Department of Health

Equality Impact Assessment: PCT Resource Allocations 2011-12

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Equality Impact Assessment: PCT Resource Allocations 2011-12

Prepared by DH Financial Planning and Allocations Division

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Introduction

The Department of Health allocates revenue funding to Primary Care Trusts (PCTs) on the basis of the relative size and relative needs of their populations. These allocations are based on a formula which aims to allow PCTs to commission similar levels of health services for populations with similar needs. The formula is known as the weighted capitation formula and an updated and revised formula has been developed to inform 2011-12 allocations to PCTs. The revised formula is covered in this equality impact assessment. An earlier equality impact assessment for resource allocations to PCTs in 2009-10 and 2010-11 was published in December 2008[1].

PCT allocations

Introduction to PCT allocations

In December 2010 the Department of Health announced revenue allocations to PCTs for the financial year 2011-12 based on an updated and revised weighted capitation formula. Under these allocations, PCTs will receive a total of £85 billion, representing over 80% of the total NHS revenue budget. These are known as recurrent allocations. There are also separate allocations of around £4 billion for certain services, such as dentistry and support for joint working between health and social care, which are not based on the weighted capitation formula.

From their recurrent allocations, PCTs fund general practices, NHS hospitals and other community and public health services. Each PCT is given a single total recurrent allocation. The allocations are not broken down into separate blocks each of which can only be used for a particular type of service: rather it is for PCTs to determine how best to use their resources to meet their local needs and priorities, within national standards and the direction and requirements set out in the Department of Health's Operating Framework for the NHS.

The national weighted capitation formula is used to calculate PCTs' target shares of resources. Target shares are in proportion to each PCT's population weighted, or indexed, by need (such as that due to the age distribution of the population) and unavoidable variations in the costs of providing healthcare

[1] Available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/index.htm

services between different geographical areas across England. Pace of change policy determines how far PCTs are moved towards their target allocations each year and thus determines their actual revenue allocations each year.[2]

The principle of a weighted capitation formula was established in 1976 following the *Report of the Revenue Working Party (RAWP)*. RAWP interpreted its terms of reference as being: "to reduce progressively, and as far as feasible, the disparities between the different parts of the country in terms of the opportunity for access to health care of people at equal risk"[3]. As well as this goal of equitable access to healthcare for all, in 1999 the objective was added that the weighted capitation formula should also contribute to the reduction in avoidable health inequalities.

Local commissioning

As described above, resource allocation determines each PCT's share of the available revenue resources as a single budget not broken by programme area. The deployment of their funding through the commissioning of health care services for their local populations is a matter for PCTs.

As public bodies, PCTs and other NHS organisations have a statutory obligation to meet the general and specific duties of the Equality Act 2010. The main provisions of the Act came into force in October 2010 and the public sector equality duty will come into force in April 2011. The public sector duty covers age, disability, gender reassignment, pregnancy and maternity, race religion or belief, sex and sexual orientation, which are known as the protected characteristics. All public bodies must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation,
- advance equality of opportunity, and
- foster good relations between those who share a relevant protected characteristic and those who do not.

This general duty is underpinned by specific duties to help public bodies meet the general duty.

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[2] Further information on the application of the weighted capitation formula can be found in the forthcoming Resource Allocation Weighted Capitation Formula (Seventh Edition) and pace of change in the forthcoming 2011-12 Exposition Book. These will be available at www.dh.gov.uk/allocations.

[3] Department of Health and Social Security (1976) *Sharing Resources for Health in England*, Report of the Resource Allocation Working Party, HMSO, London

In addition, the Department and the NHS aim to reduce inequalities between people from different socio-economic groups. NHS organisations are also bound by the Human Rights Act.

PCTs are expected to use information from Joint Strategic Needs Assessment and other local planning tools to take account of the needs of different population groups and communities.

Advisory Committee on Resource Allocation

The Advisory Committee on Resource Allocation (ACRA), as in previous years, has overseen the development of the weighted capitation formula used to inform PCT revenue allocations in 2011-12. ACRA is an independent expert body whose membership includes individuals with a wide range of relevant experience and expertise from within, and outside, the National Health Service (NHS).

In carrying out the revisions to the weighted capitation formula for 2011-12, and incorporating the latest data, ACRA commissioned independent research into a number of elements of the funding formula. This research is published on the Department's website[4].

Allocations in future years

The White Papers *Equity and excellence: Liberating the NHS (Cm 7881)* and *Healthy Lives, Healthy People: Our strategy for public health in England (Cm 7985)* set out the intention that, subject to the approval of Parliament, in the future the new NHS Commissioning Board will determine allocations to the new GP consortia, PCTs will be disestablished and there will be a separate budget for Public Health England. Public Health England will include a focus on reducing health inequalities. During the transition period, the Department will continue to make allocations to PCTs.

[4] Available at www.dh.gov.uk/allocations

Revised weighted capitation formula

The weighted capitation formula

The main elements of the weighted capitation formula, as in previous years, are:

- the population base – a count of the population each PCT is responsible for in terms of funding health care
- an adjustment, or weight, for a higher need for health care services due to age (areas with more elderly populations receive higher allocations, all else equal)
- an adjustment, or weight, for additional need for health care services over and above that due to age (areas with poorer health, correlated with deprivation, receive higher allocations, all else equal), and
- an adjustment, or weight, for unavoidable differences in the costs of providing health care services due to geographical location – the Market Forces Factor (areas where the cost of living, land etc are higher receive higher allocations, all else being equal).

The adjustments for age related need and need over and above that due to age are the most relevant elements in relation to equality because they assess the relative funding needs for health care services of different population groups.

The adjustments for need are determined through formulae. There are separate formulae for:

- Health and Community Health Services (HCHS), which in turn has separate need formulae for general and acute services, maternity, mental health, and HIV/AIDS
- prescribing, and
- primary medical services.

The need formulae for general and acute, maternity, HIV/AIDS and primary care services are unchanged from those used for 2009-10 and 2010-11 PCT allocations. A new formula has been developed for mental health and a revised formula for prescribing.

HCHS is by far the largest component, accounting for 79% of the overall weighted capitation formula. Prescribing accounts for 11% and primary medical services 10%. Within HCHS, general and acute services account for 78%, maternity 5%, mental health 16% and HIV/AIDS 1%.

In terms of the other elements of the weighted capitation formula, the population base used in the formula is comprehensive and, as in previous years' allocations, is GP registrations constrained to the latest Office for National Statistics' (ONS) population projections. The purpose of the Market Forces Factor is to equalise the commissioning power of PCTs by adjusting for unavoidable variations in provider (Foundation Trusts, NHS Trusts, primary care or PCT) costs directly related to location, and reflects geographical differences in market rates of pay, land prices and buildings' costs.

Calculation of the need formulae

The need formulae for HCHS and prescribing were informed by independent research commissioned by ACRA: the *Combining Age Related and Additional Needs (CARAN) Report*[5] for general and acute and maternity, and the *Report of the Resource Allocation for Mental Health and Prescribing Project (RAMP)*[5] for mental health and prescribing. The formula for primary medical services continues to reflect the new GMS contract.

Potential health need cannot be observed directly. Age related need is estimated from the national average use of health care services by age group, The use of different types of services are weighted together based on their relative costs.

The formulae for additional need over and above age for general and acute, maternity, mental health and prescribing are estimated using statistical modelling. The modelling estimates relative need from the relationships across small geographical areas[6] in England between the use of health care services and the population and other characteristics of those small areas. Population characteristics include, for example, the age distribution within

[5] Available at www.dh.gov.uk/allocations
[6] ONS's Middle Level Super Output Areas (MSOA) for general and acute and maternity, Lower Level Super Output areas for mental health, and GP practices for prescribing

each small area and other characteristics include, for example, relative deprivation. The modelling of utilisation takes account of the types of services used and the relative costs of each type of service, as measured by the NHS national reference costs and other sources.

The modelling considers a wide range of need characteristics that potentially influence utilisation of health care services. For general and acute, initially a starting set of 358 potential needs indicators was considered, which was reduced to 59 for the actual modelling. These variables are listed in Annex A. The initial set was reduced to 59 on the basis of statistical criteria and face validity[7].

The sub-set of variables used in the preferred models are set out in Annex B. They were selected on the basis of statistical criteria relating to the statistical significance of each characteristic and the statistical goodness of fit of the overall model.

Most of the characteristics used in the modelling are indicators of need rather than direct measures of need, and as such are indicators of the underlying determinants of need. The modelling was necessarily limited to considering those characteristics for which consistent data are available for every small area.

DFLE adjustment

ACRA believed the current statistical modelling of need captured met need better than previous models. However, as the model is based on the utilisation of health care services, it captures the NHS's response to need and existing levels of health inequality. ACRA felt the modelling did not adequately address the objective of contributing to the reduction in avoidable health inequality, and that at present it is not technically possible to do so in an approach based on current patterns of utilisation.

To target allocations towards areas with the worst health outcomes, ACRA recommended a separate formula. This uses the measure Disability Free Life Expectancy (DFLE), which is the average number of years a new born baby is expected to live which are free of limiting long standing illness. ACRA recommended that the separate formula is based on the difference in DFLE in each PCT from a benchmark of 70 years.

[7] See Appendix 7 of the CARAN report.

ACRA considered a number of ways of determining the possible weight that might be given to the DFLE adjustment. However, due to lack of evidence ACRA concluded that it is not currently technically possible to determine the cost of reducing health inequalities between PCTs in a way that could be used to inform allocations. Therefore, no technical way of assessing how much weight should be applied to the DFLE adjustment compared to the utilisation formulae, could be found. Ultimately, ACRA considered the weight to be applied to the DFLE adjustment to be a ministerial decision.

Ministers decided to give a weight of 10% to the DFLE adjustment in the weighted capitation formula used to inform 2011-12 allocations. Ministers judged that until further work on allocations to GP Consortia and the Public Health Service has been completed, a weight of 10% provides the appropriate balance to ensure that funding for work on health inequalities, including public health, continues and that funding to support access to healthcare, and to respond to the need for healthcare, is sufficient. The weight for 2009-10 and 2010-11 was 15%. A weight of 10% is within the range first discussed by ACRA when considering the weight to be attached to this adjustment.

Population groups

The weighted capitation formula has a high potential to benefit equality. The formula is based on relative needs between different populations.

Age

The weighted capitation formula includes very clearly the different needs by age group, primarily the greater use of health care services by older age groups, and the significantly greater use by the oldest age groups. This is captured for acute services by separate models for each of 18 age groups. For prescribing, mental health and primary medical services, there is a two stage approach. The first stage uses the age-cost curve - the average cost of use of health care services by each age group. The second stage uses statistical modelling to estimate additional need over and above the age–cost curve.

Gender

The formulae for prescribing and primary medical services directly take account of the differential usage of health care services by gender in each age group. The age-cost curve is more precisely defined as the age/gender-cost curve. Additional needs are modelled over and above the age-gender cost curve.

The general and acute formula is based on age groups rather than age-gender groups. This was to make the estimation of the models practical by limiting the number different groups - 18 age groups versus 36 age-gender groups. In the analysis for general and acute, it was found that age is a much more important predictor of utilisation of health care services than gender. Maternity health care needs are modelled separately.

There are separate formulae for mental health for working age and older adults. Within these two formulae, consideration in the future will be given to using age/gender groups rather than age groups in the formula.

Disability

The aim of the formula is to equalise allocations relative to health needs across PCTs, and therefore directly reflect need due to disability. There are a number of variables in the formulae directly related to disability, such as the number of disability allowance claimants and the proportion of the population

with limiting long term illness, health problem or disability (see Annex B). A number of the other factors included in the formula are also likely to be correlated with disability.

Mental health is a separate component of the overall weighted capitation formula in order to reflect the specific need for mental health care services.

As described above, there is a separate DFLE adjustment accounting for 10% of the overall formula. This is based on the measure disability free life expectancy. The disability free element is based on the question in the 2001 Population Census ‘Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?’

Ethnicity

The statistical modelling considered in depth the inclusion of ethnicity variables. Ethnicity variables did not emerge through the selection of variables to be included in the models on the basis of statistical criteria, except for the working age mental health formula, which includes the proportion of the population who describe their ethnic group as Black Caribbean or Black African.

The CARAN research team attempted to include in the general and acute models data on the proportion of the population in each of seven ethnic groupings (see Annex A), and all these groups combined. However, these did not generally emerge as statistically significant. In addition, adding the ethnicity variables to the models made little difference to the variability or range of the overall need indicators between areas. Furthermore, no plausible pattern was found for the statistical significance, or positive or negative sign of the ethnicity variables between consecutive age groups. On the basis of these findings, ethnicity variables are not included in the final formulae[8].

There are a number of possible interpretations of this finding. These may include that the association between ethnicity and use of health services is being identified through other variables in the models, and that there are issues about access to services that could not be identified through modelling of utilisation.

Data on ethnicity for small areas are from the 2001 population Census. Analysis using these data show a weak, positive association between ethnicity and 2011-12 allocations per head. An increase in the proportion of

[8] See CARAN report, e.g. sections 9.5.5 and 12.5

those in the 'non-white'[9] ethnic groups is associated with a slight increase in allocation per head (as is also the case for an increase in the proportion from Black and Asian ethnic groups). However, as stated above, this finding could be driven by other factors included in the formula associated with ethnicity, such as age or deprivation. For example, a PCT with a high proportion of 'non-white' residents could also be relatively more deprived and the latter would result in a higher allocation as deprivation is captured in the formula.

Religion or belief

The formulas do not include variables related to religion or belief. There is a lack of comprehensive data on patients' use of heath care by religion or belief. Delivery of services by the NHS at the local level is important to advance equality of opportunity by religion or belief.

Sexual orientation

The formulas do not include variables related to sexual orientation. There is a lack of comprehensive data on patients' use of heath care by sexual orientation. Delivery of services by the NHS at the local level is important to advance equality of opportunity by sexual orientation.

Socio-economic disadvantage

PCTs with greater socio-economic disadvantage are also likely to have higher levels of deprivation. The formulae include a number of indicators of deprivation (see Annex B) which were found to be statistically significant and resulted in higher allocations per head for relatively more deprived areas. The formula results in the 10% most deprived PCTs (measured by the Index of Multiple deprivation, 2007) having allocations per head of around one-third higher than the 10% least deprived PCTs, little changed from 2009-11.

[9] 'Non-white' includes to the following ethnic groups from the 2001 Census: Mixed: White and Black Caribbean, White and Black African, White and Asian or Other Mixed; Asian or Asian British: Indian, Pakistani, Bangladeshi or Other Asian; Black or Black British: Black Caribbean, Black African or Other Black; Chinese or Other Ethnic Group.

Monitoring and Review

NHS organisations are bound by the equality duties set out in legislation. They have a duty to monitor their own performance, and in addition the Care Quality Commission assesses performance.

This equality impact assessment will be reviewed as part of the review of the allocations formula that will be undertaken for resource allocations in the future to PCTs and, subject to Parliamentary approval for their establishment, GP Consortia.

Annex A: Measures assessed for inclusion as indicators of additional need for general and acute formula

- ONS. Birth rate. 2001-5
- 2001 Census. Percentage of residents in non NHS Communal establishment, 2001
- Administrative data. Proportion claiming Disability Allowance, 2005
- Administrative data. Proportion under 16 claiming Disability Allowance, 2005
- Administrative data. Proportion 60-69 claiming Disability Allowance, 2005
- Administrative data. Proportion over 60 claiming Disability Allowance, 2005.
- 2001 Census. Percentage of people aged 16-74 who are permanently sick / disabled, 2001
- ID2004. Percentage of young people not staying in education, 2001
- 2001 Census. Proportion Indian, 2001
- 2001 Census. Proportion Pakistani, 2001
- 2001 Census. Proportion Bangladeshi, 2001
- 2001 Census. Proportion Black Caribbean, 2001
- 2001 Census. Proportion Black African, 2001
- 2001 Census. Proportion Chinese, 2001
- 2001 Census. Proportion Non-white, 2001
- ONS. Generalised fertility ratio, 2001-5
- ID2004. Households central heating Indicator, 2001
- 2001 Census. Proportion lone parent with dependent children, 2001
- ONS. Proportion of live births born in the home or outside of a communal establishment, 2001-5
- Administrative data. Mean house price for all dwellings, 2005
- Administrative data. Proportion claiming Incapacity Benefit/Severe Disability Allowance, 2005
- ID2004. Education, skills and training deprivation domain, 2001
- ID2004. Employment deprivation domain, 2001
- ID2004. Living environment deprivation domain, 2001
- ID2004. Health deprivation and disability domain, 2001
- ID2004. Income deprivation domain, 2001
- ID2004. Income deprivation affecting children, 2001
- ID2004. Income deprivation affecting older people, 2001
- Administrative data. Proportion claiming income support, 2005
- Administrative data. Proportion claiming Jobseeker's Allowance + New Deal

for Young People + New Deal for the Long Term Unemployed, 2005

- Administrative data. Proportion claiming Jobseeker's Allowance, 2005
- 2001 Census. Proportion with limiting long-term illness, 2001
- 2001 Census. Standardised limiting long-term illness, 2001
- 2001 Census. Proportion aged 16 and over separated (but still legally married), 2001
- 2001 Census. Proportion aged 16 and over divorced, 2001
- 2001 Census. Proportion aged 16 and over widowed, 2001
- 2001 Census. Proportion aged 16 and over separated or divorced or widowed, 2001
- ID2004. Mental Health Indicator, 2001
- ONS. Proportion of live births over the period 2001-2005 born to mothers aged over 40, 2001-5
- Administrative data. Proportion claiming New Deal for Young People, 2004
- Administrative data. Proportion claiming New Deal for the Long Term Unemployed, 2004
- 2001 Census. Proportion reporting not good health and LLTI – standardised, 2001
- 2001 Census. Households with one person aged 65 and over with LLTI and no carer, 2001
- 2001 Census. Persons aged 75 and over living alone, 2001
- Administrative data. Proportion aged over 60 claiming Pension Credit, 2005
- ONS. Proportion of births that are low birth weight, 2001-5
- 2001 Census. Proportion aged 16-74 with no qualifications, 2001
- ONS. Standardised birth ratio, 2001-5
- ONS. SMR, all ages, 2001-5
- ONS. SMR, 0-64 years, 2001-5
- ONS. SMR, 0-74 years, 2001-5
- 2001 Census. Proportion in lowest occupation grade, 2001
- 2001 Census. Proportion in lowest social grade, 2001
- 2001 Census. Standardised proportion aged 16-74 with no qualifications, 2001
- 2001 Census. Proportion of all people in households in owned houses, 2001
- 2001 Census. Proportion of all people in households in social rented houses, 2001
- 2001 Census. Proportion of all people in households in private rented houses, 2001
- ONS. Proportion of live births over the period 2001-2005 born to unmarried mothers, 2001-5
- ONS. Years of Potential Life Lost Indicator, 2000-2003

Source: Combining Age Related and Additional Needs (CARAN) Report, Appendix 8.

Annex B: Additional need indicators included in final models

Table B1: General and acute

	0-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	20-24 yrs	25-29 yrs
Age specific death rate	X	X	X	X	X	X
Standardised no qualifications	X	X	X			X
Young people not staying in education				X	X	
Standardised limiting long term conditions				X	X	
Pension credit claimants						
Low birth weight births	X					
IMD 2004: income deprivation affecting children	X	X				
Disability Living allowance claimants under 16			X			
New Deal for Young People claimants						X
Disability Living Allowance claimants						X
Incapacity Benefit/Severe Disability Allowance claimants						
Disability Allowance claimants over 60						

Table B1: General and acute continued

	30-34 yrs	35-39 yrs	40-44 yrs	45-49 yrs	50-54 yrs	55-59 yrs
Age specific death rate	X	X	X	X	X	X
Standardised no qualifications	X		X	X	X	X
Young people not staying in education		X				
Standardised limiting long term conditions		X	X	X	X	X
Pension credit claimants				X	X	X
Low birth weight births						

	30-34 yrs	35-39 yrs	40-44 yrs	45-49 yrs	50-54 yrs	55-59 yrs
IMD 2004: income deprivation affecting children						
Disability Living Allowance claimants under 16						
New Deal for Young People claimants	X					
Disability Living Allowance Claimants	X					
Incapacity Benefit/Severe Disability Allowance claimants		X	X			
Disability Allowance claimants over 60						

Table B1: General and acute continued

	60-64 yrs	65-69 yrs	70-74 yrs	75-79 yrs	80-84 yrs	85+ yrs
Age specific death rate	X	X	X	X	X	X
Standardised no qualifications	X			X	X	
Young people not staying in education						
Standardised limiting long term conditions	X					
Pension credit claimants	X	X	X	X	X	X
Low birth weight births						
IMD 2004: income deprivation affecting children						
Disability Living Allowance claimants under 16						
New Deal for Young People claimants						
Disability Living Allowance claimants						
Incapacity Benefit/Severe Disability Allowance claimants						
Disability Allowance claimants over 60		X	X			X

Source: Combining Age Related and Additional Needs (CARAN) Report, Table 14.5.

The symbol X in a cell indicates the characteristic was included in the final model.

B2: Prescribing

The following variables are used over and above age and gender.

- LISI (Low Income Scheme Index) for GP practices, 2008
- Share of those aged over 75 years who are aged over 85 years
- Proportion claiming Disability Living Allowance, 2008
- Standardised Mortality Ratio (SMR), 2004-2008
- Generalised fertility rate, 2004-2008
- Age standardised prevalence of coronary heart disease (CHD), 2007
- Age standardised prevalence of diabetes, 2007
- Age standardised prevalence of hypertension (CHD), 2007

Source: RARP 35 Report of the Resource Allocation for Mental Health and Prescribing (RAMP) project, Table 3.2.

B3: Maternity

The following variables are used:

- Number of births
- Proportion of births that are low birthrate
- Mean house price

Source: Combining Age Related and Additional Needs (CARAN) Report, Table 17.5.

B4: Mental Health

The following variables are used over and above age.

Working age adults

- Incapacity Benefit/Severe Disability Allowance with mental health diagnosis
- Standardised Mortality Ratio (SMR) where a mental health condition is recorded (excluding dementia)
- Proportion of population who describe their ethnic group to be Black Caribbean or Black African

Older adults

- Standardised Mortality Ratio (SMR) where a mental health condition is recorded

- Proportion of population aged 60+ that are single pension claimants
- Income deprivation affecting adults

Source: RARP 35 Report of the Resource Allocation for Mental Health and Prescribing (RAMP) project, Tables 2.12 and 2.13.

B5: HIV/AIDS

The following variables are used.

- Number diagnosed with HIV
- Cost of treatment
- For prevention, the number of 15-44 year olds

Source: Resource Allocation: Weighted Capitation Formula, Seventh Edition, Department of Health

B6: Primary Medical Services

The following variables are used over and above age and gender.

- Standardised limiting long term illness
- Standardised mortality ratio for those aged under 65

Source: Resource Allocation: Weighted Capitation Formula, Seventh Edition, Department of Health