Scottish Executive Health Department

FAIR SHARES FOR ALL

A Short Guide to the Report of the National Review of Resource Allocation for the NHS in Scotland

Consultation arrangements for the report of the National Review of Resource Allocation for the NHS in Scotland

This is a short guide to the full report of the National Review of Resource Allocation for the NHS in Scotland, which is a consultation document on which responses are invited at any time until 14 November 1999, the final date for receipt of comments.

Requests for copies of the full report, and any written comments and questions, should be sent to:

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Following the completion of the consultation period the First Minister of the Scottish Executive will make a decision on the proposals, taking into account comments received.

In the interests of openness copies of the responses received will be made available on request to the public, unless respondents indicate that they wish all or part of their reply to remain confidential. In such cases the confidentiality of responses will be strictly respected.

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Fair shares for all: short guide

1. Introduction

1. The National Review of Resource Allocation was established by the Government in December 1997 as part of its programme of renewal for the NHS in Scotland (NHSiS), outlined in the Health White Paper *Designed to Care* (December 1997). The Review has the following remit:

> *To advise the Secretary of State for Scotland on methods for allocating the resources available to the National Health Service in Scotland, including both primary and secondary care, which are as objective and needs-based as available data and techniques permit, with the aim of promoting equitable access to health care; and to bring forward recommendations to Ministers by June 1999.*

These terms make clear that the Review has been tasked with looking at ways of sharing out among Scotland's regions the available annual Scottish Health budget. ***The size of that budget and the ways in which each region spends its share are outside the Review's remit.***

2. The Review has been independent of Government and overseen by a Steering Group chaired by Professor Sir John Arbuthnott, Principal and Vice-Chancellor of Strathclyde University. It has looked at revenue spending on hospital and community health services, general medical services (GP services), and GP prescribing of drugs – its proposals therefore cover some 80% of the NHSiS' total annual budget.

General background

3. Each year the Scottish Executive Health Department shares out the available revenue resources for the NHSiS in block allocations among Scotland's 15 area Health Boards. Each Board then decides how to spend its allocation to deliver healthcare to its local population through a range of local health services.

4. This Review has been asked to devise the fairest possible method of sharing out the available budget among the 15 Boards. To do this the Review has sought to measure the varying levels of need for healthcare from one Health Board population to another.

5. Some 61% of the current Health budget is already distributed through a weighted formula called SHARE. This calculates each Board's need for resources on the size and nature of its population. However SHARE is now over 20 years old and requires updating. It is also limited because it covers only the hospital and community health services share of the overall Health budget.

6. The Review has therefore developed a new formula which, by including the budgets for GP prescribing and primary care (GP) services as well as the spend on hospital and community health services, is more comprehensive than SHARE and therefore more equitable (although it does not extend to general dental services, general ophthalmic services, chemists' remuneration, or a number of budgets allocated centrally from the Scottish Executive Health Department). This formula is now recommended to the Scottish Executive as the preferred method for sharing out the Health revenue budget among Scotland's Health Boards.

Key principles underpinning the Review's recommendations

7. Among the Review's key principles are *equity* (each Health Board should receive its fair share according to its need for resources); *objectivity* (the formula for sharing out resources should, as far as possible, be evidence-based); *transparency* (the workings of the formula should be reasonably transparent to the non-expert); and *practicality* (the formula should be easily updateable year-on-year). In applying these principles the Review has sought to minimise the amount of assumption and judgement used to develop its formula, while maximising the evidence base.

Building a responsive formula: the key elements

8. The formula has four key elements, which echo those adopted by SHARE:

a) First, a measure of the size of each Health Board's population.

b) Second, an adjustment to account for the profile of each Board's population in terms of age and sex.

c) Third, an adjustment to reflect the needs arising from ill health (morbidity) and life circumstances (such as deprivation, poverty and ethnicity) in each Board's population, over and above the needs arising from the size, age and sex of each local population.

d) Finally, an adjustment to reflect the unavoidable excess costs of delivering healthcare in rural and remote areas of Scotland.

The care programmes

9. The formula is divided into eight different healthcare programmes: acute hospital services; mental illness services; care of the elderly; maternity services; specialist services for people with learning disabilities; community health services; GP prescribing; and general medical services delivered from GP practices. Figure 1 shows how much was spent last year on each of these programmes.

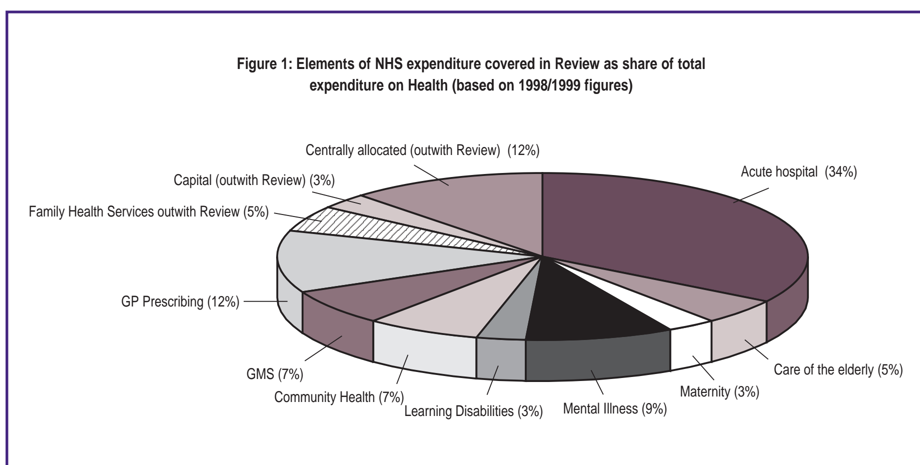
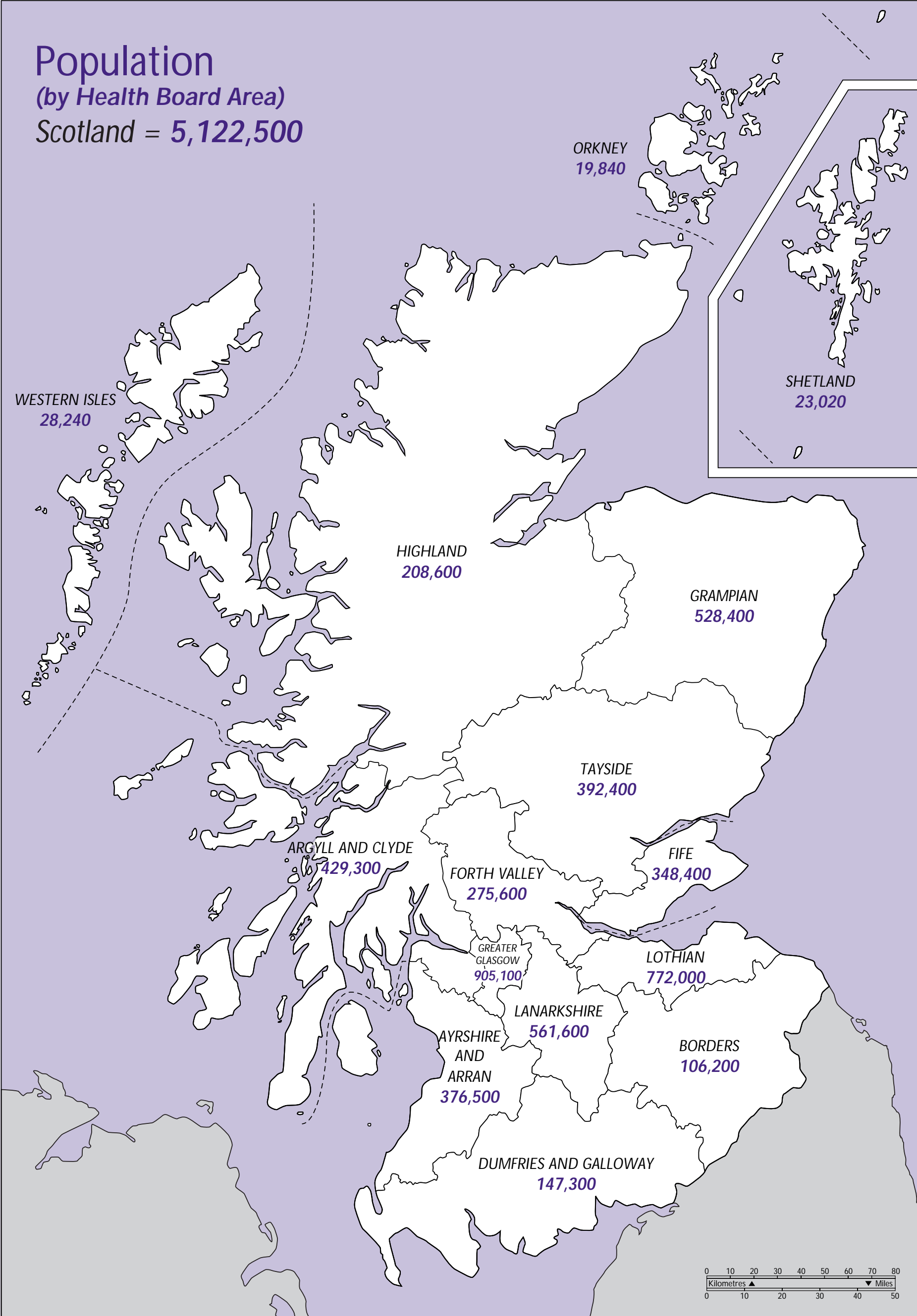


Figure 1: Elements of NHS expenditure covered in Review as share of total expenditure on Health (based on 1998/1999 figures)

2. Measuring the size of the population

10. The primary determinant of a Health Board's need for health resources is the size of its population. All other elements of the formula are adjustments to this measure.

Health Board Populations



11. The map on page 4 shows the extreme variation in Scotland's distribution of population, from Greater Glasgow (population 905,100), one of the UK's most densely populated health authorities, to Orkney (19,840), the least populous. This pattern is far from static. For example, Greater Glasgow's population has been steadily declining, from around £1.1m in 1974 to 0.91m today, whereas Grampian's population has increased from 0.45m to 0.53m over the same period. Current trends suggest that these movements will continue - it is projected, for example, that Argyll and Clyde's population will decline by 4.6% between 2000 and 2010, while Highland's will increase by 2.56% over the same period.

12. Most population measures are based on the ten-yearly Census, last taken in 1991. Having taken advice from the General Register Office of Scotland, which is responsible for the Census records, **the Review recommends that mid-year population estimates should be used as an annual measure of the population size**. These estimates are the best available annual updates of the census figures, taking into account births, deaths and population shifts between Health Boards.

3. Measuring the age and sex of the population

13. The second element of the formula adjusts for the age and sex profile of each Board population. This is important because people of a certain age (for example the very old and the very young) tend to require more Health resource than others, as do women of child-bearing age. Therefore a Board with, for example, a more elderly population than the national average will have a greater requirement for resources and this needs to be reflected in the allocation of funds.

14. For each care programme the formula splits Board populations by sex and into a number of age bands (generally ranging from 0-4 years to the over 85 year-olds). It allocates resources according to the resulting age-sex profile exhibited by each Board.

15. This adjustment includes various refinements, accounting for aspects such as:

- the higher rate of inpatient care required by a more elderly population, compared to the greater scope for less costly daycase treatment in a younger population;
- the varying costs of different specialties (for example, cardiac surgery costs considerably more than ear, nose and throat surgery), which are practised more in some age bands than others and can vary by sex;
- the length of time spent in hospital, which varies according to age (the elderly tend to have longer stays).

4. Measuring the relative morbidity and life circumstances of the population

16. As well as reflecting the size, age and sex of Boards' populations the formula also takes into account the relative morbidity and life circumstances of those populations in determining the amount of funding they should receive.

17. Although difficult to measure directly, morbidity is associated with a number of measures which can be used as *indicators* of ill health. SHARE took one of these, the death rate for those under 65, as a general indicator of relative morbidity – Boards with a higher than average death rate were deemed to have greater morbidity in their populations than those with a lower than average rate.

Using indicators of morbidity and life circumstances

18. Many morbidity indicators are closely related to differences in lifestyle (such as smoking, diet and exercise) which in turn are closely linked to underlying life circumstances. Above all there is a strong link between morbidity, mortality and deprivation, so Boards with higher levels of deprivation in terms of unemployment, housing, education, physical environment, dependency, crime and so on, will tend to have more ill health in their populations than Boards with less deprived communities. Much of the deprivation in Scotland is concentrated in certain areas, and this element of the formula makes efforts to ensure that resources are directed to these areas.

19. The Review has improved on SHARE by identifying, as well as the early death rate, over 50 other indicators of ill health, grouped into factors such

as morbidity and mortality (for example, the proportion of adults reporting a permanent sickness in the Census), social circumstances (for example, lone parent households), deprivation (for example, unemployment), housing (for example, rate of owner occupation), ethnicity, and remoteness. It has then identified the needs arising from morbidity and life circumstances in each Board by finding which of these indicators are most strongly related to the local use of health services, after adjusting for the effects of the existing supply of services (see paragraph 23) in each care programme. This approach is illustrated below:

Unemployment rates and the proportion of overcrowded households are two indicators which may have some influence on the pattern of health service use across Health Boards. For example, unemployment rates have a strong link with the use of hospital mental illness services (insofar as the local use of mental illness services rises sharply with increases in local rates of unemployment) – this indicator is therefore deemed to have a relatively strong influence on the resource needs of that care programme.

On the other hand, local rates of overcrowded households do not have a strong link with the use of hospital mental illness services - that indicator has therefore not been taken into account in measuring the relative need for such services. The result is to direct more resources for hospital mental illness services to Boards with high rates of unemployment, on the basis that unemployment is a strong indicator of relative need for those services.

20. In most care programmes several different indicators show significant links with the use of services. In each programme these indicators have been amalgamated to form an *index* which reflects the relative need arising from the morbidity and life circumstances in each Health Board.

21. Programmes were sub-divided into disease-specific groups, each with its own index, where these offered a more precise reflection of need (for example, the mental illness programme was sub-divided into schizophrenia, dementia, substance mis-use, non-psychotic conditions and other conditions). For some care programmes a review of previous research studies was used to

examine a smaller group of indicators known to be closely associated with morbidity in those particular areas of healthcare. The relative merits of each of these approaches were tested by the Review for each care programme.

22. It should be noted that for any given care programme Boards with an *above* average level of morbidity must necessarily be balanced by those with a *below* average level of morbidity; this means that while some Boards will receive a greater share of resources, others will see their relative share decreased.

Factors influencing the use of services

23. There are two influences on the use of services which need to be accounted for when using the method explained in paragraphs 18-22:

> Supply: The use of health services is influenced by their proximity as well as by the morbidity of the population. For example people in remote areas may make less use of health services because of the greater difficulties faced in travelling to those services. In order not to understate the health need which exists in such areas a technical adjustment is made to ensure that as far as possible the formula measures the variation in underlying health need rather than simply echoing the variation in availability of services.
>
> Inequalities in healthcare: There is evidence that some population groups – more deprived communities, rural communities, or minority ethnic groups - may not make as effective use of available services as others, despite having similar degrees of ill health. This seems likely to have resulted in inequalities of healthcare.
>
> An approach based on past use of services may not adequately reflect the needs of these groups. This problem has been carefully considered by the Review, which intends - on completion of the period of public consultation and following further research - to bring forward firm recommendations on a further adjustment which might be made to the formula to direct extra resources towards Boards where inequalities in healthcare need to be tackled.

Morbidity and life circumstance indices across the care programmes

24. Paragraphs 18 to 23 described the method adopted by the Review to account for health needs arising from each Board's morbidity and life circumstances. The resulting needs indices for each care programme are as follows:

Acute hospital care programme

25. Different indices are proposed for six different disease groups (circulatory diseases; cancer; respiratory diseases; diseases of the digestive system; injuries and poisonings; and other diseases). These indices comprise 22 indicators of need for acute hospital services, including markers of mortality (early death rates); deprivation (eg, local rates of unemployment, benefits claimants, local rates of overcrowding); and social dependency (eg, local rates of lone parent and single carer households).

Mental illness programme

26. Different indices are proposed for five different disease groups within mental illness services (schizophrenia, dementia, non-psychotic conditions, substance misuse and other miscellaneous conditions). These include 14 indicators of social dependency (eg, lone parent households), deprivation (eg, unemployment), mortality (early death rates), ethnicity (households of South East Asian origin), remoteness (proportion of people living in urban locations), housing conditions (people living in non-self contained accommodation, such as bedsits etc), and people reporting an illness in the Census.

Care of the elderly

27. An index comprising 8 indicators is proposed. These include indicators of mortality (early death rates), deprivation (eg, income support claimants) and social dependency (eg, people living alone over the age of 75; lone parent families with dependent children).

Maternity programme

28. An index is proposed comprising two indicators – people living in non-self contained accommodation (bedsits etc); and children in lone parent

families. It should be noted that most of the need in this care programme is expressed in the pattern of the birth rate across Boards, which is picked up as part of the measure of the female population and its age profile.

Specialist services for people with learning disabilities

29. An index comprising three indicators is proposed – limiting long-term illness reported in the 1991 Census returns; dependents in single-carer households; and the proportion of income support claimants aged under 65.

Community health services programme

30. An index is proposed (based on data for district nursing and health visiting) comprising 10 indicators of social class (heads of households in manual classes), density (people living in urban locations, number of residents per hectare), deprivation (eg, unemployment) and ethnicity (households of Chinese, certain Asian and other ethnic groups). It is proposed that this index, which is based on the district nursing and health visiting services, should be applied across the entire community services care programme, given the lack of data available for developing separate indices for the other parts of the programme.

GP prescribing

31. Different indices are proposed for six different drug categories which make up the GP prescribing programme. These are: digestive drugs; circulatory drugs; drugs for mental illness; drugs for infections; drugs for musculoskeletal and joint diseases; and other drugs not covered by the other categories. These indices include 9 indicators of deprivation (eg, income support claimants, unemployment), social dependency (households with dependents cared for by a single carer) and ethnicity (heads of households born in the New Commonwealth).

General medical services

32. Different indices are proposed for seven different disease groups (respiratory; musculoskeletal; mental and behavioural disorders; circulatory disease; disease of the nervous system, eye, ear and mastoid process; disease

of the skin and subcutaneous tissue; and other conditions). These comprise 15 different indicators, including markers of deprivation (eg, unemployment, benefit claimants) and social dependency (eg, elderly people living alone, children in lone parent households).

5. Measuring the excess costs of remoteness

33. The final element of the formula is an adjustment to reflect the excess costs of delivering healthcare in remote areas. Scotland has some of the remotest geography in Europe, reflected by a crenated coastline and a large number of inhabited islands separated from health facilities elsewhere. These factors bring special challenges to the delivery of services.

34. SHARE addressed these aspects through a relatively simple *sparsity index,* based on the distance patients live from their local GP. This applied only to a small part of the total budget. The new formula proposes a more comprehensive and sophisticated remoteness adjustment to apply to community, GP and hospital services.

Adjustment for community services

35. The adjustment seeks to reflect two key cost factors associated with rurality and remoteness:

- the **excess time** taken to deliver healthcare in rural and remote areas, for example because a district nurse will require to travel around a larger rural area (time being a more precise measure of excess costs than distance);
- the **extra skills** which rural nurses may need in order to deliver a more flexible and comprehensive service in remote areas. For example an island community separate from the nearest GP may require a multi-skilled resident nurse who can deal with a range of emergency medical procedures among her duties. This will represent an extra cost for the Health Board.

36. This adjustment would be applied to community services delivered to peoples' homes, including district nursing, health visiting, community

psychiatric nursing and midwifery services. There remain a number of clinic-based community services (such as immunisation, family planning and chiropody). These would receive the same remoteness cost adjustment as that applied to rural GP practices, which follow a similar mode of healthcare delivery and are subject to the same kind of cost factors.

Adjustment for hospital services

37. The proposed formula applies remoteness adjustments to each hospital care programme (acute, mental illness, maternity, care of the elderly, and specialist services for learning disabilities). These reflect the evidence that in remote areas (and in particular in island Boards) services are more costly to deliver because, for instance, hospitals are smaller and cannot benefit from the economies of scale enjoyed by urban services. There is also likely to be less scope in such areas for using day surgery instead of more expensive inpatient treatment, because of the longer distances that patients have to travel.

38. The remoteness adjustment is based on the difference between each Board's actual expenditure on hospital services and what these services would cost if they were provided at the average cost for all hospitals in Scotland. This highlights the difference in costs between rural and urban Boards. Rural Boards have higher costs than the national average and would receive an adjustment to their allocation accordingly.

Adjustment for general medical services (GP services)

39. Expenditure on GP services includes a number of fees, payments and allowances made to each GP practice. Some of these are related, to varying degrees, to the remoteness of the practice. The proposed formula identifies for each Health Board the proportion of the overall spend on GP practices which is influenced by remoteness. In Boards with rural and remote areas one would expect this proportion to be higher than the national average proportion. The formula then examines in each Board the relationship between this proportion and various indicators of remoteness, such as population density and the proportion of the local population living in communities of over 500.

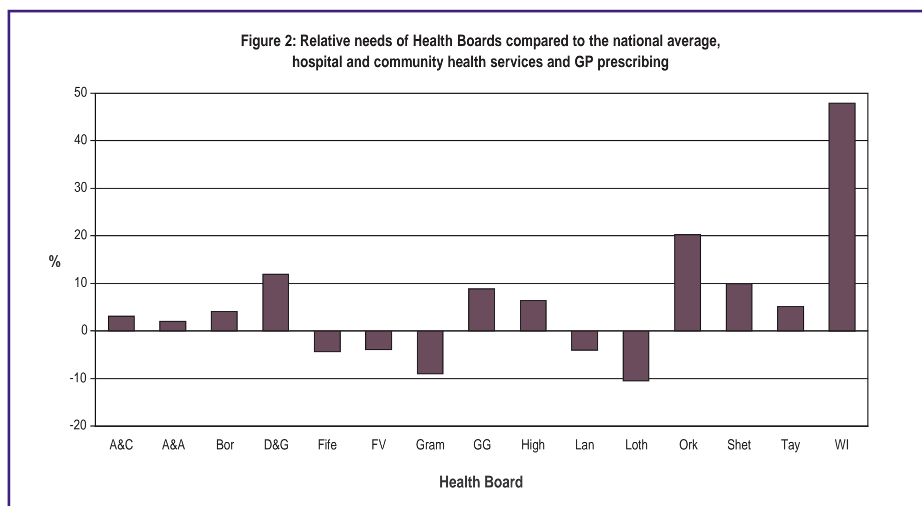
40. This analysis shows that the payments which are influenced in some way by remoteness are a significantly higher proportion of overall GP costs in

Boards with substantial sections of their populations living in rural and remote areas, compared to Boards with populations concentrated in urban communities. This calculation is used to estimate the degree to which Boards covering rural and remote areas require above-average resources, compared to the below-average costs incurred by Boards covering more urban areas.

6. Overall effect of the proposed formula on relative needs for hospital, community health and GP prescribing services

41. Figure 2 shows the overall relative need for resources indicated by the proposed formula in each Health Board for hospital, community health and GP prescribing services, compared to the national average. These range from needs which are 48.0% greater than the Scottish average in Western Isles to needs in Lothian which are 10.5% below the average.

Figure 2: Relative needs of Health Boards compared to the national average, hospital and community health services and GP prescribing



42. Table 1 shows the breakdown of these relative needs for each of the different elements of the formula and, in the final column, how these needs translate into changes from Boards' current allocations (including, in the case of the island Boards, extra allowances which have been awarded to top up the SHARE formula in recognition of their particular needs).

43. These changes show that at one extreme Western Isles' current allocation is 7.2% below what it should receive according to its assessed health

needs; at the other extreme Shetland's current allocation is 6.4% greater than indicated by its assessed needs. Of the mainland Boards Lothian, which currently receives an allocation 4.5% in excess of its assessed needs, shows the greatest change.

Table 1: Relative needs						Impact on current allocations
Relative needs compared to the National Average due to:						
Composite Hospital and Community Health Services and GP Prescribing	Health Boards	Age/Sex Weights %	Morbidity and Life Circumstances %	Remoteness %	Total %	Changes in allocations compared with current position %
	Argyll & Clyde	0.3	2.4	0.5	3.2	-0.6
	Ayrshire & Arran	2.5	-0.2	-0.2	2.1	1.2
	Borders	10.7	-11.3	6.1	4.2	-0.6
	Dumfries & Galloway	8.0	-3.6	7.5	12.0	3.9
	Fife	1.1	-4.3	-1.3	-4.4	0.3
	Forth Valley	-0.6	-3.2	-0.2	-4.0	-0.8
	Grampian	-2.6	-9.2	2.7	-9.1	0.8
	Greater Glasgow	-0.8	14.7	-4.4	8.8	1.7
	Highland	1.7	-4.4	9.6	6.4	3.9
	Lanarkshire	-5.9	3.6	-1.5	-4.0	0.2
	Lothian	-1.4	-6.6	-2.8	-10.5	-4.5
	Orkney	3.3	-6.0	23.8	20.2	6.9
	Shetland	-3.7	-8.4	24.7	9.9	-6.4
	Tayside	5.8	-2.2	1.6	5.2	-1.6
	Western Isles	9.5	8.1	25.0	48.0	7.2

44. It is noteworthy that the changes from current allocations shown in Table 1 are less than the extremes experienced on the introduction of SHARE, which heralded changes, for example, of +39% and -16%. This reflects the fact that the movements currently proposed are largely from an existing formula-based distribution which already takes into account many of the basic factors associated with need for health resources.

45. The changes to allocations represent the corrections which each Health Board has to make from its current share (as distributed by SHARE and, in the case of the GP prescribing budget, on the basis of largely historic

patterns) in order to arrive at its new share, as indicated by its newly-assessed needs shown in Figure 2 and the first four percentage columns of Table 1.

46. For example, Lothian's total need for health resources is assessed at 10.5% below the national average. This results from having less-than-average needs in terms of the age-sex structure of its population, its morbidity and life circumstances, and its excess costs arising from remoteness. Lothian's current relative share of resource over-estimates this level of need by 4.5%; a redistribution of resource in the light of its relative needs results in a decrease of 4.5% to bring Lothian into line with its assessed needs. ***(However if the Review's recommendations are accepted this does not mean that Lothian's cash allocation would actually be reduced by 4.5% - see paragraph 54).***

7. Effect of the proposed formula on relative needs for general medical services (GMS)

47. General medical services (GP practices) are distinct from other health services insofar as they are generally delivered by independent contractors who are not employees of the NHSiS. GPs also have to respond to the demands of those on their lists who access their practices, unlike hospital and community health services, which treat only patients who have already been assessed as having a clinical need.

48. A consequence of this is that some 75% of the general medical services budget (covering GP income) is *non cash limited* (the overall amount to be spent is indicated but a cash limit is not imposed on that amount). The other 25% (covering non-GP staffing costs, most premises costs, and IT costs) is *cash limited* (capped in terms of the amount of cash available to it). It is also the case that the distribution of GP practices is not determined by the government but is a matter for the Scottish Medical Practice Committee (SMPC) to decide in consultation with the Health Boards.

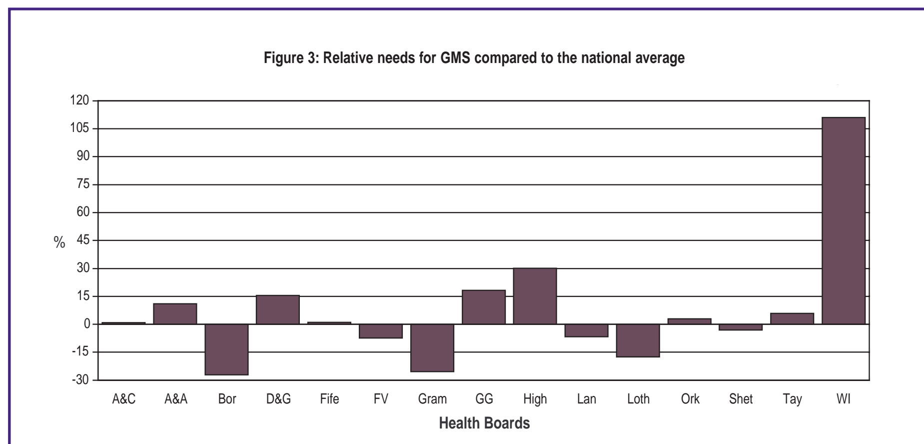
49. It is therefore recommended that:

- the proposed formula should be adopted for allocating the *cash limited resources*;

- for *non cash limited expenditure* the pattern of need identified by the Review should be used as an indicative tool, to be considered by the SMPC and Health Boards in their decisions and forward planning. The Steering Group notes that there are significant differences between the pattern of need identified by the Review and the current distribution of non cash limited resources (see Table 2 in Section 8). This raises serious questions about the distribution of these resources.

50. Figure 3 shows the overall pattern of need for both elements of GP resources as indicated by the proposed formula, compared to the national average. The island Boards have significantly above-average needs, in particular the Western Isles, which show needs 110.9% greater than the average. This results largely from significantly above-average needs arising from remoteness. Remoteness is also the key factor affecting Dumfries and Galloway and Highland, the two mainland Boards with the greatest relative needs. At the other extreme Borders, Grampian and Lothian show needs between 17% and 27% below the national average; in all three cases this is largely due to below-average needs arising from morbidity and life circumstances.

Figure 3: Relative needs for GMS compared to the national average



8. Impact and implementation

Impact

51. Table 2 shows the combined overall impact of the Review's proposals on the current distribution of resources. The three columns to the left of the table

show the impact of those elements of the formula which it is proposed should be adopted for allocating resources (hospital and community health services, GP prescribing and cash limited general medical services). The final column shows what the impact would be on the non cash limited element of general medical services; this remains indicative as any changes in this element would depend on decisions taken by the SMPC and Health Boards.

52. These figures indicate the changes required in relative shares to bring the current distribution of resource in line with the pattern of health needs identified by the Review. The changes shown in the first column of the table, covering hospital and community health services and GP prescribing, have already been discussed in Section 6. It is noteworthy that the changes to the cash limited GMS distribution, shown in the second column, are significantly greater than those shown in the first column. They range from –25.3% for Grampian to +24.3% for Lanarkshire. The disparity between the overall changes to allocations shown in Table 2 and the relative needs shown in Table 1 (and Figures 2 and 3) represents the distance which Boards have to travel to bring their shares of resource into line with their assessed needs.

Table 2: Changes in the share of resources allocated to each Health Board (1999/2000figures)

Hospital and Community Health Services (HCHS) and GP Prescribing (£3804 million)		General Medical Services (GMS) Cash Limited (£97 million)		Total (HCHS, Prescribing and GMS Cash Limited)		Health Board	General Medical Services Non Cash Limited (£265 million)	
£'000	%	£'000	%	£'000	%		£'000	%
-1,941	-0.6	909	12.5	-1,032	-0.3	Argyll & Clyde	-765	-3.3
3,343	1.2	1,228	18.4	4,571	1.6	Ayrshire & Arran	3,102	16.7
-512	-0.6	-277	-15.7	-789	-0.9	Borders	-2,349	-37.3
4,662	3.9	235	7.8	4,897	4.0	Dumfries & Galloway	193	2.2
803	0.3	405	6.5	1,207	0.5	Fife	1,997	12.4
-1,638	-0.8	-96	-1.9	-1,733	-0.9	Forth Valley	702	5.5
2,982	0.8	-2,566	-25.3	416	0.1	Grampian	-6,350	-23.7
12,022	1.7	2,195	12.1	14,216	1.9	Greater Glasgow	9,212	19.7
6,266	3.9	376	7.9	6,641	4.0	Highland	-1,479	-9.5
872	0.2	1,924	24.3	2,795	0.7	Lanarkshire	565	2.1
-23,745	-4.5	-3,171	-20.7	-26,916	-5.0	Lothian	-5,248	-13.8
1,148	6.9	27	7.2	1,175	6.9	Orkney	-751	-41.6
-1,305	-6.4	-26	-5.8	-1,331	-6.4	Shetland	-534	-31.6
-5,137	-1.6	-1,186	-13.1	-6,323	-2.0	Tayside	1,160	5.7
2,185	7.2	25	2.2	2,209	7.1	Western Isles	543	20.8

Date of implementation

53. The date on which any new formula could be implemented is subject to the result of public consultation and final decisions by Ministers. If decisions were to be taken by the end of this year then implementation from April 2000 would be possible, although this would leave Boards a relatively short time to adjust to changed allocations. The alternative would be to postpone implementation until April 2001.

Pace of change for hospital and community health services and GP prescribing

54. In order to avoid disruption to existing services it is envisaged that the movement to new share allocations (known as the movement to parity) will need to be phased in over a period of time – the speed with which that is accomplished is called the *pace of change*. The Review offers the following guidance on this matter:

- a more equitable distribution of resource should be reached as soon as practicable. Given the size of the proposed changes one would expect parity to be achievable within, say, six years;
- assuming that the overall Health budget will continue to grow year-on-year the movement to parity should avoid reducing any allocations, by shifting resources on the basis of *differential growth* – that is, by awarding above-parity Boards with smaller rates of growth than below-parity Boards, until parity is reached by all. In this way the re-distribution of resources would be achieved by ***a general levelling up of allocations,*** whereby all Boards could continue to enjoy some real terms growth;
- the pace of change should be reviewed year-on-year to ensure that it can respond to annual changes in the overall growth in the Health budget and to any changes in Boards' local circumstances.

Pace of change for cash limited general medical services (GMS)

55. In considering the pace of change in moving to the new parity for cash limited GMS the principles outlined in paragraph 54 apply. However the Steering Group advises that a **longer period of transition** should be applied

to this particular element of the formula, given the relatively large changes in relative shares arising from it.

Maintenance and development of the formula

56. The Review recommends that a standing group should be appointed to review the formula and advise on its maintenance and longer-term development in the light of advances in techniques and data, and taking into account the results of research into areas such as inequalities of healthcare.

Recommendations for further work

57. The Review considers that these proposals represent the best possible evidence-based approach currently available. It also recognises that there will always be considerable scope for developing a more precise allocation of resources as fresh data and expertise emerges. Bearing this in mind it has identified the following key areas of further work which it believes could yield considerable benefits in the future:

- *research into issues relating to inequalities of healthcare provision.* As mentioned at paragraph 23, the Review intends after the period of public consultation to bring forward firm recommendations for making an adjustment to the formula to address the different levels of inequality in healthcare existing among Health Boards. In the longer term it also recommends that the Chief Scientist's Office of the Scottish Executive Health Department should make this area, where the evidence base is currently rudimentary, a priority for research funding;
- *development of more comprehensive and robust epidemiological data on morbidity* to provide more direct evidence on the incidence of disease in the population;
- *further examination of the possibility that a Market Forces Factor may have a material effect in Scotland;*
- *development of more comprehensive data on activity in general medical services and community health services, and on the excess costs of delivering services in rural and remote areas.* These are all areas where data sets are considerably less robust than in the acute hospital sector.

9. Conclusions

58. This Review has sought to address some of the biggest questions around the funding of the Health Service in Scotland: How do we share out over £4 billion of public money per year? How do we measure the need for healthcare that exists around Scotland? How do we address in the distribution of resources the links between deprivation and ill health in seeking to tackle inequalities in provision?

59. It has not been an easy task. The Review has spent 18 months looking across the widest range of options to arrive at the best possible set of evidence-based recommendations for distributing resources, striving always to achieve equity of access for the individual according to his or her needs.

60. In conclusion the Steering Group wishes to emphasise the following points:

- This Review has been about the distribution of resources to Health Boards, not about funding specific services or institutions directly. Boards have well-established mechanisms for investing funds outside their own territories, for example to provide specialist services to their residents that are not available locally. In this way resources which are re-distributed as a result of this Review may well find their way back to services provided in other Board areas.
- Scotland has some renowned centres of medical excellence which are important to the overall well-being of the Health Service in Scotland. These are of benefit to all the people of Scotland and not just to the residents of the Health Boards in which they are sited. The Steering Group is sure that the Scottish Executive recognises the worth of these centres and the importance of health expenditure outside the remit of this Review which is distributed through allocations that in large part benefit these centres of teaching and research.

61. Some readers of this guide and the full report may be tempted to identify "winners" and "losers" among the Health Boards. Only in a narrow sense can this be the case. In a wider sense all Scotland wins if a more equitable distribution of resources for all the country's citizens can be achieved - that is the real prize of delivering *fair shares for all.*