# Why don't rural areas get their fair share of health funding?

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# Outline

- The NHS: Two equity principles
- Which definition drives the distribution of NHS resources?
- Which definition *should* the NHS prioritise? Moral, evidence-based & technical objections to extra-welfarism
- 2010 and beyond

# The NHS: Two equity principles

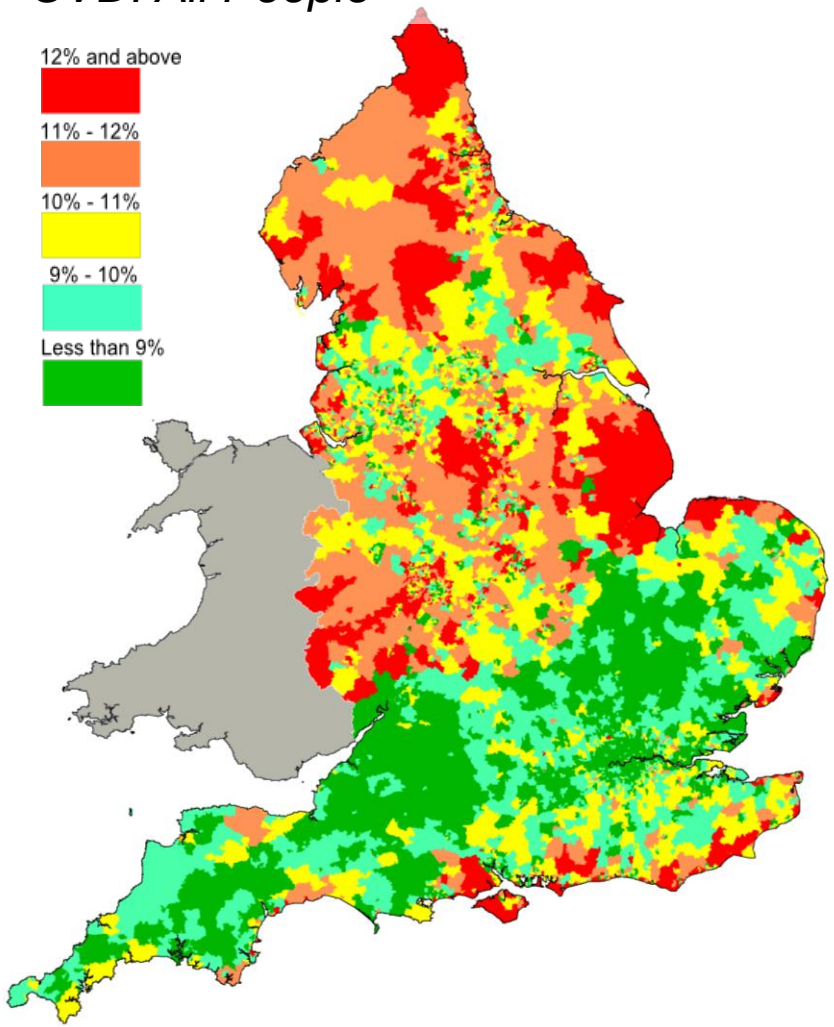
- *Health care equity*: health care resources should be geographically distributed to ensure 'equal opportunity of access to health care for people at equal risk'
- *Health equity*: resource allocation should 'contribute to the reduction of avoidable inequalities in health'
- Are the two principles reconcilable?
- Which one should – and does – the NHS prioritise?

## Health Care Equity:

- Distribution of funding should reflect the existing burden of disease

- The health communities grappling with the highest burdens of chronic illness, disability & mortality in *crude* terms serve the most ageing areas (rural dimension)

*Prevalence of Self-Reported CVD: All People*

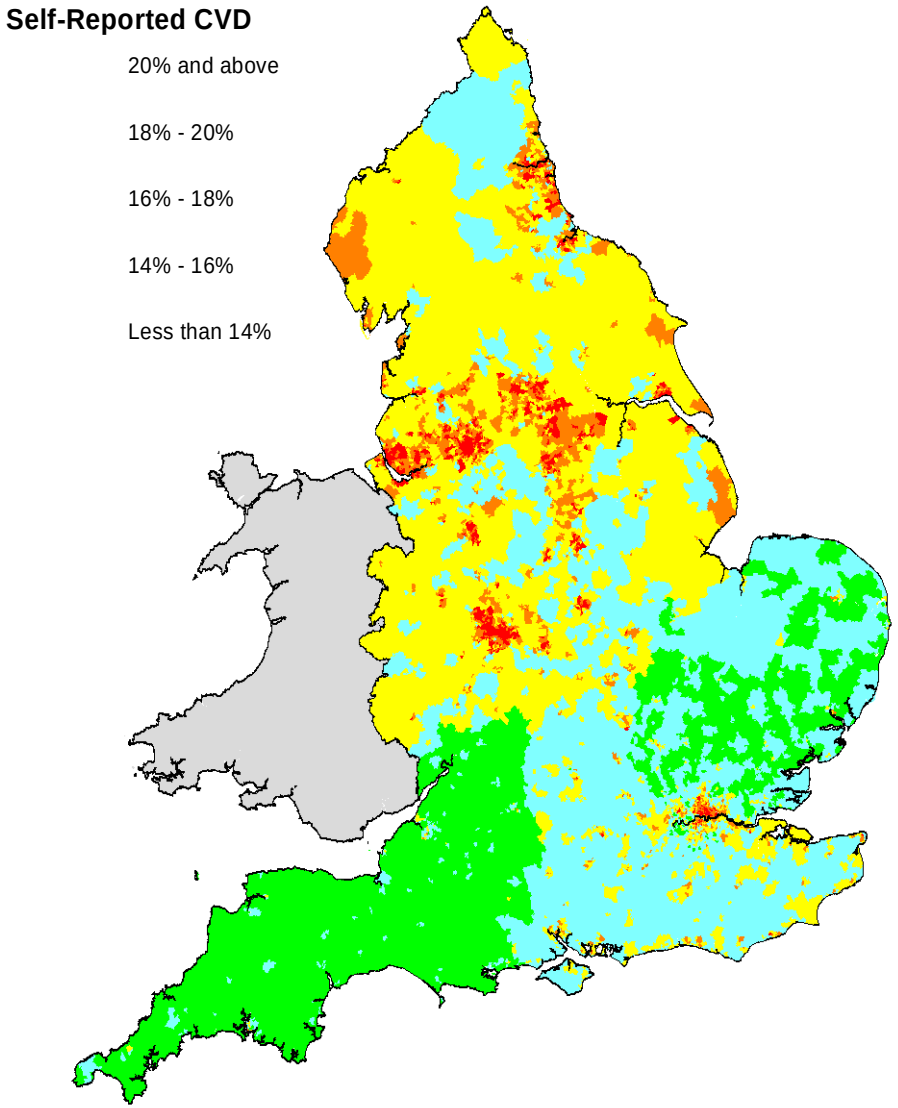


# Health Equity

- Funding should be targeted so as to reduce the health gap between the most and least advantaged areas in *age-adjusted* or *age-standardised* terms

- The health communities grappling with the 'worst' health are deprived urban and declining industrial areas

*CVD Prevalence, Males, 45-64*



- The widespread perception that urban deprived areas have the highest ‘needs’ for NHS services – and have been systematically underfunded – needs to be qualified
- Data interpretation issues
  - Which equity definition is being used?
  - Standardised vs unadjusted measures
  - Inverse correlation between deprivation & demography
  - Distribution of ‘needs’ for health care equity and health care varies

# Which definition drives the distribution of NHS resources?

# Mortality, morbidity and allocations for PCTs with the youngest and oldest demographies, 2010-11

| *Primary care trust* | *%pop >75* | *Average Deprivation Score (IMD2010)* | *All Cause Standardised Mortality Ratio (SMR)* | *Crude Mortality Rate (per 100k)* | | | *% GP patients on cancer register* | *Cancer spend per cancer patient* | *Per Capita Allocation (2010-11)* |
|---|---|---|---|---|---|---|---|---|---|
| | | | | *All Cause* | *Cancer* | *Circulatory Disease* | | | |
| Dorset PCT | 12.7% | 14.6 | 84.5 | 1,159.1 | 334.0 | 399.4 | 2.49% | £4,075 | £1,560.50 |
| Hastings and Rother PCT | 12.1% | 26.8 | 98.5 | 1,275.8 | 374.5 | 486.0 | 2.01% | £6,282 | £1,836.98 |
| East Sussex Downs & Weald PCT | 11.9% | 16.7 | 88.1 | 1,210.4 | 310.8 | 456.1 | 2.08% | £5,784 | £1,603.68 |
| Torbay Care Trust | 11.7% | 26.8 | 97.4 | 1,281.7 | 341.2 | 432.9 | 2.07% | £5,000 | £1,747.03 |
| :: | :: | :: | :: | :: | :: | :: | :: | :: | :: |
| City and Hackney Teaching PCT | 3.9% | 41.3 | 97.3 | 494.1 | 138.6 | 168.2 | 0.91% | £9,996 | £2,235.39 |
| Camden PCT | 3.8% | 25.4 | 93.6 | 480.1 | 146.7 | 154.2 | 1.16% | £15,890 | £1,881.29 |
| Newham PCT | 3.5% | 41.8 | 114.5 | 539.7 | 148.4 | 187.6 | 0.62% | £11,080 | £2,116.47 |
| Tower Hamlets PCT | 3.4% | 39.6 | 109.7 | 441.4 | 136.6 | 146.6 | 0.77% | £13,087 | £2,084.35 |

| Practices by deprivation (IMD2004) and demography (% patients 65+): | Patients per GP | 2006/07 Practice-level QOF Prevalence Rates per GP | | | | | |
|---|---|---|---|---|---|---|---|
| | | CHD | Stroke & TIA | Hyper-tension | Diabetes | COPD | Hypo-thyroidism |
| Oldest & most deprived practices (n=173) | 1,783 | 91.0 | 39.3 | 283.6 | 76.2 | 37.2 | 57.9 |
| Oldest and least deprived (n=422) | 1,684 | 70.2 | 35.4 | 250.9 | 61.6 | 22.6 | 52.7 |
| Youngest and most deprived (n=558) | 2,003 | 39.1 | 16.2 | 163.2 | 68.7 | 18.5 | 25.6 |
| Youngest and least deprived (n=169) | 1,935 | 37.7 | 17.3 | 164.5 | 49.7 | 15.7 | 38.3 |

| | 2006/07 Practice-level QOF Prevalence Rates per GP | | | | | |
|---|---|---|---|---|---|---|
| | Cancer | Mental Health Illness | Asthma | Dementia | Chronic Kidney Disease | Obesity |
| Oldest & most deprived practices (n=173) | 20.8 | 12.3 | 105.5 | 8.9 | 55.0 | 149.5 |
| Oldest and least deprived (n=422) | 21.3 | 10.1 | 99.8 | 9.0 | 52.7 | 109.9 |
| Youngest and most deprived (n=558) | 9.6 | 18.8 | 95.3 | 3.9 | 24.0 | 133.5 |
| Youngest and least deprived (n=169) | 12.4 | 10.2 | 107.2 | 4.3 | 28.5 | 124.5 |

# Which definition *should* the NHS prioritise?

- Extra-welfarism: claims that the objective of achieving *health equity* is more 'ethical' than the goal of achieving health *care* equity
- Domination of health economists in the debate (e.g. see Williams (Fair Innings); Culyer (QALYs)
- Moral, evidence-based & technical objections

# Moral objections

- How can we reconcile the goal of vertical equity with institutionalised ageism?
- E.g. cancer. UK's relatively poor performance largely accounted for by poor outcomes in the elderly
- Hospitals with the poorest funding contexts & oldest catchment populations have significantly higher standardised hospital mortality (and significantly lower numbers of staff)

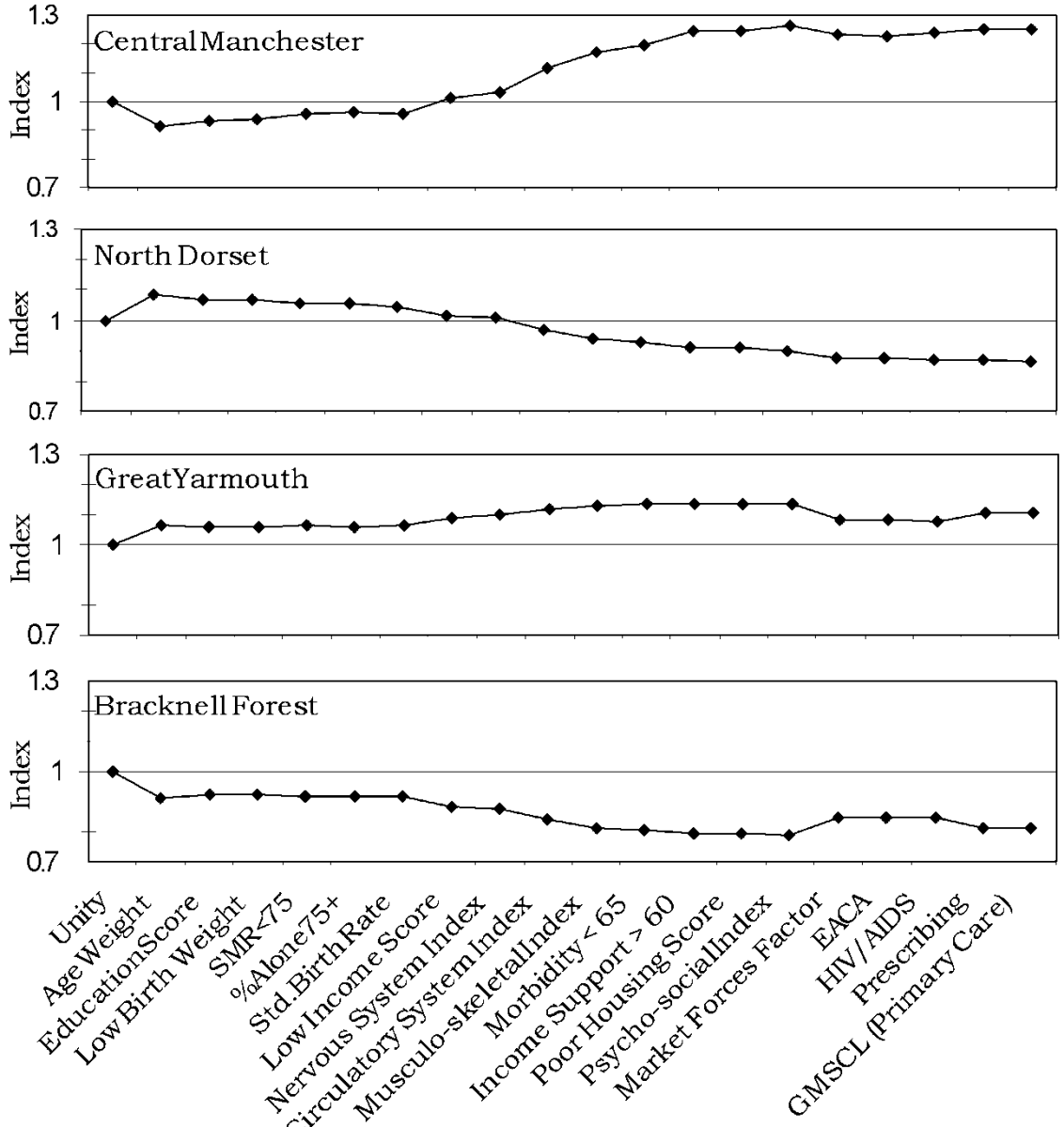
# Evidence-based objections

- *Can* the NHS play a significant role in addressing health inequalities?
- Some preventive interventions are effective – but they are also very CHEAP!
- Most of the factors associated with health inequalities have little to do with the delivery and distribution of *health care* (guesstimates suggest 12-20% impact)
- Justification of additional funding due to inverse care law – evidence is highly equivocal

# Technical objections

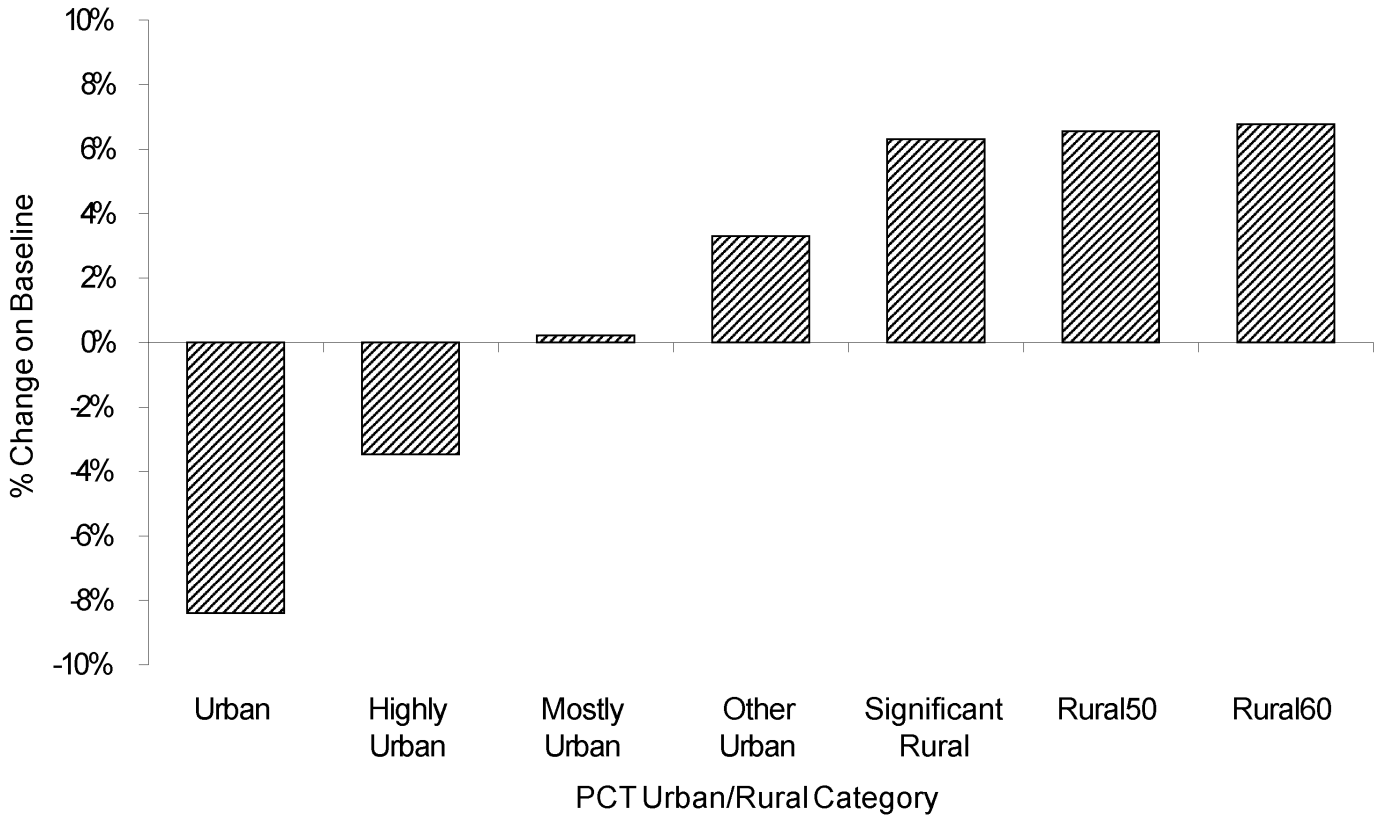
- The current distribution of funding owes much to the HIGHLY flawed 'AREA' formula that was introduced in 2002 and which guided allocations until 2009
- Two-step procedure used to model age-related and additional needs (deprivation) effects, the latter effectively cancelling the former out
- PCTs with more ageing populations would usually have been better off if there were no weightings at all!

# Sequentially Incorporated factors in the AREA Capitation Formula



- CARAN review (2007)
- Acknowledged shortcomings of AREA and would have resulted in a very significant redistribution of revenue income *away* from the most deprived urban PCTs and *towards* rural areas

# 'Needs Only' CARAN Allocations relative to AREA-based Baseline Allocations; by Urban/Rural Category



- Fudge through introduction of the new Health Inequalities (HI) Adjustment *(*set at 15% to maintain the *status quo)*
- 10 most deprived PCTs: £1417 per capita (needs based formula); £365 per capita (HI formula). 10 least deprived PCTs: £1152 and £77 respectively (2009-10)

# 2010 and beyond

- HI adjustment reduced, changing pattern of under- and over-target PCTs
- Lansley's proposal that the CCG formula should better reflect the relative influence of age and deprivation on health care needs widely lambasted
- ACRA remains responsible for overseeing allocations and ACRA remains committed to the *empirical approach* (regression modelling of utilisation data) despite its limitations

- Formula proposed by ACRA in 2012 *would* have benefitted demographically older rural areas
- Rejected by NHS Commissioning Board because this goes against the health equity principle (i.e. shifting resources from areas with worse to better health outcomes)
- Signs of some willingness to make an adjustment for *additional* costs of providing services in rural areas (peanuts compared to the needs element of the formula!!)

- Consultation (NHS England) September 2013 – outcome still awaited
- Darzi review recommendations (to shift the allocation of GP resources further towards deprived areas) are still on the table
- Strong ideological opposition to taking resources away from deprived areas – which makes fairer funding politically difficult