THE SCOTTISH OFFICE

NHS
MEL(1996)19

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG
26 February 1996

Dear Colleague

THE INDICATIVE PRESCRIBING SCHEME: 1996-97 ALLOCATIONS

Summary

1. This letter informs Health Boards of their Indicative Prescribing Scheme (IPS) allocations for 1996-97 and provides information on how they were determined.

Background

2. The attached Appendix sets out the framework and principles on which the allocations have been set. These reflect recommendations by a recently established (November 1995) Prescribing Allocations Review Group (PARG) to review the methodology for determining and applying IPS allocations. Annex A reports their remit and the principles they recommended for 1996-97 allocation purposes.

3. Annex B provides details of the IPS total for 1996-97 and how the uplifts and PARG recommendations have been applied in determining individual Health Board allocations. It also provides advice on the treatment of contingency sums.

Action

5. Health Boards should now set target budgets for each GP practice in their area taking account of the advice and guidance material provided.

6. As soon as practice budgets have been settled Health Boards should advise the Pharmacy Practice Division (PPD) of the target budgets for all practices in their area, and the prescribing budgets for their fundholders. Details of the total allocated to GP fundholders should also be notified to the Management

Addressees

For action:
General Manager, Health Boards

For information:
Chief Executives, NHS Trusts

General Manager, Common Services Agency

General Manager, State Hospitals Board for Scotland

General Manager, Health Education Board for Scotland

Executive Director, SCPMDE

Enquiries to:

Mr Stephen Tither
Directorate of Primary Care
Room 76
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 3096
Fax: 0131-244 2326

Executive for GPFH prescribing allocation purposes. All details for both returns should be with PPD and the Management Executive respectively no later than 31 March 1996.

Yours sincerely

AGNES ROBSON
Director of Primary Care

APPENDIX

INDICATIVE PRESCRIBING SCHEME: 1996-97 ALLOCATIONS AND MONITORING FRAMEWORK

Allocation Framework

1. A number of important principles underlie the IPS allocation process:

- patients have an entitlement to receive all the medicines they clinically require;
- the direct relationship between the Public Expenditure Survey (PES) settlement and allocations at Health Board level;
- recognition of the efforts made by many GPs to improve the quality and cost-effectiveness of their prescribing, and of the scope for further economy;
- a continuing emphasis on the personal and professional responsibility of all family doctors to prescribe optimally to ensure that, while patients receive the medicines they need, there is an appropriate balance between resources spent on medicines and other health services provided to the population locally;
- recognition that some Health Boards and GPs may need transitional support to stay within budget next year, whilst adjustments to their prescribing practices are implemented;
- the need for transparency in the allocation process.

At Health Board Level .....

2. The allocation process for 1996-97 reflects these principles. It is based on last year's allocations, with a real terms increase for all Health Boards, but also provides help on a transitional basis to those Boards who are experiencing difficulty living within their 1995-96 budget.

3. The Management Executive has already signalled a commitment to the longer term objective of basing IPS allocations on a system of weighted capitation. This year's IPS allocations introduce a step towards the goal by providing a relatively small amount of additional growth to those Health Boards whose allocations per head of resident population last year were significantly below the national average after adjusting for age and sex, populations on GP lists (adjusted for estimated list-size inflation and an indicator of underlying morbidity). Work on refining the method will continue during 1996-97 to inform the 1997-98 allocation process. The pace at which moves towards weighted capitation allocations can be made in future years will be determined by the level of resources available and the success of Health Boards, in containing expenditure within their budget.

At Practice Level ....

4. It is currently not possible to develop a wholly reliable formula for allocating prescribing resources at practice level. Health Boards will need to continue to exercise local judgements in determining prescribing allocations which meet the needs of different practices. However, in principle a Board's objectives should be to:

- allocate to each practice a fair prescribing budget taking account of the prescribing needs of its population;

- ensure equity for all patients, regardless of whether the practice is fundholding or non-fundholding;

- work with practices to promote high quality, clinically appropriate prescribing;

- continue to work closely with those practices where there is judged to be most scope to improve efficiency by more cost-effective prescribing.

6. Additionally, for fundholding practices, budget offers should follow the national framework for GPFH budget setting as set out in MEL(1995)93.

Management and Performance Monitoring of Expenditure on the Drugs Bill

7. Provision for expenditure on the drugs bill is not cash-limited. However, any overspend on the national total in a financial year raises the starting point for the following year so restricting the amount available to distribute for Hospital and Community Health Services (HCHS). Provided that all reasonable efforts are made to identify and reduce the level of clinically inappropriate prescribing, Health Board allocations for 1996-97 should be sufficient to ensure that all patients continue to receive all the drugs they need.

8. Health Boards' primary aim should therefore be to meet the clinical needs of patients whilst containing expenditure within budget provision. However, as indicated above, a number of Boards are receiving an uplift for movement towards their assessed weighted capitation share. Even after allowing for the possibility of an overspend at a similar level to that incurred on their 1995-96 allocation, the effect will be that these Boards have 'new' money for prescribing purposes. If those Boards plan to, and achieve, a full spend of that 'new' resource in an uncontrolled manner, whilst other Boards fail to live within their allocation, the result would be further inflation on the drugs bill.

9. It follows that Boards with 'new' money, and that could include Boards with no weighted capitation uplift but who expect to see earlier work on effecting prescribing efficiencies bearing fruit in 1996-97, should not automatically distribute the additional resource as a matter of course. Accordingly all Boards are strongly advised to produce plans for how, through more appropriate prescribing, they intend to manage their particular situation in order to ensure they continue to meet the clinical needs of patients whilst still exerting downward pressure on the annual rate of increase in the drugs bill.

10. Such plans should be linked to the wider strategic plans of each Health Board for the delivery of health care to its local population and, it is suggested, should include the following key areas:

- cost-effective management of prescribing resources across the primary and secondary care boundary;

- the management of new drugs in primary care;

- ensuring that practices have in place effective arrangements to review repeat prescribing;

- increasing the level of generic prescribing (and hence generic dispensing) of appropriate drugs in practices where the current level is sub-optimal.

11. Health Boards should also take into account the key policy directions set out in recent Management Executive guidance, notably:

- MEL(1995)51: Priorities and Planning Guidance for the NHS in Scotland
- MEL(1995)73: New Drugs for Multiple Sclerosis

12. **Health Boards' performance in managing their IPS allocation will be subject to review by the Management Executive through the Accountability Review process.**

ANNEX A

APPLICATION OF WEIGHTED CAPITATION PRINCIPLES TO PRESCRIBING ALLOCATIONS, 1996/97

1. Prescribing allocations to Health Boards were originally determined on the basis of the previous year's expenditure. However, there is no reason to believe that such a method of determining allocations is equitable, since the pattern of historic expenditure may be influenced by a wider range of factors than simply relative need.

2. In 1995/96, a modest element of weighted capitation was introduced into the determination of allocations (see MEL(1995)18). The weighted capitation element only took account of Health Boards' age and sex compositions. The Management Executive has already indicated that in the longer term, prescribing allocations should be informed by weighted capitation principles.

3. To assist in meeting the ME's objective, a Prescribing Allocations Review Group (PARG) was established with the following remit:

> *to review the methodology for allocating prescribing resources to Health Boards, taking account of the work done by the Department of Health's (England) Prescribing Allocations Group (PAG); and to make recommendations:-*
> *a) for prescribing resource allocations; and*
> *b) any further work required to refine a methodology for future years.*

4. PARG has therefore considered how weighted capitation principles could be applied to determining 1996/97 target allocations by drawing on the work carried out for PAG in England, commissioning a short piece of statistical work from Pharmacy Practice Division (PPD) to test out some of the English results in Scotland, and establishing what longer-term work needs to be carried out to refine the weighted capitation model used to allocate prescribing resources to Boards in Scotland for future years.

5. The weighted capitation model established by the Group to determine target allocations for 1996/97 builds on the methods used to determine target prescribing allocations in 1995/96, but also incorporates further refinements based on the work done in England, but calibrated on Scottish data. The Group however recognised that this work had a number of shortcomings and that it could provide only an interim weighted capitation model. Accordingly, the Group felt that a conservative pace of change policy towards weighted capitation targets would be appropriate for 1996/97 (Annex B), pending the results of longer-term research. This Annex provides details of the weighted capitation model used to determine target prescribing allocations for 1996/97.

Principles

6. The objective of the weighted capitation model is to allocate resources in line with relative need for them. In other words, the model is a method of calculating "fair

shares" of prescribing resources for Boards. It is important to distinguish between the fair share calculated using such a formula and the actual allocations which Boards are given. The formula calculates target shares towards which the Management Executive would expect to move Boards over a number of years, depending on the total resources available for prescribing, the distance Boards currently are from their fair budgets, and how much adjustment from their historical pattern of prescribing Boards can be expected to cope with each year. In other words, the formula is a method of calculating targets; actual allocations take account of targets, but also other factors as well.

7. Since the formula is designed to allocate resources in line with relative need, it is important to decide what factors are likely to determine relative need. In principle, the major determinants of relative need for prescribed medicines at the Health Board level are likely to be:

- the total population registered with the GPs managed by the Health Board, adjusted for list size inflation;
- the age and sex composition of the population; and
- the underlying morbidity of the population.

The following paragraphs deal with how each of these factors is allowed for in turn in the provisional weighted capitation model which the Group recommended for 1996/97.

Population

8. The Indicative Prescribing Scheme (IPS) is designed to cover the population on the GP lists of those GPs managed by each Health Board, rather than the resident population. Consequently the population basis for a weighted capitation formula has to be the patients on GP's lists. This means that for example, the population basis used for Dumfries and Galloway and Borders Health Boards includes English residents registered with GPs over the border, but excludes Scottish residents registered with GPs in England. Populations, in other words, are allocated to the Board in which their GP is.

9. The problem with using GP list data however, is that in aggregate, the total population registered with a GP exceeds the official estimates of the Scottish population (by 4.1% in 1995). Moreover, this list-size inflation varies between GP practices and between Health Boards.

10. It is not possible to measure accurately the degree of list-size inflation for each GP practice. However, an estimate can be made for each Health Board by comparing the GRO(S)'s forecasts of the resident population of each Health Board with the number of patients on GP's lists resident in that Board (whatever the Board of management of the GP). The list size inflation factors thus estimated for each Board for 1996 are as follows:

Table 1: List-size inflation adjustment factors by Health Board

Health Board	List-size inflation scalar
Ayrshire & Arran	0.968
Argyll and Clyde	0.970
Borders	0.982
Dumfries & Galloway	0.971
Fife	0.999
Forth Valley	0.965
Grampian	1.000
Greater Glasgow	0.916
Highland	0.986
Lanarkshire	0.958
Lothian	0.948
Orkney	1.006
Shetland	1.014
Tayside	0.966
Western Isles	0.984

(Note: these are calculated by applying 1996 forecast resident populations to 1995 data on list sizes by Health Board of residence. Therefore, they allow for projected changes in population between 1995 and 1996).

11. These scalars are used to adjust downwards the population on GP lists resident in each Health Board. The resulting adjusted resident population registered with GPs is then converted back to a Health Board of management basis using data on patients living in one Health Board, but registered with a GP in a different Board, supplied by ISD.

Age and sex

12. Need for prescriptions varies with the age and sex of the patient. DH (England) uses the method of ASTRO-PUs to adjust populations for age and sex. These are a set of relative cost weights for people in different age and sex bands based on research done in England. However, PPD were able to provide a set of age and sex cost-weights from Scottish data. The 2 sets of weights are similar, but not exactly the same. The Group considered the relative merits of using the ASTRO-PUs and the Scottish age and sex cost weights. It was felt that, on balance, the Scottish weights offered the following advantages:

- The weights were based on the pattern of prescriptions written in Scotland, and were therefore more relevant; and
- The Scottish weights could be updated each year to reflect changes in prescribing practice, whereas ASTRO-PUs are fixed.

However, the Group also felt that it was important to investigate further, and if necessary improve, the stability and robustness of the Scottish weights for future years.

13. PPD's analysis provides an estimate of the national average relative Gross Ingredient Cost (GIC) per capita by age and sex bands. The relative cost of a patient

in each age and sex group, compared with a female patient aged 5-15 (the cheapest patient) is shown in the following table:

Table 2: Relative GIC per head by age and sex-group (relative to females aged 5-15)

Age Band	Male	Female
Under 2	1.7	1.2
2-4	1.2	1.2
5-15	1.6	1.0
16-24	1.3	2.3
25-44	2.3	3.0
45-59	5.3	7.4
60-64	5.3	10.6
65-74	10.0	9.6
Over 74	13.3	13.1

14. Medical Prescribing Advisers (MPAs) may find these age and sex relative cost weights useful in determining fair budgets at practice level. Work on improving the robustness of these weights and investigating their stability is in hand. Depending on the outcome of this work, it may be possible to update these weights in time for next year's allocations.

Morbidity

15. Work carried out for PAG in England has determined that the best proxy for morbidity, as it relates to need for prescribing resources, is the proportion of the population of working age who are unable to work owing to permanent sickness, as measured in the 1991 Census. This is can be argued to be a proxy measure of the excess self-reported morbidity, over and above that due to the effects of age and PAG felt it had a degree of plausibility as a proxy for morbidity differences among FHSAs. This variable accounted for about 54% of the variation in prescribing expenditure per head remaining after age and sex was accounted for among the 140 or so English FHSAs.

16. Statistically, 15 is too few Health Boards to be able to replicate the fairly extensive search process involved on Scottish data and determine whether there are any better measures of morbidity in Scotland. In the longer term, for statistical and theoretical reasons, it is preferable anyway to attempt to model data at the practice level to find the most suitable indicators of need. This work is in hand in Scotland, but the results will not be available for some time. In the interim, the Group believed that it would be appropriate to use the permanent sickness variable as a proxy for morbidity at Health Board level in our formula, but that the weight with which it should be applied should be determined from the Scottish data. A statistical analysis revealed that 63% of the variation in prescribing costs per age and sex-weighted head could be explained by the permanent sickness variable in Scotland. The variable was highly statistically significant.

Target shares of resources

17. Using the results from the analyses described above, the GP list populations of each Health Board have been weighted for list-size inflation, age and sex composition and morbidity. The resulting weighted GP list populations have been converted into percentages of the Scottish total and are shown in the table below. These percentages indicate each Health Board's target share of prescribing resources. The table also compares these target shares with the Board's share of the national resident (unweighted) populations.

18. Health Boards for which the ratio of the weighted population to the resident population is greater than 1.00, as calculated by the provisional weighted capitation formula, have a higher than average need for prescribing resources per head of their resident population, whereas those Boards where the ratio is less than 1.00 have a lower than average need per resident head described here. A Board may have a ratio of greater than 1.00 for any or some of the following reasons:

i) It is a net "importer" of patients - i.e. the population managed by its GPs is substantially larger than its resident population after those registered outside the Health Board are netted off;
ii) Its list-size inflation is lower than the average for Scotland;
iii) Its age and sex composition is skewed towards those age-groups with high relative prescribing costs (e.g. the elderly);
iv) It has a higher than average percentage of its population of working age who are unable to work owing to being permanently sick.

Future work

19. The Group recognises that the model selected to determine weighted capitation populations for 1996/97 cannot be regarded as definitive, and that much further work remains to be done. In particular, the following issues will be researched further with the aim of building a more robust weighted capitation formula to distribute prescribing resources equitably in the future:

- investigation of robustness and stability of age-sex cost weights;
- investigation into most suitable indicators of morbidity for Scotland, and the weights with which they should be applied in a Health Board formula.

Table 3: Target shares of prescribing resources by Health Board, 1996/97

Health Board	% share of resident population, 1996	% share of weighted population, 1996	Ratio of weighted to resident population
Ayrshire & Arran	7.35%	7.65%	1.04
Argyll & Clyde	8.38%	8.46%	1.01
Borders	2.07%	1.99%	0.96
Dumfries & Galloway	2.89%	2.98%	1.03
Fife	6.88%	6.86%	1.00
Forth Valley	5.33%	5.44%	1.02
Grampian	10.49%	9.32%	0.89
Greater Glasgow	17.62%	19.20%	1.09
Highland	4.09%	3.75%	0.92
Lanarkshire	10.92%	11.37%	1.04
Lothian	14.84%	13.95%	0.94
Orkney	0.39%	0.37%	0.94
Shetland	0.45%	0.39%	0.85
Tayside	7.73%	7.69%	1.00
Western Isles	0.57%	0.57%	1.01
Scotland	100.00%	100.00%	1.00

Application to determining practice-level budgets

20. In order to investigate the issues described in paragraph 18 above, databases of practice-level information are being constructed on which to carry out statistical modelling work. However, whilst it is methodologically more appropriate to carry out analysis at the practice level, the results of the modelling are only intended for determining budgets at the Health Board level. It will never be possible to capture all the local variations in circumstances which MPAs may wish to incorporate into their practice allocations into a national formula, and therefore, whilst MPAs may wish to consider the results of the development of a national formula in setting local budgets, there will always be room for local discretion.

ANNEX B

INDICATIVE PRESCRIBING SCHEME: 1996-97 ALLOCATIONS

1. The amount provided for GP drug expenditure in 1996-97 is £463m Net Ingredient Cost (NIC). After adjusting for chemist contractors' discounts and VAT payments this converts to a Gross Ingredient Cost of £491m for indicative prescribing allocation purposes. The individual Health Board allocations totalling this sum are detailed in the attached Table.

2. The allocations provide for at least a 7.8% cash increase on 1995-96 allocations for all Health Boards. The remaining resources have been allocated to:

I. additions for those Boards estimated to be significantly below the national average for their weighted population (as described in Annex A); and

II. transitional support to those Health Boards which are experiencing difficulty living within their 1995-96 allocation.

3. In more detail, the cash uplift provides for basic allocations totalling £479.74m. Of the £10.86m left available for distribution, £6.52m, or 1.33% of the total, has been allocated for moves to weighted capitation and the balance of £4.34m (0.88%) allocated as transitional support.

4. The 1995-96 allocation for all Boards has been uplifted by a straight 7.8%. The weighted capitation and transitional support elements have been calculated as follows.

I. **Weighted capitation allocation**: for the 9 Health Boards whose basic allocation including the 7.8% uplift (column 4 in the attached Table) was less than their weighted capitation 'share' (column 3), one third of the difference between their share and basic allocation was added, subject to a maximum uplift on the estimated out-turn for 1995-96 of 9.5%.

II. **Transitional support allocation**: the remaining 6 Boards not requiring a weighted capitation uplift were given 57.4% of their projected cash overspend for 1995-96, further uplifted by the basic uplift of 7.8%.

5. On this basis, the individual Health Board allocations are as shown in the attached Table.

Allocations to Practices

6. The IPS covers both fundholders and non-fundholders. Fundholders' budgets are produced by converting their GIC figure to a NIC equivalent. For 1996-97 allocations the appropriate factor for converting to NIC is to multiply GIC by 0.93 (reflecting an average discount rate of 7%).

7. The aggregate total of fundholder drug budgets, expressed in GIC terms, target budgets for non-fundholding practices, and any contingency reserves, should be equal to the total IPS allocation.

Contingency Reserves for Fundholding and Non-fundholding Practices

8. The management arrangements for fundholders' and non-fundholders' contingency reserves are different, owing to the differences in the financial regimes within which the two types of practices manage their prescribing resources. It means that, once established, the two reserves are totally separate and virement between them is not possible.

9. Contingency reserves should be created from within the IPS budget for 1996-97 by top-slicing from the allocations in the Table above. **The contingency amount should be no more than 1% overall.** The actual size, and the criteria for use, of the contingency reserve for fundholders should be determined in discussion with practices or the appropriate GP representatives. Health Boards are encouraged to do likewise with non-fundholding practices. Thereafter the following will apply.

Fundholders

10. The funding for contingency reserves for fundholders will be included in the inter-Vote transfer of funds from non-cash limited drugs bill provision to the cash limited fundholding (and HCHS) provision. The contingency element will then be included in the formal cash limit adjustments issued to Health Boards to provide funds to support fundholder prescribing costs in 1996-97.

11. Health Boards may add to their fundholder contingency reserves by virement from other cash limited budgets (except GMS cash limited which is subject to a ring fence which precludes outward virement).

12. Any unspent fundholder contingency reserves may be redeployed by the Health Board for other related purposes or may be carried forward as a prescribing contingency for the following financial year. The proposed treatment of any unspent contingency should be clearly set out, in discussions with fundholders or their representatives, at the same time as the overall size of the contingency is determined.

Non-fundholders

13. Non-fundholders' prescribing expenditure is non cash-limited. This means that their prescribing allocation, including contingency reserves, are not supported by a cash-limited allocation of funds which is available to Health Boards to manage. Therefore, underspends on non-fundholder prescribing budgets may not be redeployed for other purposes by the practice or the Health Board. Similarly, any overspend cannot be met by virement of funds from any cash limited budget held by the Health Board.

Table : Indicative Prescribing Scheme Allocations, 1996/97

Column No:	1	2	3	4	5	6	7	8	9	10	11
	Factors informing allocations			Components of 1996/97 allocations				Results of 1996/97 allocations			
£m GIC (See Note:) Health Board	Allocation 1995/96	% overspend on 1995/96 allocation (a)	1996/97 "Fair share" (b)	Basic allocation incl. 7.8% uplift for all Boards	Wtd cap allocation (c)	Transitional support (d)	**Total allocation 1996/97 (e)**	Allocation per wtd head (£)	**% uplift on out-turn**	% uplift on allocation	% distance from target
Argyll & Clyde	£40.505	2.1%	£41.510	£43.664	£0.000	£0.534	**£44.198**	£101.51	6.8%	9.1%	6.5%
Ayrshire & Arran	£35.890	3.2%	£37.548	£38.689	£0.000	£0.715	**£39.404**	£100.07	6.4%	9.8%	4.9%
Borders	£8.810	-0.6%	£9.773	£9.497	£0.092	£0.000	**£9.589**	£93.54	9.4%	8.8%	-1.9%
Dumfries & Galloway	£13.740	4.3%	£14.621	£14.812	£0.000	£0.368	**£15.180**	£99.09	5.9%	10.5%	3.8%
Fife	£28.735	3.4%	£33.677	£30.976	£0.899	£0.000	**£31.876**	£90.24	7.3%	10.9%	-5.3%
Forth Valley	£25.475	3.2%	£26.707	£27.462	£0.000	£0.507	**£27.969**	£99.86	6.4%	9.8%	4.7%
Grampian	£37.650	3.7%	£45.712	£40.587	£1.707	£0.000	**£42.294**	£88.21	8.4%	12.3%	-7.5%
Glasgow	£82.430	1.7%	£94.188	£88.860	£1.774	£0.000	**£90.634**	£91.74	8.1%	10.0%	-3.8%
Highland	£16.260	4.1%	£18.385	£17.528	£0.285	£0.000	**£17.813**	£92.37	5.3%	9.6%	-3.1%
Lanarkshire	£53.330	4.8%	£55.802	£57.490	£0.000	£1.567	**£59.057**	£100.94	5.7%	10.7%	5.8%
Lothian	£59.335	3.4%	£68.446	£63.963	£1.493	£0.000	**£65.456**	£91.17	6.7%	10.3%	-4.4%
Orkney	£1.345	1.9%	£1.811	£1.450	£0.051	£0.000	**£1.501**	£78.46	9.5%	11.6%	-17.1%
Shetland	£1.456	5.9%	£1.890	£1.570	£0.107	£0.000	**£1.676**	£84.55	8.8%	15.1%	-11.3%
Tayside	£37.770	2.8%	£37.719	£40.716	£0.000	£0.649	**£41.365**	£104.42	6.6%	9.5%	9.7%
Western Isles	£2.295	4.2%	£2.809	£2.474	£0.111	£0.000	**£2.585**	£87.76	8.1%	12.7%	-7.9%
Scotland	£445.026	3.1%	£490.598	£479.738	£6.520	£4.340	**£490.598**	£95.34	7.0%	10.2%	0.0%
							Ranges:				
							Max	£104.42	9.5%	15.1%	9.7%
							Min	£78.46	5.3%	8.8%	-17.1%

Notes:

(a) % projected overspends as of 30 November, 1995 from Pharmacy Practice Division.

(b) "Fair shares" allow for: population, list-size inflation, age, sex and morbidity. See Annex to MEL.

(c) Increment for Wtd Cap calculated by giving all Boards who would be under-target after the 7.8% uplift, one-third of the difference between the basic allocation and their target budget, except Orkney. Orkney's wtd capitation allocation was smaller than this, in order to cap its % increase on out-turn to 9.5%

(d) Of the HBs getting no Wtd Capitation uplift, 57.4% of the projected cash overspend in 1995/96, further uplifted by the basic uplift of 7.8%, is added to their allocations.

(e) Total allocation is sum of: Basic allocation (col. 4) + Wtd Cap allocation (col.5) + Transitional support (col. 6).