TALKING POINT

NHS priorities and RAWP

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The debates on Health Service priorities and on resource allocation are relevant to the long-term planning of the Service. We have tried to show how recent decisions on priorities can be incorporated into the resource allocation formula.

Since 1976 the Department of Health and Social Security's authority over the Health Service has been strengthened and more clearly defined. In that year the consultative document on health service priorities¹ instigated a debate designed to encourage the NHS to move towards a nationally consistent set of service priorities. Previously, all the services of the NHS might have been described as priorities. But the use of a programme analysis of expenditure, allocating spending among client groups, allowed relative growth priorities to be discussed in precise terms for the first time. For example, in the consultative document the share of the total budget going to primary care services was planned to increase from 16.8% to 18.4%, while general and acute hospital and maternity services were scheduled to fall from 43.1% to 40.7% (estimates for 1975-6 to projected spending 1979-80). This clearly and quantitatively established the growth priority of the former and an overall emphasis on the non-acute services.

In 1976 the Department of Health adopted the new and explicit set of resource allocation criteria recommended by the Resource Allocation Working Party.² The criteria aim to relate spending to need for health care resources rather than to demand for, or supply of, existing facilities. The criteria, a set of formulae, are open to examination, and have attracted considerable attention.³⁻⁵ But the authority of the NHS to allocate resources between services is not queried in the RAWP report, which makes a clear distinction between the *allocation* and the *deployment* of resources, and restricts its concern to the former. In avoiding entanglement in the planning of the NHS, RAWP fails to link the debate about service priorities to that about resource allocation: "RAWP's methods provide no basis whatever for exercising centrally formulated preferences between competing areas of medical care as proposed in the consultative document."⁶ There is, in fact, some evidence that the service priorities planned for the NHS are not influencing actual spending locally, and that the priority groups—the elderly, children, the mentally ill, and the handicapped—are still lagging in their growth rates behind acute services.⁷

The basic procedure in RAWP calculations is to create a rank order among regions in terms of the size of the population. Then, to refine these population numbers in the direction of need for Health Service resources, the crude population is adjusted twice. It is adjusted to take account of its age and sex structure and then to take account of regional morbidity differences that exist even when the population composition is taken into account. The age and sex weighting in RAWP is derived from national hospital utilisation rates for each age-sex band (bed days/1000), and morbidity, a proxy measure, is based on regional standard mortality ratios. Each region's crude population is adjusted in this way and the resulting figure determines the regional target. Population calculations are made seven times for each region with variations of this formula to take account of service needs under the headings of non-psychiatric inpatient services, services for the mentally ill, etc. Further refinements are added to take account of cross-boundary flows, teaching costs, etc.

Weighting of RAWP groups

The seven service categories used in RAWP are non-psychiatric inpatients, all day patients and outpatients, community health services, ambulance services, mental illness inpatient services, mental handicap inpatient services, and family practitioner committee administration. Seven different population figures are produced for each region and a weighted average of these is taken to determine regional revenue and capital targets. The weighting given to each of the seven service groups reflects the relative importance ascribed to it by the DHSS. So it encapsulates a judgment and is not a purely technical consideration. To derive these weights in an uncontroversial manner RAWP uses past expenditure breakdowns. Thus for calculating revenue allocation for each year the pattern of expenditure for previous years between these service groups is used (table I).

This approach illustrates actual service priorities of the past, since these proportions result from the multiple conflicts and decisions on priority that occur in the NHS. The proportions, therefore, represent the views of all who affect the provision of services. They suffer, however, from two limitations. Firstly, they are not formulated as conscious decisions on service priority, but emerge as a result of numerous piecemeal modifications to the status quo. Secondly, they are several years old (the revenue allocations for 1978-9 necessitate the use of some expenditure data from 1975-6). Even if figures from the most recent financial year were available it would not necessarily be appropriate to use them for planning future resource allocation, however, since planning means specifying the nature and extent of change from the present. The desired mix of

TABLE I—Estimated proportions of revenue expenditure on each service category*

	%
Non-psychiatric inpatients	55.9
Day and outpatients	13.4
Community health	8.8
Ambulances	3.5
Mental illness inpatients	12.2
Mental handicap inpatients	5.7
FPC administration	0.5
	100.0

The DHSS has set out weights to be used in 1978-9 revenue calculation as:

	%
Non-psychiatric inpatients	55.5
Day and outpatients	12.8
Community health	9.3
Ambulances	3.3
Mental illness inpatients	12.5
Mental handicap inpatients	6.1
FPC administration	0.5
	100.0

*Source: DHSS, *Sharing Resources for Health in England*.²

services rather than the present pattern is, therefore, the relevant planning information. In fact, the DHSS has recently shown in the consultative document and in *The Way Forward*⁸ its intentions to establish quantitative future priorities between different component services of the NHS. So there exists precisely the information that RAWP needs to make it link more closely with DHSS medium- and longer-term planning.

The broad consequence of recent DHSS proposals on service priorities is to restrain the growth of acute, hospital-based services in order to allow for faster growth in services for primary care, the mentally ill, elderly and physically handicapped, and the mentally handicapped. Unfortunately, the service categories used for setting priorities do not coincide precisely with those used by RAWP. But, by using the programme analysis of expenditure given in the consultative document a set of comparable categories can be derived. Table II gives this information arranged for RAWP service categories. Inserting these values brings about adjustments in the population distribution (table III). Augmenting the importance of the caring rather than the curative services would divert some population (and therefore resources) away from the North-western, Yorkshire, and South-western regions and to the West Midlands, North Thames, and Oxford.

As a rough index of the financial implications of these population shifts, per capita NHS revenue spending (for RAWP purposes) in 1975 was about £54, which would mean a revenue loss of about £420 000 from the North-western Region's target and a gain of about £324 000 from the West Midlands. These changes are small in relation to the total revenue budgets of the regions concerned—

TABLE II—Estimates of projected expenditure based on the consultative document¹

	%
Non-psychiatric inpatients	52.9
All day and outpatients	13.6
Community health	9.2
Ambulances	3.8
Mental illness inpatients	13.5
Mental handicap inpatients	6.5
FPC administration	0.5
	100.0

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Accident and emergency services

Report on staffing

In October 1977 the Joint Consultants Committee invited Mr Walpole Lewin to inquire into the medical staffing of the accident and emergency services. The committee had been worried at the numbers of consultants appointed and the criteria for appointment. Various professional bodies were also concerned about the standards of such appointments. The JCC saw the problem as urgent and asked Mr Lewin to do the inquiry on his own, "taking such advice as was thought appropriate." He had informal discussions with a wide range of organisations and individuals, but Mr Lewin who is a vice president of the Royal College of Surgeons and past chairman of the BMA council, makes it clear that the report's recommendations are his own.

The JCC discussed the report in July and it has just been published as a booklet. Regional committees for hospital medical staff have been invited by the JCC to answer a series of questions arising from the report. We publish here the summary and principal recommendations of the report, along with the JCC's questions to regional committees and a paragraph from the report on the work of a consultant in accident and emergency medicine.

Summary and principal recommendations

The accident and emergency services for England and Wales should be based on a two-tier system with A/E departments at most district general hospitals, and a peripheral

casualty service. The situation in Scotland has been described.

CONSULTANTS IN A/E DEPARTMENTS

All A/E departments should have effective consultant supervision.

There is general support for consultants in the specialty of accident and emergency medicine as one way of running a department, provided that as with other specialties there is a training programme for future consultants. It is estimated that in England and Wales there may be 130 consultants in accident and emergency medicine in post by the end of March 1979.

All doctors should have a responsibility to the accident and emergency services whether in general practice or in hospital practice and whatever their specialty. In addition to surgeons, general practitioners in training, and those in the medical specialties should be encouraged to spend part of their training period in an A/E department.

A/E subcommittees, including representatives of all the specialties concerned, should be set up in hospitals to support the consultants in charge of the A/E departments, to receive their reports, and to promote co-operation.

The main responsibilities of a consultant in charge of an A/E department are set out in Appendix "E." These criteria will require minor revision in the light of this report, particularly with regard to paragraph 4. The consultant should take his place on the rota for on-call. [See box.]

An adequate agreed job description should be provided for each consultant post.

The aims of the Specialist Advisory Committee on Accident and Emergency Medicine to inspect departments with a view to recognition for senior registrar training, and thereafter to monitor the training programme of the individual senior registrar, should be supported.

The Specialist Advisory Committee should consider a revision of the training programme to clarify further its aims and simplify its content.

The number of senior registrar posts should be related to expected consultant vacancies. The growth of the new training grade will necessarily be gradual.

The role of the royal colleges is crucial and complementary to the work of the Specialist Advisory Committee in maintaining standards. This is particularly so in the early years when the training grade is being developed. The present criteria guiding college assessors is described. Through their regional advisers the colleges can now satisfy themselves that the work load and facilities of the post satisfy the requirements for a consultancy.

The suggestion of a specialist diploma is not recommended at present but the Specialist Advisory Committee could be invited to advise further if and when appropriate.

Examination of the present figures suggests that the present limitation of 11 new consultant posts in accident and emergency medicine for 1978-9 should remain and no new consultant posts for 1979-80 should be approved as

Talking point—continued

about 0.22% for the North-western—though they are considerably larger when taken as a proportion of the revenue actually redistributed by RAWP.

As an additional test of the sensitivity of the existing formula to changes in these weights a second set of service priorities, still further

reducing the share of non-psychiatric inpatient services (this time to 50%), was inserted into the calculations; and, though the consequent population loss from the North-western Region rises to 12 000—approximately £650 000—the overall ranking among regions remains unchanged.

Conclusions

Two principal considerations emerge from this analysis. Firstly, for a range of reasonable alternative judgments about the relative importance of the different services, the RAWP formula appears relatively robust—changes in the assumptions can be made that do not alter the basic geographical pattern of resource allocation determined by RAWP: the changes in regional targets are marginal. Even so, the fact that there is some change in target calculations does emphasise the need for explicit discussion about the basis on which the regional population figures should be aggregated. There has been little debate about the actual choice of weights used in making RAWP calculations, and at least one region has quite inappropriately followed RAWP's use of historic national expenditure proportions in making its subregional target calculations.

Secondly, it becomes clear which regions would stand to gain by the implementation in

RAWP of nationally promoted service priorities and which benefit from the present use of historic expenditure weights. Table III shows gainers and losers and the relative magnitude of their changes for each of the sets of care-emphasising weights. At all levels of the NHS a reassessment of service priorities is likely to alter resource needs as calculated by RAWP. So the integration of planning priorities into national and regional resource allocations is a step towards overcoming the arbitrary separation of planning from resource allocation in the NHS.

References

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- ⁶ Knox, E G, *Journal of Epidemiology and Community Health*, 1978, **32**, 3.
- ⁷ Huckleby, D J, and Snaith, A H, *Lancet*, 1978, **1**, 659.
- ⁸ DHSS, *The Way Forward*. London, HMSO, 1977.

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TABLE III—Effect of using future priorities* expenditure on RAWP calculations (adjustments to calculated regional population in thousands)

Region	Adjusted population (thousands)
West Midlands	+6.0
North-west Thames	+4.1
Oxford	+4.0
North-east Thames	+3.5
Trent	+1.8
East Anglia	0.0
South-west Thames	0.0
Northern	-0.5
Wessex	-1.2
Mersey	-1.3
South-east Thames	-1.5
South-western	-3.5
Yorkshire	-3.8
North-western	-7.8

*Based on comparison of service weights from consultative document (table II) substituted for those in the RAWP report (table I).