribution is included in Chapter 5, Table 5. This has increased since 1996-97 (when the budget was administered centrally) by 57% cash/39% at constant prices.

£64 million is distributed by formula for cash limited General Medical Services (practice staff, cost rent schemes and equipment). This has increased since 1996-97 by 34% cash/19% at constant prices.

£65 million is for central budgets - held centrally for allocation outside the formula to: NHS Direct, consultant distinction awards, Calman Hine cancer staff development etc. This has increased since 1996-97 by 19% cash/5% at constant prices.

£10 million is for brokerage (repayable loans to support recovery plans for HAs or Trusts in deficit). This is the lowest level for brokerage in recent years.

B. Hospital and Community Services Capital £77 million

This budget comprises £52 million for Trust discretionary capital and £25 million for the capital modernisation fund and all Wales capital programme. The £52 million is allocated to individual Trusts in accordance with a formula based on income and cumulative depreciation of assets. The £25 million is for new capital schemes and is awarded in accordance with national priorities. The key criteria for capital modernisation fund allocations has been health and safety and contribution to financial recovery programmes.

Past levels of capital expenditure have fluctuated considerably as capital has been squeezed by more immediate priorities. In 2001-2 provision is projected to be some 29% lower in real terms than in 1996-97. Improving Health in Wales says that investment in buildings and equipment in the NHS in Wales has been neglected for two decades, that investment in information and communications technology is now badly out of step with appropriate comparators and that these trends will be reversed with investment being sustained at or improved over the 2002-3 level.

C. Education and training £111 million

This budget covers the cost of training for all NHS Wales medical and non-medical staff groups, including doctors, dentists, nurses, pharmacists and opthalmists. This has increased since 1996-97 by 55% cash/37% at constant prices, but this increase includes the recurrent transfer of some £5 million from FHS demand-led funding for GP training from 2001-02. The budget also provides funding for 50% of the basic salary costs of junior doctors in approved training posts – reflecting the portion of time spent on study and not in providing services to patients. The funding is distributed via the PostGraduate Dean to the employing Trusts, not by formula but on the basis of agreed training numbers and places.

D. Family Health Services demand led £334 million

This is allocated not by formula but managed as a demand led budget with provision determined by the forecast cost of contractual payments to General Practitioners, dentists, pharmacists and ophthalmic practitioners. The main expenditure driver therefore is the number of practitioners and where they are located, where prescriptions are dispensed and eye tests carried out. This has increased since 1996-97 by 31% cash/16% at constant prices. The inclusion of some £3 million new money in this budget from 2000-01 for costs associated with the new flu vaccination campaign distorts the increase in the table for that year. The trend in recent years has been increases of some 5-6% annually. The overall budget is currently held and managed by the Assembly although health authorities hold the contracts and process payments. The budget also assumes some £27 million of receipts for fees (mainly income from dental charges) in 2001-2. An analysis of how the existing expenditure on these services across health authority areas compares with a population or weighted capitation formula distribution is included in chapter 5, table 6.

E. Other Health Services £26.892

This budget covers the forecast running costs of the Public Health Laboratory Services, Tribunals and Advisory Committees and the Welsh contribution to the running costs of the National Institute for Clinical Excellence and the Commission for Health Improvement (which is shared between the countries of the UK on a pro rata basis). The figures for increases in the tables are distorted by the effect of budget transfers and recategorisation).The largest single component is the £15 million budget for Research and Development which is adminstered by grant-aiding schemes for health and social research addressing medical/policy problems. This is the responsibility of the Welsh Office of Research and Development, now part of the Assembly, advised by the Welsh R&D Advisory Committee.

In addition the Sustainable Health Action Research programme (SHARP) was established in 2000 – the budget for 2001-02 is £0.5 million – to support 7 action research projects across Wales.

F. Health Promotion and Tobacco Control £4million

These Assembly managed budgets were introduced in 1999-00 and support the implementation of the national strategy to promote health and well being which includes smoking prevention and cessation measures set out in the Tobacco Control White Paper. Some £0.9 million goes to support Local Health Alliances and Healthy Schools Schemes and some £0.8 million supports local smoking cessation initiatives The remainder is spent on centrally driven action, local pilots and voluntary schemes to benefit vulnerable and hard to reach groups.

G. Health Improvement £3 million

These Assembly managed budgets were introduced in 1999-00 and are for all-Wales public health initiatives and campaigns including publicity for the influenza vaccination campaign, immunisation against hepatitis B and C, and the ongoing costs of the meningitis vaccination programme.

H. Inequalities in Health Fund £4 million

This budget was introduced for 2001-2, is to be managed centrally and is being distributed mainly through a bidding process targeted at the most deprived areas of Wales.

I. Food Standards £2 million

These Assembly managed budgets were introduced in 1999-00 and support the Food Standards Agency Wales to protect public health from risks in connection with the consumption of food; and to protect the interests of consumers. The budget supports a programme of work agreed with the Minister.

J. Welfare Foods £12 million

This budget funds an entitlement for pregnant women and mothers of young children in receipt of Income Support/ Family Credit under the Social Security Act 1988 which is adminstered by the Assembly. It is a demand led budget driven mainly by the numbers of people with young children on income support.

Disposition of expenditure by health authorities

3.7. Of the £2.543 billion distributed to health authorities for expenditure in 2001-2, £1.801 billion is distributed as a discretionary allocation for authorities to use to commission services for their populations. Although this is unhypothecated Ministers have issued directions to the NHS on the priorities they wish to see implemented through the discretionary allocation eg in recent years Ministers have directed sums of money to be spent on reducing waiting times and developing primary care. In addition there are standing targets for authorities to spend 0.5% of their discretionary allocations on health promotion and improvement measures and 0.4 % in tackling substance misuse.

3.8. Within these constraints health authorities have to set priorities for responding to local pressures including for example the cost of high cost continuing care cases and plans to reconfigure services and tackle problems of access and quality/governance in their areas. Authorities' plans for spending the discretionary allocation are not subject to Assembly approval.

Disposition of expenditure by NHS Trusts

3.9 Health authorities use the money allocated to them by the Assembly to commission services from NHS Trusts under long term agreements or to meet the costs of out of area treatments provided for a patient registered in their area by a Trust with which the health authority has no long term agreements. In agreeing its LTA with Trusts the health authority will specify what level of activity it expects to require for its patients, both in relation to emergency and elective services. Trusts normally seek health authority approval for new developments and are required to secure health authority approval for new consultant appointments. However to a degree expenditure is demand led and actual expenditure levels may vary from those planned – with authorities and Trusts required to ensure that overall spending is within agreed limits.

3.10 Trusts provide the Assembly with details of their expenditure broken down by specialty, function and programme. However because these returns are designed to record activity from a budget perspective, it is difficult to analyse it to discern broad trends such as changes in the balance of provision for different conditions, or to determine the balance eg between different groups of patients. For example much of overall expenditure on cancer or cardiac services is hidden within the relevant surgical specialty areas.

3.11 There are also problems of consistency in the recording of the data. A study is currently underway to develop a more standardised approach which will give greater confidence in the data collected and enable comparisons to be made with England.

3.12 Bearing these qualifications in mind the available data on the period between 1996-97 and 1999-00 does show the following broad trends within Trust expenditure:

- spending on medical specialties – some 28% of the total - has increased by 32% over the period and surgical specialties by 25%

- headline expenditure on psychiatric specialties has increased by 12% over the period after taking account of the transfer of funding for learning disability patients to social service budgets, other areas of psychiatric expenditure have increased by 15-25% and forensic psychiatry by 85%

- of the cancer treatments which can be identified separately medical oncology expenditure has increased by 124% from a low reported baseline to £5.5 million (0.4% of the total), radiotherapy by 33% (1.4% of the total) amd screening costs by 126% to £13.5 million

- of the cardiac services which can be identified spending on cardiology (0.8% of the total) has increased by 78% over the period and cardiothoracic surgery expenditure by just over 10%.

Chapter 4: Alternative models of allocation

4.1. Once the total is decided the budget for health services is broken down in different ways:

- amounts allocated by formula to health authorities

- amounts allocated by other considerations, including some amounts passed on to health authorities.

For budget purposes the overall total is split into the expenditure blocks discussed in Chapter 3. At this level decisions are taken about the funding requirements of each component taking account of cost pressures of which pay is the most significant - comprising 70-75% of HCHS.

4.2. Once the funding for each component is agreed it is distributed according to the existing allocation process – formula or otherwise. For distribution purposes the blocks of expenditure to be shared out by formula are divided into blocks representing the estimated proportion of expenditure - at an all- Wales level - which is spent on each service. Each block is then allocated between health authorities on the basis of weightings calculated separately for each expenditure block. These blocks are used purely for the purposes of sharing out cash resources: they are not intended to dictate actual spend on these services at local level, with the exception of ring fenced or protected allocations and the GMS cash limited budget. The final overall share of resources allocated to each health authority is the sum of these calculations.

Coverage of the formula

4.3. A key aspect of the Review is to examine whether the coverage of the formula approach should be changed.

The key areas here are primary care and tertiary/teaching services. In respect of primary care the two major elements of expenditure (prescribed drugs £390 million and payments to primary care contractors £334 million) are currently outside the Welsh formula and determined on the basis of historic spend. Task Group E has identified the factors which would need to be covered if these elements were to be taken into account in a formula approach. There are legislative constraints on action in relation to non cash limited contractual payments – the current Health Bill provides that the Health Secretary/Assembly may take spending on these elements into account when determining overall health authority allocations- but they cannot themselves be subject to a formula. In practice it may only be feasible to take into account the GMS elements because people do not necessarily live where they visit pharmacists, ophthalmists or dentist.

4.4. Task Group D is reviewing the current approaches to tertiary and teaching services and is likely to recommend a strengthening of the strategic all Wales element of tertiary commissioning and some refinement of the costings used for teaching services.

Impact of the present formula

4.5 The impact of the formula on the distribution of the HCHS and GMS budgets to which it currently applies can be illustrated by comparing each HA's share of the revenue allocation against its share of the population.

The following table shows how the 2000-01 revenue allocation of £2.4 billion was distributed to health authorities (a.) and how the shares received (b.) compare with

- a distribution based simply on population (c.)
- a distribution based on the weighted capitation formula shares alone (e.)

Table 1

allocation	NW	DP	IM	BT	G	Wales
a. total£m	549	396	410	609	439	2,402
b. total %	22.8	16.5	17.1	25.3	18.2	100
c. pop £m	538	393	409	607	455	2403
d. pop %	22.4	16.4	17.0	25.3	19.0	100
e. cap £m	552	404	409	586	451	2403
f. cap%	23.0	16.8	16.9	24.6	18.6	100

These figures show that the effect of the present Welsh formula in redistributing resources at health authority area level is not markedly different from a population distribution.

Table 2 shows these shares expressed as £ per head of population

Table 2

Per capita	NW	DP	IM	BT	G	Wales
a. actual dist	835	823	821	820	789	818
c. pop dist	818	818	818	818	818	818
d. cap dist	840	841	819	789	811	818

The difference between the actual share allocated and the capitation shares is due to 2 factors:

a. the inclusion of centrally funded services, primarily SIFT, which are distributed to providers, not on a formula basis

b. the inclusion of GP prescribed drugs which is allocated on the basis of forecast expenditure.

Table 3 shows the distribution of the revenue allocation without Centrally Funded services (a and b)

Table 3

allocation	NW	DP	IM	BT	G	Wales
a. total£m	547	396	410	578	439	2,369
b. total %	23.1	16.7	17.3	24.4	18.5	100
c. pop %	22.4	16.4	17.0	25.3	19.0	100
d. cap%	23.0	16.8	16.9	24.6	18.6	100

Table 4 shows the distribution after removing the drugs budget.

Table 4

Allocation	NW	DP	IM	BT	G	Wales
a. total£m	465	337	347	524	373	2045
b. total %	22.7	16.5	17.0	25.6	18.2	100
c. pop %	22.4	16.4	17.0	25.3	19.0	100
d. cap%	23.0	16.8	16.9	24.6	18.6	100

Removing the drugs budget makes little difference to the shares because although the budget is funded on a forecast spend basis the actual expenditure is close to what would be produced by applying the population shares, as illustrated by Table 5.

Table 5 net drugs out-turn 1999-2000

Drugs spend	NW	DP	IM	BT	G	Wales
a. total£m	75.9	52.9	56.8	78.6	60.5	324.7
b. total %	23.4	16.3	17.5	24.2	18.6	100
c. pop %	22.4	16.4	17.0	25.3	19.0	100
d. cap%	23.0	16.8	16.9	24.6	18.6	100

Table 6 shows the same comparison for FHS spending which is also funded on a forecast spend basis – but not included in HA allocations and therefore not included in Tables 1-5 (figures are for cumulative spending 1996-97 to 1999-2000 – the latest available).

Table 6

FHS spend	NW	DP	IM	BT	G	Wales
a. GMS £m	119	91	90	133	99	533
b. total %	22.4	17.1	16.9	24.9	18.7	100
c. pharm£m	55	40	42.6	61.7	45.4	243.9
d. pharm%	22.3	16.3	17.5	25.3	18.6	100
e. opth £m	12	10	13	21	17	73
f. opth %	17.1	13.5	17.2	28.9	23.2	100
c. pop %	22.4	16.4	17.0	25.3	19.0	100
d. cap%	22.9	16.8	17.0	24.4	18.8	100

For payments to GPs the shares of actual spend are close to the population shares. There is much greater variation in the payments to pharmacists and ophthalmic practitioners and receipts for prescription income which may reflect a tendency to get prescriptions dispensed and eye sight tests/spectacles in the major urban areas where people work and shop rather than where they live.

Application of the formula at health authority and LHG level

4.6 The need for the formula approach to be capable of application at LHG level is a key issue for the Review because it requires a much greater degree of accuracy and robustness than is required by the present process of allocation to 5 health authorities. Because the 5 health authorities cover large areas encompassing a range of health needs the detailed effects of a formula are averaged out. The existing formula has not been used to determine allocations below HA level although authorities are working to map existing expenditure patterns against indicative figures based on applying the formula at LHG level.

4.7 This resource mapping work is being reviewed by Task Group A and is subject to major data collection problems because NHS resources held in different budgets have not been accounted for at this level. We do not yet have a clear picture what the effect of applying the present formula at LHG level would be.

4.8 This work confirms that a key element of evaluating new approaches to the formula would be to look at the fit between the results and the evidence of health need and provision at LHG level.

Current approaches to the formula across the UK

4.9 Chapter 3 of the draft report of the research team reviews the health service resource allocation formulae currently used in Wales, Scotland, Northern Ireland and England. Each is based on a weighted population approach to sharing out each expenditure component within the overall total - in 3 stages

- Stage 1 – calculating the age and sex of the population and applying weights to reflect the costs of the use of services by each group compared with the average
- Stage 2 – adding weightings for additional needs by measuring the impact of social circumstances on the use of services
- Stage 3 – adding weightings for additional costs eg in respect of remoteness and rurality.

4.10 The major non technical differences between the current Welsh formula and the others are in respect of

- the treatment of additional needs and costs – which are given less weight than in the other countries
- the coverage of the formula – there is less top – slicing and hypothecation of hospital and community services in Wales
- GP prescribing is excluded in Wales, pending the outcome of the RAR, but included in England, Scotland and Northern Ireland.

Additional needs

4.11 In the current Welsh formula process the under 75 Standardised Mortality Ratio is used to adjust the population weightings – this is designed as a proxy measure for relative ill health between areas. The SMR is generally acknowledged to be an incomplete indicator of health need because the death rate does not measure for example long term chronic sickness in a population.

4.12 In England, Scotland and Northern Ireland the formula includes weightings designed to capture the additional health needs caused by social deprivation. The under 65 SMR(thought to be a better measure of health need than the under 75 SMR) is included in the Scottish formula but supplemented by other deprivation measures. The weightings are derived from a statistical analysis which determines which deprivation indicators best explain the additional utilisation of services in that country, over and above the utilisation determined by the

age profile of the population. This includes the SMR supplemented by other factors.

4.13 The additional needs arising from social deprivation have been addressed by Task Group B. The Group has

a. confirmed through a review of research literature the correlation between deprivation and health related to:

- cumulative effects of social deprivation across the life course
- lifestyle
- social and community networks
- housing
- education
- socio-economic conditions
- socio-economic environmental factors
- transport

b. made the connections with the role of NHS as developed in Improving Health in Wales in addressing social deprivation and avoidable health inequalities, acting both directly and in partnership

c. commissioned work by the research team to test the relationship between deprivation and rates of emergency hospital admissions.

Additional costs

4.14 The Welsh formula includes a weighting for the additional costs of providing services in sparsely populated areas in relation to community and ambulance services and cash limited General Medical Services (administrative support to GPs). The English formula includes a market forces factor designed to capture the above average costs of providing health services in high cost areas like the South East of England, but applies a weighting for sparsity only to expenditure on the emergency ambulance service, which represents just under 2% of the hospital and community budget. The Scottish formula includes a weighting for remoteness and rurality in relation to all services covered by the formula approach.

4.15 Task Group C has reviewed work by both NHS and non NHS bodies on the impact of rurality on service provision and has concluded that the most relevant piece of research is the Scottish Fair Shares for All report. Its evaluation of other research indicated that whilst in general significant costs of service provision were attributed to rurality the methodology employed was either not directly relevant or not robust enough to be of value to the Review. The research team is now evaluating the validity of applying the Scottish approach to Welsh circumstances and will be reporting back to the Task Force.

4.16 Task Group A is evaluating whether there is a need for a weighting to reflect additional health care needs associated with an urban environment eg whether there are additional service delivery costs for the same health need in urban areas or whether there are specific health resource problems associated with urban population groups that would not be captured by the formula approaches discussed below. The Group has established that

there is evidence of increased health needs in an urban environment but that the majority are likely to be taken into account by steps to make the formula more effective in capturing health need. But there are some specific needs which may not be captured by the formula and which tend to be concentrated in inner city areas and the Task Group is gathering evidence to establish whether these require a separate weighting in the formula:

Inner city needs

- HIV/AIDS
- Haemophilia
- Genetics, particularly children
- Children with multiple disabilities
- Forensic Psychiatry
- Drug and Alcohol Abuse
- Ethnic population
- Homelessness
- Fragmentation of urban families
- Students
- Renal services
- Schizophrenia

The indirect approach to measuring health need

4.17 The methodology currently used by all the UK countries can be described as an indirect method of capturing relative need because it uses evidence of the utilisation of services between different age and social groups in the population as a proxy for their relative health need. The Scottish approach is the most detailed variant of the indirect approach and uses the most sophisticated statistical techniques.

4.18 However the Scottish formula (along with all variants of the indirect method) relies heavily on service utilisation data - data recorded in hospitals and surgeries on the treatments received by individual patients. This utilisation data is widely recognised to be subject to significant accuracy problems such as definitions and recording conventions. The more the process is refined the greater this data dependency becomes.

4.19 The research team estimate that updating the Welsh formula along Scottish lines would take at least 2 years because the Welsh health service data is not all collected in the form required ie recording for all treatments the post code of each patient so that analysis of utilisation on the small area basis needed to determine the impact of social factors can be made. Although health services data in Wales is in some respects better than elsewhere, it has not been designed for the purpose of formula calculations.

Introducing direct measures of health need

4.20 In the light of the limitations of the indirect approach: of principle because it uses utilisation as a proxy for need, and the practical problems of data accuracy, the research team have examined other ways of revising the formula approach based on the direct measurement of health need. Such an approach would measure the incidence of disease in local populations as measured by the Welsh Health Survey and epidemiological data such as cancer registrations and distribute resources to each area on the basis of the prevalence of disease in that area.

4.21 This innovative approach is an option in Wales, but not so far in the other countries because of the existence of additional information here including the WHS. Work is currently in hand to test the robustness of the data available for applying this approach and for evaluating its merits for each expenditure component by comparison with the indirect utilisation approach.

4.22 Where the direct approach was the recommended measure there would be no need for further adjustment to take account of socio economic factors because their effect would already be captured in the relative incidence of disease. It would not however deal with relative costs – the additional costs associated with delivering health services in rural or urban areas would therefore need to be examined separately.

Evaluating direct and indirect approaches

4.23 In England ACRA has adopted a set of criteria (Annex 5) which should be met by any resource allocation formula. The final report will draw on this in evaluating different approaches and explaining the recommended approach. Work now in progress is testing the availability and quality of the data needed for each expenditure component. The aim is to advise the Committee on the approach which best captures relative need for each component of spending. Thus for example there may be some components where the indirect method (based on service utilisation) will be preferable and others where the direct method (based on the incidence of disease or population characteristics) will be better.

Role of expenditure in determining relative need

4.24 It is worth noting that both the direct and indirect approaches use existing expenditure to calculate the weightings to be applied to determine the importance of different aspects of health need. Thus the direct approach calculates relative need for cancer treatment by applying evidence of the incidence of cancer across areas and then applies these shares to the current cost of cancer treatment across Wales.

Distributing resources on a basis independent of NHS spending

4.25 An alternative - to both the direct and indirect approaches - would be to distribute health resources between areas on the basis of an index which was totally independent of health service expenditure eg the Welsh Index of Deprivation or the health summary scores produced by the Welsh Health Survey. The difficulty with this (setting aside the issue of which index to choose) is that we have no basis for calculating the weights to be attached to relative deprivation or relative health status eg should an area which according to the index is twice as deprived get twice as much health service cash resources or some other figure.

4.26 For example the present Welsh formula attaches a weighting of 1 to the Standard Mortality Ratios ie an area with a death rate 10% higher than another gets 10% more resources. But this is not evidence based – we do not know whether the SMR relativities actually reflect a 100% differential in the cost of treating the differential health need captured by the SMR. This is separate from the question of the extent to which the SMR is a good proxy for health need.

4.27 For this reason all the formula approaches under consideration use current spending as the basis for calculating the weightings to be applied to the different measures of health need. For example the relative effect on the resource allocation weightings of a high incidence of respiratory disease will be determined by the current share of expenditure devoted to treating that condition. Thus the amount of money currently spent by the NHS in responding to different aspects of health need is used to determine the weightings between different aspects of the health need differential between areas.

Chapter 5: Emerging conclusions at end January 2001

5.1. This report represents both continuity and change. It continues the well-established tradition of research documentation of health inequalities in relation to area populations, and provides up-to-date information for Wales to facilitate the preparation of a revised formula for the purpose of allocating a large part of NHS resources by area. But it also includes a form of financial analysis not developed in previous reports of a similar kind in the UK.

Data about trends in expenditure – and reasons both for the different categories of expenditure as well as trends in recent years - are of equal importance to data about population ill health in constructing more efficient plans for expenditure.

This is intended to pave the way for more realistic appraisal of the use of resources in relation to principles of equitable distribution. There are of course major problems of tracing local and individual outcomes in terms of utilisation and therefore demonstrating how resources may be distributed more equitably. We are investigating different ways of overcoming such problems. This report explains the contribution of the Resource Allocation Review towards fulfilling the aim of tackling health inequalities announced by the Minister for Health and Social Services in July last year (para 2.14 above).

The latest position in relation to the key areas covered by the Review can be summarised as follows.

Principles underlying the resource allocation process

5.2 The full scope of possible action to address poor health and inequalities in health status (within which the resources distributed by formula and variations to that formula can be applied) need to be expressed as

1. action within the NHS, in the context of a universal service responding to the needs of all patients, to encourage sensitivity to the needs of the poorest patients and ensure equality of service access;

2. action outside the NHS but within the policy responsibilities of the Welsh Assembly to improve community services, reduce deprivation and unemployment, and improve housing, environmental and other services;

3. action outside the NHS to advise the UK Government on appropriate and necessary measures to reduce material and social deprivation, poverty and social exclusion, and increase low incomes.

The process of resource allocation – formula methodology and coverage

5.3 The work of the research team was presented to NHS stakeholders at a seminar on 25 January which discussed a range of issues including:

- margins of error in both direct and indirect approaches
- incidence of illness as an indicator of need for treatment
- sample size and stability in the Welsh Health Survey
- applicability of approaches at LHG level.

The emerging views were as follows:

coverage of formula approach

the present distribution of the NHS budget needs to change to bring more expenditure into an equitable formula approach – the main candidate is the primary care drugs budget

viability of direct method

there is positive support for the research report and for the 'direct' approach to resource allocation subject to confirmation of technical points and data quality issues. The approach will be validated by the Office of National Statistics who are the recognised authority on statistical techniques. Key issues will include validity at LHG level, how many expenditure programmes can be covered by this

approach and in what timescale. The research team are on course to produce recommendations by end of March 2001 – until the detail of their recommended formula structure is available it is not possible to determine what share of formula allocated expenditure would be covered by the direct approach

indirect method

we should not discontinue work on the indirect approach - which would take longer to develop - until the direct approach is confirmed

implementation

a phased approach to implementation will be needed (see para 59 below) based on introducing the best measure of relative need for each component of spending, recognising that there is no perfectly robust method since there are concerns about data quality and reliability in relation to both the indirect and direct method. This may involve introducing the direct approach to expenditure programmes where it has the greatest confidence and continuing with the indirect approach where that seems more reliable

inequalities

the direct method will capture directly the differential need caused by poverty and deprivation and will share out resources in direct proportion to the incidence of ill health in each area. It will thus enable higher per capita spending by NHS bodies in deprived areas than in more affluent areas in order to address inequitable receipt of health care, to take remedial action as discussed in Chapter 2 and contribute to wider health promoting partnerships

Inequalities in Health Fund

there will be a clear role for a separate Fund alongside moves to more equitable target shares. In the longer term the focus for the Fund could shift increasingly towards a broader preventative and health improvement agenda

updating indirect method

if the recommended approach includes continuing with the indirect method for some expenditure programmes – the final report will include recommendations about the extent of updating which is needed pending the wider introduction of the direct approach

split between expenditure programmes

since the shares produced by both the direct and indirect method need to be applied to the actual expenditure components of the health budget – it will in any case be necessary to update the shares used by the present formula which in some cases is based on evidence from 1992 or earlier

the final report will review the amounts allocated by budget to different categories of health expenditure, such as primary and secondary care, hospital and community care etc The reasons for trends in such components of expenditure - such as the above-average rise in cost of drugs - will be elucidated

differential costs

separate decisions will be needed on how to take account of differential costs in remote/rural/urban areas – incorporating the direct approach will capture additional needs but will not address differential costs

Local Health Groups

the need for the new approach to be capable of application at LHG level is a major consideration which will be addressed in detail in the final report – it means that the need for accuracy and credibility is far greater than if the approach is applied only at health authority level which masks the sharper effects of any formula approach.

Process for implementation

5.4 In view of the complexity of the issues and process needed to implement the recommended changes it seems likely that the final report will be recommending to the Committee a process comprising:

- clear direction of travel in terms of coverage of the formula and the balance between direct and indirect approaches
- timetable for a phased approach to implementation for each expenditure component in turn
- process for ongoing review of the formula by a Standing Group of NHS and Assembly representatives
- preliminary recommendations on how non-formula related financial issues, for example on the balance between primary and secondary care, hospital and community care can be considered in future.

Timetable

5.5. The final report will include some exemplification of the outcomes to be expected from the recommended approach at health authority level and will thus enable the identification of target shares from the proposed changes.

5.6 Whatever changes are agreed a phased approach to implementation ie moving from actual to target shares will be needed to enable service continuity on the ground and to allow time for health authorities and LHGs to adjust to the new shares. In Scotland the final Fair Shares for All report proposes that implementation should be timed within the constraint that all boards should receive a minimum year on year increase and that growth money over and above that minimum should be targeted on boards whose allocation shares need to rise according to the new formula. Decisions on a minimum level of this sort will be needed, taking into account the implications for the financial viability of organisations and the speed of change which is feasible.

Annex 1

Terms of Reference for NHS Resource Allocation Review

The Health & Social Services Committee agreed to set up a review of the current arrangements for allocating financial resources to the NHS in Wales. Professor Peter Townsend has been appointed as the independent Chair of the National Steering Group which is to oversee the review. The Terms of Reference of the review are as follows:

(1) To advise the Health and Social Services Committee on the most appropriate means of allocating available resources to fund the provision of the full range of primary, community, secondary, and tertiary health services to the population of Wales in order to promote equitable access to appropriate quality health services in accordance with health need.

(2) The review is particularly expected to ensure that the recommended resource allocation mechanisms take into account the health needs of areas of socio-economic disadvantage but it is also to take due account of:

- the needs of other disease, population, and minority groups with particular healthcare needs;
- the unavoidable extra costs and measures of providing services in rural or remote areas or areas where market forces factors impact significantly on costs;
- the legitimate additional costs associated with the provision of all Wales services, including pre and post graduate medical education, tertiary services, and contributing to UK and England and Wales services;
- the capability of the recommended mechanisms to inform and promote the equitable distribution of resources:
- for the provision of all elements of NHS provision (for hospital, community, and ambulance services, GP support costs, GP prescribing expenditure, and contractor professions' fees and allowances) while encouraging a whole systems approach;
- to Local Health Groups;
- the availability and resource implications of obtaining and maintaining quality data, experience to date with the existing formulae, other relevant work undertaken and formulae applied elsewhere; and
- the need for appropriate transition arrangements for the implementation of the new funding arrangements.

3. The review team is to present its emerging findings report to the Health

and Social Services Committee by 31 December 2000 and a final report for

consultation by 31 March 2001 with a view to recommended changes to the

main formula being introduced progressively from 2002-3.

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Annex 2

NHS Resource Allocation Review

Project Group Structure

Health and Social Services Committee

National Steering Group

Chair : Prof. Peter Townsend

Project Review Group

Chair : P Gregory

Emerging Findings Report Reports

Discussion Papers

Issues Papers

Task Groups

Task Group A Task Group B Task Group C Task Group D Task Group E

Review of Social Deprivation Rurality/ Teaching/ Prescribing, Research Remoteness Tertiary GMS, CS,

Chair Chair Chair Chair Chair

Mr N Patel J Williams S Gray M Aikman E Williams

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Research Team

Head

Dr D Gordon

Annex 3

Task Group – Remit/Tasks

Task Group A – Review of Research

Chair – Nick Patel

- Co ordinate the work of the research team to ensure that task group research support to task groups is being fully met.
- Monitor and liaise with the research team to ensure the achievement of the action plan including the development of the formula.
- Summarise and prepare papers for the PRG / NSG on the different resource allocation formula options which have been reviewed by the research team.
- Arrange a resource mapping exercise covering all health authorities.
- Prepare discussion papers on issues not covered by task groups.
- Capital charges.
- Resource allocation formula methodology.
- To consider urban issues and the influence of demographic factors and utilisation of service/environmental factors.
- Draft Emerging Findings Report for consideration by Task Groups, PRG and NSG.

Task Group B – Social Deprivation

Chair - Jan Williams

- To describe the impact of social deprivation and disadvantage on health status in whatever settings people live, rural, urban, or valleys.

- To set out the ways in which social deprivation, occupational class and health inequalities drive NHS expenditure.

- To explore the potential future role of the NHS in reducing avoidable health inequalities through the redistribution of existing resources/targeted deployment of new resources.

- To consider urban issues (except those relating to demographic factors and utilisation of service/ environmental factors which are being dealt with by Task Group A).

- Review the emerging findings of the National Steering Group in line with the points above.

Task Group C – Rurality/Remoteness

Chair – Stuart Gray

- Review current literature and information on excess costs of the health service provision in rural/remote areas.

- Define rurality and remoteness in the Welsh context.

- Identify the inequities in access in health as a result of rurality.

- Estimate the additional costs of delivering health care services to rural/remote locations.

- Estimate the additional costs to patients in accessing health services in rural / remote areas.

- Recommend to the Project Review board an appropriate range of determinants/adjustment to the allocation formula to account for excess costs for rurality/remoteness.

- Comment on the draft emerging findings report.

Task Group D - Teaching & Tertiary Services

Chair – Maggie Aikman

- To ensure that the recommended resource allocation mechanism take into account the legitimate additional costs associated with the provision of all Wales services including:

- Under- graduate and post graduate Medical & Dental Services

- Tertiary Services

- Research and Development

This would also involve consideration of the trade off between the need to maximise equality of access (ie fair resource distribution) and the need to maintain a viable Teaching and Research base with access to sustainable locally provided "leading edge" tertiary services.

- To review the appropriateness of the factors and mechanisms used in the current resource allocation methodology to provide and safeguard all Wales services.

- To undertake a literature search to ensure that the most up to date thinking on the subject area is available to the group. This should include a critical review of approaches adopted in England, Scotland, and elsewhere.

- To identify the issues involved and specify any further work that is required.

- To develop an action plan that supports the timetable set out by the National Steering Group to meet the overall programme.

- Comment on draft Emerging Findings Report.

Task Group E - Prescribing, GMS, Community Services, Family Health Services

Chair – Eifion Williams

- To advise the Project Review Group of the NHS Resource Allocation Review on the issues to be included/ recognised by an appropriate formulae for the distribution of financial resources to Health Authorities and Local Health Groups in Wales for :

- Community Services

- Family Health Services

- GP Prescribing

- GMS (Cash Limited)*

- Ambulance Services

Where appropriate, the group would make recommendations on the appropriate formulae. The work of the group needs to consider the evidence of the relative need for resources across health communities and consider the appropriation of available relevant factors to reflect this. The outcome of the work should be the production of a formula by the All Wales Review process that can be supported by relevant and accurate data to produce an equitable distribution of resources to meet the relative needs of the population of each Health Authority and Local Health Group for each service.

The terms of reference vary to take account of the emerging findings of the review

- Comment on draft Emerging Findings Report

* GMS (Non Cash Limited) to be reviewed in light of developments highlighted by English National Plan.

Task Group Membership

Task Group A - Review of Research

Mr Nick Patel (Chair) - Project Director, NAW

Mr Ken Alexander - Secretariat, NAW

Mr Robin Jones - Health Statistics and Analysis Unit, NAW

Dr David Gordon - Head of Research Team, Bristol University

Dr Rhiannon Edwards - Health Economist, North Wales Health Authority and Bangor University

Mr Jack Straw - Director of Finance, Bro Taf Health Authority

Mr Eifion Williams - Director of Resources/Performance – Iechyd Morgannwg Health Authority

Mr Geoff Lang – Director of Finance, North Wales Health Authority

Mrs Maggie Aikman - Director of Finance, Gwent Health Authority

Mr Alun Lloyd - Deputy Director of Finance, Bro Taf Health Authority (Resource Mapping)

Mr Nigel Moss – Previously, Information Manager, Bro Taf Health Authority. (Now, Specialised Health Service Commission For Wales)

Dr W Ritchie - Director of Health Policy and Public Health, Dyfed Powys Health Authority

Task Group B - Social Deprivation

Mrs Jan Williams (Chair) - Chief Executive, Bro Taf Health Authority

Dr Jennie Deville - Research Manager, Institute for Rural Health

Dr Chris Godwin - Chair, Blaenau Gwent Local Health Group

Dr Ronan Lyons - Consultant in Public Health, Iechyd Morgannwg Health Authority

Dr Stephen Monaghan - Deputy Director of Public Health, Bro Taf Health Authority

Ms Nina Parry-Langdon - Health Promotion Division , NAW

Ms Hilary Pepler - Chief Executive, North Wales NHS Trust

Mr John Puzey - Director, Shelter Cymru

Mr Chris Riley - Performance Management Division, NAW

Dr Martyn Senior - Senior Lecturer, Cardiff University

Mr John Bader - Housing Community Renewal Division, NAW

Mr Andrew Jones – Senior Policy Officer, Caerphilly County Borough Council (WLGA)

Task Group C – Rurality/Remoteness

Mr Stuart Gray (Chair) - Chief Executive, Dyfed Powys Health Authority

Mr Alan Coffey - Director of Finance, Powys Health Care NHS Trust

Dr John Wynne-Jones - Director, Institute for Rural Health

Mr M Woodford - Chief Executive, Powys Health Care NHS Trust

Professor Peter Midmore - Welsh Rural Institute

Mr Keith Thompson - Chief Executive, North West Wales NHS Trust

Dr W Ritchie - Director of Health Policy and Public Health, Dyfed Powys Health Authority

Ms Ann Moazzen - Pembrokeshire Association of Voluntary Organisations

Mr John Howard - Chief Officer, Montgomery Community Health Authority

Mr David Ellis - Regional Manager, Mid and South Wales Division, Welsh Ambulance Services

Dr Will Roberts - Chairman, Anglesey Local Health Group

Mr Hefion Francis - General Manager, Gwynedd Local Health Group

Ms Non Williams – Social Services, Gwynedd County Council

Task Group D – Teaching & Tertiary Services

Mrs Maggie Aikman – Director of Finance, Gwent Health Authority

Mr Alun Lloyd – Deputy Director of Finance, Bro Taf Health Authority

Mr Stuart Davies – Director of Finance, Specialised Health Service Commission for Wales

Mr Charlie Mackenzie – Swansea Trust

Mr Gary Thomas – Health Information Analyst, Gwent Health Authority

Mr Andrew Cotton – Director of Finance, Gwent Healthcare NHS Trust

Mr Chris Lewis – Cardiff & Vale Trust

Mr Wayne Harris – Director of Finance, Wrexham Trust

Kim Tester – Human Resources, NAW

Dr Alan Roberts – NHS College Liaison, College of Medicine, University Hospital of Wales

Malcolm Green – Gwent Health Authority

Task Group E – Prescribing, GMS, Community Services, Family Health Services

Mr. Eifion Williams (Chair) – Director of Resources/Performance – Iechyd Morgannwg Health Authority

Mr Gwyn Phillips – Director of Contractor Services, Bro Taf Health Authority

Dr Doug Russell – IMA/Head of GP Development, Dyfed Powys

Mr Alan Wilson – Director of Community Partnership, Iechyd Morgannwg Health Authority

Mr Geoff Lang – Director of Finance, North Wales Health Authority

Mr Julian Baker – Manager, Caerphilly Local Health Group

Mr Mik Webb – North Region, Ambulance Service

Mr Barrie Wilcox - Head Primary and Community Health, NAFW

Dr Quentin Sandifer – Director of Public Health, Iechyd Morgannwg Health Authority

Annex 5

Evaluation Criteria for Resource Allocation Formulas

(Source: Department of Health, 1999)

The following list suggests some basic criteria for evaluating resource allocation formulas. Criteria (1) to (6) are deemed essential, (7) to (13) are deemed desirable. Whilst expressed in terms of allocating to health authorities, the criteria are equally applicable to allocations made to any other set of NHS bodies.

Essential:

1. **Technical robustness**

   The analytical techniques used to develop the formula should have an established academic pedigree, and should be evidence based and used in accordance with proper practices in relation to those techniques.

2. **Transparency**

   In general the formula should be simple to understand although the detail may be more complex. Analytical techniques should normally be capable of objective quality assessment, such as is provided by tests of statistical significance. Ideally, although this is difficult to quantify, the outcome of the

   process should command a wide degree of acceptance, ie "felt to be fair" on the ground.

3. **Objectivity**

   The formula should be objective and capable of application consistently to all Health Authorities and be capable of being extended to Local Health Groups.

4. **Plausibility**

   The plausibility of the relationships defined by the formula should be capable of reasoned and unambiguous explanation.

5. **Freedom from perverse incentives**

   The formula should not create financial incentives which appear to conflict with sensible operation of HA services.

6. **Reliability of calculation**

   The formula should use data whose quality is sound, is consistent between HAs and is available for all HAs.

   Desirable:

7. **Comprehensibility to non-specialists**

   The formula, and the means by which it has been arrived at, should be capable of commonsense justification to non-specialists. This means that the *substantive effect* of analytical techniques should be capable of explanation in plain English, even if the *process* of calculation is understood only by specialists.

8. **Durability**

   There should be reasonable grounds for expecting that the influence of an indicator on the need for HA services or the cost of providing them will continue for some years.

9. **Practicality**

   The scale of work required to derive or update a formula should be manageable within the time constraints of the annual financial cycle.

10. **Clarity of contribution of indicators**

It is desirable that the relative significance of individual indicators can be quantified unambiguously.

ends