THE SCOTTISH OFFICE
Department of Health

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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG
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Dear Colleague

**GUIDANCE ON SETTING GP FUNDHOLDER ALLOTTED SUMS FOR 1996/97: THE NATIONAL FRAMEWORK**

**Summary**

1. This guidance is principally directed at Health Boards and GP Fundholders and sets the framework within which GP Fundholders' allotted sums should be set for 1996/97. The guidance differs in style and content from that issued in previous years in concentrating on principles and keeping detailed advice on methods to a minimum. This approach has been adopted so that refinements and variations, consistent with this national framework, can be agreed locally between Health Boards and GP Fundholders.

2. However, the guidance issued for 1995/96 (NHS MEL(1994)99) remains a reference point for budget-setting. As in previous years the benchmarks for the HCHS element have been calculated using, as far as possible, the national weighted capitation formula (SHARE) methods. The benchmarks for 1996/97 however, incorporate 3 main developments in the method of calculation (further details are given in Appendix 1):

i) Last year's guidance stated that further work would be undertaken during 1995/96 with a view to testing the possibility of extending the use of weighted capitation benchmarks into the area of outpatient services. This work has now been completed, and benchmarks for outpatient services are included;

ii) For inpatient and daycase services, the calculation of benchmarks has taken greater account of the variation in need for resources due to differences in the age and sex composition of practice populations; and

**Addressees**

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For information:
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Enquiries from GP fundholders should be to the Health Board

File Ref:

iii) Differences in relative need for resources per head caused by variations in morbidity over and above age and sex have been allowed for by incorporating the 0-64 Standardised Mortality Ratio 0-64 SMR) for each practice.

3. It should be noted that in calculating these benchmarks, Health Board average prices by specialty for 1994/95 have been used. If Boards wish to use some other set of prices - e.g. if there is a reason to believe that prices for procedures included in the fundholding scheme have changed relative to those not included in the scheme since 1994/95 - then some adjustments to the benchmarks will be required.

4. The setting of alloted sums should take place on the basis of shared information between Health Boards, providers and GP Fundholders with the continuing aim of establishing fair budgets. The timetable to which all parties to the budget-setting process should adhere is set out in this year's "Priorities and Planning Guidance for the NHS in Scotland" (NHS MEL(1995)51).

**Action**

4. General Managers are asked to ensure that copies of this guidance are distributed to Directors of Finance and GP Fundholding Liaision Officers and that copies are issued to all existing and prospective GP Fundholders in their Board area.

5. Health Board staff should use this guidance as the framework within which to set GP Fundholder alloted sums for 1996/97.

AGNES ROBSON
Director of Primary Care

ANNEX A

# GUIDANCE ON SETTING GP FUNDHOLDER ALLOTTED SUMS FOR 1996/97: THE NATIONAL FRAMEWORK

## Introduction

1. This document sets out the national framework within which GP Fundholder budget-setting should take place. It applies to both the - staffing and HCHS components of fundholders budgets.

2. Health Boards are reminded that they are required by statute (the NHS and Community Care Act (1990) which amends the NHS (Scotland) Act (1978)) to "make arrangements for the setting of allotted sums for GP Fundholders determined in such manner and by reference to such factors as the Secretary of State may direct". Boards are therefore requested to apply consistently the principles set out in this note.

3. Health Boards have responsibility for the budget-setting process, including ensuring consistency between local developments and the national framework. However, within the national framework, Health Boards and GP Fundholders are best placed to work together to implement budget-setting procedures which are informed by local knowledge.

4. The guidance on setting budgets for 1995/96, issued under NMS MEL(1994)99, contained a fairly detailed description of the basic national method for GP Fundholder budget-setting. That document remains a valid point of reference for setting budgets for 1996/97, and is not repeated here. Instead, this document concentrates on the principles of budget-setting, so that refinements and variations, consistent with this framework, can be agreed locally by Health Boards and GP Fundholders.

5. This national framework therefore first explains the **principles** that should guide the budget-setting process, including those which should underpin moves towards budget-setting based on relative need. It then lists the **factors** which may be taken into account, and outlines the **specific responsibilities** of the various parties involved in the process.

## Principles

6. The principles of the budget-setting process are:

### Equity

- budget-setting should take place with the continuing aim of establishing budgets which are fair (in terms of allocating resources) to the populations cared for by both Fundholding and non-Fundholding GPs, within available resources;

- budget-setting at practice level should take account of moves towards capitation targets for HCHS set by the Management Executive for each Health Board and other relevant factors such as local service developments (eg moves towards community-based services);

- the pace of change towards weighted capitation targets should be agreed with Fundholders and should be based on achieving a reasonable pace of change over a feasible timescale;

**Effective communication**

- GP Fundholders should be fully involved in developing local approaches to budget-setting;

- GP Fundholders and Providers should be involved from the start of the process. The timetable defined in "Priorities and Planning Guidance for the NHS in Scotland: 1996/97" (NHS MEL(1995)51) and their respective responsibilities (see paragraph 17 below) should be recognised and adhered to by all parties;

**Robust information**

- good quality and timely information is vital to the success of the budget-setting process. Relevant data (e.g. historic activity; benchmarks; provider prices etc) should be shared with local GP Fundholders, as soon as they are available;

- early, firm prices should be established by providers on the basis of notified purchasing intentions and forthcoming Costing for Contracting guidance.

**Moves towards budgets based on relative need**

. The overall policy objective is that resources should be allocated between different populations based on relative need, so that there is equal opportunity of access to health care for all, regardless of where they live or whether they are registered with a Fundholding or non-Fundholding GP practice. The policy objective of moving GP Fundholder budgets towards a pattern of resource allocation based on relative need is thus identical to, and wholly consistent with, the policy objective of the national weighted capitation (SHARE) formula, which is used to distribute HCHS resources to Health Boards. Since its inception, guidance on Fundholder budget-setting has been consistent with this principle.

9. The moves towards a more needs based approach to Fundholder budget-setting began in 1993/94 with the issuing of weighted capitation benchmark allocations for inpatient and daycase services by ISD. These benchmarks were calculated using the general approach employed in the national SHARE formula, except that Health Board-specific age-sex weights and costs were used in place of national average values. This method has been followed again for 1996/97, but for the first time similar benchmarks - based on the national SHARE approach, but using Health Board-specific data - are being introduced for outpatient services. The intention is that, as it becomes feasible, local benchmarks will be made available across the full range of services, within the scope of the Fundholding scheme. In addition, the methods of calculating benchmarks for inpatients and daycase services will be kept under review. Comments on the methods used this year and suggestions for future improvement should be directed to either Karen Hancock, Economics and Information Division, SO Department of Health or Mike Muirhead of ISD.

9. Moving towards more needs-based budget-setting for practices requires reductions in unjustifiable variations in budgets per capita between practices. However, there may be many legitimate reasons for variations in per capita budgets between practices. In addition, many of the variables which govern legitimate variations are not easily measured.

10. For these reasons, it would not be appropriate:

i) to use a wholly mechanistic, formula-driven approach to setting individual practice budgets; nor

ii) to seek to move practices over too short a time-period away from historic funding and towards an assessed fair share of resources. Rather, health Boards should be sensitive to the possible influence of local factors which may be hard to capture in benchmark formulae. Proposals that seek to reduce historical differences in the use of services (i.e. referral and prescribing behaviour) that cannot be explained by factors attributable to the relative needs of practice patients or to local differences in the way those needs are met, should be accompanied by realistic pace of change policies agreed with local GPs.

11. In developing and agreeing local pace of change policies, Health Boards and GP Fundholders should begin by seeking to establish, as far as possible, the reasons for the historic variations between GPs' practices in their patients' use of NHS services. These variations may results from a range of factors such as:

- differences in the health needs of the population, including:
  - ✳ demography:
  - ✳ relative morbidity;
- well-established differences in the way these needs are met, including:
  - ✳ extent of facilities locally available for inpatients;
  - ✳ accessibility of services;
  - ✳ levels of private medical insurance cover;
- differences in clinical practice.

12. There will also remain genuine differences of view among GPs about the most clinically appropriate and cost-effective referral and prescribing practices. Because of this it would not be appropriate to seek to eliminate all variations suddenly. Nevertheless, over time, it is appropriate for each practice to receive funds more according to an objective assessment of its patients' needs, relative to those of other practices, whilst allowing each practice to decide how those resources can best be used on its patients' behalf.

13. While taking forward the budget-setting process, Health Boards and GP Fundholders should also collaborate in developing risk-sharing and appropriate financial management methods to ensure that any changes are implemented smoothly and without adverse consequences.

**Factors determining budgets**

14. Budget-setting must be conducted taking into account such factors as the Secretary of State directs, and these are listed below. However, within this framework, Health Boards and GP Fundholders have flexibility to agree which factors to use, the weighting given to each, the pace of change policy, and the details of the information collections and definition.

15. The factors which may apply to both staff and HCHS components of the budget are:

- the total Health Board allocation;
- previous budgets and previous spending and activity of the practice;
- comparative information for the whole Health Board;
- evidence from practices on planned developments;
- local strategies for health service developments; and
- size and characteristics of the practice list.

16. In addition, the following factors may be used for individual elements of the budget:

**HCHS element:**

- Practice benchmarks on activity or cost;
- actual or local average provider prices;
- any other indicators related to need, demand morbidity or local supply of HCHS services;
- risk management arrangements involving the practice.

**Staff element:**

- to be calculated consistent with the method for the reimbursement of non-Fundholder costs for GMS staff.

**Specific responsibilities**

17. The Management Executive expects Health Boards, Providers and GP Fundholders to work constructively together, in the best interests of all patients and the local community. In particular:

**Health Boards** will be responsible for:

- liaising with local providers and GP Fundholders to collect robust information, reconciling any differences between GP and provider collected data;
- sharing information relevant to the budget-setting process with local GP Fundholders as soon as it becomes available;

- obtaining early, firm prices from providers, seeking justifications for any significant changes from previous years or significant differences from Board or national averages;

- assessing the impact of year-on-year changes in provider tariffs and taking account of these where appropriate;

- agreeing budgets with practices, within available resources, which are fair to both the patients of Fundholding GPs and non-Fundholding GPs in the Board, in the light of previous budgets, historic and benchmark information, changes in provider prices (where relevant) and any other factors listed in paragraph 16;

- resolving budget-setting issues between themselves and GP Fundholders and/or between GP Fundholders and Providers;

- making final budget offers to practices by February 1996.

**Providers** will:

- work with Health Boards and GP Fundholders to establish robust information to support budget-setting;

- work with Health Boards and GP Fundholders to produce prices to the timetable in the Priorities and Planning Guidance on the basis of notified purchasing intentions and in line with forthcoming Costing for Contracting Guidance.

**GP Fundholders** will:

- work with Health Boards to continue to develop an approach to budget-setting that is fair to the patients of all GPs in the area;

- signal to Health Boards and to providers any major purchasing shifts - to the timetable in the Priorities and Planning Guidance - to assist with provider pricing and local service planning;

- work with Health Boards and providers to establish robust information to support budget-setting;

- try to reach early agreement with Health Boards on budgets.

**Ensuring fairness**

18. Methods adopted by Health Boards in determining GP Fundholder budgets which follow the principles of this national framework set out in paragraph 6 above will be considered fair, provided that the Boards' approach has been agreed with local GP Fundholders.

**Appendix 1**

## WEIGHTED CAPITATION BENCHMARKS FOR INPATIENT, DAYCASE AND OUTPATIENT ACTIVITY FOR GPFH PRACTICES, 1996/97

1. Each Health Board's GP Fundholding Liaison Officer will be supplied with weighted capitation benchmarks for HCHS inpatient, daycase and outpatient activity within the scope of the extended Standard Fundholding scheme which becomes effective from April 1996. This note explains the calculation of the benchmarks and illustrates their presentation and use with hypothetical figures for an imaginary Health Board.

2. The benchmarks are issued in the form of a weighted percentage of population for each of inpatients, daycases and outpatients, together with an overall composite weighted population for each practice. A set of sample benchmarks for a hypothetical set of 6 practices in a hypothetical board is attached as Tables 1 and 2. All non-FH practices within a Board are aggregated and designated "other" in the Tables. However, benchmarks for individual non-FH practices will be available, if required, from Mike Muirhead of ISD, Tel: 0131-551-8972. Details of the methods used to calculate the benchmarks are given below (paras 4-7). Further enquiries about these methods should also be directed to Mike Muirhead of ISD.

### Converting benchmarks into target budgets

3. In order to convert the overall composite weighted population into a target financial allocation for each practice, Health Boards can follow one of 2 methods, depending on what data are available. The first method is the more accurate, and is preferred. The second involves an estimate of the share of total expenditure within the Health Board accounted for by services within the scope of the FH scheme:

i) If the Board knows, or can calculate, the total value of expenditure on inpatient, daycase and outpatient activity within the scope of the new scheme, whether incurred by a Fundholder or not, then a practice's benchmark allocation is obtained by applying the relevant percentage as it appears in Table 1 to the total value of that expenditure. For example, Practice no. 1's share would be 2.162%, and Practice no. 2's would be 1.544% and so on.

ii) If the Board does not know the total value of the expenditure as in (i), then a practice's benchmark allocation is obtained by applying the relevant percentage as it appears in Table 2 to the total of its SHARE (general revenue) plus capital charges plus ambulance services allocations for 1996/97 minus the value of the A&E ambulances contract which the Board has with SAS. For example, Practice no. 1's benchmark would be 0.533% of that sum.

Note: These 2 methods need not give the same answer because in order to calculate the shares in Table 2, an estimate was required of what percentage the fundholding element was as part of total expenditure. This has been made by applying the hospital and specialty-specific average cost to the hospital activity data. In other words, it has been assumed that the cost per bed-day within say General Surgery is on average the same irrespective of whether activity is fundholding or not, i.e. irrespective of whether the admission was

emergency or elective. Some Boards may find their providers use different costs for the different categories of admission. If providers charge less for elective bed-days than for emergency ones, then the target shares in Table 2 will be slightly over-estimated.

**Method of calculating benchmarks**

4. As in previous years, the method of calculating benchmarks is based as closely as possible on the national weighted capitation (SHARE) formula used for distributing HCHS revenue resources to Health Boards. The main difference from the national formula is that instead of national average costs and age/sex bed-day weights being used, these benchmarks are calculated using Health Board provider costs and age/sex weights. In addition, in comparison with last year's benchmarks, there have been 3 developments in the method of calculation:

i) for the first time, benchmarks for outpatient attendances have been calculated;

ii) the age-sex group weights have been calculated separately for each specialty, so that the method of weighting for demography is now more sensitive to differences in specialty-mix; and

iii) in order to take account of differences in morbidity between practice populations, they were weighted by an estimated 0-64 Standardised Mortality Ratio for the practice.

These developments have been introduced with the objective of making the calculation of benchmarks more sensitive to differences in relative need.

**Inpatient benchmarks**

Demographic differences between practice populations were taken into account by calculating for each specialty, age and sex-specific utilisation rates from 1992, 1993 and 1994 for elective activity within the scope of the expanded Standard scheme for each Health Board. The aggregation over 3 years is intended to minimise the effect of random fluctuations due to rates being based on relatively small numbers in some specialties and/or Health Boards. These age, sex and specialty-specific utilisation rates were then applied to the age and sex composition of each practice's patients. This gives an estimated activity level for each specialty, taking into account the differences in age and sex profiles of the practices' patients.

Morbidity differences between practice populations were then allowed for by adjusting age-sex weighted activity by a 0-64 Standardised Mortality Ratio (SMR) for each practice. The practice's SMR was taken to be that of the Local Government District (LGD) in which its patients were based. Where significant numbers of patients were in a different LGD, a weighted SMR was calculated. The weights were simply the relative proportions of the practice's list resident in the various LGDs. Weighted SMRs were calculated for the non-FH practices aggregated together. It is recognised that in using an LGD-based measure of morbidity, some quite wide differences in morbidity between practice populations are averaged-out and therefore effectively ignored. We are working on refining the index of morbidity for future years, but in the interim it is arguably more equitable to make some adjustment for morbidity differences than none at all.

A further adjustment was made to the practice's population aged 65 and over by applying the Geriatric Cost Factor (GCF) to inpatients over the age of 65. This adjustment is made - as in the national weighted capitation formula - to reflect the fact that although elderly people stay in hospital longer than younger people, the cost per bed-day is generally lower.

Aggregating the specialty groups: The age-sex, morbidity and GCF-adjusted activity rates for each of the specialty groups were weighted together to give an overall total for inpatients using the Board's estimated expenditure on each specialty derived from 1994/95 "Blue Book" specialty and provider costs (excluding the estimated provider subsidy to teaching hospitals) and SMR activity data.

The result is an age and sex cost-weighted, 0-64 SMR-weighted number of bed-days for each practice. This is expressed as a percentage of the equivalent number of bed-days calculated for the remaining practices in the Board for inpatients. Thus Practice No 1's relative need for non-psychiatric, non-obstetric (NPNO) inpatients is 2.433% of the Board's total for standard fundholding bed-days, as shown in Table 1.

**Daycase benchmarks**

5. A similar procedure was followed for daycase activity, except that no geriatric cost factor was applied.

The result is an age and sex cost-weighted, 0-64 SMR-weighted number of daycases for each practice. As with inpatients, this is expressed in Table 1 as a percentage of the equivalent number of daycases calculated for the remaining practices in the Board. Thus Practice No 1's relative need for NPNO daycases is 1.786% of the Board's total for standard fundholding bed-days, as shown in Table 1.

**Outpatient benchmarks**

6. We have produced outpatient benchmarks for the first time this year using SMR0 data on new outpatient attendances within the scope of the standard scheme. Age, sex and morbidity are taken account of for each practice in a similar manner as for daycase benchmarks.

**Composite benchmarks**

7. Benchmarks for inpatient, outpatient and daycase activity are then aggregated together using expenditure weights to give a final weighted composite population. This was done in 2 ways:

Table 1 shows the results using expenditure weights calculated from standard fundholding expenditure only by applying 1994/95 Blue Book costs by hospital, specialty and patient type within each Health Board to the relevant activity.

Table 2 shows the results calculated from using total estimated expenditure (FH and non-FH). The expenditure weights used in Table 2 are standard FH expenditure by specialty and service as a percentage of overall total expenditure, again calculated using "Blue Book" costs.

**Table 1: Populations of 6 hypothetical FH practices by service as a percentage of total for hypothetical Board (using standard FH expenditure only)**

| Practice # | Base population | % Base population | Weighted populations (%) | | | |
|---|---|---|---|---|---|---|
| | | | NPNO Inpatients | NPNO Daycases | Outpatients | Composite |
| 1 | 6,461 | 2.584 | 2.433 | 1.786 | 1.659 | 2.162 |
| 2 | 2,686 | 1.074 | 1.588 | 1.479 | 1.475 | 1.544 |
| 3 | 10,396 | 4.158 | 3.560 | 3.411 | 3.442 | 3.504 |
| 4 | 8,237 | 3.295 | 2.785 | 2.463 | 1.889 | 2.599 |
| 5 | 10,027 | 4.011 | 3.799 | 3.212 | 4.000 | 3.643 |
| 6 | 5,859 | 2.344 | 2.001 | 1.956 | 1.845 | 1.972 |
| Other | 206,334 | 82.534 | 83.834 | 88.905 | 85.690 | 84.576 |
| Board Total | 250,000 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Table 2: Populations of 6 hypothetical FH practices by service as a percentage of total for hypothetical Board (using total expenditure)**

| Practice # | Base population | % Base population | Weighted populations | | | |
|---|---|---|---|---|---|---|
| | | | NPNO Inpatients | NPNO Daycases | Outpatients | Composite |
| 1 | 6,461 | 2.584 | 0.608 | 0.429 | 0.398 | 0.533 |
| 2 | 2,686 | 1.074 | 0.397 | 0.355 | 0.354 | 0.380 |
| 3 | 10,396 | 4.158 | 0.890 | 0.819 | 0.826 | 0.862 |
| 4 | 8,237 | 3.295 | 0.696 | 0.591 | 0.453 | 0.501 |
| 5 | 10,027 | 4.011 | 0.950 | 0.771 | 0.960 | 0.897 |
| 6 | 5,859 | 2.344 | 0.500 | 0.469 | 0.443 | 0.485 |
| Other | 206,334 | 82.534 | 95.959 | 96.566 | 96.380 | 96.342 |
| Board Total | 250,000 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |