



Department of Health

Dear Colleague

**ALLOCATION OF HIV/AIDS HEALTH PROMOTION
AND PREVENTION RESOURCES**

1. This letter informs Health Board General Managers and those responsible for the provision of HIV health promotion and prevention services of future arrangements for the allocation of resources and monitoring of expenditure.

Summary

2. For the year 1 April 1998 to 31 March 1999 the amounts of HIV prevention funding for individual health boards will be the same as in 1997-98. Allocations will now be made direct by the SODoH and NSD will no longer be involved in allocating or monitoring of HIV/AIDS health promotion and prevention funds. Subject to the views of Health Boards, allocations from 1999-2000 will be made on the basis of a formula (described in para 5 below). These funds will continue to be earmarked, but Boards may apply additional resources from their general allocations as they consider appropriate.

3. Letters will be issued to Boards shortly, confirming their allocations for 1998-99. The use of the funds will be monitored through the normal performance management process against the background of the priorities in prevention identified in the UK Health Departments' policy statement "*HIV and AIDS Health Promotion - An Evolving Strategy*" issued to Health Boards in November 1995 under cover of NHS MEL(1995)85.

Action

4. The provisions of this letter are effective from 1 April 1998. General Managers, who have already been advised by National Services Division that there is no need to submit funding bids for 1998-99 allocations, should ensure the letter is circulated to appropriate staff and taken into account in the planning and provision of services.

FP062304

13th May 1998

Addressees**For action:**

General Managers, Health Boards
Chief Executives, NHS Trusts
General Manager, State Hospital

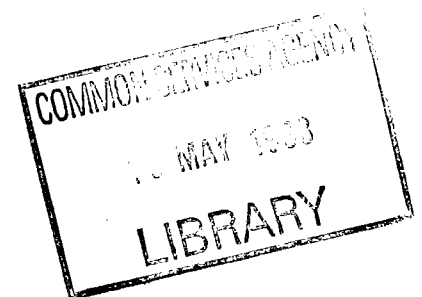
For information:

Director, National Services Division
AIDS Co-ordinators in Health Boards

Enquiries to:

Lee Thorburn
Public Health Policy Unit
Room 401
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2241
Fax: 0131-244 2157




SCOTTISH HEALTH SERVICE	
STANDARD FORM NO. 1002	
Date	
Ref.	
No. IP-1D: 102603	
Date 18.5.98	Price

5. A Working Group set up by the Department in 1997 has considered the present arrangements for allocation of HIV prevention resources and concluded that allocations should in future be based on a formula that takes account of local prevalence and incidence of HIV infection and population. The Department is disposed to accept the recommendation of the Working Group, but would welcome the views of Health Boards on the fairness and appropriateness of the proposed formula. A copy of the Working Group's report is attached. For illustrative purposes the impact of applying the proposed formula to individual Boards' allocations is shown in respect of 1997-98 at Table 1 of the report.

6. Although the Working Group recommended phased implementation from 1 April 1998, the intention is that the change to formula-based allocation will come into effect fully ie without phasing, from 1 April 1999. General Managers are asked to submit any comments on the proposed formula and implementation arrangements by 31 July 1998.

Yours sincerely



MRS NICOLA MUNRO
Under Secretary
Public Health Policy Unit



DR PETER COLLINGS
Director of Finance

**INTERIM REPORT OF A WORKING
GROUP ON FORMULA DISTRIBUTION
OF DRUG MISUSE AND HIV/AIDS
HEALTH PROMOTION AND
PREVENTION FUNDING**

PART I

**HIV/AIDS HEALTH PROMOTION AND
PREVENTION FUNDING**

OCTOBER 1997

GMF00803

CHAPTERS

- 1. BACKGROUND**
- 2. HIV & AIDS FORMULA**
- 3. RECOMMENDATION AND IMPLEMENTATION**

**ANNEX A -Recommended HIV/AIDS Health Promotion and
Prevention Formula**

CHAPTER 1

Background

1.1 Funding to Health Boards for drug misuse and HIV/AIDS health promotion and prevention work is currently ring-fenced and is allocated on the basis of service level agreements which are struck between individual Boards and the National Services Division (NSD) of the Common Services Agency. NSD distribute funds on an individual project basis in negotiation with Boards, enabling them to respond appropriately to developing service needs, and to fund the development of specific initiatives to which The Scottish Office attached priority.

1.2 While this has proven to be useful in focusing funding on appropriate initiatives, there have been a number of developments over the past few years which suggest that the time is right for changes in the distribution arrangements. These include the development of local strategies, under the auspices of Drug Action Teams; the evolution of commissioning arrangements; HIV/AIDS care and treatment funding now being part of the core allocation to Health Boards; and the development of drug services guidance which aligns the mechanisms for drug service provision and accountability arrangements more closely with those for other health and social services. It follows, therefore, that Boards should be given greater control over the use of their resources, with due regard to the advantages of them being able to enter into longer-term contractual arrangements.

The Working Group

1.3 Against this background, a short-term Working Group was set up to look at the issues surrounding the possible allocation of funds for HIV/AIDS health promotion and prevention and drug misuse on a formula basis, and agree suitable formulae for these allocations. The intention was that any new arrangements should take effect from 1 April 1998 albeit with transitional provisions. The Group was charged with making recommendations to the Department of Health and to Ministers.

1.4 The Working Group comprised:-

FORMULA WORKING GROUP MEMBERSHIP

Chairman:	Mr E M C Mackay, PHPU-2
-----------	-------------------------

Members:	Dr L Gruer, Greater Glasgow Health Board Mrs W Hatton, Ayrshire and Arran Health Board Mr J Aldridge, ME Policy and Performance Management Directorate Ms K Hancock, ME, Economics and Information Directorate Dr A Findlay, CSA National Services Division Mr P Knight, CSA Information Services Division
----------	---

Dr B Davis, PHPU
Mr B Callaghan, PHPU-2
Mr A Oliver, PHPU-1
Mrs M Cuthbert, PHPU-2

Secretary: Mrs M Robertson, PHPU-2

1.5 The Group was established in May 1997 and had met on 5 occasions prior to the preparation of this report on HIV/AIDS.

1.6 The Group is not yet in a position to report on its work on drug misuse funding. However, it was decided that this should not delay a recommendation on the HIV/AIDS Health Promotion and Prevention Funding formula, where agreement has been reached. This Report, therefore, is confined to that subject.

1.7 Chapter 2 sets out the history of the HIV/AIDS funding to Health Boards; the key parameters for a formula; measuring need; the financial implications of the formula; and, finally, our conclusions.

1.8 Chapter 3 summarises the impact of the formula on respective Health Board allocations - with the 'winners' and 'losers' - and recommends a 2 year phasing in of the formula from 1 April 1998 to manage pace of change sensibly.

CHAPTER 2

HIV & AIDS Formula

Purpose of the resources

2.1 These resources are designed to help prevent the spread of HIV/AIDS by a combination of general health education and initiatives targeted at high risk groups. In 1997/98, NSD's contracts with the 15 Health Boards and the State Hospital for HIV/AIDS Health Promotion and Prevention (HP&P) totalled £5.15 million. This figure includes around £450,000 from the HIV/AIDS & drugs related budget. Contracts were made with Boards for HP&P and for HIV/AIDS & drugs related separately. ***It was decided that it would be more appropriate to have a single budget for HIV/AIDS and another for drugs misuse. Health Boards were asked to detail how much of the HIV/AIDS and drugs related budget was spent on HIV/AIDS and this was included in the HP&P total.***

2.2 The Fundamental Review of AIDS expenditure (1995) concluded that, since there was neither a vaccine against HIV nor a cure for the disease, prevention of HIV and AIDS should be a high priority. In order to ensure that this priority was adhered to, NSD continued to contract centrally for HP&P of HIV & AIDS, even though the Care and Treatment element of HIV/AIDS expenditure was devolved to Health Boards in 1995/96. Some Health Boards have specifically asked NSD for devolution of the HP&P money whilst others have asked for NSD to retain it in order to ensure a continuing high priority being afforded to the issue.

2.3 This chapter looks at the issues involved in developing an equitable resource allocation formula for HIV/AIDS HP&P. It discusses previous allocation methods. We then look at the theory behind weighted capitation before discussing the issues specifically related to a formula for HIV/AIDS HP&P. ***The chapter finishes by reporting the conclusions of the working group; the resource allocation formula recommended by the group; and the financial implications for Health Boards.***

Previous allocation methods

2.4 Prior to the existence of NSD, resources for both care and treatment and promotion and prevention were allocated to Health Boards by HPPHD using a weighted capitation formula. The promotion and prevention component of the formula simply used Health Board populations aged 15-44, with no further weighting.

2.5 In 1995/96, the number of new Sexually Transmitted Diseases (STD) cases per head of 15-44 population was used as an indicator of relative risk from catching HIV/AIDS. However, the budgets arrived at were only indicative, and NSD themselves decided the precise size of individual Health Board contracts. These were awarded by Health Boards putting forward projects for which funding was required. However, ***the distribution of the resources which resulted seems to have very little relationship to the underlying needs of the population.*** Extensive regression analyses of the sizes of NSD's contracts with Boards in 1996/97 in terms of a variety of possible needs factors, could find no systematic explanation of the pattern of contracts, which were dependent on the standard of proposals submitted by Health Boards.

A weighted capitation formula

2.6 The idea behind a weighted capitation formula is to distribute resources so as to allow equal access to resources for the services for which they are intended for areas in equal need. When devising a formula, it is important that the indicators of need used should be objective. That is to say, they should not use data which the recipients of funds might have an incentive to distort, or which reflect previous allocations of resources which might be inequitable. *This means for example, that one needs to be sure that the needs indicators are capturing genuine differences in needs rather than historical differences in supply of services.*

2.7 A second important principle is that the targets which emerge from such formulae should be considered for their own merits, independently of what are termed “pace-of-change” issues. That is to say, it is not a valid test of a new formula to compare it with the existing distribution of resources and note that because there are large distances between existing and target allocations, the formula must therefore be wrong. By making feasible adjustments to allocations year-on-year, it is possible to reach even far-distant targets using an appropriate pace of change policy. *Instead, the appropriate test of a new formula is whether it adequately reflects the distribution of relative need.* If there are large distances from target which emerge, it is usually more appropriate to ask whether the existing distribution of resources is fair.

Key parameters for the formula

2.8 There are 3 *main issues* directly relating to a resource allocation formula for HIV/AIDS health promotion and prevention. These are:

- (i) what proportion of the budget should be allocated on the basis of higher-risk population and what proportion should be allocated on the basis of the general population,
- (ii) should there be an element in the formula to cover minimum fixed costs, and
- (iii) what is the best measure of need to use for the targeted and untargeted proportions?

We discuss each of these in turn.

2.9 The Fundamental Review noted that prevention should remain a high priority. A strategy document published by the Department of Health (DH) (England) in 1995 (*HIV & AIDS Health Promotion: An Evolving Strategy*) called for increased targeting of prevention measures towards those at relatively higher risk of the disease in order to obtain better value for money. *So a key question is: what proportion of the overall budget should be allocated on the basis of higher-risk populations, and what proportion should be allocated on the basis of the general population?*

2.10 In England, the old NE Thames Region argued that the fixed costs of running a basic HP&P programme for a general population of 250,000 (a typical English DHA) would account for 60% of the total prevention budget. They therefore suggested that it would be

desirable to target no more than 40% of the total budget according to relative risk and no less than 60% according to the relevant population age-group. Guidance was given to the service in England in 1996 (EL(96)30) which called for approximately 50% of the total prevention allocation to be used to develop locally targeted HIV HP&P programmes. DH argued that it would be difficult therefore to have a targeted part of the allocation which was very far from 50%.

2.11 It is questionable whether we should adopt the same 60:40 split suggested by NE Thames in Scotland. Firstly, our Health Boards are much more variable in population size (20,000 in Orkney to 907,000 in Glasgow) than in England. Secondly, if there genuinely are fixed costs in running a HP&P service then, based on the NE Thames work, this implies a fixed cost of roughly £160k per Health Authority, or £2.4 million in Scotland, which equates to just under 50% of NSD's total spend. Given that Orkney, Shetland, W Isles, Borders, Dumfries & Galloway and Highland all currently provide some sort of service within budgets which are substantially less than this, £160k does not appear to represent an irreducible minimum fixed cost in Scotland. Thirdly, the populations of some of the rural health boards are so small it would be unlikely that an untargeted proportion based on some measure of population share would cover their fixed costs. Under such a formula they would not be able to provide a viable service.

2.12 *It is important, therefore, that our formula contains an element which allows the smaller boards to cover their fixed costs.* The best way to do this is to give every board an amount that covers fixed costs independently of the targeted and untargeted share. As mentioned in paragraph 2.5, we looked at the relationship between NSD's 1996/97 health board contracts and population size to try to identify a minimum economic scale of service, i.e. the costs of a service which do not vary with the population size. However, we were unable to find a significant relationship. Orkney and Shetland have the lowest budgets of £26,800 and £32,850 respectively and have managed to provide a HP&P service within this. It follows that the fixed costs will be below £26,800. After looking at how the smaller boards actually spent their budgets *it was agreed to give each health board a minimum of £20,000, as a fixed cost.*

2.13 This results in a total cost of £300,000 to cover the minimum fixed costs of all 15 Health Boards. When calculating new Health Board budgets this figure is taken out of the total untargeted share. For example, for a split of 50:50 targeted and untargeted, £300,000 would be subtracted from the untargeted share (50% of the £5.15 million total budget) and the remaining amount would be allocated according to the relative shares of the 10-34 population.

2.14 The NE Thames work argues that no more than 40% of resources should be targeted at higher risk groups in order to cover fixed costs. By giving each health board a minimum budget of £20,000 to cover fixed costs we have reduced the need to have such a high proportion untargeted on general population share. Based on the Fundamental Review's advice that resources should be targeted in order to achieve better value for money, *the working group decided to target 2/3 of the total budget at higher risk groups.* The general population is also at risk and it is important that a degree of general education is carried out. For this reason 1/3 of the total budget will be allocated according to the shares of the general population.

Measuring need for the untargeted proportion

2.15 *We then need to know: what are the best measures of need for the untargeted and targeted proportions?* Implicitly, in the past, need for the untargeted share of resources has been simply measured by the distribution of the population aged 15-44, since it was thought to be rather a waste of money formally to allocate resources to age-groups outside this range, given their low probability of engaging in high-risk behaviour. DH have proposed adopting the same age-range for the untargeted part of their formula. This age-range was also proposed by N E Thames.

2.16 Basic sex education, including preliminary advice about the risk of HIV infection is being given routinely in some primary schools to P6 and P7s, and in most secondary schools in S1. This suggests that it may be appropriate to widen the age-range for the formula to include children aged 10-14. *The working group decided to allocate the untargeted proportion according to the 10-44 age-group.*

Measuring need for the targeted proportion

2.17 The targeted proportion of the budget needs to be directed at those sections of the population at relatively higher risk of HIV infection. In Scotland, the main transmission route for the infection has been through injecting drug use, although more recently there has been a growth in the number of infections through homosexual and heterosexual sex. This last category includes those people who may have contracted their infection through travel or family links with high prevalence regions of the world (e.g. sub-Saharan Africa), or through sexual contact with current or past drug injectors.

2.18 Ideally, one would like a formula which includes measures of the proportion of Health Board populations which engage in these high-risk activities. However, since the high-risk activities are either illegal or otherwise difficult to measure, this does not seem feasible. Instead, therefore, we are forced to resort to using proxies for areas at high risk.

2.19 A good proxy for risk would be the number of people coming forward for HIV tests. These people presumably come forward for testing because they have been engaging in high risk activities, whether or not they test positive. SCIEH collect these data for most health boards in the Denominator study. However, there are no data currently available for Borders and since we need measures of relative risk throughout Scotland we were unable to use these data.

2.20 It seems not unreasonable to suggest that the current levels of HIV infection (prevalence) in a population might be a reasonable proxy indicator for relative risk. The prevalence numbers are relatively high and are therefore more stable than some other measures, especially for the smaller rural boards. There may also be the argument that it is people with the virus who pass it on and it is important that this is included in a formula. The DH have suggested using HIV prevalence as a proxy for relative risk. They argue that the distribution of HIV+ cases probably reflects relative risk better than the distribution of AIDS cases. However, they do not extend this argument to consider simply the distribution of new incident HIV cases.

2.21 It might be argued that, since there can be a significant length of time between first positive test and death, the number of infected people alive at any one time is dominated by those who may have had the disease for some time. People who have been HIV positive for some time may no longer be engaging in high-risk behaviour, and it might therefore be argued to be more appropriate to use new cases (i.e. incidence) as the measure of current relative risk. The argument for this is that a high number of newly diagnosed cases indicates where there is more prevention work needing to be carried out. Incidence figures, if updated say annually, give a more up-to-date guide to recent relative risk.

2.22 A problem with using HIV incidence figures is that numbers can be quite small in some Health Boards and show large year-to-year fluctuations. This could make the funding formula quite unstable and inhibit forward planning by Health Boards. Instead, therefore, it may be wiser to take incidence over a number of years as the needs factor to give a little more stability. It is important that the number of years over which incidence is measured is small enough to for it to remain sensitive to any changes in relative risk, but also large enough for the measure not to become unstable. *It was decided that a 3-year measure would satisfy both conditions.* A new case is taken as a positive test and is based on the year of testing.

2.23 Incidence and prevalence, as measures of need, have both pros and cons and neither is unambiguously superior. The group felt that both measures reflected different aspects of the complicated nature of risk and it was decided that the targeted measure should be based on a combination of incidence and prevalence. *After weighing up the pros and cons of both measures a split of 2/3 prevalence and 1/3 incidence was agreed.* Both measures can be updated annually.

Allocation through the SHARE formula

2.24 Some Boards appear to be worried that these resources may be distributed through the HCHS weighted capitation formula (SHARE). The SHARE formula weights Health Board populations for demographic structure (a higher weight is given to the elderly population) and for morbidity. The main morbidity indicator used is the 0-64 Standardised Mortality Ratio for most of the expenditure. The Community component of the formula currently covers Boards' non-HIV/AIDS Health Promotion expenditure and is also weighted for demography, the 0-64 SMR and a sparsity factor.

2.25 There are arguments for and against using the SHARE formula to distribute these resources. Against such a move is the notion that what we know about the distribution of risk from HIV infection is that it is very different from the distribution which would result from using the SHARE formula. For example, Glasgow's 0-64 SMR is 1.26, compared with 0.92 for Lothian (the national average is 1.00). Yet we know that the rates of HIV infection are the highest in Scotland in Lothian. Using the SHARE formula would imply a major redistribution of resources away from Lothian therefore when compared with a formula using HIV incidence or prevalence. In addition, the SHARE formula is under review and may well be altered. So it does not form a very useful basis for comparison.

2.26 On the other hand, the SHARE formula is designed to be very broad-brush, on the presumption that although for individual diseases, the national distribution of relative need

may be very unlike the 0-64 SMR, when considering the broad picture of need for HCHS across all diseases between Health Boards, it represents a reasonable proxy. Including HIV/AIDS promotion and prevention in the expenditure allocated through the SHARE formula would therefore be consistent with its principles: Boards which feel under-provided for this area of service, are likely to be over-provided in some other area of service and can transfer money in. After all, the main needs indicator - the 0-64 SMR - includes deaths from all causes, including HIV and AIDS, although they actually account for a very small proportion of the total.

2.27 *The working group decided that the SHARE formula was not the most equitable way of allocating HIV/AIDS HP&P funds.* The incidence and prevalence data in Scotland is of such a high quality that it would seem irrational not to use it to develop an HIV/AIDS specific formula.

Method used to distribute Grant-Aided Expenditure (GAE) for Social Work Services care of HIV/AIDS cases to local authorities

2.28 Finally, the group considered how the GAE assessment for HIV/AIDS in the distribution of funds to Scottish local authorities is made, to see if a more useful alternative is available. In 1997/98, a total of £1.329 million was distributed to local authorities for the provision by social services for HIV/AIDS cases in the community, including casework and administration.

2.29 The GAE in support of HIV/AIDS is simply distributed to local authorities according to their share of known cases of HIV/AIDS in Scotland from SCIEH's database. A weighting of 0.167 is applied to HIV cases, as these are generally less costly than AIDS cases for local authorities. The evidence for the cost weighting came from a special study carried out in 1990 and updated in 1992 by a joint SWSG/COSLA working group. It is based on the relative social work services costs of HIV cases versus AIDS cases.

2.30 *Our assessment of this method is that it is not particularly relevant to HP&P needs.* The resources are not used for HP&P work, so naturally the GAE formula does not include an untargeted component. The data source on the distribution of cases we already use. And the relative cost weighting for HIV and AIDS cases is specific to the provision of social work services and should therefore not be imported into the health context. We conclude that there is no merit in examining further the effects of using the GAE formula for the distribution of HP&P funds.

Financial implications of the formula

2.31 To summarise the group decided that:

- 2/3 of the budget should be allocated on the basis of higher risk populations and 1/3 should be untargeted.
- Each Health Board should get £20,000 to cover minimum fixed costs. The £300,000 total will come out of the untargeted proportion.

- Relative risk in the targeted proportion should be based on a combined measure of 2/3 prevalence of HIV infections and 1/3 incidence of new HIV positive tests. Incidence will be averaged over 3-years for stability.
- The untargeted proportion should be allocated according to Health Board shares of the population aged 10-44.

2.32 The formula was used to calculate 1998/99 Health Board target allocations. These targets take account of 1994-based population projections of Health Board populations aged 10-44 for 1998 (revised version); HIV prevalence figures minus those known to have died by Health Board as of June 1997; and HIV incidence figures by year of specimen by Health Board for 1994-96. *Table 1 shows the resulting Health Board allocations and the percentage change from the current 1997/98 budgets.*

State hospital

2.33 The state hospital was been left out of the simulations which follow. It has 220 beds but no current HIV+ cases, so would receive very little for the untargeted proportion of resources and nothing for a targeted proportion under a purpose-built formula. The 1997/98 NSD contracts give the state hospital £27,000 which is £200 more than Orkney. This works out at roughly 30 times more per 10-44 aged head in the state hospital (assuming all 220 state hospital patients fall within this age band) than in Orkney. This figure rises to 90 times greater if the all-age population is used. *This clearly suggests that the state hospital is a very special case and should be looked at carefully outwith a formula.*

Table 1: 1998/99 HIV/AIDS health promotion & prevention budget target allocations based on 2/3 targeted (2/3 prevalence, 1/3 incidence (3-year)), and 1/3 untargeted (10-44 population)

Health Boards	Total Budget 1997/98 £	New Target 1998/99 £	Distance to new Target %
Argyll & Clyde	263,629	230,197	-12.7%
Ayrshire & Arran	178,360	185,236	3.9%
Borders	103,400	76,845	-25.7%
Dumfries & Galloway	155,347	87,768	-43.5%
Fife	123,940	243,462	96.4%
Forth Valley	186,188	182,998	-1.7%
Grampian	172,710	366,737	112.3%
Greater Glasgow	824,000	989,955	20.1%
Highland	261,556	128,718	-50.8%
Lanarkshire	322,250	270,197	-16.2%
Lothian	1,528,314	1,694,817	10.9%
Orkney	26,800	25,143	-6.2%
Shetland	32,850	34,405	4.7%
Tayside	906,100	577,269	-36.3%
Western Isles	35,500	27,197	-23.4%
SCOTLAND	5,120,944	5,120,944	

2.34 *Table 1 shows that a total of 6 boards would gain under the new formula. Grampian and Fife appear to be highly under-funded at the moment. Grampian would gain around £194,000 or just over 112% of its current allocation, Fife gains £119,000 or 96%. Lothian and Glasgow both gain. Lothian remains the neediest health board with the highest allocation. Tayside loses around £329,000 or just over 36% of its budget. In general, it is the more rural boards which seem to be relatively over-funded at the moment.*

Conclusions

2.35 The working groups conclusions are as follows:

- 1) the existing distribution of resources seems to bear little relationship to apparent need for them;*
- 2) a purpose-built formula would be more closely related to need than the SHARE formula, or its replacement;*
- 3) a purpose-built formula should be used to allocate the HIV/AIDS health promotion & prevention budget;*

4) the level of funding to the State Hospital needs to be re-considered.

5) Health Boards' target allocations should be calculated as outlined in paragraph 2.31. The details of the proposed formula are set out in Annex A.

CHAPTER 3

Recommendation and Implementation

3.1 Members of the Working Group were content with the conclusions reached on a possible formula for HIV & AIDS health promotion and prevention funding. Table 1 in Chapter 2 outlines the revised allocations, under which a total of 6 Health Boards would gain under the formula, most significantly Grampian (+ 112%) and Fife (+ 96%). Lothian and Glasgow would also gain. In general, the rural boards lose out under the new formula. However, the formula can be strongly defended as the calculations are directly related to fairly robust data and population size.

3.2 The Working Group therefore recommend the implementation of the formula with effect from 1 April 1998. In order to manage the implementation effectively, it is suggested that it should be phased in over 2 years possibly with 1/3 being allocated in year 1, with the remainder allocated in year 2, provided Health Boards can demonstrate that they are in a position to effectively use the remaining resources. This method should allow for the planned development of additional services in gaining boards; the orderly reduction of services in losing boards; and also reduce the risk of funds being used inappropriately.

3.3 It is also recommended that when allocations are notified (soon) to Health Boards, it is emphasised that ring-fencing in this area does not preclude the provision of additional resources at a local level, particularly for other blood-borne viruses. In addition, the Department should indicate that it expects Boards to utilise funds in the most effective and appropriate manner.

3.4 During consideration of the formula proposal, there was a lack of evidence to justify the level of funding allocated to the State Hospital for HIV/AIDS health promotion and prevention. It is suggested that this funding is reconsidered outwith the work of this Group.

Proposed Formula for HIV/AIDS Health Promotion and Prevention Funding

$$\begin{aligned} & \left(\frac{\text{POP}(10-44)_i}{\sum_i \text{POP}(10-44)_i} \right) * \left(\left(\frac{1}{3} * \text{TOTAL} \right) - \text{£}300k \right) + \\ & \left(\frac{2}{3} * \frac{\text{INCIDENCE}_{3,i}}{\sum_i \text{INCIDENCE}_{3,i}} + \frac{1}{3} * \frac{\text{PREVALENCE}_i}{\sum_i \text{PREVALENCE}_i} \right) * \frac{2}{3} * \text{TOTAL} \end{aligned}$$

where:

- £20k is the minimum fixed cost component,
- $i = 1 \dots 15$ = Health Boards,
- $\text{POP}(10-44)_i$ = population aged 10-44 in Health Board I ,
- TOTAL = total funds available for distribution,
- £300k = the total fixed costs,
- $\text{INCIDENCE}_{3,i}$ = 3-year incidence of HIV+ cases,
- PREVALENCE_i = latest prevalence data of HIV+ cases.