PRIMARY CARE ALLOCATIONS

INTRODUCTION

1. The proposed primary care formula is based on:

   a. primary medical care - the Carr-Hill formula which is also the contractual basis for global sum payments to GP practices;

   b. primary dental services – the number of patients using NHS services by age, gender and IMD of patient’s place of residence, combined with national average gross costs for each of these groups. A deduction is made for patient charges at Area Team level;

   c. pharmaceutical services – in proportion to the prescribing component of the CCG formula;

   d. ophthalmic services – no formula is proposed as spend is relatively small and absence of appropriate data.

2. The purpose of the formula is to allocate 2014-15 primary care budgets for the 25 Area Teams, who will hold a single budget for all these services together. Area Teams will have flexibility to allocate funds to each service as they see fit, within the constraints of their contractual commitments. The Mandate states “The Government expects the principle of ensuring equal access for equal need to be at the heart of NHS England’s approach to allocating budgets. This process will also need to be transparent, and to ensure that changes in allocations do not result in the destabilising of local health economies.”

3. ACRA asked TAG to consider the primary care formula and this paper feed backs TAG’s views.

ACTION FOR ACRA

4. ACRA is asked for:

   • its views on the proposed formula following TAG’s comments;
   • what recommendations it wishes to make to NHS England on the primary care formula, and what caveats it wishes to include.

OVERALL APPROACH

5. At the last meeting ACRA recognised that limited time had been available to develop a formula and the formula therefore used the best sources currently available. ACRA supported the proposed approach as a pragmatic, evidence based solution for 2014-15, and agreed further development work is required for future years. Caveats ACRA raised also included the lack of time to develop options and develop other data sources; the data currently available are not ideal and do not cover all primary care services (for example, the Carr-Hill formula
covers a proportion of primary medical care services); and the formula represents primary care as currently delivered and not how it may be delivered and contracted in the future. TAG agreed with this view, noting also that the data in the primary medical formula are dated though it is not practical to update for 2014-15, and that there are no supply variables in the formula.

6. In line with the Mandate, the aim of the formula is to support equal access for equal need. The Carr-Hill formula, the prescribing formula used for pharmaceutical services and the dentistry formula all have an adjustment for age and an additional adjustment for need over and above age, and are based on current NHS unit costs for cost weighting activity (eg costs by age and IMD for dentistry and the Carr-Hill formula is a key component of GP practice pay under nGMS). Both the Carr-Hill and prescribing formulae are based on detailed statistical modelling by academic researchers - details of the modelling work undertaken for the Carr-Hill formula are in RARP 27 GMS Contract Workload Formula and RARP 28 An Analysis of the Factors Predicting GP Consultations: a Small Area Analysis Using Health Survey for England Data, and for the prescribing formula in RARP 35 Report of the Resource Allocation for Mental Health and Prescribing (RAMP) project¹.

7. Contractual commitments are reflected to a high degree in the proposed formula since they reflect workload which is based (though not necessarily fully) on need, and current unit cost are used to weight activity. It would be expected that further consideration of contractual commitments would be included in pace of change policy.

8. The prescribing formula is the same as ACRA agreed for use in the CCG formula, and is very similar to that in the former PCT formula. The Carr-Hill formula was also the basis of the primary medical care formula in the PCT formula.

9. For ACRA’s information, it is likely that NHS England will consider making an adjustment to the primary care formula for unmet need and health inequalities, and this will use the same measure as for the CCG formula – the SMR<75 as weighted in the public health formula.

SPECIFIC ISSUES CONSIDERED BY TAG

10. TAG was asked if the number of new registrations, average distance from practice and population density variables be included in the Carr-Hill formula for primary medical care.

11. These variables are included in the Carr-Hill formula but were not included in the adapted Carr-Hill formula used in the primary medical care component of the PCT formula. The modelling underpinning the Carr-Hill formula found new registrations were statistically significant on workload (there were higher consultation minutes) and average distance to practice and population dentistry

were found to be statistically significant in modelling GP expenses having controlled for factors such as the age and deprivation structure of the population.

12. TAG had no strong views on a technical basis whether these variable should be included. TAG felt if the purpose of the primary medical care formula is to model workload then the three variables should be included, but if the purpose is to model need it is arguable the variables should be excluded as there is limited evidence they reflect need or unavoidable costs. TAG noted excluding the variables gives a slightly better model fit compared with expenditure as measured by the higher R-squared statistic, but current expenditure is not necessarily the same as need. TAG felt distance to provider may be closer to a supply variable than a measure of unavoidable cost, as it partly reflects past decisions on the location of practices, and if so should be excluded. There are also interactions between the different funding streams i.e. changing one could influence demand for services funded through another.

13. Removing these variables would reduce the allocation in the more rural ATs by up to 2.6%. Given this is an interim formula, there may be advantages in retaining these variables while work for a formula for future years is developed. There are larger issues surrounding the reliability of the primary care formula. What are ACRA views on the including these variables in the primary medical care formula?

14. TAG was asked its views on uplifting the dental weighted populations to take into account of those who tried but were unable to access NHS dentistry.

15. The dental formula is based on people who currently use NHS dental services. It is possible to make an approximate adjustment based on survey data to uplift the formula to take into account those who have tried, but were unsuccessful, in getting an NHS dental appointment in the past 2 years. There was a general consensus at TAG for an unmet need adjustment but this adjustment on its own does not take into account poor dental health (which is related to deprivation), those who did not try to access dentistry at all, and those who did not try to access NHS dentistry as they believed no dentists were available. TAG felt that a policy steer is needed on the priorities for improving access to NHS dentistry. Do ACRA agree that without a policy steer it is not possible to recommend whether the dental formula includes an adjustment for those who have tried but were unsuccessful in accessing NHS dental services.

OVERALL PRIMARY CARE MODEL

16. The primary care model has seen the following updates since presented at the last ACRA meeting in September:

- we have updated the dental services formula to take into account IMD;
- the individual weighted populations of GP, dental and pharmaceutical services and now weighted together in line with final month 6 forecast spend

17. Figure 1 shows a scatter plot of target allocations per head (based on final month 6, 2013-14 plan primary care spend) against IMD by AT. On the vertical axis, the
level of deprivation increases the higher the point on the axis. The model correlates reasonably well ($R^2 = 0.556$) but a number of ATs have high deprivation scores and relatively low spend per head, and vice versa. Figure 2 shows distance from target plotted against IMD.

**Figure 1**

*Primary Care model - 2013-14 target spend per head vs IMD score*

$R^2 = 0.5569$

**Figure 2**

*Primary Care model - % distance from target vs IMD score*

$R^2 = 0.3546$

NHS England
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