

EXECUTIVE SUMMARY

REPORT OF A STATISTICAL ANALYSIS FOR AN EQUALITY IMPACT ASSESSMENT OF THE UK GMS RESOURCE ALLOCATION FORMULA

Allocation formula

1. Resources to enable GP practices to provide for the delivery of “essential” and “additional” services to patients, cover staff costs and provide for career development and protected time will, in future, be allocated to practices through a “global sum”. The allocation of this sum to practices will be determined by means of an allocation formula which takes account of six key determinants of practice workload and circumstances:
 - i. patient gender and age for frequency and length of surgery and home visits;
 - ii. patient gender and age for nursing and residential home consultations. The research which lies behind this formula shows these to be an average of 1.43 times higher than (i) by age and gender;
 - iii. morbidity and mortality;
 - iv. newly registered patients, who generate around 40% more workload in the first year than the average;

- v. unavoidable costs of rurality, to take account of population density and dispersion; and
 - vi. unavoidable higher costs through a Market Forces Factor applied to all practice staff.
2. During negotiations on the new contract, it was recognised that the key determinant factors in the proposed formula could differ if available Northern Ireland data was used and it was agreed that refinements to the formula could be introduced in Northern Ireland in the light of statutory equality impact assessments under section 75 of the Northern Ireland Act 1998. A working group tested each element of the workload formula against Northern Ireland equality legislation and recommended evidence-based refinements where deemed necessary to avoid or minimise adverse impact across any of the 9 equality dimensions specified in Section 75.

Results

3. The work and findings in each element of the allocation formula are summarised as follows:
 - **Age/gender workload (Chapter 6 of the report).** For both males and females the UK weights are higher than NI for those aged 0 – 4 but the NI weights are steeper through adulthood. As far as females are concerned, the steeper curve during childbearing years reflects the higher birth rate in Northern Ireland and,

therefore, better reflects NI need. This is because the estimate used in the NI weighting is based on actual surgery consultations and better reflects the relative workload generated by each age group whereas the UK figure is based on file openings which has little bearing on the estimate of length of consultation and associated workload impact of this age group.

Like GB, the NI curve results in differentials mainly in age, religious belief and people with/without dependants. Resources are more appropriately skewed to the elderly as opposed to children, (and consequently to Protestants in comparison with Roman Catholics and to people without dependant children compared to those with such children). These impacts are justifiable. Protestants and those without dependant children will tend to have an older age structure. Given that the intention is to skew resources towards needs and that higher needs are associated with elderly populations, the application of NI data in the formula's workload curve provides for a more equitable distribution for Northern Ireland. It is therefore recommended that, on equality grounds, the NI workload curve should be adopted as the age gender adjustment for the allocation formula.

- **Additional needs adjustment (Chapter 7 of the report).** As well as the impact on practice workload generated by differing age and gender groups, any

weighted formula also needs to reflect differential relative need for medical services associated with for example different levels of morbidity or socio-economic conditions.

Both the UK additional needs index and the NI index result in differential impacts over a number of equality dimensions. The impact of both indices is to skew resources towards children (compared to the elderly), Roman Catholics (compared to Protestants) and single people compared to those who are married. Likewise resources are skewed towards those in receipt of health-related benefits compared to those who are not, and those self-reporting an illness or disability benefit over those without an illness or disability. Again, these differentials are all justifiable given that the index is designed to direct resources to practice populations most in need as demonstrated by higher levels of morbidity and/or poorer socio-economic circumstances. The relative skewing of resources is, however, more pronounced when using the Northern Ireland index thus providing for a more equitable and needs-sensitive distribution of resources. It is recommended that the NI index should be used in the allocation formula.

- **Rurality and diseconomies of scale (Chapter 8 of the report).** Rurality and remoteness are likely to be important factors influencing the costs of providing GP

services and the aim of this adjustment is to skew resources to practices in rural areas to allow them to provide the same level of services as an urban GP.

Both the UK and NI indices skew resources in this manner, however, more people gain under the NI Rurality Index (51%) as under the UK index where 45% gain, albeit by larger amounts. Given that the NI index is based on local data, it would suggest that this is a more equitable distribution for Northern Ireland and since it spreads resources across more practices it is considered to better promote equality.

- **Nursing and residential home (Chapter 9 of report).**

Northern Ireland data was well represented in the surveys used to inform the work on the UK formula and it was considered that the local data would not have been sufficiently robust on its own to derive an adjustment. It is recommended, therefore, that the UK adjustment for nursing and residential homes should continue to be adopted within the Northern Ireland formula.

- **Newly registered patients (Chapter 9 of the report).**

Areas with a high list turnover often have higher workloads, as newly registered patients tend to have more consultations in their first year of registration. A Northern Ireland data source was not available to estimate this factor and the group was content with the

UK data source and method used to derive the additional workload factor in the UK formula. It is recommended, therefore, that the UK adjustments be adopted within Northern Ireland.

- **Market forces factor (Chapter 9 of the report).** This component recognises the potential geographical variation in staff costs that practices will incur and a market forces factor adjustment is used to compensate for this in the UK formula. It is proposed to apply the UK weightings in the NI formula for 2004-05 but the Department will wish to subject the inclusion of the factor here to further research in the course of next year.