SUPPLEMENT

How should district allocations be altered for changes in cross boundary flows?

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The main principles underlying finance of health authorities in the United Kingdom are, firstly, that a health district's (or health board's) allocation ought to move towards a target that consists of an estimated fair share of resources by the district's residents and, secondly, the costs of treating non-residents.¹⁻³ Where a district's current allocation exceeds its target this tends to be because its residents are using services at a level higher than their estimated fair share,^{4,6} and where a district's allocation is less than target this tends to be because its residents are using less than their fair share of services.

Existing arrangements of accounting for services provided by one district for residents of another mean that where there is a change in the pattern of services this does not automatically result in a change in allocations. If, for example, one district provided a new service or changed the volume of services provided for another it would take two years for this change to be reflected in targets. This delay is because of the time taken to collect and process the necessary data. The decision on how to alter allocations in the light of changes in targets depends on how far districts' allocations are from their targets. If a district's allocation is close a change in its target may be fully reflected in its allocation. Where a district's allocation is a long way from its target the district's region may have decided that only gradual reductions in allocations are manageable and that the requirement for these reductions to be made would be unaffected by changes in the district's target.

The NHS Management Board's *Review of the Resource Allocation Working Party Formula* recommended speeding up changes made in adjusting targets for changes in services.⁷ Districts' immediate concerns, however, are not so much over speeding up recognition in targets as the relation between changes in services and changes in allocations. This paper explains why separating changes in a district's allocation from changes in services provided for other districts has resulted in attempts to impose barriers to treatment. The implications of different systems of cross charging as a means of adjusting allocations to reflect changes in services are examined.

Reasons for barriers to treatment

Separating changes in allocations from changes in services results in frustration when finance for new services is at best delayed and may be only a remote possibility. For this reason one district that is over its target has sought to impose charges on non-residents for use of a new service.⁸ This district wants immediate recognition in its allocation for increases in its target for services provided for residents of other districts but a delay maintained in moving its allocation towards its target.

Separating changes in allocations from changes in services also provides opportunities. Districts that are above their targets could maintain services for district residents where allocations are being cut by reducing services for non-residents.² This would reduce the size of these districts' target two years hence by reducing credit for non-residents, but the impact on future allocations would be unclear.^{2,4,9} By refusing to treat non-residents districts below their targets could increase services for their own residents. As these districts' allocations would be unlikely to exceed their targets reduced by that action districts might expect their allocations to be unaffected.

Cross charging: an idea whose time has come?

Cross charging would relieve frustration of existing arrangements by providing immediate finance for new services. If cross charging were introduced as the universal means of accounting for services delivered to other districts as part of an internal market for the NHS district allocations would be rapidly adjusted for changes in these services. The opportunity to exploit current arrangements and impose barriers to treating non-district residents at no immediate cost would then be removed.¹⁰ The implications of cross charging are examined here both as part of an internal market and in the more limited application of financing new developments.

IMPLICATIONS OF AN INTERNAL MARKET FOR THE NHS

Enthoven proposed an "internal market" for the NHS. Districts would receive the residential component of their Resource Allocation Working Party (RAWP) target; they would then decide where their residents would receive non-emergency care on grounds of quality and cost by comparing local services with those of other districts and the private sector and negotiating contracts outside the district where this would be beneficial.¹⁰ Enthoven's internal market required, firstly, equalisation forthwith at district level and, secondly, that family doctors should contract for their services with districts instead of family practitioner committees.

The implementation of an internal market with district equalisation implies cuts in services available to residents of districts that were over target and so they would have to impose severe restrictions on hospital referrals. Equalisation would, however, mean that below target districts would not have to impose barriers to treating non-residents to give their residents their fair share of services. The review of RAWP rejected an internal market for the NHS because of the problems of achieving equity forthwith (and the green paper on primary care did not even mention the proposal that general practitioners' contracts should be with districts¹¹).

The review of RAWP, however, supported exploration by regions of the freedom they currently have to take cross boundary flows out of the RAWP formula and cross charge directly through adjustments to allocations on a mutually agreed basis. The review pointed out that this differed from the RAWP cross boundary flow

adjustment: the adjustment is based on agreed costs for planned (or forecast flows) and made to actual allocations rather than on estimated national average costs for past flows to targets.

The imposition of barriers to treatment or unilateral cross charging has been criticised by the National Association of Health Authorities¹² and two committees of the British Medical Association.¹³ In a recent parliamentary answer the Minister for Health, noted that an individual health authority has power neither to impose charges on residents from other districts nor to refuse access to services where no payment has been made.¹⁴ This would make life difficult for districts that were above target to develop new services. But should these difficulties be resolved by unilateral imposition of cross charging?

IMPLICATIONS OF CROSS CHARGING FOR NEW DEVELOPMENTS

The view that a district ought to be able to develop a service for other districts and impose charges means that the "participation" by these districts in the decision about their residents' use of this service is really a form of moral blackmail. Districts know nothing until the service has been developed, general practitioners have referred patients, and the districts are faced with the choice of extra charges or the patient not being treated. Why should priority be given to the problems of a district that has developed a service without regard to the problems caused for other districts which then have to finance that development? For districts above their targets these problems only add to and complicate the painful decisions of where cuts have to be made. For districts below their targets these problems may make the struggle to develop less glamorous, basic local services even harder.

It may be argued that priority should be given to the district developing the new service because the costs of development are concentrated in that district but use would be shared between many districts. To establish this as a principle of finance, however, could open the floodgates for new developments in all districts, with massive additional costs to be borne as a consequence of each district's residents using a vast range of new services. There would also be intense argument over whether a service was really "new" or merely a modified "old" service—for example, lithotripsy would be a new service, but would percutaneous surgery also be classified as new? It would be most peculiar to justify cross charging solely on grounds of novelty. Why should a "new" service be given higher priority than expansion of a treatment well proved to be cost effective. And if expansion merits immediate recognition why not also immediately recognise all services provided for other districts? But this would mean a modified version of Enthoven's proposal and require bringing districts' allocations immediately to their target levels.

Health authorities are expected to decide priorities for their populations' fair share of a cash limit. Authorities are not entitled to claim increased allocations on grounds of reasonable costs of the number of patients treated. Yet means are sought to increase allocations on those grounds provided that the cases come from other districts. But, as an inflow to one authority is an outflow from another, protecting the inflows to one authority also means depriving those authorities which provide these cases the power to decide whether those expenditures are indeed a priority. The problem for districts that are above target with new developments ought to be seen to be one of reaching agreement in advance that these services should be financed from those other authorities for which the service is to be provided. This is difficult because these authorities may not want the service, and managers may be unaware of or unable to stop clinical development in a district. But where that is so the problem is one for that district and ought not to be exported to other districts by cross charging.

Conclusion

Enthoven proposed a coherent way of handling cross boundary flows.¹⁰ General practitioners should have contracts with districts,

which in turn would negotiate arrangements for cross charging. This would, however, mean districts imposing barriers to treating patients referred by general practitioners. Cross charging with freedom of referral by general practitioners is an incoherent policy.^{15 16} Enthusiasm for it can result only from a curiously one sided view of cross boundary flows. A district is keen to get immediate credit for inflows, but what is to happen if outflows are also immediately debited?

Existing policy is that general practitioners have a free choice of referral of patients; that the consequential patient flows are reflected in targets; that policy decisions are then made about how to adjust allocations in the light of movement towards targets; and that districts may also agree adjustments for new services by cross charging. This policy is coherent and the last additional refinement has the implication that a district developing a service for residents of other districts requires agreements in advance if charges are to be levied immediately the service starts.

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30 YEARS AGO

To put it another way, it does not require a great deal of skill to keep on the right side of the G.M.C. fence: at least, so it would seem to me. But medical ethics should go deeper than this. Anyone who writes medical articles for the newspaper and periodical Press on disease should always ask himself what is likely to be the effect on the reader's mind of what he writes. Articles on disease will often tend to stir up fear or to raise false hopes. I think that articles on disease should be written much more with a view to illustrating principles of medical science, and that the bandying about of words like "wonder drugs" does untold harm. But doctors have a duty to keep the public informed about health, hygiene, and preventive medicine. The Press can and does play a valuable part in encouraging by timely articles immunization campaigns against, for example, diphtheria and poliomyelitis. There can be no infringement of conventional medical ethics if doctors attach their names to articles on such subjects in the lay—that is, non-medical—Press.

[Dr H A Clegg in *Medical Ethics*. London: Lloyd-Luke (Medical Books) Ltd, 1958.]

(*British Medical Journal* 1958;i:343.)