Allocating resources for health and social care in England

Ken Judge, Nicholas Mays

This is the second of a series of five articles

The fair allocation of resources for health and social care in relation to the needs of the population in different parts of the United Kingdom has become particularly important since the implementation of the new arrangements for community care in April 1993. These depend on close collaboration between health authorities and local authority social services departments. Yet funding reaches these authorities by different means and according to different criteria. Most health authority funds come through a weighted capitation formula that overemphasises the effects of age, while family health services funding is largely not cash limited and hence demand led. Funds to local authorities for community care are being transferred from the social security budget but on a basis that partly reflects past provision of residential and nursing home care. None of these mechanisms responds to underlying needs that give rise to demands on the health and social care system as a whole, and none makes any attempt to compensate for defects in the others. The solution includes better research and a unified weighted capitation system for all sources of funding.

Equity of access to health care on the basis of need alone remains one of the central values of the National Health Service. Since its inception the NHS has endeavoured to distribute resources across the United Kingdom on the basis of population needs.[1] Most social care, however, is provided not by the NHS but by local authorities. Here again resources are distributed on the basis of need, but the criteria used are different from those used to fund NHS health care needs. Moreover, local authorities have some discretion over how much to spend on social care in the light of local priorities. Local priorities may not, however, reflect local needs. This fact, combined with the major shifts that have taken place—most recently, the NHS and Community Care Act 1993—in the funding and provision of some NHS services, have brought into sharper focus the need for equity in the allocation of resources for both health and social care (see later paper in this series by Challis and Henwood[2]). The central issue is the lack of coordination of the different funding arrangements both within and across health and social services. For example, funds for hospital and community health services, general practitioners, prescribed drugs, and personal social services are determined largely in isolation from one another. The scope for agencies to abdicate responsibility and for inequities to flourish is much greater than is commonly supposed.

This paper identifies the most important sources of health and social care funding in England and reviews some of the strengths and weaknesses associated with each. New forms of policy development are long overdue, and in the final section we briefly outline how new approaches to resource allocation might be developed in future.

The National Health Service

In 1994-5 the government plans to spend almost £31 billion on the NHS in England.[3] Figure 1 illustrates the main NHS financing pathways. Seventy five per cent of the total expenditure is devoted to hospital and community health services and 22% to family health services (provided by general practitioners, dentists, opticians, and pharmacists). The most important single block of expenditure is the 60% which is made available to regional health authorities for hospital and community health services through the system of weighted capitation introduced in 1990-1.

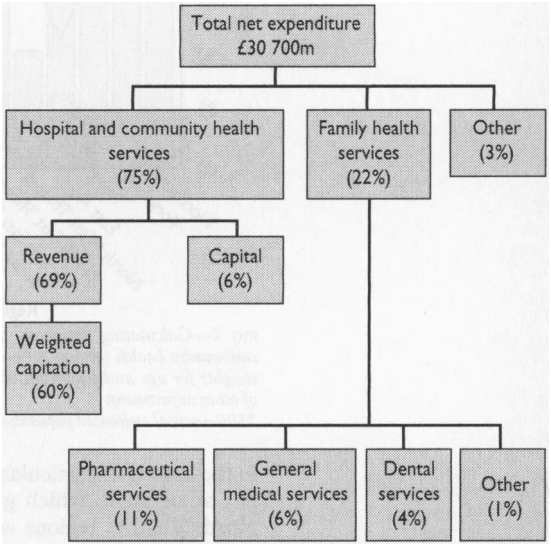

FIG 1—*NHS spending plans for England 1994-5*[3]

WEIGHTED CAPITATION

Weighted capitation allocations to regional health authorities are determined by a formula in which population projections are weighted to take account of key determinants of the need for and the costs of providing health care.[4] Firstly, regional populations are adjusted for national variations in the use of hospital beds by different age groups (the so called age-cost weights). Secondly, population shares are adjusted to take account of differences in health needs not already accounted for by population size and age structure by means of a measure of standardised mortality which is associated with variations in hospital use. Currently, this is the square root of the all cause standardised mortality ratio for the population under 75 years of age.

The combined effect of the age and need factors on regional estimates of population is illustrated by the bars in figure 2 (100=each region's unadjusted estimated population for 1994-5). For example, Northern has its population share increased by 8·2%, South East Thames remains more or less constant, and Oxford loses 12·4%.

Each region is then subject to a final set of adjustments. These mainly reflect the higher labour costs of providing health care in the Thames regions and consist of the effect of London weighting on salary expenditure; an additional market forces adjustment; and a further percentage addition to the four Thames regions which was introduced in *Working for Patients* "to reflect the higher costs of and demands for services

King's Fund Institute, London W2 4HT
Ken Judge, *director*
Nicholas Mays, *director of health services research*

Correspondence to:
Dr Mays.

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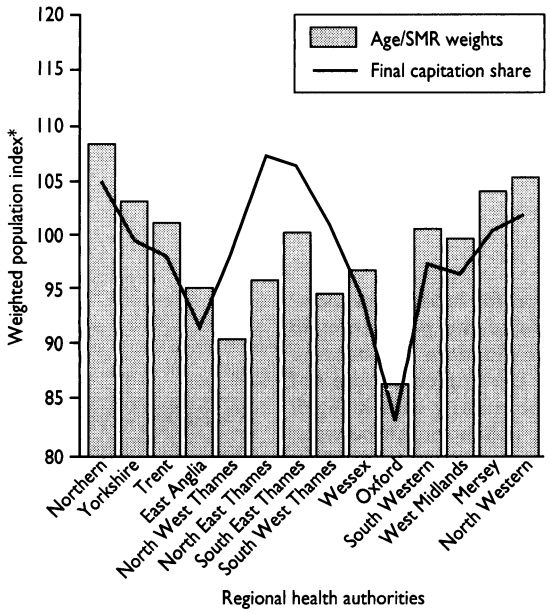


FIG 2—*Calculating weighted capitation funding for hospital and community health services for each English region. Bars show effect of weights for age and standardised mortality ratios and line shows effect of other adjustments*
**100 = actual estimated population of region*

in the capital in particular."[5] The empirical basis of this last adjustment, which gives an additional 3% to the North Thames regions and 1% to the South Thames regions, has never been fully explained. In 1994-5 a small additional sum of £31m was redistributed to the Thames regions at the discretion of ministers. This was calculated separately from weighted capitation and is not shown in figure 2.

The line in figure 2 shows the effect of the complete weighted capitation formula on regional population shares. The adjustments for higher labour costs in the Thames regions result in the return of resources to the Thames regions from elsewhere. The overall effect at the regional level is that North East Thames is the main beneficiary and Oxford the biggest loser. The line in figure 2 is very close to what regions received in 1994-5. The gap between allocations and capitation share ranged from −0·57% in Wessex to +1·45% in North West Thames.

DISTRICT CAPITATION

Each region has also been pursuing its own version of weighted capitation in making its allocations to districts. However, much larger proportionate shifts in resources have resulted between districts than between regions. As a consequence regions have faced many practical difficulties in implementing a capitation approach. The implementation of district level capitation involves substantial changes in funding for many localities. For example, some of the biggest losers include Newcastle, Sheffield, and substantial parts of Birmingham, Manchester, and inner London (Department of Health, unpublished analyses, September 1993).

Since the NHS reforms were introduced in 1991 it has become increasingly clear that in some districts the gradual introduction of weighted capitation has been one of the key pressures on local health services, leading to phenomena such as reductions in numbers of acute beds. In these circumstances it becomes crucial that redistribution should reduce rather than exacerbate inequity.

Most of the criticism of the present national system of weighted capitation has been directed at the health needs element of the formula. However, the age-cost weights are the most important determinants of change in funding levels.[6] They have been criticised for overcompensating for the costs of providing health care to elderly people because of their crude method of calculation.[6] They exclude the costs of day cases and do not distinguish between the hotel and treatment costs of hospital episodes, which are known to vary with age. Other criticisms include that the population projections are subject to considerable uncertainty, especially for some subgroups which are intensive users of health care[6]; that the needs factor was derived on the basis of inappropriate methods[7-10] and possibly fails to take sufficient account of the socioeconomic determinants of the demand for health care[11]; and that some of the extra finance for London and the south east is determined without a secure empirical grounding.

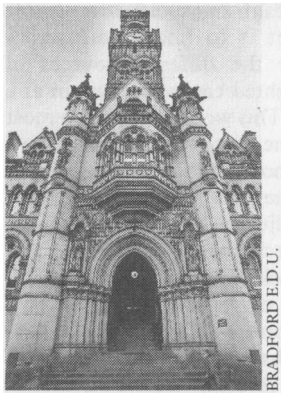
Proposals currently being considered by ministers should tackle some of the main weaknesses of the present formula. With the abolition of regional health authorities in 1996 there is likely to be a single formula in England which will determine weighted capitation shares for district health authority resident populations, although it remains unclear how resources for general practitioner fundholders will be allocated.[12] If the system of weighted capitation is revised to allocate funds directly to districts an important question will be how quickly it is possible to move each district to its capitation share.

Unfortunately, there is every likelihood that any new system of allocating purchasing power for hospital and community health services will remain as separated from other health and social financing mechanisms as it has been since 1948. This is regrettable because the compartmentalised way in which different streams of funding are allocated to local communities represents the biggest barrier to a proper assessment of whether resources are distributed in proportion to needs.

FAMILY HEALTH SERVICES

One of the main criticisms of weighted capitation is that it takes no account of the distribution of spending on family health services. Family health services authorities are funded on the basis of previous spending, both for their administrative and service costs. They in turn provide funds to practices in a variety of ways. Overall there is no guarantee that resources are made available on the basis of local population needs. In part this system has arisen because family health services spending has largely been determined since 1948 by the behaviour of health professionals and patients. Although the administrative budgets of family health services authorities and the sums the authorities make available to family practitioners to improve their premises are cash limited, family health services spending itself is not cash limited. The government is currently consulting on a proposal to cash limit general practitioners' prescribing costs, but a final decision has not yet been taken. Nevertheless, there are substantial variations in the availability of family health services at local level, and they are likely to influence demands for hospital care.

For example, in the latest year for which information is available there were 8·4 (whole time equivalent) general practitioners per 10 000 patients in Manchester compared with only 5·6 in Rotherham.[13] In fact, these statistics understate the real extent of inequality because they fail to take account of variations in the underlying needs of different populations, such as variations in age structure or the prevalence of morbidity. Estimates of the need for general practitioners in different family health services authority areas in comparison with the actual availability of doctors imply the persistence of substantial inequalities in access to general practice (M Benzeval, K Judge, unpublished results).



Town halls have discretion over their spending—and not all spend up to their allocations on community care

Social and community care

The resources for social care which are most relevant to the activities of the NHS currently come from the social security budget and the Department of the Environment's funding of local authorities under several different systems of allocation. None of these systems formally recognises the effects of NHS allocative systems on the overall availability of resources for health and personal social services in different areas. Yet since April 1993 local authorities have become the lead agency for purchasing care in the community for dependent client groups. This has meant that the shift of continuing care from the NHS and local authorities and its expansion in the private and voluntary sectors which occurred in the 1980s will no longer be funded from the social security budget but will be paid for by local authorities. As a result, attempts are being made to provide local authorities with additional resources to take on their enlarged responsibilities.

Figure 3 shows the relatively complex pattern of allocations for local authority social services and highlights the three main flows of resources for local authority services which should have an impact on NHS provision.[3] The most important factor is the calculation of personal social services standard spending assessments. These represent the government's view of what each local authority needs to spend to provide a standard level of services for children; elderly people; and other groups, such as people with learning disabilities, people with mental health problems, and younger people with physical disabilities. The standard spending assessments are based on calculations of the potential number of clients in each of the three service groups and use a mixture of weighted demographic, morbidity, and social indicators for each local authority. The variables are included on the basis of their statistical association with past numbers of clients. These standard spending assessments sums, which are made available through the local authority rate support grant, are not ring fenced, since local authorities have some discretion to determine their own spending priorities. As a result, not all local authorities spend up to their standard spending assessments on social services.

There are, however, central sums which are earmarked for specific purposes. At present the most important of these are the so called community care reform monies. These are specifically intended to implement the gradual shift of responsibility from the social security budget to local authority budgets for the financial support of people in need of care in the community.

For the first four years of the implementation of the community care reforms (1993-4 to 1996-7) the community care reform monies are being distributed to local authorities as a special transitional grant. In 1994-5 the largest part of the grant for the community care reforms consists of funds transferred from the Department of Social Security so that local authorities can continue to take on more of the responsibility for the financial support of people who need community and residential care. The special transitional grant is allocated to local authorities partly on the basis of the past pattern of spending and location of residential and nursing home places and so perpetuates present inequities between areas. In 1993-4 the transfer amounted to £398·6m and in 1994-5 it amounts to £651·8m. After the first year (1993-4) a proportion of each year's community care reform monies has been shifted from the special transitional grant to become part of the normal calculation of personal social services standard spending levels, thus allowing the grant to taper and disappear in 1996-7. A total of £538·6m is available for community care through the standard spending assessments in 1994-5, giving a total of £1274·5m for the community care reforms (see fig 3). In addition, in 1994-5 a further £1830m will continue to be spent through the social security budget on elderly people with preserved entitlement to social security support.[14] These are the roughly 186 000 people who entered residential care before the community care reforms of April 1993 and whose fees were publicly subsidised.

The third and smallest source of resources for services which impinge on the responsibilities of the NHS is personal social services specific grants, which relate to activities that the government particularly wishes to encourage. The mental illness specific grant, for example, has provided a focus for collaboration in 800 new projects between health and local authorities in 1993-4. In addition to these central government resources, local authorities, unlike health authorities, can raise limited amounts of money locally from the council tax to add to their income from user charges.

By 1996-7 the special transitional grant for the community care reforms will have been phased out and the transfer of funds from the Department of Social Security to local authority social services completed. Community care expenditure will then lose its protected status and become dependent on the calculation of the standard spending assessments and the spending priorities of local authorities. It is important, however, that the resources available for community care at that point should be related more closely to population needs than to the past distribution of provision.

Currently there are wide variations between local authorities in the availability and use of residential and community care for elderly people. Although this is likely to influence the ability of the corresponding health authorities to meet the needs of their elderly population, these variations are not taken into account in determining weighted capitation in the NHS. Data from the 1991 census indicate that the proportion of the population aged 75 years and over in the shire counties in non-NHS residential and nursing homes ranged from 6·1% in Cambridgeshire to 12·8% in

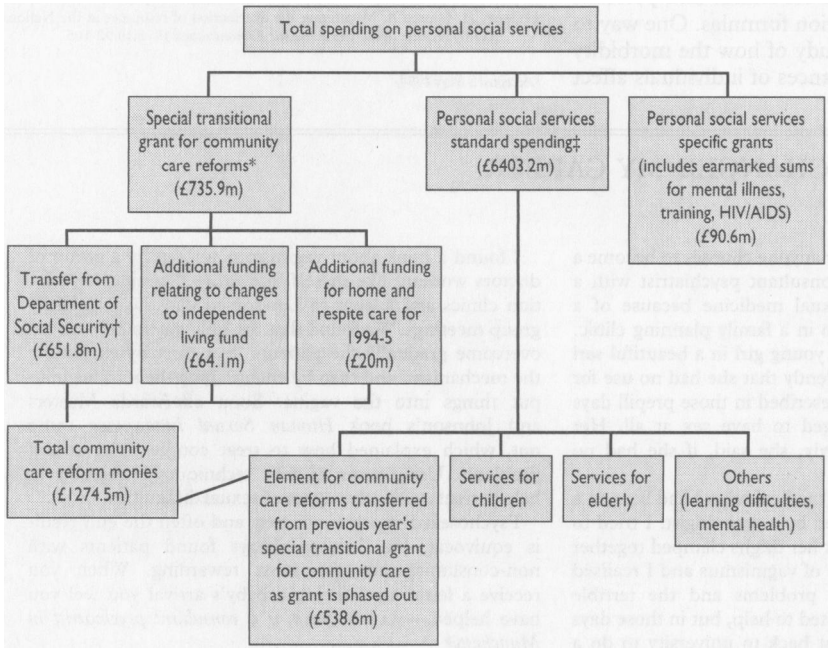


FIG 3—*Planned total English local authority personal social services current expenditure 1994-5 from central government sources*[3 14]

**To be phased out in 1996-7 and incorporated into personal social services standard spending.*

†An estimated £1830m will continue to be spent directly by the Department of Social Security in 1994-5 to support people in residential care or nursing homes. By 1996-7 all this spending will have been transferred to local authorities and will become part of personal social services standard spending.

‡This money forms part of local authorities' rate support grant allocation and is therefore not earmarked specifically for personal social services. It represents the amount that the government calculates would be appropriate for local authorities to spend to provide a standard level of service.

Devon. In metropolitan areas the range was even wider, from 2·2% in the City of Westminster to 17·0% in Sefton.[15]

A similar story of local variations could be told in relation to many local authority social services. The key point is that observed differences are not obviously related to relative needs and that they have virtually no relation to NHS resource allocation. Fair access to health and social care resources in different areas is more than simply a matter of administrative neatness. NHS care is generally free at the point of use, whereas local authority provision and the fee subsidy to residential care of elderly people are both usually means tested. It is patently inequitable if where a person lives dictates whether free or means tested care becomes available to them.

The way ahead

None of these various mechanisms that are used to distribute health and social care resources respond adequately to the underlying needs of different communities which give rise to demands on the health and social care system as a whole. Moreover, there is no guarantee that an area which is deficient in resources in one sector is compensated by more resources for complementary services in another. In fact, the opposite is more likely. The piecemeal approach to resource allocation almost certainly exacerbates inequalities in access to health and social care.

We suggest that two different forms of action are required to improve the situation. The first is for improved research. At its most basic level, descriptive research should be undertaken to chart the distribution and use of personal social services, hospital and community services, family health services and other resources in relation to a range of need indicators. Do allocations and provision reinforce or mitigate inequalities and is this effect the same in all areas? Very few studies have looked at these issues.[16] Those that have are generally confined to the NHS at regional level and are more than 20 years old.[17-19] More fundamental research should also be undertaken to improve the measures of population need for health and personal social services used in capitation formulas. One way to do this would be a cohort study of how the morbidity and socioeconomic circumstances of individuals affect their needs for and use of health and social care.

The second requirement is to find a satisfactory way of bringing together the different sources of funding into a unified weighted capitation system at a single level of aggregation. This would expose the most significant inequalities in the present system and allow central policymakers to choose the most convenient way of tackling them. At the same time it would allow local decision makers to adjust the balance of services in ways which best reflect the opportunities and constraints on service development in their areas. A start would be to fund all or part of the activities of family health services authorities through some system of weighted capitation. Whatever way the systems of health and social services resource allocation evolve, resources should be matched to the relative needs of populations. Without this, geographical equity cannot be achieved.

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A PATIENT WHO CHANGED MY CAREER

The girl in the sari

Have you ever wondered how anyone chooses to become a sex therapist? I became a consultant psychiatrist with a special interest in psychosexual medicine because of a patient I met many years ago in a family planning clinic. The door opened and a slim young girl in a beautiful sari came in. She explained diffidently that she had no use for one of the diaphragms we prescribed in those prepill days because she had not managed to have sex at all. Her marriage might be in jeopardy, she said, if she had no children.

The only mention of sex in medical school had been in a lecture on sex hormones given by a pathologist. I tried to do a vaginal examination, but her thighs clamped together tightly. She was my first case of vaginismus and I realised my ignorance about sexual problems and the terrible distress they can cause. I wanted to help, but in those days there was no training. I went back to university to do a Diploma in Psychological Medicine, but there was little mention of sex even in that.

The patients were usually quite interested in sex, and could often be aroused and responded to orgasm from clitoral stimulation. But they had a phobic anxiety about penetration.

I found a book about vaginismus written by a group of doctors working like myself in Family Planning Association clinics and I went to London to join the fortnightly group meetings. We found that the best way to help was to overcome gradually the patients' fear, first by explaining the mechanism, and then by encouraging them to begin to put things into the vagina. Soon afterwards Masters and Johnson's book *Human Sexual Inadequacy* came out, which explained how to treat couples with sexual problems. Using some of their techniques I was able to help patients with other types of sexual difficulties.

Psychosexual work is not easy and often the end result is equivocal, but I have always found patients with non-consummations the most rewarding. When you receive a letter announcing a baby's arrival you feel you have helped.—MAY DUDDLE *is a consultant psychiatrist in Manchester*

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